List of Policies and Procedures for JCC Review 8-18-26

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	
New	LHHPP	TBD	Airborne Transmissible Disease Control Plan	**W. Spaul** **J. Francis**	New policy.
Revised	LHHPP	01-01	Approval and Format of Hospital-wide and Departmental Policies and Procedures	**N. Zahir**	1. Replaced "San Francisco Health Network (SFHN) internet website" with "policy and procedure management system " 2. Deleted "request for the Word document of the LHHPP being revised from the Administrative designee. " 3. Added "inform the Administrative designee of revisions and will make edits to the policy in the policy and procedure management system" 4. Added "in the policy and procedure management system" 5. Replaced "posted on the intranet" with "published on the policy and procedure management system" 6. Replaced "LHH and SFHN Intranet", "webpage" and "SFHN website" with "policy and procedure management system" 7. Deleted "to transform" 8. Added "moving" 9. Deleted "Infection control guidelines;" 10. Deleted "an soon as practical"
Revised	LHHPP	01-10	Departmental Responsibility and Accountability	**N. Zahir**	1. Deleted "/service" and "/services" 2. Replaced "intranet" with "policy and procedure management system"
Revised	LHHPP	01-11	Standard Formatting Template for Policies and Procedures	**N. Zahir**	1. Added "facility-wide and departmental" 2. Deleted "(LHHPP)" 3. Updated the "Page Set-up" section 4. Removed the "Headers and Footers" section 5. Added "Policy" to "title" in section 2 and removed parts a.i-a.iv 6. Replaced "LHHPP" with "policy and procedure" 7. Deleted Body Content section 8. Deleted the "Dates: New, Revised, Reviewed and Original Adoption " section 9. Added the "Dates: Origination, Last Approved, Effective, Last Revised and Next Review" section 10. Deleted the " Finalizing the Document" section
Revised	LHHPP	20-06	Out on Pass	**N. Zahir**	1. Changed "The Facility" to "LHH" 2. Changed "their attending" to "a LHH" 3. Deleted "Admissins & Eligibility (A&E) and" 4. Deleted "Surrogate Decision Maker (SDM) or representative" 5. Added "If and when possible, the resident and/or SDM shall provide" 6. Replaced "2" with "1" 7. Deleted "new" 8. Replaced "for up to 90 days" with "until the next quarterly RCC" 9. Added "and should be re-evaluated at the time of the next scheduled quarterly RCC" 10. Deleted "for each request" 11. Added "and/or SDM" in various places 12. Deleted "Determine when education will be provided" 13. Deleted "Notes: A new RCT is valid for up to 90 days for a given type of leave of absence request if all parameters are exactly the same. A new RCT meeting is needed if ANY of the parameters above is different or if a change in condition. (For example, if a resident returned from last OOP with concerning medical condition, behaviors, or contraband.)" 14. Added "shall be provided", "the", and "or representative" 15. Replaced "Coordinator" with "Clerk" 16. Added "Clerk shall inform the LHH physician for a discharge order and then the Licensed Nurse/Unit Clerk" 17. Added "in the Unit Manager" 18. Deleted "to participate in and comply with the procedure" 19. Added "if and only if consent is provided"
Revised	LHHPP	70-01 A1	Emergency Preparedness Committee	**N. Zahir**	1. Replaced "neighborhood" with "unit" 2. Replaced "respective departmets or neigborhoods" with "their respective areas" 3. Replaced "The Committee" with "EPC" 4. Added "no less than quarterly" 5. Replaced "and when approved at the subsequent meeting submitted to the Hospital Executive Committee" with "and approved at the subsequent meeting." 6. Replaced "Emergency Preparedness Committee" with "EPC" 7. Removed "Department Manager" in several places. 8. Added "department or unit staff", "guide", "(HVA)" and "annual" 9. Deleted "Approved for renumbering to 70-01 Section A, B, and C: 18/02/23"

Revised	LHHPP	70-01 A2	Emergency Preparedness	**N. Zahir**	1. Added "CCSF" in various places 2. Added "DSWs may also" 3. Deleted "disaster service workers" 4. Added "of thei staff" 5. Added "LHH new employee" and "(NEO)" 6. Added "through the Department of Education and Training (DET)" 7. Added "coordinated through the Emergency Preparedness Committee (EPC)" 8. Deleted "Training and department specific goals emphasize continuous home preparedness development and maintenance." 9. Added "staff from Social Services." 10. Replaced "neighborhood" with "unit" 11. Added "through EPC " 12. Added "Food and" and "policy and procedure" 13. Replaced "to protect patient safe and healthy" with "are maintained for resident wellbeing."
Revised	LHHPP	70-01 A3	Emergency Resources and Maps	**N. Zahir**	1. Added "Nursing Home Incident Command System (N" 2. Updated staff list 3. Added "DON" 4. Deleted "WSEM" 5. Replaced "COO" with "ANHA"
Revised	LHHPP	70-01 B1	Emergency Response Plan	**N. Zahir**	1. Added "San Francsico" 2. Added "/Nursing Home Administrator " and "NHA" throughout the document 3. Deleted "Acting" 4. Deleted "Chief Nursing Officer (CNO)" 5. Added "/ Medical Director " 6. Added "Chief Quality Officer (CQO)" 7. Deleted "we shall serve" 8. Updated phone numbers 9. Replaced "Sheriff" with "San Francisco Sheriff's Office (SFSO)" 10. Deleted "according to their Departmental Procedure"
Revised	LHHPP	70-01 B2	Continuity of Operations Plan	**N. Zahir**	1. Added "(CCSF)" and "Department of Public Health's (DPH)" 2. Changed "14" to "13"for units and "60" to "50" for beds 3. Added "services" and "food and nutrition services" 4. Deleted "meal service and nutrition consultation" 5. Added "and Nutrition" 6. Added "the Nursing Home Incident Command System" 7. Added "/Nursing Home Administrator " to CEO throughout the document 8. Replaced "Chief Nursing Officer (CNO)" with "Director of Nursing (DON)" 9. Added "/Medical Director " to Chief Medical Officer" 10. Replaced "Chief Operations Officer (COO)" with "Assistant Nursing Home Administrator (ANHA)" 11. Replaced "Quality Management Director" with "Chief Quality Officer (CQO)" 12. Added "Operations" 13. Replaced "Operations Nurse Manager" with "Nursing Operations Supervisor" 14. Replaced "QM Director" with "DOCC Nurse Director" 15. Replaced "QM" with "DOCC"
Revised	LHHPP	70-01 B3	Resident Evacuation Plan	**N. Zahir**	1. Replaced "for" with "to the" 2. Deleted "the NHICS team" 3. Added "per" 4. Changed "neighborhoods" to "units" 5. Added "Nursing Home Administrator" and "/NHA" 6. Added "(ELM) through the Department of Education and Training (DET)" 7. Deleted "Workplace Safety and" 8. Replaced "apprised" with "notified" 9. Replaced "social worker" with "staff from Social Services"
Revised	LHHPP	70-01 B4	Requesting to Operate Under a CMS 1135 Waiver	**N. Zahir**	1. Replaced "Hospital" with "Nursing Home" 2. Added "(CQO)" and "(QM) 3. Replaced "hospital administration and the Chief Quality Officer" with "the Chief Executive Officer/Nursing Home Administrator and CQO"
Revised	LHHPP	70-01 C1	Fire Response Plan	**N. Zahir**	1. Added "the San Francisco Fire Department" 2. Replaced "SFSD" with "the San Francisco Sherrif's Office (SFSO)" 3. Deleted "WSEM" 4. Added "Emergency Management" 5. Added "Nursing Home Incident Command System (N" 6. Deleted "(Previously numbered as LHHPP 70 02)

Revised	LHHPP	70-01 C2	Spill Response Plan	**N. Zahir**	1. Deleted "The Spill Response Plan has been established" 2. Deleted "for you" 3. Deleted "you do not have" 4. Added "is not available" 5. Corrected phone numbers 6. Added "Facility Services " 7. Deleted "& Emergency Management (WSEM)" 8. Added "San Francisco Department of Public Health" 9. Added "San Francisco" and "(DPW)" 10. Deleted "Approved renumbering from 74 01 to 70 07: 15/01/13" 11. Deleted "Approved for renumbering to 70 01 Section A, B and C; 18/02/23"
Revised	LHHPP	70-01 C3	Earthquake Response Plan	**N. Zahir**	1. Added "Staff are to ensure the safety of all persons and continue providing quality care to the residents and patients." 2. Deleted "Ensure Safety of all Persons and Continue Quality Care of Residents" 3. Changed "neighborhoods" to "units" 4. Updated fax to "628-754-4671" 5. Added "as outline"
Revised	LHHPP	70-01 C4	Laguna Honda Hospital Medical Surge Plan for Nursing Home Incident Command Activation Due to Public Health Emergency / Mass Casualty Event	**N. Zahir**	1. Replaced "care of LHH residents" with "safety and wellbeing of the residents at LHH" 2. Replaced "Chief Nursing Officer (CNO)" with "Director of Nursing (DON)" 3. Replaced "SF" with "San Francisco"
Revised	LHHPP	70-01 C5	Emergency Responder Antibiotic Dispensing Plan	**N. Zahir**	1. Added "Hospital and Rehabilitation Center (LHH)" 2. Replaced "Laguna Honda" with "LHH" in various places 3. Updated contacts and information in coordinator table. 4. Replaced "Executive Administrator" with "Chief Executive Officer/Nursing Home Administrator (CEO/NHA)" 5. Replaced "Administrator" with "CEO/NHA or AOD" 6. Added "for NHICS operations" 7. Added "Services" 8. Replaced "Education" with "Department of Education and Training (DET)"
Revised	LHHPP	70-01 C6	Pandemic Respiratory Illness Plan	**N. Zahir**	1. Made minor text corrections 2. Changed "Infection Control and Prevention (ICP)" to "Infection Prevention and Control (IPC)" 3. Changed "(ICP)" to "(IPC)" in various places 4. Added "/Nursing Home Administrator " 5. Added "/NHA" to :CEO" in various places 6. Replaced "Infection Control Nurse" with "IPC staff" 7. Replaced "event. Links to those documents are included below as attachments 1 and 2." with "outbreak" 8. Deleted "Approved for renumbering from 72-06 to 70-08: 15/01/13" 9. Deleted "Approved for renumbering to 70-01 Section A, B, and C: 18/02/23"
Revised	LHHPP	70-01 C7	Power Outage Response Plan	**N. Zahir**	1. Added "LHH" 2 Added "facility" 3. Deleted "Ensure Safety of all Persons and Continue Quality Care of Residents" 4. Added "Staff shall ensure the safety of all persons and continue to provide quality care to the residents of LHH" 5. Changed "neighborhood" to "unit" 6. Updated fax to "628-754-4671" 7. Changed "Watch engineer" to "The Facility Services Watch Engineer"
Revised	LHHPP	70-01 C8	Water Disruption Plan	**N. Zahir**	1. Added "and Rehabilitation Center (LHH)" 2. Added "CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities1. Added "LHH" 2 Added "Chief Executive Officer/Nursing Home Administrator (CEO/NHA)" 3. Updated phone numbers 4. Added "CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities"
Revised	LHHPP	70-01 C9	Heat Emergency Plan	**N. Zahir**	1. Updated title to "Heat Emergency and Heat Illness Prevention Plan: Indoor and Outdoor Heat Stress Conditions" 2. Added "To comply with California Department of Industrial Relations Indoor Heat Stress Program Section 3396 and the Outdoor Heat Stress Standard 3395, both of which require that a heat illness prevention plan be developed." 3. Added Definitions 4. Updated "Recognizing a Heat Emergency" section to be in accordance with Cal OSHA" 5. Added section for "When the Indoor Temperature reaches 87 F or higher" 6. Added Training section.

Revised	LHHPP	70-01 C10	Code Silver – Active Shooter	**N. Zahir**	1. Updated phone numbers 2. Changed "The Sheriff's Office" to "SFSO" 3. Replaced "Executive Administrator" with "Administrator Chief Executive Officer/Nursing Home Administrator (CEO/NHA)" 4. Added "the Nursing Home Incident Command System " 5. Removed "Approved for renumbering to 70 01 Section A, B, and C: 18/02/23
Revised	LHHPP	70-01 C11	Laguna Honda Hospital MDF/IDF Support	**N. Zahir**	1. Changed title to "Laguna Honda Hospital Main/Intermediate Distribution Frame Support – Facility Services 2. Added "Facility Services" 3. Added "Facility Services Watch" 4. Added "Administrator on Duty"
Revised	Nursing	C 3.0	Documentation of Resident Care by LN	**C. Figlietti**	1. Added section for Weekly Summary documentation 2. Added to ADL section "The Licensed Nurse, in collaboration with the resident care team develops a plan of care to meet the resident's/patient's needs, while promoting as much functional independence as possible."
Revised	Nursing	C 3.2	Documentation of Resident Care by NA	**C. Figlietti**	1. Revised policy #4 to state "Nursing assistant notifies the charge nurse or the licensed nurse and documents change in condition and notification in the Notes section of EHR." 2. Updated to reflect current documentation on EPIC 3. Removed Introduction section, which explains how EPIC works 4. Referring to the following nursing policies for details in documentation - G 1.0 Vital Signs - G 3.0 Intake and Output - G 4.0 Measuring the Resident's Height - G 7.0 Obtaining, Recording, and Evaluating Resident Weight 5. Added details to Daily Cares Activity section per current practice 6. Added "Restorative Nursing Programs: Do NOT document restorative minutes unless the resident is receiving Restorative care for range of motion. Note: Restorative Care Flowsheet tab (within the Flowsheet Activity) is for Restorative Nursing Assistants." 7. Removed sections on Flowsheet Activity tab (repetitive), and Restorative Interventions (this is addressed in Daily Cares section)
Revised	Nursing	D3 1.0	Oral Hygiene	**C. Figlietti**	Removed Home Health Aides
Revised	Nursing	D6 1.1	Battery Operated Lift Transfer C-625 EZ Way	**C. Figlietti**	1. Revised policy 5 to state "For residents demonstrating aggressive behavior, unable or unwilling to follow directions, or has other conditions that might place resident and/or staff at risk, ask for additional nursing staff assistance and/or do not proceed with transfer util resident is calm." 2. Added to turn off lift when not in use 3. Added to refer to sling tags for weight capacity 4. Removed contents on lift operation (as this is addressed in appendix 3: operating the battery-operated lifts) – referred it to the appendix 5. Removed contents on sling application and referred this to appendix 2: Sling Application
Revised	Nursing	D6-01.1_Appendix2	Sling Application	**C. Figlietti**	1. Combined Seated U Shape of Mesh Sling and Seated U Shaped Padding Slings (they are the same) 2. Added Align top of sling with top of the shoulders and top of "U" shape at the base of the sling at the tailbone. When applying sling under resident, ensure the resident is positioned in the middle of the sling." to low back and seated slings
Revised	Nursing	D6-01.1_Appendix3	Operating the Battery-Operated Lifts (Ceiling & EZ)	**C. Figlietti**	1. Removed "The straps on each side of the sling are generally attached to the corresponding side of the carry bar." They are usually crossed over and this is already addressed in Appendix 2
Revised	Nursing	F 2.0	Assessment and Management of Urinary Incontinence	**C. Figlietti**	1. Updated continence assessment to reflect how it is currently completed based upon current EPIC documentation and CMS regulations and requirements 2. Changed "Cactus Sheet/Bladder Diary" to "Continence Status" 3. Removed details on CAA and referred to CMS RAI Version 3.0 2025
Revised	Nursing	F-02.0_Appendix1	Continence Assessment Cactus Sheet Bladder Diary	**C. Figlietti**	This is no longer used

Revised	Nursing	F 3.0	Assessment and Management of Bowel Function	**C. Figlietti**	1. Added policy statement: "Registered Nurse shall assess, document and monitor bowel function upon admission within 7 days, quarterly, annually and when a significant change occurs as part of MDS/RAI process." 2. Added monitoring and documenting of bowel movements every shift by nursing assistant to policy. 3. Added "Licensed Nurse shall administer prn laxatives and/or stool softeners per physician bowel regiment, and monitor and document effects. If ineffective, notify physician for further orders." 4. For procedure section, referred to Elsevier for procedures on - Fecal Impaction Removal - Use of Enema 5. Referred to manufacturer's instructions for use of rectal tube
Revised	Nursing	F 7.0	Replacement and Care Management of an Existing Suprapubic	**C. Figlietti**	1. Reorganized policies and prioritized "Initial replacement of a suprapubic (SP) catheter is performed by a physician. Thereafter, a registered nurse (RN) may replace the existing SP catheter with a physician order specifying the size of catheter, catheter type, balloon volume, type of dressing (if any), and indication for the catheter." 2. New policies: - Drainage bags will be changed based on clinical indication such as infection, obstruction, or when the closed system is compromised - Intake and output will be measured every shift for residents with a suprapubic catheter 3. PCAs no longer have access to document urine color, appearance, and odor. This needs to be documented by the LN 4. Updated equipment for replacement of existing suprapubic catheters according to current LHH supplies 5. Updated care and replacement of catheters based on Elsevier and manufacturer recommendation for current supplies 6. Updated Documentation to reflect EPIC
Revised	Nursing	J 1.1	Obtain Handle Store Meds	**C. Figlietti**	1. Updated section on Obtaining Medication from Pharmacy according to current practice to include "Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room." 2. Added details for Pass Medications (Short Term Medications) to include reference to Pharmacy P&P 02.01.04, details on relabeling of bulk medication for pass medications, and for licensed nurse to review directions and check the number and appearance of the drug with the resident or responsible person 3. Labeling Medications section: Added details for relabeling medications that are already dispensed, and pharmacy coordination for medications removed during off pharmacy hours. 4. For Medication Cart section: added details on separation of medications for different routes and the storage of topical medications for skin conditions in a separate drawer for med cart. 5. Referred to Standard Work on LHH Nursing Process to Prevent Expired Mediation on Units and Reaching Patients 6. Added labeling of irrigation solutions with date/time opened and nurse's initials 7. Medication Refrigerator: Referred to NPP D9 9.0 Maintaining Tep of Med and Nourishment Refrigerators/Freezers via Temptrak Cleanliness of Refrigerators) 8. Added details to handling of Liquid Medications (e.g., calibrated medicine cup, oral syringes, etc) 9. Added to Hazardous Medications section "Instructions for administering the medication can be found in administration instructions on the EHR Medication Administration Record (MAR) 10. Updated injectables section to reflect current practice re: expiration dates, storage, inspection, expiration of multiple packaged iv fluids, etc 11. Removed section on "Monthly Pharmacy Ward Survey" as this is not a nursing procedure
Revised	Nursing	J 6.0	IV Therapy Maintenance	**C. Figlietti**	1. Updated to mirror ZSFG P&P 2. Reorganized policy statements 3. Added to policy "5. Physician order is required for placement of PIVs in the foot or ankle, and have a maximum duration of 24 hours" – this is per ZSFG 4. Question: please verify if LHH RN's can remove extended dwell or midline PIV? 5. Moved preparation and labeling of IV fluids (currently in the Preparation for PIV insertion section) to Administering Medications section 6. Referred to Elsevier for PIV insertion procedure 7. Added to Administering Medications section the checking of physicians order and what needs to be included in the order (e.g., type of iv solution, etc) 8. Updated link to Pharmacy website 9. Updated Access and Maintenance of IV site to include details that mirror ZSFG and referenced from Elsevier (no changes to procedure here) 10. Updated section for IV Administration Set Changes to list details on labeling and include definitions, and include a chart for "Summary of Adult Fluids/Medications and Tubing Maintenance. 11. Updates Visual Infusion Phlebitis Scale (mirrors ZSFG)

Revised	Nursing	J 7.0	CVAD Management	**C. Figlietti**	1. Deleted Policy #3 stating "LVN may monitor infusions via CVAD…" 2. Added policy "For administration of parenteral nutrition, refer to Hospitalwide Policy & Procedure 25-08 Management of Parenteral Nutrition." 3. PPV changed routinely with dressing changes and IV tubing changes. 4. Procedure change: Dressing changes are changed every 4 days (currently states every 3 days), with the exception of PICC lines which are changed every 7 days. 5. Added activating Code Blue for CVAD accidentally expelled or broken 6. Updated Flushing section to "Accessing and Flushing" - Updated to reflect ZSFG and the "Accessing Bundle" 7. Removed section on discontinuation of CVAD, as only LHH physician can d/c CVAD 8. Revised Documentation section to reflect current practice and EPIC 9. Broke down procedure section to the following - Accessing, Flushing and IV Medication Administration - Blood Withdrawal - Dressing Change - Documentation
Revised	Nursing	J 7.1	PICC Management	**C. Figlietti**	1. Reorganized policies and moved PICC line management related policies to the PICC Management section 2. Removed outdated and broken links/references 3. Updated background section to reference Elsevier 4. Updated to reflect ZSFG and the "Accessing Bundle" 5. Broke down procedures to the following sections (reflecting ZSFG procedures) - Accessing PICC Line and Flushing Protocols - Administering Medications or Flush via PICC - PICC Dressing Change Procedure - Assessing Mid upper PICC Arm Circumference - Assessing the Need for Continued Use of PICC Line - Blood Withdrawal via PICC - Patient/Resident Education - Documentation
Revised	Nursing	K 10.0	Prevention and Management of Skin Tears	**C. Figlietti**	1. Kept Background section not just Skin Tear Categories according to the International Skin Tear Advisory Panel 2. Under Prevention section addressed exercising caution during care to prevent skin from catching onto objects 3. Added encouraging the use of protective clothing/devices and/or equipment 4. Added following physician's orders for skin tear treatment 5. Removed specifics for treatment of skin tears and added to follow physician's orders for skin tear treatment 6. Removed use of steri-strip as this is no longer a preferred treatment option of choice for skin tears

New Hospital-wide Policies and Procedures

AIRBORNE TRANSMISSIBLE DISEASE (ATD) CONTROL PLAN 2023

POLICY:

1. The controls required by the Occupational Safety and Health of California (Cal/OSHA) ATD standard (CCR Title 8, Sections 5199 and 5199.1) include infection control procedures such as providing surgical masks or other personal protective equipment (PPE) to symptomatic persons who enter the facility. It also outlines the use of airborne infection isolation rooms (AIIR) and PPE to protect employees against exposure to aerosolized infectious particles and droplets.

2. This Aerosol Transmissible Diseases Exposure Control Plan works in combination with the San Francisco Health Network Transmission Based Precautions, Tuberculosis (TB) Exposure Control Plan, Respiratory Hygiene, Hand Hygiene, and Disaster Preparedness policies.

PURPOSE:

1. This program is designed to:

    a. Help reduce exposure to aerosol transmissible pathogens (ATP).

    b. Identify infection control measures for ATDs and ATPs.

    c. Identify responsible personnel for implementation of the plan and methods for annual review of the plan with employees in accordance with Cal/OSHA Title 8 CCR Section 5199.

    d. Reduce and/or eliminate exposure to contaminants by engineering controls (i.e., general, and local exhaust ventilation, enclosure, or isolation), or substitution of a less hazardous process or material where feasible.

    e. Use of respiratory PPE will be required as a work practice control in addition to, or in the absence of engineering controls.

Note: For facilities with an existing ATD Control Plan, it is acceptable to have different assigned responsible parties or committees based on the organizational structure; however, each responsibility must have the individual Position and / or Committee clearly identified in the ATD Control Plan.

DEFINITONS:

3. **Aerosol Transmissible Disease (ATD) or aerosol transmissible pathogen (ATP):** A disease or pathogen for which droplet precautions or airborne isolation are recommended. An aerosol includes any particles or droplets suspended in air.

4. **Aerosol Transmissible Pathogen – laboratory (ATP-L):** A disease or pathogen for which droplet precautions or airborne isolation are required (appendices B and C).

5. **Air Change or Exchange** means replacement of the quantity of air contained by a room or enclosure with an equal quantity of fresh air or HEPA filtered air.

6. **Airborne Infection Isolation (AII):** Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

7. **Airborne Infection Isolation Room or area (AIIR):** A room, area, booth, tent, or other enclosure that is maintained at negative pressure to adjacent areas in order to control the spread of aerosolized *M. tuberculosis* and other airborne infectious pathogens and that meets the requirements stated in subsection (e)(5)(D) of this standard.

8. **Airborne Infectious Disease (AirID):** Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which AII is recommended by the Centers for Disease Control and Prevention (CDC) or California Department of Public Health (CDPH), or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

9. **Airborne Infectious Pathogen (AirIP**): Either: (1) an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent, and for which the CDC or CDPH recommends AII, or (2) a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that it is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

10. **Confirmed Infectious TB Case** means a person who has been diagnosed with pulmonary or laryngeal TB by positive smear or culture of *Mycobacterium tuberculosis* in respiratory secretions or tissue, unless medically determined to be non-infectious.

11. **Droplet precautions:** Infection control procedures, as described in CDC Guideline for Transmission-based Precautions, designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of

the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

12. **Employee** means any person employed by or under the supervision and control of the San Francisco Department of Public Health to include nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the Healthcare Facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care or congregate living setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, industrial hygiene, administrative, billing, and volunteer personnel).

13. **Exposure incident:** An event in which all of the following has occurred: (1) An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or to equipment that is reasonably expected to contain ATPs associated with a reportable ATD; and (2) The exposure occurred without the benefit of applicable exposure controls required by this section, and (3) It reasonably appears from circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

14. **Guideline for Isolation Precautions:** The Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007, CDC.

15. **Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings:** The Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 2005, CDC.

16. **Health care provider:** A physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

17. **Health care worker:** A person who works in a health care facility, service or operation.

18. **High Efficiency Particulate Air (HEPA) Filtration** refers to filtration which is 99.97 percent efficient against 0.3 micrometer challenge aerosol.

19. **High Hazard Procedures:** Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include,

but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

20. **Individually identifiable medical information** means medical information that includes or contains any element of personal identifying information enough to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

21. **Infection Preventionist (IP):** An infection control professional who is knowledgeable about infection control practices, including routes of transmission, isolation precautions and the investigation of exposure incidents.

22. **Infectious:** Having the ability to transmit TB or ATD/ATP to other people via respiratory droplet nuclei, fomites or during autopsy.

23. **Initial treatment:** Treatment provided at the time of the first contact a health care provider has with a person who is potentially an AirID case or suspected case. Initial treatment does not include High Hazard Procedures.

24. **Isolation Unit** means a commercially available apparatus which is used to provide atmospheric isolation.

25. **Laboratory:** A facility or operation in a facility where the manipulation of specimens or microorganisms is performed for the purpose of diagnosing disease or identifying disease agents, conducting research or experimentation on microorganisms, replicating microorganisms for distribution or related support activities for these processes.

26. **Local health officer:** The health officer for the local jurisdiction responsible for receiving and/or sending reports of communicable diseases, as defined in Title 17, CCR.
**NOTE: Title 17, Section 2500 of CCR requires that reports be made to the local health officer for the jurisdiction where the patient resides.*

27. **Multidrug-resistant TB (MDR TB)** means a strain of *Mycobacterium tuberculosis* bacteria that is resistant to at least isoniazid and rifampin, the two most potent TB drugs.

28. ***M. tuberculosis*** **(TB or *M. tb*) means *Mycobacterium tuberculosis*:** The scientific name of the bacterium that causes tuberculosis.

29. **Negative pressure:** The relative air pressure difference between two areas. The pressure in a containment room or area that is under negative pressure is lower than

adjacent areas, which keeps air from flowing out of the containment room or area and into adjacent rooms or areas.

30. **NIOSH:** The National Institute for Occupational Safety and Health.

31. **Novel or unknown ATP:** A pathogen capable of causing serious human disease meeting the following criteria:

    a. There is credible evidence that the pathogen is transmissible to humans by airborne and/or droplet transmission and

    b. The disease agent is:

        i. A newly recognized pathogen, or

        ii. A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or

        iii. A recognized pathogen that has been recently introduced into the human population, or

        iv. A not yet identified pathogen.

            **NOTE*: Variants of seasonal influenza virus that typically are not considered novel or unknown ATPs. Pandemic influenza strains that have not been fully characterized are novel pathogens.

32. **Occupational exposure:** Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs if protective measures are not in place. In this context, “elevated” means higher than what is considered ordinary for employees having direct contact with the public outside of the facilities, service categories and operations listed in subsection (a)(1) of this standard. Occupational exposure is presumed to exist to some extent in each of the facilities, services and operations listed in subsection (a)(1)(A) through (a)(1)(H) of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases. Whether a particular employee has occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. For example, occupational exposure typically does not exist where a hospital employee works only in an office environment separated from patient care facilities or works only in other areas separate from those where the risk of ATD transmission, whether from patients or contaminated items, would be elevated without protective measures. It is the task of employers covered by this standard to identify those employees who have occupational exposure so that appropriate protective measures can be implemented to protect them as required. Employee activities that

involve having contact with or being within exposure range of cases or suspected cases of ATD, are always considered to cause occupational exposure. Similarly, employee activities that involve contact with, or routinely being within exposure range of, at-risk populations are considered to cause occupational exposure. Employees working in laboratory areas in which ATP are handled or reasonably anticipated to be present are also considered to have occupational exposure.

33. **Physician or other licensed health care professional (PLHCP**) means an individual whose legally permitted scope or practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all health care services required by this section.

34. **Powered Air Purifying Respirator (PARR):** Air-purifying respirators (APRs) work by removing gases, vapors, aerosols (droplets and solid particles), or a combination of contaminants from the air through the use of filters, cartridges, or canisters. These respirators do not supply oxygen and therefore cannot be used in an atmosphere that is oxygen-deficient or immediately dangerous to life or health. PAPRs come in two main types – loose-fitting (hood style) and tight-fitting face PAPRs. Tight-fitting PAPRs need to be fit-tested annually, whereas loose-fitting hood style PAPRs do not need to be fit-tested.

35. **Purified Protein Derivative (PPD):** The substance used in a skin test to determine presence of hypersensitivity to tuberculin protein, signifying exposure to the organism.

36. **Referral:** The directing or transferring of a possible ATD case to another facility, service or operation for the purposes of transport, diagnosis, treatment, isolation, housing or care.

37. **Reportable aerosol transmissible disease (RATD):** A disease or condition which a health officer, in accordance with Title 17 CCR, Division 1, Chapter 4, and which meets the definition of an aerosol transmissible disease (ATD).

38. **Respirator:** A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been Tested and Certified by NIOSH for the purpose for which it is used.

39. **Respiratory Hygiene/Cough Etiquette in Health Care Settings: Respiratory Hygiene/Cough Etiquette in Health Care Settings,** CDC, November 4, 2004, which is hereby incorporated by reference for the sole purpose of establishing requirements for source control procedures.

40. **Risk:** The likelihood of an individual acquiring or having acquired TB by virtue of behavior, underlying medical condition, occupation, international travel, personal contact or socioeconomic conditions.

41. **Screening (health care provider):** The initial assessment of persons who are potentially AirID or ATD cases by a health care provider to determine whether they need airborne infection isolation or need to be referred for further medical evaluation or treatment to make that determination. Screening does not include diagnostic testing.

42. **Screening (non-health care provider):** The identification of potential ATD cases through readily observable signs and the self-report of patients or clients. Screening does not include diagnostic testing.

43. **Significant exposure:** An exposure to a source of ATPs or ATP-L in which the circumstances of the exposure make the transmission of a disease sufficiently likely that the employee requires further evaluation by a PLHCP.

44. **Source Case** refers to a patient or client who has been confirmed to have infectious TB or is highly suspected of having infectious TB.

45. **Source control measures:** The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having any ATD.

46. **Surge:** A rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment, and public health services in the event of an epidemic, public health emergency, or disaster.

47. **Susceptible person:** A person who is at risk of acquiring an infection due to a lack of immunity as determined by a PLHCP in accordance with current CDC or California Department of Health guidelines.

48. **Suspected case:** Either of the following:

    a. A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence to probably have a disease or condition listed in Section IV. A. 6 of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases.

    b. A person who is considered a probable case, or an epidemiologically- linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Section IV. A. 6 of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases.

49. **TB or *M. tb*:** The organism *Mycobacterium tuberculosis*, the causative agent of the infection which leads to disease of people infected.

50. **TB conversion:** A change from negative to positive as indicated by TB test results, based upon current CDC or California Department of Public Health guidelines for interpretation of the TB test.

51. **TB transmission:** The spread of TB from one person to another. This occurs via the airborne route by inhalation of droplet nuclei, small (1-5 micron) residual of aerosols suspended in air exhaled by a person with active disease. Most TB is transmitted by patients not known to have active disease, but who in fact have cavitary, pulmonary, laryngeal disease, by coughing, speaking, singing, or spitting. Individuals with exposure to air contaminated in such a way have a risk of acquisition of organisms proportionate to the degree of contamination of the air and the total volume of that air inhaled. Highest risk of acquisition is in household settings, or enclosed locations of poor ventilation, such as shelters, aircraft, or older engineered facilities.

52. **Treatment:** The use of chemotherapy to kill ATD in patients or employees with disease, including chemoprophylaxis.

53. **Test for Tuberculosis Infection (TB Test):** Any test, including the tuberculin skin test (TST) and blood assays for M. Tuberculosis (BAMT) such as interferon gamma release assays (IGRA) which: (1) has been approved by the Food and Drug Administration for the purposes of detecting tuberculosis infection, and (2) is recommended by the CDC for testing for TB infection in the environment in which it is uses, and (3) is administered, performed, analyzed and evaluated in accordance with those approvals and guidelines.

54. **Tuberculosis (TB or *M. tb*):** A disease caused by *M. tuberculosis.*

PROCEDURE:

1. **Job Classifications and Tasks**

   a. Job classifications are categorized into three categories (see Appendix A for a table of job classifications in which an employee has the potential for occupational exposure to ATD):

      i. **Category I – Have Exposure:** Job classifications in which **ALL** employees have potential occupational exposure to ATD/ATP.

      ii. **Category II – Potential Exposure:** Job classifications in which **SOME** employees have potential occupational exposure to ATD/ATP.

      iii. **Category III – No Exposure:** Job classifications in which **NO** employees have occupational exposure to ATD/ATP. Job classifications not listed are category III. If job classification categorization changes, please contact Infection Control Department

2. **Respiratory Protective Equipment**

   a. Respiratory protection shall be worn by all personnel in all circumstances during which suspected or known exposure ATD, or ATP may occur.

   b. National Institute for Occupational Safety and Health (NIOSH) Tested and Certified respirators shall be worn whenever respiratory protection is required.

   c. San Franciscos Health Network (SFHN) has selected N95 Respirators that have been Tested and Certified by NIOSH, in a variety of sizes for use.

   d. Powered air purifying respirator (PAPR) with High Efficiency Particulate Air (HEPA) filter is also available for respiratory ~~protection, but~~protection but may also require a source control N95 respirator to protect others.

3. **Respiratory Protection, Personal Protective Equipment and Engineering Controls**

   a. An N95 Respirator (or higher rated NIOSH Tested and Certified respirator) or Powered Air Purifying Respirator (PAPR) is required upon entering an airborne isolation room (AIIR) for patients with suspected or confirmed diseases transmitted via the airborne route (diseases/pathogens which require airborne precautions are listed on page 3.V.A)

   b. PAPR, gloves, fluid resistant gown hand hygiene and an AIIR room* are required during a “High Risk” procedure on a patient with a suspected or confirmed aerosol transmissible infectious disease (AirID) (diseases/pathogens which require airborne precautions listed on page 3.V.A) unless the employer determines that this use would interfere with the successful performance of the required task(s). This determination shall be documented and reviewed annually. “High Risk” procedures include but are not limited to the following:

      i. Bronchoscopy

      ii. Sputum induction (unless patient is in ventilated booth)

      iii. Aerosol medication administration (unless patient is in ventilated booth)

      iv. Intubation or airway suctioning

      v. Pulmonary function testing

      vi. Autopsy

      vii. Wound irrigation

viii. All other surgical, lab or clinical procedure that aerosolizes pathogens.

*Note: If an AIIR room or isolation unit is not available and the treating physician determines that it is detrimental to the patient's condition to delay performing the procedure, High Hazard. Procedures may be conducted in other areas provided employees use the required PPE, door is closed, a portable HEPA filter (if available) is present, and the room is closed off for 2 hours following the procedure.

4. **An N95 Respirator (**or higher rated NIOSH Tested and Certified respirator), **PAPR is required** when entering an area where patients with aerosol transmissible pathogens are being housed outside of a negative pressure isolation room.

   a. An N95 Respirator (or higher rated NIOSH Tested and Certified respirator) or PAPR is required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

   b. An N95 Respirator (or higher rated NIOSH Tested and Certified respirator) or PAPR is required when working in an area occupied by an AirID case during decontamination procedures after the person has left the area.

   c. An N95 Respirator (or higher rated NIOSH Tested and Certified respirator) or PAPR is required when performing a task for which the Pathology and Clinical Laboratory Safety Policies & Procedures or Exposure Control Plan requires respirators.

   d. An N95 Respirator or PAPR is required when transport of an AirID case or suspected case within the facility or in an enclosed vehicle when the patient is not masked.

   e. Standard Precautions are required for all patients. Contact or Droplet precautions may be added for specific diseases or conditions (refer to Standard Precautions and Transmission Based Precautions Policies)

5. **Maintenance of Respiratory Protective Equipment**

   a. N95 respirators are single use and must be discarded after each use.

   b. Disposable respirators may be discarded as regular waste.

   c. The following methods shall be used to maintain PAPR equipment.

      i. Inspection and Maintenance

- The PAPR must be inspected before and after each use to ensure that the equipment is clean and intact. Each PAPR user is responsible for this procedure.

- PAPR maintenance shall be performed by biomedical engineering according to manufacturer's specifications.

ii. Cleaning and Disinfecting

- The PAPR will be cleaned and disinfected according to manufacturer's specifications.

- Employees using the PAPR device will be responsible for cleaning and disinfecting the equipment. The employees must be trained in the cleaning and sanitizing of the PAPR.

iii. Repair

- Repair and replacement of damaged parts must be done before the respirator can be used.

- Replacement parts must be those of the manufacturer of the equipment.

Substitution with another manufacturer's parts is prohibited and invalidates the certification of the PAPR.

6. **Medical Evaluation and Services**

a. A medical evaluation is conducted to determine the employee's ability to use a respirator before the employee is fit tested.

b. Employee Occupational Health Services (OHS) at ZSFG will provide initial evaluation using a medical questionnaire. The questionnaire shall be administered confidentially.

c. Employees will not be allowed to wear respirators until a physician or other licensed health care professional (PLHCP) has determined that they are medically able to do so.

d. Any employee who is determined by a physician or licensed health care professional (PLHCP) as medically unable to be fit tested cannot work in an area requiring respirators. The employee must provide medical documentation from their medical provider stating that they have a medical condition that prohibits them from being fit tested.

e. Fit Testing of N-95 respirators and tight-fitting PAPRs

a. Qualitative or quantitative fit testing shall be performed using the same size, make, model and style of respirator the employee will use.

   i. Fit testing shall be performed according to the following schedule:

      - Upon hire
      - Annually thereafter

   ii. If any of the following conditions occur, additional fit test will be conducted:

      - Significant weight gain or loss
      - Dental changes
      - Facial scarring
      - Cosmetic surgery

f. Employees must pass both the medical evaluation and the fit test to wear a Respirator, and be trained in the use, care, and limitations of the respirator.

   i. Employees may not wear N95 respirators if they have facial hair that comes between the sealing surface of the face piece and the face.

   ii. If employee failed Fit testing, they will be instructed on how to use a PAPR. Fit testing is not required for loose-fitting (hood style) PAPR equipment.

g. Vaccinations/Post-Exposure Prophylaxis

   i. Recommended vaccinations or post-exposure prophylaxis shall be made available to all employees who are at risk or who have had an occupational exposure after the employee has received training as defined in section “training” of this plan and within 10 days of initial assignment unless:

      - The employee has previously received the recommended vaccination(s) and is not yet due for another vaccination dose, OR
      - A PLHCP has determined that the employee is immune as per CDC and CDPH guidelines, OR
      - The vaccine(s) is/are contraindicated for medical reasons.

   ii. Aerosol Transmissible Disease Vaccination Recommendations for Susceptible Health Care Workers (Mandatory) are as follows:

- Influenza – 1 dose annually
- Measles – 2 doses of MMR
- Mumps – 2 doses of MMR
- Varicella – 2 doses of Varicella
- Tetanus, Diphtheria, and Acellular Pertussis (Tdap) – 1 dose, booster as recommended.

iii. OHS shall make additional vaccine(s) available to employees as soon as possible upon the issuance of any new CDC, CDPH and/or SFDPH recommendations.

iv. OHS shall make participation in a prescreening serology program a prerequisite before the administration of certain vaccines if there is no proof of immunity, unless directed otherwise, by CDC, CDPH or SFDPH. Vaccination Recommendations except for Tdap, are a condition of employment, unless the vaccine (s) is/are contraindicated for medical reasons.

v. For those employees choosing to obtain vaccination(s) or laboratory testing from a non-OHS PLHCP, OHS shall request the PLHCP administering a vaccination or determining immunity to provide only the following information to the OHS:

- The employee's name and employee identifier such as DOB

The date(s) of the vaccine dose (unless already documented in the California state immunization registry) or determination of immunity.

- Whether the employee is immune to the disease, based on a positive titer, and whether there are any specific restrictions on the employee's exposure or ability to receive vaccine.

vi. OHS shall ensure that employees who decline Tdap when recommended and offered, sign a "declination statement". If the employee declines Tdap, but later, while still covered under the standard, decides to accept the vaccine, OHS shall make the vaccine available to the employee within 10 working days of that request.

***Note:** If OHS is unable to offer the vaccine(s) due to a lack of availability, OHS shall document efforts to obtain the vaccine(s) in a timely manner and notify employees of the status of the vaccine availability. OHS shall check into the availability of the vaccine periodically but not more than 60 calendar days and inform the employee when the vaccine(s) becomes available.

7. Engineering And Work Practice Controls

The following measures shall be implemented to reduce the risk of introducing ATD/ATP into the facility:

a. Practices for Isolation of patients on Contact, Droplet and Airborne isolations in accordance with CDC Guidelines. See Infection Control policy", "Transmission Based Precautions", "Blood Borne Pathogen Exposure Control Plan", and "Tuberculosis Exposure Control Plan".

b. Visual Alerts-Signage:

   i. Signs will be posted in public areas of the facility instructing patients and/or visitors to inform healthcare personnel of symptoms of a respiratory infection. Refer to Respiratory Hygiene/Cough Etiquette policy.

   ii. Signs will be posted in public hallways and near the elevators instructing patients and visitors to perform hand hygiene (e.g., hand washing with soap and water, alcohol-based hand rub, or antiseptic hand wash). Refer to Hand Hygiene Policy.

c. The rooms listed below have been designated as AIIR at LHH:

   i.

Unit	Negative Pressure Rooms
S4	428A, 448A
S5	528A, 548 A
S6	628A, 648A
PM Acute	56A

   ii. Decontamination shower: An emergency eye wash and decontamination shower are in the Soiled Utility Room as one enters each neighborhood just after exiting the elevator.

d. Specific requirements for AIIRs

   i. Negative pressure shall be maintained in AIIRs or areas. The ventilation rate shall be 12 or more air changes per hour (ACH). The required ventilation rate may be achieved in part by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than 6 ACH.

   ii. Negative pressure shall be **visually** demonstrated by smoke trails or equally effective means daily while the room is in use for AII.

iii. Engineering controls shall be maintained, inspected and performance monitored for exhaust or recirculation filter loading and leakage at least annually, whenever filters are changed, and more often, if necessary, to maintain effectiveness. Problems found shall be corrected in a reasonable period. If the problem(s) prevent the room from providing effective AII, then the room shall not be used for that purpose until the condition is corrected.

iv. Ventilation systems for AII rooms or areas shall be constructed, installed, inspected, operated, tested, and maintained in accordance with 5143, General Requirements of Mechanical Ventilation Systems.

v. When a case or suspected case vacates an AIIR, the room (assuming a minimum of 12 ACH) shall be ventilated for one hour before permitting patients or employees (without respiratory protection) to enter.

vi. Engineering department will be responsible for maintenance, testing, monitoring and record keeping.

e. Work Practice Controls:

i. Refer to Transmission Based Precautions and Respiratory Hygiene & Cough Etiquette policies.

ii. Early Identification: Efforts to identify suspected or confirmed AirID patients will begin as soon as the patient enters the facility. All personnel are encouraged to identify patients who are experiencing symptoms of AirID. Patients will be assessed for AirID symptoms or risk factors when they enter the facility with a complaint related to respiratory symptoms or an abnormal chest x-ray.

iii. Masking and Separation of Persons with Respiratory Symptoms:

- Follow Respiratory Hygiene/Cough Etiquette policy.

- Persons who are coughing will be encouraged to don a surgical mask, or cough into a tissue or triaged into a separate room/area when space and seating availability permit. In addition to during a Novel Respiratory Disease Pandemic, there may be other times that universal masking shall be in place for everyone entering the facility.

- Individuals identified as suspected or known ATD patients must wear a surgical mask when not in a negative pressure isolation room or a local exhaust ventilation enclosure. The purpose of the mask is to block aerosols produced by coughing, talking, and breathing. A surgical mask on a cooperative patient provides short-term protection. Patients will be

monitored to ensure compliance, and masks will be changed when damp or as necessary.

- Suspected or confirmed cases shall be identified and shall be:

  - masked or placed in such a manner that contact with employees or other residents who may or may not be wearing respiratory protection is eliminated or minimized until transfer or placement in an AII room or area can be accomplished. Staff would be required to wear proper respiratory protection; however, this requirement is to protect other residents in the general vicinity; and

  - Placed in an AII Room or area or transferred to a facility with AII rooms or areas. Placement or transfer will be implemented in a timely manner.

iv. Transfers within the facility: Transfers to AII rooms or areas shall occur within 5 hours of identification. If there is no AII room or area available within this time, facility shall transfer the individual to another suitable facility in accordance with the Cal-OSHA ATD Standard.

v. Transfers to other facilities: Transfers to other facilities shall occur within 5 hours of identification, unless a physician or the physician's representative documents, at the end of the 5-hour period, and at least every 24 hours thereafter, each of the following:

  - Facility has contacted the local health officer at San Francisco Public Health Department.

  - There is no AII room or area available within that jurisdiction.

  - Reasonable efforts have been made to contact establishments outside of that jurisdiction.

  - All applicable measures recommended by the local health officer, or the Infection Control physician or other licensed health care professional have been implemented.

  - All employees who enter the room or area housing the individual are provided with, and use, appropriate PPE, and respiratory protection.

    EXCEPTIONS:

    - Where the treating physician determines that transfer would be detrimental to a patient's condition, the patient need not be transferred.

In that case the facility shall ensure that employees use respiratory protection when entering the room or area housing the individual. The patient's condition shall be reviewed at least every 24 hours to determine if transfer is safe, and determination shall be recorded. Once transfer is determined to be safe, transfer must be made within 5 hours.

- Where it is not feasible to provide AII rooms or areas to individuals suspected or confirmed to be infected with or carriers of novel or unknown ATPs, AHS shall provide other effective control measures to reduce the risk of transmission to employees, which shall include the use of respiratory protection.

- High hazard procedures shall be conducted in AII rooms or areas, such as a ventilated booth or tent. Persons not performing the procedures shall be excluded from the area, unless they use respiratory, and PPE required for employees performing these procedures.

  - **EXCEPTION:** Where no AII room or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas. In that case, employees working in the room or areas where the procedure is performed shall use respiratory protection and personal protective equipment. A high-volume portable HEPA-filtered air unit should also be used.

f. Patient/Visitor Education: Information/education about appropriate use and disposal of PPE shall be provided to patients/visitors by hospital staff verbally, written instructions or posted signs.

g. Novel Aerosol Transmissible Pathogens:
   i. Individuals with suspected or confirmed novel or unknown aerosol transmissible pathogens require a combination of Airborne, Droplet and Contact Precautions.

   - These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Airborne Precautions.

   - The room door will be closed when occupied by a suspected or known ATD infectious patient.

   - Appropriate Transmission-Based Precautions sign will be placed to alert staff to use proper precautions. The sign will remain on the door and will only be removed when the room is safe to enter after the patient leaves.

- Isolation precautions for patients who have novel influenza symptoms should be continued for the 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in the facility.

- Facility will follow recommendations of CDC, California Department of Health, or San Francisco Public Health Department if they differ from what's stated above.

8. **Employee Training**

a. All employees with occupational exposure risk for exposure to ATD/ATP will participate in a training program:

i. At the time of initial assignment to tasks where occupational exposure may take place.

ii. At least annually, but not to exceed 12 months from previous training.

iii. When changes, such as introduction of new engineering or work practice, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures.

iv. Training material appropriate in content and vocabulary to the educational level, literacy and language of the employees shall be used.

b. The training program shall contain the following elements:

i. An accessible copy of the regulatory text of the Cal-OSHA ATD Standard.

ii. A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.

iii. An explanation of the modes of transmission of ATPs or ATPs-L and applicable source control procedures.

iv. An explanation of facility's ATD Exposure Control Plan and/or Laboratory Safety Policies and Procedures, and how the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.

v. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATPs or ATPs-L.

vi. An explanation of the use of limitation of methods that will prevent or reduce exposure to ATPs or ATPs-L including appropriate engineering and work

practice controls, decontamination, and disinfection procedures, and personal and respiratory protective equipment.

vii. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination, and disposal of items of personal protective equipment employees will use.

viii. A description of the surveillance procedures, including the information that persons who are immune compromised may have a false negative test for LTBI.

ix. Meet training requirements for use of a respirator.

x. Information on vaccines made available by the employer, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccines and vaccination will be offered free of charge.

xi. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.

xii. Information on the surge plan as it pertains to the duties that employees will perform (surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from person who may have been contaminated because of a release of a biological agent, how to access supplies needed for response including PPE and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

c. The training program shall include an opportunity for interactive questions and answers with a person who is knowledgeable in the subject matter of the training as it relates to workplace that the training addresses and who is also knowledgeable in the employer's ATD exposure control or Laboratory Safety Policies & Procedures. Training not given in person shall fulfill all the subject matter requirements and provide interactive questions to be answered within 24 hours by a knowledgeable person as described above.

9. **Occupational Exposure Incidents**

a. In the event of an exposure incident, the employee shall report the incident as soon as possible to his/her supervisor, employee health services or infection control. All employees who had significant exposure will be offered post - exposure medical evaluation and follow-up as soon as feasible. Depending on

the day and time of the incident the medical evaluation and follow-up are provided by:

i. Occupational Health Services during scheduled hours.

ii. Emergency Department: All other times and holidays

b. Medical Surveillance

i. Medical surveillance will be done for any employee with occupational exposure for any ATD and infection with ATPs and ATPs-L.

ii. ZSFG OHS will advise the employee of their right to refuse post exposure prophylaxis treatment, vaccination, post-exposure evaluation and follow-up following an exposure. If requested, ZSFG OHS shall make available to the employee a confidential vaccination, medical evaluation, or follow-up from a PLHCP. Precautionary removal of employees from their assignment will be made on a case-by-case basis. The decision will be made with input from the PLHCP (Licensed Health Care Professional) in consultation with IC.

c. Post-Exposure Evaluations and Follow-Up:

i. ZSFG OHS will report SF DPH employees with Aerosol Transmissible diseases to Infection Prevention and Control team.

- Information reported is to include the following:
  - Employee's name, address, phone number
  - Employee's job title, assigned department, other employers
  - Circumstances of exposure and date
  - Employee's physician
  - Where the employee was diagnosed
  - Laboratory reports

d. Upon receipt of the above information, ZSFG OHS will:

i. Report the case to the local health officer, in accordance with Title 17. RSV in adults is only reportable if part of an outbreak.

ii. Determine, to the extent possible, whether the employee(s) employed at other institutions/healthcare settings might have exposed others while performing their routine/assigned duties. IPC shall notify such institutions/healthcare settings within 72 hours of discovery of the diagnosis of the date/time/nature of potential exposure and will provide any other information necessary for the other employer(s) to evaluate the potential risk of exposure to his/her other employees. OHS will provide IPC with all necessary confidential employee information to accomplish this.

Note: Each facility is obligated under SB432 to identify an infection control officer or designee to be available to notify prehospital emergency medical care personnel of potential exposure to a communicable disease and advise them to contact the county health officer (this is separate from the BBPE Ryan White, Title 17

e. Upon recognition of an employee(s) exposure or risk of exposure to a ATD case, or suspected case, or to an exposure incident involving an ATP-L, OHS shall do the following:

i. Within 72 hours of awareness, conduct an analysis of the exposure to determine which employees might have been exposed. This analysis shall be conducted by OHS with support by ICP and unit managers and will include at least the names and any other employee identifier included in the analysis. The analysis should also record the basis for any determination that an employee need not be included in the post-exposure follow up because the employee did not have significant exposure or because an OHS MD determined that the employee is immune to the infection in accordance with applicable public health guidelines.

ii. If the exposed employee(s) is/are deemed immune to infection or experienced insignificant exposure, the employee(s) will not be given post-exposure follow-up unless requested. The person making such determination, including any consultation with PLHCP and local health officer shall be documented.

iii. Within a timeframe that is reasonable for the specific disease, but in no case later than 96 hours of becoming aware of the potential exposure, Zuckerberg San Francisco General Hospital (ZSFG) Occupational Health Clinic (OHC) will notify employee(s) who had significant exposure will be notified of the date, time, and nature of the exposures ZSFG OHS has agreed to assist with TB exposures. The decision regarding treatment or RTW for TB is coordinated by OHC in concert with the TB clinic.

iv. As soon as feasible, ZSFG OHS will provide post-exposure medical evaluation to all employees who had a significant exposure. This evaluation will be conducted by an OHS provider who is knowledgeable about the

specific disease, including any appropriate vaccination, prophylaxis, and treatment. For M. tuberculosis, and for any other pathogens as recommended by the CDC and CDPH, this evaluation shall also include testing of the isolate source individual or material for drug susceptibility, unless the OHS MD determines that this is not feasible.

v. Obtain from the OHS provider any recommendation and/or written opinions regarding work status as described in this section of the plan. Determine if the employee has any other employer(s) as per their records. If so, Infection Control shall notify these employer(s) within 72 hours of awareness of exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the diagnosing ZSFG OHS MD. The notifying employer shall not provide the identity of the source patient to the other employer. This is if one of our employees work in another outside facility. We cannot them with the name of our positive residents.

f. The ZSFG OHS MD is responsible for making determinations and performing procedures as part of the medical surveillance program shall be provided with a copy of this standard and any applicable CDC or CDPH guidelines. For any respiratory medical evaluations, ZSFG OHS and/or Infection Control shall provide information regarding the type of isolation/PPE used, a description of the job being performed, and the work effort required of such job, any other special environmental considerations that exist (e.g., heat, limited space, confined entry), any additional requirements for PPE, and information on the duration and frequency of respirator use.

g. The ZSFG OHS MD who evaluates the employee after an exposure incident shall be provided the following:

i. A description of the exposed employee’s job duties as they relate to the exposure incident.

ii. The circumstances in which the exposure occurred.

iii. Any available diagnostic test results, to include drug susceptibilities, and any other information that might assist in the medical management of the employee, and

iv. All the facility’s medical records regarding the employee, including any PPD test results, any other relevant tests, determinations of immunity status, or previous vaccination history relevant to treatment/management of the employee.

h. Employees who convert their skin tests will receive a TB Symptom Review Survey, chest x-rays and referral to the ZSFG OHS Clinic. The results of the evaluation from the ZSFG OHS Clinic will be sent to the LHH Clinic. This is

specific for employees who have TST conversion. The ZSFG OHS Medical Director or designee will review these results and provide clearance for the employee to continue work.

i. The ZSFG OHS MD will be requested to convey any recommendation for precautionary removal immediately via phone or fax and document the recommendation in the writing.

j. If the ZSFG OHS MD or the local health officer recommends removal from the workplace because the employee may be contagious, then the employer must maintain the employees' earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited,

    i. These precautionary removal rights do not apply if alternate work is available or if the employee is unable to work for reasons other than precautionary removal.

k. ZSFG OHS shall provide the employee(s) with the written opinion of the ZSFG OHS MD within 15 working days of the completion of all medical evaluations required as per this plan.

l. For any TB conversions and RATD and ATP-L exposure incidents, the written opinion shall be limited to the following:

    i. The employee's TB test status or applicable RATD test status for the exposure of concern

    ii. The employee's infectivity status

    iii. A statement that the employee has been informed about the results of the medical evaluation and has been offered any appropriate vaccinations, prophylaxis, or treatment.

    iv. A statement that the employee has been informed about any medical conditions resulting from exposure to any ATD/ATP that require further treatment or evaluation, and that the staff has been informed of treatment options.

    v. Any recommendations for precautionary removal from the employee's regular assignment.

m. All laboratory tests shall be conducted in an accredited laboratory.

n. All other findings or diagnoses will remain confidential and won't be included in the written report.

o. ZSFG OHS will make available seasonal influenza vaccine to all employees with occupational exposure. OHS will ensure that employees who decline the season influenza vaccine complete a declination and wear a light surgical mask per as mandated by San Francisco County.

p. Seasonal influenza vaccine will be provided during the period designated by the CDC for administration, and need not be provided outside of those periods, unless stated otherwise by California Department of Public Health (CDPH) and/or San Francisco Department of Public Health (SFDPH).

10. **Record Keeping**

a. Medical records

i. ZSFG OHS will establish and maintain an accurate record for each employee with occupational exposure. This record may be combined with other exposure records but may not be combined with non- medical personnel records.

ii. This employee's record shall include:

- The name of the employee and the employee identifier.
- The employee's vaccination status for all vaccines required by this standard, including the dates of all vaccinations, any signed declination statements, any determinations of immunity, and medical records relative to the employee's ability to receive vaccinations if applicable. Employee Health record will contain the most recent seasonal flu declination form signed by the employee.
- A copy of all results of examinations, medical testing, evaluation and follow up of exposure incidents.
- A copy of all written opinions provided by a PLHCP in accordance with this standard, and the results of all TB assessments.
- A copy of the information regarding the exposure incident that was provided to the PLHCP or another license healthcare professional.
- ZSFG OHS shall ensure that employee medical records are kept confidential and are not disclosed or reported without the employee's written consent to any person within or outside the workplace except as

required by this Standard and by law. Medical records are retained and coordinated by the Employee Health Department.

- ZSFG OHS health records, as required by this section, shall be maintained for at least the duration of employment plus 30 years for any occupationally related exposure.

b. Training Records

i. Training records shall include the following:

- Date(s) of the training session(s),
- Contents or a summary of the training session(s),
- Names and qualifications of persons conducting the training sessions,
- Names and job titles of persons attending the training sessions.

ii. Training records shall be retained for three (3) years from the date of the training. A copy of the training records shall be maintained by the Human Resources Department.

iii. When the E-learning computer assisted self- study/evaluation is used, the same information will be kept, and the E-learning computer program will be listed as the instructor. For E-Learning for OSHA-required courses, a person must be available to answer questions during the first 24 hours after the course has been completed, and the name of that person should be listed with the training record. Records will be maintained by the Human Resources Department for a period of 3 years.

c. Records of Implementation of ATD Plan

i. Records of annual review of the ATD Plan shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusions. The record shall be retained for three years.

ii. Records of exposure incidents will be retained and made available as employee exposure records in accordance with the standard. These records will include the following:

- The date of the exposure incident
- The names, an any other employee identifier used in the workplace, of employees who were included in the exposure evaluation.

- The disease or pathogen to which employees may have been exposed.
- The name and job title of the person performing the evaluation.
- The identity of any local health officer and/or PLHCP consulted.
- The date of the contact and contact information for any other employer who either notified the employer or as notified by the employer regarding potential employee exposure.

iii. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.

iv. Records of the unavailability of AIIR rooms or areas shall include the name of the person who determined that an AIIR room or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer aiding, and the times and dates of these contacts. This record shall be retained for three years.(CCR 8 Section 5199(i) 3 iv)

v. Records of decisions not to transfer a patient to another health care facility or agency for AIIR for medical reasons shall be documented in the patient's chart. This record shall be retained for three years.

vi. Records of inspection, testing and maintenance of non-disposable engineering controls (e.g., ventilation and other air handling systems) shall be maintained for at least 5 years and shall include the names(s) and affiliation(s) of the person(s) conducting the test, inspection or maintenance, the date, and any significant results and actions implemented.

vii. Records of the respiratory protection program will be established and maintained in accordance with the standard. SFDPH will provide fit-test screening and retain the screening record for two (2) years.

d. Availability of Records

i. AHS shall ensure that all records, other than the employee medical records as described in Section C, that are required to be maintained by this section shall be made available upon request to the Chief, NIOSH, Cal-OSHA and the local health officer for examination and copying.

ii. Employee training records, the exposure control plan and/or biosafety plan, and records of implementation of the ATD exposure control plan and

biosafety plan, other than medical records containing individually identifiable medical information, will be made available as employee exposure records in accordance with the Cal-OSHA ATD Standard for examination and copying.

iii. Employee medical records shall be made accessible to the employee, anyone having the written consent of the employee, the Department of Health Officer and NIOSH

e. Transfer of Records:

i. Facilities shall comply with the requirements as set forth in this plan involving the transfer of employee medical and exposure records.

ii. If SF DPH cease to do business and there is no successor employer to receive and retain the records for the prescribed period, SF DPH shall notify the Chief and NIOSH, at least three (3) months prior to the disposal of the records and shall transmit them to NIOSH, if required by the NIOSH to do so, within that three-month period.

iii. Employee Medical Records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days using the appropriate procedures for the release of medical information.

ATTACHMENT:
Appendix A: Position/Committee Responsible and Responsibilities
Appendix B: Diseases/Pathogens Requiring Airborne Isolation
Appendix C: Diseases/Pathogens Requiring Droplet Precautions

REFERENCE:
[1] California Department of Public Health. California's Aerosol Transmissible Disease Standards and Local Health Departments. Richmond, CA: California Department of Public Health, Occupational Health Branch, January 2018. (https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/ATD-Guidance.pdf)

https://www.dir.ca.gov/dosh/dosh_publications/ATD-Guide.pdf

APPENDIX A. Position/Committee Responsible and Responsibilities

Position/Committee Responsible	Responsibility
Industrial Hygiene Program Manager	1. The facility's IH program manager is the ATD plan's "administrator" and is responsible for the establishment, implementation, and maintenance of the ATD plan and infection control procedures. The administrator has the authority to perform in this role and is knowledgeable in industrial hygiene and infection control principles. 2. The ATD plan is a program jointly by the Departments of Workplace Safety and Emergency Management (WSEM), Facilities, Emergency Management, and Infection Control. 3. The ATD plan shall require the same responsibilities for supervisors, employees, and designated staff as the Illness and Injury Prevention Program (IIPP)
IH and Employee Health Services (EHS) Staff and/or Manager	1. Perform risk assessment annually. 2. Review and revise Exposure Control Plan at least annually.
IH Committee	Review and approve ATD Exposure Control Plan

EHS Manager/Director	1. Develop and administer the TB screening program for employees, physicians, and volunteers. 2. Perform respirator fit testing upon hire and thereafter in accordance with Cal-OSHA regulations. 3. Develop and administer the Vaccination/Immunization Program for employees, physicians, and volunteers. 4. Maintain employee vaccination, fit-testing, medical records.
Occupational Safety & Health with Infection Prevention and Control	Respiratory Protection Program
Emergency Management Committee	Administer Surge Plan, Disaster Plan, and disaster training
Director of Clinical Laboratory	Laboratory Safety Policies & Procedures on ATP
Director of Materials Management	Ensure an adequate supply of PPE and other equipment necessary to minimize employee exposure to ATPs in normal operations and in foreseeable emergencies.
Education/Human Resources Department(s)	Provide and document initial ATD education and annual training thereafter.
Department Managers	Monitor compliance with ECP and report compliance issues for resolution.
Facilities in cooperation with the Nursing department	Monitor and maintain engineering controls (e.g., negative pressure room alarms and required testing). Information about the unavailability of an AII room or areas is required in the Cal/OSHA ATD standard CCR 8 Section 5199 (j) Recordkeeping 3. iv.
Biomedical Engineering/Industrial Hygienist	Maintain PAPRs according to manufacturer's specifications, including checking filters and replacing filters quarterly or semi-annually.
All employees, physicians, contractors and volunteers	Comply with all elements of the ECP, including attending education sessions,

	obtaining required screening, using respirators when indicated, using safe work practices, and reporting all ATD exposures to EH and IC.

APPENDIX B. DISEASES/PATHOGENS REQUIRING AIRBORNE ISOLATION*

*Requires AIIR and PAPR or N95 respirator. (PAPR for High Hazard Procedures, N95 if PAPR not available).

1. Aerosolized spore-containing powder or other substance that can cause serious human disease, (e.g., Anthrax/*Bacillus anthracis)*

2. Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)

3. Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out.

4. Measles (rubeola)/Measles virus

5. MPox virus

6. Novel or unknown pathogens

7. Severe acute respiratory syndrome (SARS)

8. Smallpox (variola)/Variola virus

9. Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion: Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected.

10. Any other disease for which public health guidelines recommend airborne infection Isolation.

APPENDIX C. DISEASES/PATHOGENS REQUIRING DROPLET PRECAUTIONS*

**Does not require an AIIR.*

1. Diphtheria pharyngeal

2. Epiglottitis, due to *Haemophilus influenzae* type b

3. *Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children

4. Influenza, human (typical seasonal variations)/influenza viruses

5. Meningitis
   a. *Haemophilus influenzae*, type b known or suspected,
   b. *Neisseria meningitidis* (meningococcal) known or suspected.

6. Meningococcal disease sepsis, pneumonia (see also meningitis)

7. Mumps (infectious parotitis)/Mumps virus

8. Mycoplasmal pneumonia

9. Parvovirus B19 infection (erythema infectiosum)

10. Pertussis (whooping cough)

11. Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,

12. Pneumonia
    a. Adenovirus
    b. Haemophilus influenzae Serotype b, infants, and children
    c. Meningococcal

d. *Mycoplasma, primary atypical*

e. *Streptococcus Group A*

13. Pneumonic plague/*Yersinia pestis*

14. Rubella virus infection (German measles)/Rubella virus

15. Severe acute respiratory syndrome (SARS)

16. Streptococcal disease (group A streptococcus)

    a. Skin, wound or burn,

    b. Pharyngitis in infants and young children,

    c. Pneumonia,

    d. Scarlet fever in infants and young children,

    e. Serious invasive disease.

17. Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses

18. (Airborne infection isolation and respirator use may be required for aerosol-generating procedures)

19. Any other disease for which public health guidelines recommend droplet precautions.

Revised Hospital-wide Policies and Procedures

APPROVAL AND FORMAT OF HOSPITAL-WIDE AND DEPARTMENTAL POLICIES AND PROCEDURES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) establishes, issues, and maintains, Laguna Honda Hospital-wide Policies and Procedures (LHHPP).

2. LHHPP shall be implemented only after approval of the Performance Improvement and Patient Safety (PIPS) Committee and the Joint Conference Committee (JCC); unless resident safety may be impacted and/or there is a DPH Director of Health mandate.

3. Each department manager/supervisor is responsible for maintaining a current manual of their Departmental Policies and Procedures (DPP).

4. DPPs that impact disease/clinical care management require approval by the Nursing Executive Committee (NEC) and Medical Executive Committee (MEC) prior to implementation.

5. LHHPPs and DPPs shall be reviewed at least every year in accordance with Title 22 requirements.

6. A standardized formatting template shall be utilized for LHHPPs (refer to LHHPP 01-11).

7. The file numbers of deleted LHHPPs may be re-assigned to newly developed LHHPP the following year, after the annual review of process for LHHPPs for the calendar year.

8. LHH areas that have access to the ~~San Francisco Health Network (SFHN) internet website~~policy and procedure management system are not required to maintain a hard copy of the LHHPP or Nursing DPP.

PURPOSE:

1. To provide unified and consistent statements for LHHPP and DPP.

2. To describe procedures for developing and reviewing departmental policies and procedures at LHH.

CHARACTERISTIC:

1. A LHHPP describes activities or processes:

    a. which must be executed by more than one department.

2. LHHPPs have broad application. They do not focus on the function and systems of individual departments and divisions. LHHPPs define administrative responsibility and staff performance relating to specified administrative and resident/patient care functions.

3. A DPP describes activities or processes:

   a. which occur within and need to be understood and executed only by the issuing department; or

   b. which may occur Hospital-wide but is executed only by a single department.

PROCEDURE:

1. Hospital-wide Policies and Procedures

   a. New LHHPP may be generated by:

      i. The chairperson of a medical staff committee,

      ii. The administrative liaison to a medical staff committee,

      iii. The chairperson of an administrative/clinical committee,

      iv. The chairperson of an ad hoc committee, or

      v. A member of the LHH executive staff.

   b. Revision of an existing policy and procedure may be initiated by the same person(s) identified above. The person initiating the revision shall inform the Administrative designee of revisions and will make edits to the policy in the policy and ~~procedue~~procedure management system. ~~request for the Word document of the LHHPP being revised from the Administrative designee.~~ Track changes shall be used to mark the proposed changes in the document.

   c. The draft of the new or substantially revised policy and procedure shall be submitted to the following individuals:

      i. Chair of NEC

      ii. Chair of MEC

      iii. Co-Chairs of PIPS

      iv. Administrative designee (as determined by the Chief Quality Officer), for

coordination purposes.

d. The Administrative designee shall be responsible for issuing new LHHPP file numbers.

e. The standardized formatting template in the policy and procedure management system shall be utilized for developing policies and procedures when creating the new LHHPP.

f. NEC and MEC shall review and approve all LHHPP to ensure that the procedures agree with sound hospital, administrative, medical, nursing and/or clinical practice.

g. The PIPS Committee shall review and ensure that the policies and procedures agree with the administrative philosophy and Department of Public Health (DPH) guidelines.

h. All new and revised LHHPPs require approval by NEC, MEC and PIPS, and shall be sent to the respective chairs of these committees.

i. The Administrative designee shall send the policy to appropriate individuals, committees, departments or services for review. This will help ensure that the policy agrees with current policies and practices and does not duplicate other policies. The following factors shall be taken into consideration as appropriate in order to conduct a substantive review:

    i. Relevance to other policies and procedures,

    ii. Relevance to standards of care and standards of practice,

    iii. Ethical and legal concerns,

    iv. Current scientific knowledge, and

    v. Findings from quality improvements/assurance activities

j. The policy approval process shall be sequenced in the following order: NEC, MEC, PIPS and the governing body as soon as practical.

k. When final approval is reached, the newly developed or revised LHHPP may be ~~posted on the intranet~~published on the policy and procedure management system.

l. The Administrative designee shall place the LHHPP on the calendar for an annual review by the PIPS Committee.

m. All existing LHHPP shall be submitted for an annual review to the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief of Staff, Physician Advisor if

applicable, Division Head, and Department Manager/Coordinator at the designated Annual Policy and Procedure Review meeting each year.

n. Annual review and approval of existing LHHPP shall be scheduled for review and approval by the governing body as soon as practical.

o. The Division Heads and Department Managers are responsible for disseminating information to LHH staff about new policies and revisions of existing policies and ensuring that LHHPPs are implemented at the departmental level.

p. All LHHPPs are available on the policy and procedure management system~~LHH and SFHN Intranet~~.

   i. The policy and procedure management system ~~webpage~~ is maintained by the Administrative designee.

   ii. Staff are educated and trained on how to access the policy and procedures on the policy and procedure management system~~SFHN website~~.

2. Departmental Policies and Procedures (DPP)

a. DPP must be specific to the operation of each department and define the specific scope and activities of the Department in accordance with applicable state and federal regulations.

b. Department Heads may propose ~~to transform~~moving a DPP to a LHHPP when appropriate.

c. Department Heads are responsible for:

   i. Obtaining the approval of the responsible Division Head.~~;~~

   ii. Maintaining at least one copy in the Department Manager's office.

   iii. Training employees to standards set forth in the manual.

   iv. All existing DPP shall be submitted for an annual review to the CEO, CMO, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager at the designated Annual Policy and Procedure Review meeting each year.

d. Each Department must have the following elements within their DPP, unless they are delineated by existing LHHPP:

   i. Department structure and organization;

ii. Scope of service;

iii. Applicable policies required for licensing standards and by State and Federal regulations;

iv. Policies and procedures pertaining to administrative, resident/patient, and medical care activities unique to the Department;

v. Protocols implementing or supplementing existing LHH personnel practices; and

vi. Education and training requirements.

e. Department specific procedures may supplement existing LHHPP for the following areas:

~~i. Infection control guidelines;~~

~~ii.~~i. Departmental response to both internal and external disasters and emergencies (e.g., fires, mass casualty disasters, and power failures);

~~iii.~~ii. Performance improvement;

~~iv.~~iii. Environment of care;

~~v.~~iv. Contract requirements (i.e., managed care contracts); and/or

~~vi.~~v. Health and safety requirements.

f. Approval Process for DPP

i. The Department Manager/Director gives the initial approval for the policy.

ii. When the implementation of a DPP involves other Departments, the Department Managers of these Departments review, comment, and approve the development or revision of the Policy or Procedure.

iii. When DPPs impact disease/clinical care management, the appropriate health professional and administration shall be consulted. The new or revised DPP shall be implemented after review and approval by NEC and MEC.

iv. DPPs shall be reviewed by the hospital governing body for approval ~~as soon as practical~~.

g. Implementation of DPP

i. The Department Managers are responsible for implementing DPP and for ensuring that the current DPP are readily accessible to all staff.

h. The Department Manager shall be responsible for retention of the Policy and Procedures Archives.

i. The Department Manager of each unit shall be delegated the responsibility for retaining original versions of all DPP for seven (7) years from date of origin, revision or deletion.

3. List of Minor Revisions Not Subject to JCC Approval

a. Refinements to formatting and layout.~~;~~

b. Correction of typographical errors.~~;~~

c. Correction of grammar and punctuation.~~;~~

d. Changes to procedure titles.~~;~~

e. Renumbering of the policies and procedures.~~;~~

f. Informational updates to appendices (e.g. names of personnel, contact numbers, name of vendor(s), etc.).

ATTACHMENT:
None.

REFERENCE:
LHHPP 01-10 Departmental Responsibility and Accountability
LHHPP 01-11 Standard Formatting Template for Policies and Procedures
Standard Work for Hospital-wide and Departmental Policies & Procedures (P&P) Committee Review and JCC Approval

Reviewed: (Year/Month/Day)

Revised: 08/07/22, 10/08/24, 10/12/03, 13/05/28, 13/09/24, 15/07/14, 16/01/12, 16/09/13, 19/03/12, 20/09/08, 22/02/08, 25/02/03, 25/04/14, 26/08/18 (Year/Month/Day)

Original adoption: 92/05/20

DEPARTMENTAL RESPONSIBILITY AND ACCOUNTABILITY

POLICY:

1. Departments~~/services~~ at Laguna Honda Hospital and Rehabilitation Center (LHH) shall operate according to written policies and procedures, standards, or plans.

2. The procedures outlined in this policy describe the procedural responsibilities and accountability of each department~~/service~~ to LHH.

PURPOSE:

To meet State, Federal and City regulatory and legal requirements that govern services or functions of the department.

PROCEDURE:

1. Develop and establish written plans that describe or illustrate the following information:

    a. Organizational and reporting structure.

    b. Job descriptions and departmental responsibilities.

    c. Licensure requirements, if applicable.

    d. Policies and procedures that meet or support LHH's:

        i. Strategic goals, vision, mission, core competencies, and values,

        ii. Performance improvement goals or initiatives,

        iii. Infection control standards, or

        iv. Patient safety plan.

2. Develop departmental/service policies and procedures that meet State, Federal and City regulatory requirements.

3. Submit departmental/service policies and procedures that impact clinical care services (e.g. dietetic services) for review and approval by the Nursing Executive Committee (NEC), Medical Executive Committee (MEC), and Performance Improvement and Patient Safety (PIPS) Committee prior to implementation, review, and approval by the governing body, the Joint Conference Committee (JCC).

4. Assign departmental~~/service~~ staff to participate in performance improvement, infection control, or patient safety committees organized by LHH staff.

5. Department managers are responsible for working collaboratively and consulting with appropriate health professionals and administration.

6. Department managers are responsible for updating departmental/service policies and procedures on the LHH ~~intranet~~ policy and procedure management system for their department/service and within their policy and procedure binder.

ATTACHMENT:
Appendix A: List of Laguna Honda Hospital and Rehabilitation Center Departments and Services

REFERENCE:
Title 22 General Acute Care Hospitals

Revised: 16/01/12, 20/10/13, 25/01/13, 26/08/18 (Year, Month, Day)

Original adoption: 10/12/01

Appendix A: List of Laguna Honda Hospital and Rehabilitation Center Departments ~~and Services~~

1. Activity Therapy
2. Admissions & Eligibility
3. Biomedical Engineering
4. Emergency Management
5. Environmental Services
6. Facility Services
7. Food and Nutrition Services
8. Health Information Services
~~8.~~9. Human Resources
~~9.~~10. Infection Prevention and Control
~~10.~~11. Materials Management
~~11.~~12. Laboratory Services
~~12.~~13. Medical Services
~~13.~~14. Nursing Services
~~14. Nutrition Services/ Clinical Nutrition – Diet Manual~~
15. Outpatient Clinical Services
16. Pharmacy Services
17. Quality Management
18. Radiology Services
19. Rehabilitation Services
20. Respiratory Services
21. Social Services

22. Spiritual Care
23. Vocational Rehabilitation
24. Volunteers Services
25. Workplace Safety

STANDARD FORMATTING TEMPLATE FOR POLICIES AND PROCEDURES

POLICY:

A standardized formatting template shall be followed in developing and revising Laguna Honda Hospital and Rehabilitation Center (LHH) policies and procedures.

PURPOSE:

To provide consistency in formatting LHH facility-wide and departmental policies and procedures. ~~(LHHPP).~~

PROCEDURE:

1. Page Set-Up

a. Use the standard template within the policy and procedure management system. The following sections will be predefined:

i. Title

ii. Policy

iii. Purpose

iv. Procedure

v. References

~~Header and Footer – 0.5”~~

~~Margins – 1” Top, 1” Bottom, 1” Right, 1” Left~~

~~Orientation – Portrait~~

~~**2. Headers and Footers**~~

~~a. Under view setting click on Header and Footer and apply the following format to your Header:~~

~~i. Arial 10 Font~~

~~ii. Apply a bottom border by using the grid from your toolbar.~~

~~iii. Center the header contents so that comparable blank space remains at the top and at the bottom of the Header to accommodate Headers with extensive content.~~

~~b. Under view setting click on Header and Footer and apply the following format to your Footer:~~

~~i. Arial 10 Font~~

~~ii. Apply top border by using the grid from your toolbar.~~

~~iii. Insert Auto Text Menu – Insert Page X of Y~~

~~c. Keep the footer and header aligned.~~

~~d. Titles or description of headers and footers~~

~~i. Top left: Indicate the file number and title of the LHHPP; ensure the file number is correct, especially for renumbered LHHPP.~~

~~ii. Top right: Indicate New, Revised, or Deleted and the date of approval by the Joint Conference Committee (JCC).~~

~~iii. Bottom left: Specify Laguna Honda Hospital-wide Policies and Procedures~~

~~iv. Bottom right: Specify page numbers~~

~~3.~~2. Policy Title

~~Apply the following format options to the Title (Name of a Policy or a Procedure):~~

~~Arial 14 Font~~

~~All Caps~~

~~Bold~~

~~Left Alignment~~

a. Use the singular noun form to title sections of the policy and procedure (e.g. Policy, Purpose, Procedure, Header and Footer, Attachment, Appendix, and Reference).

~~4.~~3. Policy, Purpose, Definition and Procedure

a. The Policy statement shall be stated at the beginning of each ~~LHHPP~~ policy and procedure, followed by the Purpose statement.

b. If more than one Policy, Definition or Purpose statements are stated, they shall be numbered.

c. The Definition section shall be between the Purpose and Procedure sections.

d. The Procedure section describes the steps for carrying out the policy (or policies) and meeting the purpose statement(s).

~~**5. Body Content**~~

~~a. Apply the following format options to the Body:~~

~~i. Arial 12 Font~~

~~ii. Justified Alignment~~

~~b. Sections in the body (i.e., POLICY, PURPOSE, DEFINITION, PROCEDURE, ATTACHMENT/APPENDIX, REFERENCE) are formatted as follows:~~

~~i. Arial 12 Font~~

~~ii. All Caps~~

~~iii. Bold~~

~~iv. Left Alignment~~

~~c. Subjects in the body (i.e., Page Set-Up, Headers and Footers, Title Content, etc.) are formatted as follows:~~

~~i. Arial 12 Font~~

~~ii. Bold (when applicable, with the exception of Subjects that are in the form of a paragraph or multiple sentences).~~

~~6.~~4. Bullets and Numbering

a. The Procedure section shall apply the following listing format:

i. Outline Numbered: 1., a., i, ●, ●

b. Apply Bold Setting to Subjects (primary listing 1., 2., 3., etc.) when applicable.

~~7.~~5. Attachments/Appendices

a. List Attachments and/or Appendices in ascending order. Indicate None if there are no attachments.

b. Whenever possible, insert the appendices into the MS Word version of the policy/procedure as MS Word text or as an image. Otherwise, submit the appendices as separate MS Word documents along with the policy/procedure.

c. Ensure Attachments/Appendices are correctly identified.

~~8.~~6. References

a. List references in numeric order when the reference relates to a policy number, otherwise list in ascending order. Indicate *None* if there are no references.

   i. Check all policy numbers used as references to ensure their accuracy.

b. Ensure References are correctly identified.

c. Ensure reference links are active and correct.

~~9.~~7. Dates: ~~New, Revised, Reviewed and Original Adoption~~Origination, Last Approved, Effective, Last Revised and Next Review

~~a.~~ The dates will be listed at the top of the policy before the title.~~Date format to be used is (Year, Month, Day)~~

a.

~~b.~~ Effective date will correspond with the JCC approval date.

b.

~~New, Revised and Re-numbered date(s)~~

~~Indicate New or Revised at the top right corner of the policy and procedure.~~

~~The new and revised date reflects the JCC approval date.~~

~~The reviewed date reflects the date the policy was last reviewed but not revised.~~

~~At the end of the LHHPP, indicate N/A for a new policy and procedure~~

~~List the dates of all prior LHHPP revision(s).~~

~~When a LHHPP is re-numbered, specify the old and new LHHPP number next to the revision date.~~

~~Do not delete any dates that have previously been listed.~~

~~Original adoption date~~

~~This date reflects the date when the LHHPP was first approved or when the policy and procedure was first implemented.~~

~~This date does not change.~~

~~10.~~8. Proofreading

a. Proofread document in its entirety for typographical and formatting errors.

b. Spell out abbreviations that are not previously spelled out in the file.

~~Finalizing the Document~~

~~Spacing issues:~~

~~Align each indented listing with the previous listing to keep consistency in the document (Reference spacing above).~~

~~If you are having issues with spacing at the bottom of a page, such as too much space above the Footer, try the following:~~

~~Highlight the area~~

~~Right Click~~

~~Select Paragraph~~

~~Uncheck Window/orphan control option~~

ATTACHMENT:
None

REFERENCE:
None

Revised: 11/09/27, 13/09/24, 15/07/14, 20/10/13, 23/08/08, 25/02/03, 26/08/18 (Year/Month/Day)

Original adoption: 10/12/03

OUT ON PASS POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to meet residents' physical and psychosocial needs to go out on pass (OOP). ~~The Facility~~LHH will make reasonable efforts to ensure resident safety and uphold resident rights.

2. Residents who wish to leave the grounds of LHH shall have written orders from ~~their attending~~a LHH physician and if appropriate medications the resident may take during the OOP.

3. Determining if an OOP is appropriate for the resident is the responsibility of unit Resident Care Team (RCT) and may be granted in accordance with the resident's plan of care.

PURPOSE:

To provide residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning.

PROCEDURE:

1. Notification of Out on Pass Policy

a. LHH ~~Admissions & Eligibility department (A&E) and~~ Social Services shall provide each newly admitted resident and/or ~~/~~surrogate decision maker (SDM) with information regarding the Out on Pass policy.

2. Request for an Out on Pass and the Pass Order Form

a. A resident and/or ~~Surrogate Decision Maker (SDM) or representative~~SDM may request a pass from ~~the~~ a LHH physician. If possible, the resident and/or SDM shall provide at least 1~~2~~ business ~~days~~day prior to the planned OOP.

b. ~~A Resident Care Conference (RCC) is needed in order to evaluate the specific parameters for a request. A new RCT evaluation is valid for up to 90 days for a given type of OOP request if all parameters are exactly the same. A new RCC is needed if ANY of the parameters is different.~~A Resident Care Conference (RCC) will be held to evaluate the appropriateness of an OOP request. An RCT evaluation is valid until the next quarterly RCC for a given type of OOP request and should be re-evaluated at the time of the next scheduled quarterly RCC. If a planned OOP event differs substantially, in terms of factors related to resident safety, from the approved OOP request, then new RCC approval must be obtained.

c. An OOP physician order for each ~~request by~~request shall be written in the Electronic Health Record (EHR)~~ for each request~~. ~~–~~The physician order must include medications to be taken while on OOP, if appropriate. Physicians cannot write a standing order for OOP.

d. Refer to Pharmacy Services policy and procedure 02.01.04 Pass Medications when the pharmacy is open or closed.

~~d.~~e. Nursing staff shall check the number and appearance of the OOP medication(s) and review directions and specific OOP instructions with the resident and/or SDM.

~~e.~~f. The RCT shall advise the resident and/or SDM of the consequences of not returning to ~~the facility~~LHH at the agreed ~~upon~~ date and time, unless an extension is obtained from ~~the ordering~~ a LHH physician. ~~\~~Failure to return at the designated time may result in discharge from LHH.

~~f.~~g. The Medical Social Worker (MSW) will review and provide the bed hold policy and form to the resident, ~~SDM and/or representative~~and/or SDM.

~~g.~~h. The nurse shall note in the EHR that the resident is on OOP, time of departure, instructions given, expected time of return, and actual time of return.

3. Documentation

a. Each request will be evaluated on the resident's current medical, physical, and mental health condition at the time the request is made to the RCT.

b. Each evaluation will take into consideration and document the following:

i. Indication (i.e., "having lunch with mother improves mood")

ii. Destination

iii. Who are they going with

iv. Duration/timing of OOP (typical duration ≤4 hours, exceptions should have documented justification)

v. Benefits of OOP

vi. Risks of leave, including specific notation if risks for:

- Elopement risk
- Challenges with safe decision making

- Depression / safety risk
- Contraband
- Substance use disorder risk
- Prior non-compliance with OOP parameters
- Other (i.e., medical risk, psychiatric risk, etc.)

vii. If the benefits outweigh the risks, list specific mitigation strategies, such as:

- Accompanied by a person who is responsible.
- Family is aware of risks.
- Able to demonstrate teach-back with strategies shared.
- Family is responsive and collaborative with the RCT.

viii. If the risks outweigh the benefit of the OOP, document reason(s) for declining OOP.

ix. Medication safety planning during OOP, including plan for education on administration.

- Determine what education will be provided (by whom and to whom) and when.

~~Determine when education will be provided~~

- Determine what medications will be required and ordered for a safe OOP.

x. Other caregiver safety education and planning (i.e., car transfers).

xi. Documented counseling of resident and/or ~~/~~SDM that being out past the scheduled parameters of the leave ~~will~~ may result in discharge as Against Medical Advice (AMA).

~~Notes: A new RCT is valid for up to 90 days for a given type of leave of absence request if all parameters are exactly the same. A new RCT meeting is needed if ANY of the parameters above is different or if a change in condition. (For example, if a resident returned from last OOP with concerning medical condition, behaviors, or contraband.)~~

4. Resident Education prior to an OOP

a. Nursing staff shall provide education to the resident prior to going on OOP. The education shall include:

   i. Review and verification of the RCT note and OOP order.

   ii. Medication education on administration, confirmation of medication teach-back, and signature obtained for receipt of medication supply.

      - If the resident does not demonstrate competency with ~~meds~~medications, they are not allowed the OOP privilege unless there's a representative who can be provided with education and demonstrate medication administration.

         - The RCT will document the education and return demonstration by the representative.

   iii. ~~Provision of~~A written handout or instructions shall be provided to the resident or representative (medication, treatment) prior to OOP. Use the "education" material in the EHR.

   iv. Instructions on special equipment (i.e., insulin pump, splints, etc.)/ special circumstances.

b. When nursing is ~~concern~~concerned that the resident condition is not safe for OOP, nursing will initiate the following steps below:

   i. Notify ~~on-call~~the physician and document in the EHR.

   ii. Physician will evaluate immediately and document in the EHR.

   iii. Physician will cancel the OOP order if decision is determined to not permit OOP.

   iv. Nursing staff are not to release the resident for ~~out on pass~~OOP until the physician evaluation occurs.

5. Census Management

a. The Licensed Nurse/Unit ~~Coordinator~~ Clerk shall complete the OOP information in the Unit Manager in the EHR under Leave of Absence (LOA). When the patient returns, the Licensed Nurse/Unit ~~Coordinator~~ Clerk shall mark the resident back in bed in the Unit Manager in the EHR.

b. In the event the resident does not return, the Licensed Nurse/Unit ~~Coordinator~~ Clerk shall inform the LHH physician for a discharge order and then the Licensed Nurse/Unit Clerk shall update the LOA to discharge in the Unit Manager.

6. Compliance/Adherence with Pass Privilege

a. Resident's/SDM's obligation ~~to participate in and comply with the procedure~~:

i. When leaving for an OOP and ~~on~~ returning from an OOP, residents and/or SDM shall check in and out with the nursing staff on their home unit.

- The License Nurse (LN) shall check-in with the resident within an hour of returning to LHH and document in the EHR.

- When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches, if and only if consent is provided, of the resident, a resident's room, and personal belongings, as well as property and packages brought by visitors (LHHPP 22-12 Clinical Search Protocol).

- Residents who are going OOP and would like tobacco products shall request products from the pavilion greeter. All unused tobacco products shall be returned to greeter upon return to LHH.

- Tobacco products purchased while OOP shall be surrendered in the lobby and picked up by designated unit staff.

ii. Non-adherence or non-compliance with the pass privilege shall result in a counseling meeting with the resident and/or SDM with the RCT and, if appropriate, development of an interdisciplinary care plan addressing the problem.

- ~~Resident non-adherence, non-compliance, leaving the facility without an OOP order, or in a manner inconsistent with the specified OOP parameters, shall result in the physician discharging the resident Against Medical Advice (AMA).~~

iii. Residents who violate OOP parameters and/or residents of sound mind who leave the facility grounds without an OOP order, shall be considered an elopement and may be subject to discharge AMA.

b. If a resident has not returned as expected, the nursing staff shall attempt to contact the resident and/or SDM. The LN shall document attempts in the EHR to contact the resident and/or SDM.

7. Extension of an OOP Order

a. Extension/Re-order of an OOP may be granted provided the following conditions are all met:

i. The resident's whereabouts ~~is~~are known.

ii. There was ~~a~~ verbal contact between the resident/SDM and the Nursing Unit Staff or Physician.

iii. The reason for extension is appropriate/valid.

b. The Physician shall document the reason for the extension of the LOA in the EHR.

c. If an extension occurs, the RCT shall meet to evaluate the appropriateness of the extension and document counseling with the resident/SDM about the need to follow LOA order parameters.

8. Nursing Evaluation upon Return from OOP

~~d.~~a. Nursing staff shall complete an evaluation of the resident withing one hour of returning from an OOP and ~~completion of~~complete the EHR documentation following the existing standard work (Resident Returning from an Out on Pass).

~~e.~~b. At a minimum, staff ~~to examine for~~shall examine the following:

i) Customary routine

ii) Cognitive patterns

iii) Communication

iv) Vision

v) Mood and behavior patterns

vi) Psychological well-being

vii) Physical functioning and structural problems

viii) Continence

ix) Disease diagnosis and health conditions

x) Dental and nutritional status

xi) Skin Conditions

xii) Medications

xiii) Special treatments and procedures

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-07 Against Medical Advice
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 22-12 Clinical Search Protocol
Pharmacy Services P&P 02.01.04
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold

Revised: 09/10/27, 14/01/28, 14/03/25, 17/11/14, 23/09/12, 26/08/18 (Year/Month/Day)

Original adoption: 99/04/02

EMERGENCY PREPAREDNESS COMMITTEE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to implementing an emergency preparedness program that at a minimum includes staff participation at committee meetings to plan, learn, be involved in emergency preparedness exercises, provide feedback on existing procedures and provide recommendations to improve staff performance in emergency response.

PURPOSE:

To maintain a safe environment for residents, staff, volunteers, and visitors. To~~,~~ enhance staff awareness and encourage interdepartmental collaboration to optimize staff response to emergency events.

PROCEDURE:

1. Membership

a. The Emergency Preparedness Committee (EPC) shall comprise of a representative from every department on campus.

b. The Emergency Management Coordinator shall serve as the chair of the committee, and an alternate designee assigned as necessary.

c. Departmental and ~~neighborhood~~ unit representatives may be selected to represent ~~respective departments or neighborhoods~~their respective areas at any time by Department managers to ensure active committee participation and provide new staff the opportunity to learn about the responsibilities of the EPC and emergency preparedness activities

2. Meeting

a. ~~The Committee~~EPC shall meet periodically throughout the year, no less than quarterly, or more often as the need arises.

3. Minutes

a. Written minutes shall be maintained for each meeting ~~and when approved at the subsequent meeting submitted to the Hospital Executive Committee~~and approved at the subsequent meeting.

4. Responsibilities of ~~Emergency Preparedness Committee~~EPC Members

a. Attend scheduled meetings.

b. Assist ~~Department Manager~~ in maintaining a current departmental or ~~neighborhood~~ unit staff call back roster.

~~b.~~c. Provide communication updates to ~~Department Manager and/or Staff~~department or unit staff on emergency preparedness activities, plans and procedures discussed at the committee meetings.

~~c.~~d. Assist ~~Department Manager~~ in maintaining a current Emergency Preparedness ~~binder~~ guide in respective departments or ~~neighborhoods~~units.

~~d.~~e. Participate in internal and external disaster drills at least two times a year, as applicable.

~~e.~~f. Collaborate in completing the annual Hazard and Vulnerability Assessment (HVA).

~~f.~~g. Assist in the annual review, development and implementation of emergency preparedness policies and procedures for process or systems improvements.

ATTACHMENT:
None.

REFERENCE:
LHHPP 73-01 Injury and Illness Prevention Program (IIPP)

Revised: 95/05/01, 98/11/16, 11/08/29, 13/01/29, 15/09/08, 17/03/14, 22/11/08, 26/08/18
(Year/Month/Day)
Original adoption: 92/05/20

~~Approved for renumbering to 70-01 Section A, B, and C: 18/02/23~~

EMERGENCY PREPAREDNESS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to Emergency Preparedness through a continuous cycle of planning, organizing, conducting training exercises, evaluating processes, and implementing corrective actions.

2. LHH staff ~~is~~are responsible for participating in training, exercises, and achievement of departmental and hospital-wide goals for emergency preparedness.

3. All City and County of San Francisco (CCSF) employees are mandated disaster service workers (DSWs) and are required to return to work during a disaster if called upon to do so. DSWs may be needed for their regular duties but may also be asked to perform other duties they are or will be trained to perform. DSWs may also ~~and they may~~ be asked to report to another location, including alternate care locations set up under an 1135 waiver. CCSF ~~E~~employees are provided with a ~~disaster service worker~~DSW identification badge that provides access to alternate locations.

4. Staff are responsible for providing their current emergency contact information to their Department Manager and the Human Resources (HR) department. Department Managers are responsible for maintaining an accurate call back list of their staff.

5. ~~The facility~~LHH shall utilize the Nursing Home Incident Command System (NHICS) for internal and external communication during emergency incidents and planned events.

6. Communication and coordination with the local public health department and other hospitals city wide is achieved through regular meetings, joint exercises, and coordinated planning.

PURPOSE:

To have staff trained and prepared to respond to emergency situations.

PROCEDURE:

1. Training and Exercises

a. New employees are introduced to Emergency Preparedness concepts during their LHH new employee orientation (NEO).

b. Emergency Preparedness in-service is provided at least annually through the Department of Education and Training (DET).

c. Additional training is provided through exercises, coordinated through the Emergency Preparedness Committee (EPC), that include defining and practicing departmental and individual roles with the Incident Command Structure (ICS) and development of next steps based upon exercise evaluation.

~~Training and department specific goals emphasize continuous home preparedness development and maintenance.~~

2. Communication and Coordination

a. Each department shall assign a representative to ~~the Emergency Preparedness Committee~~EPC who is responsible for continuously enhancing and sustaining emergency preparedness.

b. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of executive leadership.

c. Residents are apprised of emergency preparedness and response procedures in the LHH resident handbook, which is reviewed with the resident on admission by a ~~social worker~~staff from Social Services.

d. The department manager shall facilitate continuous updates for the emergency call back lists. The confidential call back lists are kept securely in the NHICS Command Center.

e. Emergency preparedness updates are communicated to ~~the~~ leadership forum, executive committee, ~~neighborhood~~ unit and departmental meetings, community meetings, and residents' council as necessary.

f. LHH participates in a city-wide emergency preparedness healthcare coalition to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.

g. Multiple communication systems are available and practiced to achieve redundancy in the event of technology downtime and to achieve coordination city-wide.

3. Re-Assessment and Planning

a. A Hazards and Vulnerability Assessment (HVA) is completed through EPC annually to identify emergency incident risks to drive training and exercise development.

b. Opportunities to participate in statewide, ~~city wide~~citywide, ~~DPH~~ Department of Public Health (DPH) wide and other multi-jurisdictional exercises are incorporated into exercise plans each year for a minimum of 2 exercises annually, no more than

6 months apart. Real incidents requiring NHICS activation can substitute for exercises.

c. Response plans for the following list of hazards have been developed by the facility and are reviewed annually by EPC for performance improvement opportunities:

i. Earthquake

ii. Mass Prophylaxis

iii. Fire

iv. Spill

v. Medical Surge

vi. Utility Disruption

vii. Power Outage

viii. Heat Emergency

ix. Active Shooter

x. Evacuation

xi. Shelter in Place

d. Emergency Supplies

i. Emergency equipment and supplies are stored in a central location near the Materials Management Warehouse and in the NHICS command center.

ii. Food storage during an emergency shall implement the LHH Food and Nutrition Services ~~Department~~ policy and procedure 1.03 Disaster Plan, procedure section.

- The kitchen maintains a 7-day food supply for 3,000 people (residents and ancillary staff) and water to augment the 600,000 gallons of water in towers behind the 5th floor parking lot. There are two main kitchen storage rooms for emergencies. The main storage room stores MREs (Meals Ready-to-Eat) and enteral and supplemental formulas. The second storage room stores emergency supply of paper. The stored MREs last a period of ten years and are rotated every six months. Service shall shift food items to emergency storage refrigerators.

- Staff shall identify any food stored that have been damaged and dispose of them, as directed by the Command Center. Staff shall not remove or issue food for preparation or service until it has been inspected for damage. Staff and residents shall not drink tap water until advised of its safety. Bottled or boiled water should be used.

- The Director of ~~Nutrition~~ Food Services shall activate the seven-day emergency menu as developed by the Chief Dietitian. The menus will include certain therapeutic and texture modifications diets.

- Staff shall assess any ~~damages~~damage to kitchen equipment and respond accordingly. Staff should continue to utilize existing pots and pans for the cooking process and serving utensils as required to serve the food. The dish-machines and pot-machine for the ware-washing process shall be utilized if they are functional after the initial assessment of equipment. If they are not functional, items should be washed by hand using proper dilution of chemical and rinse with a bleach-based sanitizer either in the pot-room sink and/or steam jacket kettle.

- The hospital's portable water supply may be used in the cooking and ware-washing process. In addition, there is an inventory par level of 60 cases of half liter bottled water that can be utilized as required. Staff may utilize the usage of disposable products such as pans, plates, cups and flatware, as needed.

- Deliveries of meals and nourishments shall be placed on hold until the Command Center approves movement through the facility. Kitchen staff shall coordinate with the NHICS Command Center to determine how meals will be transported to residents, employees, and visitors. Emergency food supplies should be provided through primary food vendor on a priority basis. Novation agreements supply back up food resources if the primary vendor is not available.

iii. A par level of linen maintained by the Environmental Services (EVS) Department.

iv. A cache of antibiotics for LHH Pharmacy is available for delivery from DPH storage sites. All medication refrigerators with the exception of PMS and PMA medication rooms are on emergency power. In the event of power outage, LHH to provide facility approved extension cords to PMS and PMA areas.

v. Par levels of medical and personal patient care supplies are available through most vendors.

vi. The use of alternate ~~source~~sources of energy shall implement the LHH Facility Services Department US-2 Emergency Power Generation System, procedure section.

- During a power outage two 2000kW, 3200A emergency diesel generators (in compliance with NFPA110) will supply essential power via 5000A paralleling main switchboard MSBG to the new Hospital buildings. There are eight Auto Transfer Switches automatically ~~switch~~switching the loads from PG&E power to the Emergency Generators.
- Emergency Generators will automatically start and engage the load demand within 10 seconds whenever a power interruption from the PG&E Company occurs.
- The generators provide power to all red electrical outlets, emergency lighting, elevators, fire detection devices, fire extinguishing and alarm systems, and boiler controls.
- Temperatures are maintained ~~to protect patient safe and healthy~~for resident wellbeing.~~:~~
- Facility Services continuously monitors temperatures in all spaces.
- Facility Services shall ~~setup~~set up a cooling room on each unit with portable air conditioners.
- If interior temperatures exceed 80 degrees, NHICS is activated, and relocation plan is implemented (LHHPP 70-01 B3 Resident Evacuation Plan).

4. Emergency Operations Program Plan

a. Provides the policy, purpose, and procedures for emergency response with appendices for pertinent details.

b. The manual also provides lists of resources and serves as an informational tool for responding to emergencies.

5. Staff Preparedness

a. Staff are encouraged to continuously enhance their personal preparedness.

b. Key activities recommended are having a household plan, including a communication and meeting plan, as well as assembling preparedness supplies in a kit at home and as a “Go bag,” for work or the car.

~~b.~~c. Information and links are provided on the LHH intranet.

6. Resident Preparedness

Each resident admitted to LHH receives a Resident Information Guidebook which describes the facility's emergency preparedness plans.

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B3 Resident Evacuation Plan
LHH Nutrition Services Department 1.3 Disaster Plan
LHH Facility Services Department US-2 Emergency Power Generation System

Revised: 15/07/17, 15/09/08, 18/07/10, 19/03/12, 19/09/10, 20/03/17, 21/06/08, 23/07/03, 23/09/05, 26/08/18 (Year/Month/Day)

Original adoption: 13/05/28

EMERGENCY RESOURCES AND MAPS

Staff Trained and Eligible to be Assigned Nursing Home Incident Command System (NHICS) Roles*

~~Arnaldo~~	~~Ritchele~~
~~Banaria~~	~~Nora~~
~~Banchero-Hasson~~	~~Monica~~
~~Blanco~~	~~Irin~~
Brunswick	Arnold
~~Cantor~~	~~Mark~~
Carton-Wade	Jennifer
Cecconi	Loretta
~~Chan~~	~~Sherry~~
~~Cozzi~~	~~Gary~~
~~Dayrit~~	~~Elizabeth~~
~~Duong~~	~~Susan~~
~~Durand~~	~~Kate~~
Ferrer	Valerie
Fishman	Amie
~~Fouts~~	~~Michelle~~
~~Frazier~~	~~William~~
~~Garcia~~	~~Emeterio~~
~~Garrick~~	~~Rodney~~
~~Grimes~~	~~John~~
Guina	Edward
~~Jackson~~	~~Chauncey~~
~~Kenyon~~	~~Diana~~
~~Lee~~	~~Vincent~~
~~McShane~~	~~Michael~~
~~Ng~~	~~Sandy~~
~~Nguyen~~	~~Quoc~~
Radoc	Ronald
Schindler	Elizabeth
~~Spencer-Davies~~	~~Jacky~~
~~Talai~~Zahir	Nawzaneen
~~Thanh~~	~~Olivia~~
Thompson	Kathy
~~Valencia~~	~~Madonna~~
Yarbrough	Jason

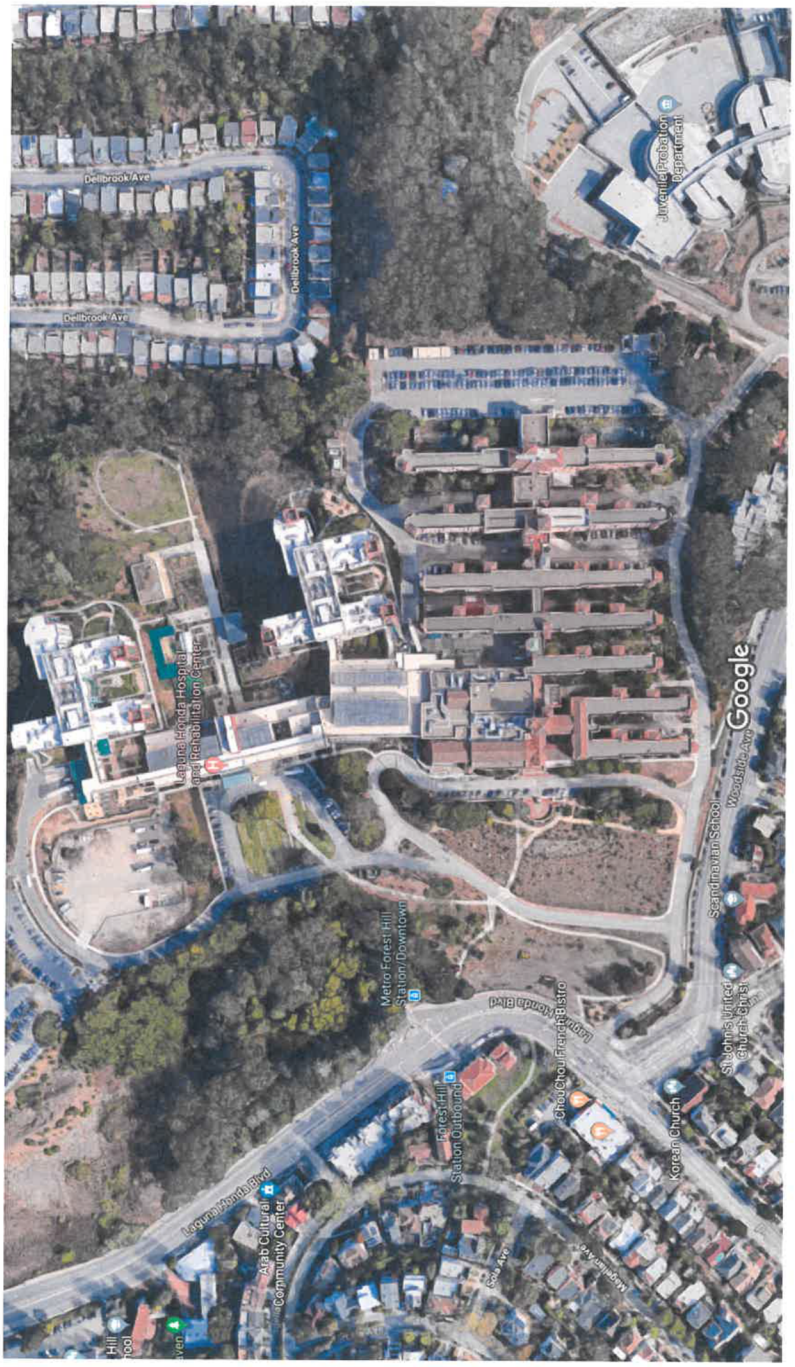
* Department, shift, and contact information are available in the Incident Commander binder in the command center

Emergency 800 MHz Radios		
Radio #	**Location**	**Staff Assigned**
119-3	1st Floor Administration Building Executive Administration Suite	CEO
137	4th Floor Administration Building A401 Command Center	CMO
269	1st Floor Pavilion Building Nursing Office	CNO/DON
173	5th Floor Administration Building Health At Home (on site at LHH – F5)	Nurse Manager, HAH
190	4th Floor Administration Building LHH IH Office	Industrial Hygienist ~~WSEM~~
191	1st Floor Administration Building Executive Administration Suite	~~COO~~ANHA
255	4th Floor Administration Building LHH ~~WS~~EM Director's Office	~~WS~~EM Director
271	4th Floor Administration Building A401 Command Center	NHICS Team
270	2nd Floor Administration Building LHH Facility Services	Facility Services Director
272	2nd Floor Administration Building LHH Facility Services	Facility Services Director

Vehicle List

TAG	VEHICLE #	VIN # s	MAKE	MODEL	YR	FUEL	L. PLATE	USE	ASSIGNED	capacity
1	555-00001	3FRWF6FL8BV592094	Ford	F650	2011	Diesel	1365853	Resident Transport.	Activity Therapy Dept	10 W/CH
2	555-00003	3FRWF6FL1BV592096	Ford	F650	2011	Diesel	1365855	Resident Transport.	Activity Therapy Dept	10 W/CH
3	555-00004	3FRWF6FLXBV592095	Ford	F650	2011	Diesel	1365854	Resident Transport.	Activity Therapy Dept	10 W/CH
4	555-105	2FMZA51656BA58080	Ford van	Freestar	2006	Gasoline	1227591	Official Staff use		7
5	555-106	1HGFA46507L000253	Honda	Civic	2006	CNG	1251056	Official Staff use		5
10	555-504	1FTSX20565EA23417	Ford Truck.	F250	2005	Gasoline	1191893	Facility Services	Engineering	Lift Gate
11	555-505	1FTYR14U75PA67978	Ford Truck.	Ranger	2005	Gasoline	1202139	Outside watch	Engineering	5
12	555-506	1FTYR14U47PA73045	Ford Truck.	Ranger	2005	Gasoline	1268066	Official Staff use	Messenger	5
13	555-522	2FDPF17M34CA36027	Ford Truck.	F150	2004	Gasoline	1179634	Fleet Maintenance	.EVS	
14	555-600	1FMNE31M62HB64380	Ford Van	E350	2002	CNG	1147190	Official Staff use		10
15	555-601	1FBSS31M02HB75170	Ford Van	E350	2002	CNG	1147195	Official Staff use		10
16	555-602	2FTJW35H3LCA41626	Ford	F350	1989	Gasoline	1004749	Facility Services	Crafts	
17	555-604	1FTSS34LX6DB25937	Ford Van	E350	2006	Gasoline	1249367	Resident Transport.	Activity Therapy Dept	8 or3 w/ch
18	555-605	1FBNE31L7YHB72237	Ford Van	E350	2000	Gasoline	1077827	Resident Transport.	Facility Services t	Lift + 4
19	555-608	1GBJG31J0V1107824	Chevrolet	3500	2000	Gasoline	1117249	EVS	EVS	Lift Gate
21	555-655	1FDWF36S7XEC19467	Ford	F350	1999	Gasoline	1021507	Gardener	Gardener	
23	555-806	1BAGJCPA0YF092466	Blue Bird	CSRE	2000	Diesel	1037333	Day Trip Bus	Activity Therapy Dept.	
25	555-906	MOHP4GX052585	John Deere		2007	Gasoline	N/A	Gardener	Gardener	
26	220-046	1FABP215320104761	Ford	Think/Neigh	2002	Electric	1147477	Materials Mgmt.	Materials Mgmt.	2
30	555-01029	1FTNE24M72HB75172	Ford	E250	2002	CNG	1147293	Clinics	Crafts	2
31	555-00039	1FTYR14UX5PA67991	Ford	Ranger	2005	Gasoline	1211400	Clinics	Crafts	2
32	555-01038	1FTNE24M62HB79911	Ford	E250	2002	CNG	1147298	Clinics	Crafts	2
	555-00005	JTDKN3DU0D1719743	Toyota	Prius	2013	Hybrid	1430024	Administration	COO	5
	555-00006	NMOGE9F77G1263046	Ford	Transit Connect XL	2016	Gasoline	1495926	Nursing	Resident transport	Lift + 4
	555-00007	JTDKN3DU8F0432501	Toyota	Prius	2015	Hybrid	1452892	Administration	CEO	5
	555-00008	JTDKN3DUXF1914090	Toyota	Prius	2015	Hybrid	1452891	Administration	Pool	5
	555-00009	1FDFE4FS8FDA12387	Ford	E450	2016	Gasoline	1473555	Shuttle Service	Muni Transport	13 + WC
	555-00010	1FDFE5FS6FDA12386	Ford	E450	2016	Gasoline	1473596	Shuttle Service	Muni Transport	13
	555-00011		Ford	F550	2015	Gasoline	1474007	Bus	Activity Therapy Dept	23 + WC

Site Map



Additional schematic maps of each floor are available from Facility Services and in the Command Center.

Revised: 13/05/28, 18/09/11, 19/05/14, 19/09/10, 22/11/08, 26/08/18 (Year/Month/Day)

EMERGENCY RESPONSE PLAN

POLICY:

1. The immediate priorities of Laguna Honda Hospital and Rehabilitation Center (LHH) during a disaster are:

   a. Protection of lives

   b. Stabilization of the incident, and

   c. Protection of property and the environment.

2. LHH shall coordinate emergency response with the San Francsico Department of Public Health (DPH) and communicate status and resource needs or requests throughout any major event to the Department Operations Center (DOC).

PURPOSE:

1. The purpose of this plan is to serve as a guide for a rapid, effective, and coordinated response to any event resulting in a disruption of normal operations at LHH.

2. The purpose of an effective response will be to provide continued, quality service to residents, maintain essential internal and external communications, manage the use of resources; facilitate recovery efforts; and reduce the impact of the event.

PROCEDURE:

1. Activating the Nursing Home Incident Command System (NHICS)

   a. If an emergency situation affects the normal operation of ~~the facility~~LHH, the employee who discovers the situation shall immediately report it to their supervisor. The supervisor shall notify the Chief Executive Officer/Nursing Home Administrator (CEO/NHA) or the Administrator on Duty (AOD) of the major event that adversely affects the facility's ability to deliver care in the usual and customary manner, or to an accepted standard.

   b. The CEO/NHA or AOD shall activate NHICS as needed and either assume or designate the role of Incident Commander.

   c. If the CEO/NHA or AOD cannot be reached, the Nursing Operations Nurse Manager shall assume the role of ~~Acting~~ Incident Commander and assign someone to notify the following, in the order listed:

      i. Assistant Nursing Home Administrator (ANHA)

ii. Director of Emergency Management (DEM)

~~iii. Chief Nursing Officer (CNO)~~

~~iv.~~iii. Director of Nursing (DON)

iv. Chief Medical Officer/ Medical Director (CMO)

v. Chief Quality Officer (CQO)

d. The first person to be reached on the above list shall assume or delegate the position of Incident Commander. Staff qualified to serve as the Incident Commander are those who have completed minimum training, which includes ICS 100, 200, 700 as well as additional NHICS training, and whom are deemed by the CEO/NHA or AOD to be qualified to manage the specific incident. A list of staff with this level of training can be found in ~~Section~~ LHHPP A3 Emergency Resources and Maps and shall be updated quarterly by the Emergency Management Coordinator.

e. If the designated Incident Commander is not on site when NHICS is initiated, the Nursing Operations Nurse Manager shall serve as ~~Acting~~ the Incident Commander ~~who shall serve~~ until the designated Incident Commander arrives to relieve them.

f. NHICS roles are activated at the discretion of the Incident Commander for emergency incidents or planned events with the number of positions activated scalable to the situation. The Incident Commander is the only position ALWAYS activated and shall assume responsibilities of any role(s) not activated.

g. An incident may be initiated from LHH, or the facility may be informed of a city-wide incident through external notification by EMS Duty Officer or DPH ~~Departmental Operation Center~~DOC.

h. Whenever NHICS is activated, all department and neighborhood managers or designees shall assess the status of their area using the Department Operating Status Report (DOSR), (see Appendix A), which shall be faxed to the Command Center at ~~415-504-8313~~628-754-4671 or delivered to the nearest DOSR collection bin within 15 minutes of NHICS activation. The DOSR collection bins are in the following locations:

i. B102

ii. Clinic Registration Area

iii. Cadet's desk at the Pavilion main entrance

iv. Nursing Office

2. Notifications

a. Whether an incident is internal or external to LHH, the sequence of notifications in Table 1 shall be followed once NHICS is activated.

Table 1: INTERNAL NOTIFICATION PROCESS		
PERSON INITIATING	**CONTACT PERSONS**	**COMMUNICATION**
Incident Commander	Nursing Office Staff at 4-2999	State message to be announced such as "Attention: NHICS has been activated due to_____. Complete your DOSRs now."
Nursing Office Staff	Facility Occupants	Announce on the overhead Public Address (PA) system as directed by the Incident Commander
Incident Commander	S.F. Sheriff Duty Officer On-Call Medical Staff	Inform of situation.
Incident Commander	Executive Staff	Using DPH Alert system (Everbridge), notify the executive team that NHICS has been activated and why.
Executive Staff	Department Managers	Follow Department Emergency Plan
Incident Commander or Emergency Manager	DPH Emergency Preparedness& Response	Notify on-call Manager that NHICS is activated, reason for activation, and if there are any immed needs.

b. Additional notifications may be sent from the command center to all employees or subgroups of employees using the DPH Alert system.

c. Whenever an incident is anticipated to impact, or require assistance from, other agencies or facilities, the CEO/NHA, AOD, or Incident Commander shall notify the DPH Emergency Response & Preparedness branch, who can notify the Director of Health and the DEM Duty Officer that LHH has activated NHICS.

3. Communications Plan

a. Communication shall be maintained with DPH throughout large scale incidents ~~in order to~~to verify status, prioritize objectives, share resources, and coordinate city-wide needs.

b. The Liaison Officer or Incident Commander shall establish communications with the EOC and/or the DPH DOC, if activated.

c. If the DOC is not activated, communications shall be established with DPH PHEPR, by calling the 24/7 on-call phone number.

d. An emergency contact list, including key LHH contacts and external agencies is available in the command center and as Appendix B.

e. The ReddiNet system shall be used to receive information from EMS, DPH, and other health facilities during multiple casualty incidents (MCIs) affecting the San Francisco health care system.

f. The Public Information Officer (PIO) or Incident Commander shall maintain communications and provide regular updates to the LHH community, including employees, residents, and resident families.

g. Any requests for information coming from the media shall be forwarded to the DPH ~~Public Information Officer~~PIO. No LHH employee shall make a statement to the media.

h. In the event that regular communications systems are unavailable, a variety of back-up communication methods are available at the discretion of the Incident Commander:

   i. Radios are available in the command center, Nursing Office, and offices for the CEO/NHA, ~~COO~~ANHA, ~~Sheriff~~San Francisco Sheriff's Office (SFSO), Emergency Management Coordinator, and Health at Home.

   ii. A Mayor's Emergency Telephone System (METS) phone is available in the command center for direct contact with city emergency services officials. The METS system is also connected to the State of California's satellite telephone system for direct communication with the Governor's Office of Emergency Services in Sacramento, as well as the emergency operations centers of surrounding counties.

   iii. Messengers shall be used if all communication devices have failed, or as needed to augment communication devices.

4. **Off-Duty Staff Response**

a. All staff are mandated disaster service workers.

b. Off duty staff are expected to:

   i. First assure their own safety and that of their family

ii. Wait to be called back to work or report for the next scheduled shift unless required to report immediately per the departmental emergency plan.

iii. Listen to the radio in case the phone lines are down (Radio stations KNBR 680, KGO 810, or KCBS 740).

c. Staff are advised to check road conditions and radio announcements before traveling. The city may also assist staff to and from their assigned locations in the event that roads and bridges are compromised, as announced on radio and other means available.

d. The Incident Commander shall activate staff to NHICS positions according to the needs of the response.

e. Additional staff may be called to either their regular duties or to the labor pool. Each department manager or ~~/~~designee leads the call back process and response ~~according to their Departmental Procedure~~. If the department manager or designee is not available, the Incident Commander or Logistics Section Chief may initiate a call back of any staff deemed necessary for the response.

5. **Staffing & Management of Volunteers**

a. **<u>Volunteer Staffing during Emergencies or Disaster</u>**

i. LHH volunteer staffing is designed to be flexible during periods of increased demand or other intermittent challenges

ii. During any emergency or disaster where additional or alternative staffing is required to sustain hospital operations, activated according to LHHPP 70-03 Emergency Response Plan, and under one or more of the following circumstances:

- Activation of the DPH Emergency Operations Plan
- Activation (partial or full) of the DPH ~~Departmental Operations Center (~~DOC~~)~~ for an emergency response
- Staff absenteeism is 20% or more than anticipated staffing for hospital
- When emergency preparedness response activities exceed staffing capabilities
- Damage or inoperability of key facilities impedes daily operations

b. **Management of Staff - Including Volunteer Healthcare Professionals at LHH during a Disaster**

i. During a major event, volunteers will assemble under the direction of their unit supervisor. Volunteers must be properly identified and have their credentials verified before being assigned to assist in any area.

c. **Licensed Independent Practitioners:**

i. In the event that the LHH Emergency Response Plan has been activated AND the ~~Hospital~~ LHH is unable to handle the immediate patient care needs, volunteer health care professional(s) who are licensed independent practitioners may be granted Disaster Privileges and assigned disaster responsibilities by the CEO/NHA.

- Before a volunteer licensed independent practitioner is considered eligible for consideration for disaster privileges, they must present valid government issued identification (for example, a driver's license or passport and at least one of the following:

  - A current picture identification card from a healthcare organization that clearly identifies professional designation;

  - A current license to practice;

  - Primary source verification of licensure;

  - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or

  - Written attestation to the Chief of Staff or their designee by a licensed independent practitioner currently privileged by LHH or by a staff member of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

ii. **Tracking Staff & Volunteers at LHH during a disaster**

- During Actual emergency NHICS Activations, ~~Department Managers and Supervisors~~ department managers and supervisors are responsible for tracking the location of all on duty staff & assigned volunteers working for their department. Using normal departmental time-keeping documents, attendance should be checked no less than every two (2)

hours, and when directed by the Incident Command Center so that appropriate badge access auditing or other search measures can be coordinated as soon as possible.

6. Equipment and Supplies

Equipment and supplies to support a safe and effective staff response are maintained by the Department of Workplace Safety and Environmental Management (WSEM), Materials Management, Nutrition Services, and the Pharmacy. Table 2 lists critical equipment and supplies along with their storage locations.

Table 2: Emergency Equipment and Supply Locations

EMERGENCY EQUIPMENT/SUPPLY	STORAGE LOCATION
Seven days' worth of food for 2000 people	Kitchen
600,000 gallons potable water	Water tanks east of facility
266 gallons of bottled water	Kitchen
Par level of linen	Clean linen storage room in S1
Evacuation equipment	H2 emergency storage
Respirators and cartridges	H2 emergency storage
Emergency lighting	H2 emergency storage and each neighborhood/department
Personal patient care supplies	H2 Central Supply/Warehouse
Tent	Container in gravel parking lot
Cots (55)	Container in gravel parking lot

7. Shelter in Place Plan

Mitigation/Preparedness: During certain emergency situations, particularly chemical/HAZMAT, biological, radioactive events or weather emergencies, it may be advisable for employees to shelter-in-place rather than evacuate the building. Shelter in-place is a strategy taken to maintain patient care within LHH and to limit the movement of staff and visitors to protect life and property from hazard. Shelter-in-place is an ideal method of self-protection from airborne contaminants, such as a toxic airborne chemical or a person with a weapon. It may be necessary to evacuate certain parts of LHH and shelter-in-place in another part of the facility.

i. Criteria for Implementation: In situations posing an immediate threat to the safety of employees and visitors, shelter in place procedures must take priority.

Shelter-in-place shall be determined by the ~~Chief Executive Officer (CEO)~~CEO/NHA or the ~~Administrator on Duty (AOD).~~AOD.

ii. Pre-Event Information: Potential terrorist incidents, such as the release of a chemical hazard may be preceded by alerts issued by local or state authorities. Information may be disseminated to LHH via PHEPR. Notification may also be made from law enforcement, HAZMAT teams or fire department via telephone.

iii. Activation of Emergency Response Procedures: Upon notification that a suspected/confirmed airborne chemical/biological hazard is likely to impact LHH the Emergency Response Plan will be activated and "Shelter in Place" will be announced overhead. Notification may be made by Mass Notification system and email.

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors. • Facilities department to shut down hospital Heating, Ventilation and Air Conditioning Unit (HVAC)
Notify residents, employees, visitors and vendors ~~as~~ to the nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.
Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

iv. Reassessment of Event: External communication via, news media, California Health Alert Network (CAHAN) notifications, ReddiNet, email notification, landline communication may provide additional information critical to the assessment and reassessment of the shelter in place response activities.

v. Recovery Strategies: Assess staffing requirements and provide an organized reporting structure. Ensure that the HVAC system and ventilator systems have returned to normal operations. Take down signs from all building entrances and exits. Notify employees, residents and vendors of the ability to enter and exit the building. Provide safe reentry pathways to the building in an organized manner.

vi. Education & Training: New employees at LHH receive emergency preparedness training at new employee orientation. All staff shall receive emergency preparedness training annually with e-learning module.

8. Contactor Contact Information

All contracts and associated contact information for entities providing services to LHH can be found in Appendix C and are maintained in two areas:

- Within four purple binders located in the Administration Suite.

ATTACHMENT:
Appendix A: Department Operating Status Report (DOSR)
Appendix B: Emergency Contact List
Appendix C: Contractor Contact List

REFERENCE:
Regulatory References: California Occupational Safety and Health Standards, California Code of Regulations (CCR), Title 8, Section 3220; and Licensing and Certification of Health Facilities, California Code of Regulations (CCR), Title 22, Sections 70741 and 72551; and the Standardized Emergency Management System (SEMS), CCR Title 19, Division 2.

Revised: 14/11/25, 17/05/09, 18/03/13, 19/05/14, 19/09/10, 20/03/17, 23/06/14, 24/12/10 (Year/Month/Day)

Original Adoption: 13/05/28

APPENDIX A
DEPARTMENT OPERATING STATUS REPORT

COMPLETE THIS FORM IMMEDIATELY FOR ALL DISASTER / EMERGENCY NOTIFICATIONS & PROVIDE TO THE COMMAND CENTER (Fax: 415-504-8313)

Date: _____ Time notified of emergency/disaster activation ____:____ Time report completed ____:____ Time report received at Command Center ____:____

Department: _____ Location: _____ Telephone: _____

Contact Person _____ Title _____ Contact by phone _____ Pager _____

If no residents in your area, skip to Section 2 **SECTION 1 – RESIDENTS**	**SECTION 2 – STAFFING**	Resident Units, Clinic, Rehab Only **SECTION 3 – CRITICAL RESOURCES**
Current Census in Department: Number of residents accounted for Have any residents been injured? ☐ Yes ☐ No Please list on the back of this form names of any injured or missing residents. Indicate type of injury or location/ likely whereabouts as applicable. Any anticipated Resident condition changes or problems resulting from this event? ☐ Yes ☐ No # of Patients eligible for discharge # of Patients eligible for Transfer	**Current Staffing in department (on duty)** RN# LVN# CNA/PCA# HHA# MD# EVS# Unit Clerk# FSW# HIS# AT# SW# Other staff: (List title and number of staff) ***Complete staff name and title on next page*** Total Staff: Any injuries to staff? ☐ Yes ☐ No If "Yes", list number of injuries by severity: Minor Delayed Immediate Expired Number of staff available for Labor Pool:	Open/Available Beds # Open/Available Negative Pressure Rooms# Open/Available Gurneys # Open/Available Wheelchairs # Available Portable O2 # Full #Partially Full Other Available Space, Equipment and Supplies

Please use back of form for additional information as needed

SECTION 4 – DEPARTMENT STATUS	**SECTION 5 – ESSENTIAL SERVICES**	**SECTION 6 – NEEDS ASSESSMENT**
Please survey your department and complete the following: ☐ Yes ☐ No Are any hallways or exits blocked? ☐ Yes ☐ No Are water lines ruptured or leaking? ☐ Yes ☐ No Are gas lines ruptured or leaking? ☐ Yes ☐ No Is there structural damage? ☐ Yes ☐ No Are there any hazardous material spills? Additional info:	**Please answer all questions:** ☐ Yes ☐ No Do you have working telephones? ☐ Yes ☐No ☐N/A Are medical gases (O2) working? ☐ Yes ☐ No Is there running water? ☐ Yes ☐ No Do you have lighting? ☐ Yes ☐ No Are your computers working? ☐ Yes ☐ No Are sewage systems intact? ☐ Yes ☐ No Do you have power? What areas are without power?	**Please check all that apply:** ☐ Yes ☐ No Do you need extra staff? ☐ Yes ☐ No Do you need medical equipment / supplies? ☐ Yes ☐ No Do you need clean-up assistance? If yes to any, specify number and type needed:

Employee Name	Classification

Appendix B: Emergency Contact List

Agency or Individual	Phone	Pager	Email
Director of Health	415-554-2525		
SFHN Director	415-554-2711		
DEM Duty Officer	415-260-2591	415-327-0543	
PHEPR On-Call Manager	415-802-7358		
DPH DOC	DOC will provide number upon activation		
DPH Communicable Disease Urgent Reporting Line	415-554-2830		
ZSFG Incident Commander	628-206-9680		
ZSFG AOD	628-206-3519	413-327-0259	
ZSFG Emergency Prep Coord	415-694-9488 text/voice		
IT On Call Engineer			
IT MOD			
EOC Turk Street	415-487-5000		
SFSO – Sheriff	~~415-759~~628-754-2319		
CDPH L&C District Office	415-554-0353		
Ombudsman	415-751-9788		

Appendix C: Contractor Contact List

LHH Contract Owner	Categories	Vendor Name	Title	Supplier Contact Name	Phone Number	Email
Carton-Wade, Jennifer	Activities	Some Things Fishy	Aquarium Maintenance Services	Ric Boschert	408-836-7761	nicefishtanks@yahoo.com
Carton-Wade, Jennifer	Activities	Eldergivers	Eldergivers	Mark Campbell	415-215-3659	mark@artwitholders.org
Carton-Wade, Jennifer	Activities	Medical Clown Project, Inc.	Medical Clown Project	Calvin Kai Ku	510-919-8310	ckaiku@medicalclownproject.org
Carton-Wade, Jennifer	Activities	Community Music Center	Spanish Speaking Choir	Sylvia Sherman	415-647-6015 x172	ssherman@sfcmc.org
Carton-Wade, Jennifer	Administration	National Research Corporation	Patient and Workforce Surveys	Molly Preston	800-388-4264	mpreston@nrchealth.com
~~Sangha, Baljeet (DPH)~~	~~Administration~~	~~Moss Adams, LLC~~	~~Consultant Services~~	~~Ryan Joyner~~	~~404-285-5183~~	~~ryan.joyner@mossadams.com~~
~~Sangha, Baljeet (DPH)~~	~~Administration~~	~~HMA, Inc~~	~~Consultant Services - CMS Certification~~	~~Rob Ross~~	~~845-325-2986~~	~~rross@healthmanagement.com~~
~~Pickens, Roland~~	~~Administration~~	~~HSAG~~	~~Consulting and Assessment Services~~	~~Barbara Averyt~~	~~602-327-2522~~	~~baveryt@hsag.com~~
Sur, Matthew	Administration	Toyon	Reimbursement Services	Carrie Yee	888-514-9312	carrie.yee@toyonassociates.com
Shuyan Wu	Environmental Services	Stericycle, Inc	Document Destruction - Shred-It	Victor Mainor	415-960-6530	victor.mainor@stericycle.com
Shuyan Wu	Environmental Services	Stericycle	Medical Waste Management	Fernando Campos	510-324-6469	fernando.campos@stericycle.com
Shuyan Wu	Environmental Services	Agurto Corporation dba Pestec	Pest Control	Luis Agurto	415-671-0300	luis@pestecipm.com
Shuyan Wu	Environmental Services	Waxie Sanitary Supplies	EVS cleaning Supplies	Ivan Lopez	510-710-9781	ilopez@waxie.com
Shuyan Wu	Environmental Services	Emerald Textile Services LLC	Linen Service	Sherry Lee	209-918-1185	slee@emeraldus.com
Shuyan Wu	Environmental Services	Recology Sunset Scavenger Company	Refuse Collection & Recycling	Marc Valentine	415-330-1315	mvalentine@recology.com

Shuyan Wu	Environmental Services	Fanta Deluxe Cleaners	Dry Cleaning Services	Joseph Park	415-495-7788	pagingjoseph@gmail.com
Shuyan Wu	Environmental Services	COIT Cleaning & Restoration	Blinds and Shades ~~installating~~installation and repair~~se~~	Ellison Penos	650-826-1394	ellison.penos@coit.com
Shuyan Wu	Environmental Services	Banner Uniform Center	Uniform and Related Ancillary Items	Frank Skubal	415-771-5593	frank@banneruniform.com
Shuyan Wu	Environmental Services	Beck's Shoes	Foodwear	Brian Baumert	831-345-9305	bnbaumert@beckshoes.com
Shuyan Wu	Environmental Services	Cole Supply	Cleaning supply	Michelle Stringer	925-876-1565	mstringer@colesupply.com
Hoffman, Samuel	Equipment	Konica Minolta	Equipment Maintenance	Jane Uong	408-387-2335	juong@kmbs.konicaminolta.us
Brunswick, Arnold	Facilities	ABCO Mechanical Contractor	Air Duct Maintenance Services	Nick Lanthier	415.648.7135	nick@abcoair.com
Brunswick, Arnold	Facilities	Hill Rom	Hill Rom Bed Maintenance	Dan Murphy	509.319.4054	Daniel_Murphy@baxter.com
Brunswick, Arnold~~Kenyon, Diana (DPH)~~	Facilities	Garrett Callahan	Boiler Chemicals	Mike Bauman	650-201-3096	mbauman@g-c.com
Brunswick, Arnold	Facilities	Rubecon General Contracting	Door, Gate, Modular Furnishing, Carpentry, Fire Rated Door Services	Rudy Rodriguez	415.987.0500	rudy@rubecon.com
Brunswick, Arnold	Facilities	Thyssen Krupp	Elevator Repair and Maintenance	Joseph Charne	415-544-8150	Joseph.Charne@tkelevator.com
Brunswick, Arnold	Facilities	International Fire	Fire Extinguishers and Pump Maintenance	Karl Reed	415-643-1767	karl.fireprotection@gmail.com
Brunswick, Arnold	Facilities	Johnson Controls, Inc.	HVAC	Andrew Aguero	510-600-5175	andrew.n.aguero@jci.com
Brunswick, Arnold	Facilities	West-Com	Maintenance	Tiffany Kraft	707-428-5902	tkraft@westcomtv.com
Brunswick, Arnold	Facilities	Union Rolling Door	Rolling Door Services and Maintenance	Carlo Doyle	415-789-3899	carlo@union-door.com
Brunswick, Arnold	Facilities	Emerson Digital Cold Chain, Inc.	Temperature Control	Jonathan Ganak	425-419-7085	jonathan.ganak@emerson.com
Brunswick, Arnold	Fire Alarm	Johnson Controls	Fire Alarm Maintenance	Andrew Aguero	510-600-5175	andrew.n.aguero@jci.com

Lavarreda, Elvis	Food and Nutrition Services	Bay Cities Product Inc	Food Service Distribution and Procurement - Bay Cities (Milk and Dairy)	Tina Swearengin	510-346-4943	tina@baycitiesproduce.com
Lavarreda, Elvis	Food and Nutrition Services	Bay Cities Produce Inc	Food Service Distribution and Procurement - Bay Cities (Produce)	Tina Swearengin	510-346-4943	tina@baycitiesproduce.com
Lavarreda, Elvis	Food and Nutrition Services	Blossom Foods	Food Service Distribution and Procurement - Blossom Foods - Premade Meals	Sue Adams	510-893-3244	1Sueadams@gmail.com
Lavarreda, Elvis	Food and Nutrition Services	Fresh & Ready	Food Service Distribution and Procurement - Grab-N-Go	Arthur Gulumain	818-433-6746	
Lavarreda, Elvis	Food and Nutrition Services	IVSF Catering	Food Service Distribution and Procurement - IVSF	Jason Angeles	415-830-0095	
Lavarreda, Elvis	Food and Nutrition Services	San Francisco Supply Master Inc.	Food Service Distribution and Procurement - SF Supply Master	Ryan Framan	415-642-0700	ryan@sfsupplymaster.com
Lavarreda, Elvis	Food and Nutrition Services	US Foods, Inc	Food Service Distribution and Procurement - US Foods	Daniel Murray	800-682-1281	ncacustomerservice@usfoods.com
Lavarreda, Elvis	Food and Nutrition Services	Bimbo Bakeries USA	Fresh Bread and Dinner Rolls	Franko	510-333-2217	
Lavarreda, Elvis	Food and Nutrition Services	Banner Uniform Center	Uniform and Related Ancillary Items	Frank Skubal	415-771-5593	frank@banneruniform.com
Lovko-Premeau, Diane	H.I.M.S.	GRM Information Management Services LLC	Document Storage Service	Michael Vlahos	800-932-3006	www.grmdocumentmanagement.com

Lovko-Premeau, Diane	H.I.M.S.	VRC Companies LLC	Medical Record Retrieval and Reproduction	Sonya Brousil	702-410-9591	sbrousil@vrcnetwork.com
Lovko-Premeau, Diane	H.I.M.S.	ACCESS (Previously DELIVEREX)	Medical Record Storage	Karen Clements	888-869-2767	Karen.Clements@accesscorp.com
Cozzi, Gary	Laboratory	Registry Network Inc	Laboratory Staffing			
Hoffman, Samuel	Medical and Industrial Gas	Airgas	Medical and Industrial Gas	Victor Trotter	916-205-8773	
Fong, Doug	Medical Equipment	AeroScout, LLC	AeroScout			
Hoffman, Samuel	Medical Equipment	Baxter Healthcare Corporation	Equipment Maintenance Service	Lawrence Jones	619-734-5233	lawrence_jones@baxter.com
Hoffman, Samuel	Medical Equipment	KCI USA Inc	Equipment Rental	Anthony Maduena	510-292-0315	amaduena@mmm.com
Hoffman, Samuel	Medical Equipment	Agiliti Health Vizient	Medical Equipment Management	Peter Galley	916-540-6066	Peter.Galley@agilitihealth.com
Brunswick, Arnold	Medical Equipment	Stryker	Stryker Bed Maintenance	Kelsy Bucklew	317-703-9607	kelsy.bucklew@stryker.com
Hoo, Lisa	Medical Services	Bay Area Communication Access	American Sign Language Interpreting Services	Arnita Dobbins	415-356-0405	bacareg@bacainterp.com
Chen, Helen	Medical Services	Regents of the University of California (UCSF)	Outpatient Clinical Services & Dental Services			
Hoffman, Samuel	Medical Supplies	Medline Industries	Medline Supply	Brian Lee	925-290-9497	bjlee@medline.com
Hoffman, Samuel	Medical Supplies	SF Supply Master	Cleaning supply and Food Serving Supply	Customer Service	415-642-0700	order@sfsupplymaster.com
Hoffman, Samuel	Medical Supplies	Cardinal Health	Medical Supplies	Keri Smith	510-570-6594	keri.smith01@cardinalhealth.com
Hoffman, Samuel	Medical Supplies	Performance Health	Medical Supplies	Cindy Nguyen	408-609-4894	cindy.nguyen@performancehelath.com
Hoffman, Samuel	Medical Supplies	Nestle Ready ReFresh	Bottled Water	Customer Service	844-855-4596	
Antoc, Maria Roella	Nursing	Cross Country Staffing	Medical Staffing			

Antoc, Maria Roella	Nursing	Tryfacta, Inc.	Medical Staffing	Adesh Tyagi	408-893-5500 517-273-4547	adesh.tyagi@tryfacta.com
Smith, David	Pharmacy	Technical Safety Services TSS	Sterile Room Testing	Grant Ono	510-845-5591	GOno@techsafety.com
Smith, David	Pharmacy	Parata	Auto Packaging Machine Service and Supplies	Teresa Rasmussen	866-559-0968	TRasmussen@parata.com
Smith, David	Pharmacy	FFF	Vaccinations	Diane Santos	800-843-7477	DSantos@fffenterprises.com
Smith, David	Pharmacy	Alta Medical	Sterility testing equipment	Ty Rudell	415-215-9599	Ty@altamedspec.com
Smith, David	Pharmacy	JMI Sourcing	Auto Packaging Supplies	Jennifer Varma	415-939-5221	VarmaJennifer@gmail.com
Smith, David	Pharmacy	Fisher Healthcare	Pharmacy supplies	Julian Barber	442-287-5293	Julian.barber@thermofisher.com
Smith, David	Pharmacy	GlaxoSmith Kline	Vaccinations	Sarah Rauh	415-470-2533	Sarah.e.rauh@gsk.com
Smith, David	Pharmacy	CME	Pharmacy supplies	Heather Pfeiffer	415-744-4476	hpfeiffer@cmecorp.com
Smith, David	Pharmacy	Muscolino	Pharmacy inventory	Ray Parsons	940-577-5241	Ray.Parsons@picsinv.com
Smith, David	Pharmacy	Nor-Cal Medical Temps	Pharmacy Staffing	Bryan Medlin	415-459-5211	bpmedlin@norcalmedtemps.com
Smith, David	Pharmacy	Soliant Health, Inc	Pharmacy Staffing	Meckal Rogers	813-749-5268	Meckal.Rogers@soliant.com
Smith, David	Pharmacy	Omnicell	Supplies	Al-x Gonzalez	650-251-6039	Al-x.gonzalez@omnicell.com
Wong, Jorge	Technology	Change Healthcare (CERME, InterQual)	Software Maintenance - Workforce Management			
Smith, David	Technology	McKesson Technologies, Inc.	Technology Services	Cristina Lizarraga	916-284-6315	cristina.lizarraga@mckesson.com
Lavarreda, Elvis	Technology	The CBORD Group, Inc	Food Software License	Jim Mitchel	607-330-3925	
Lovko-Premeau, Diane	Technology	Nuance Communication Inc	Nuance's Clintegrity System Licenses	Jeanne Nauman	866-383-9031	jeanne.nauman@nuance.com

Swiger, Dureshehwar	Therapy - OT/PT/SLP	Preferred Health Care Registry, Inc	Rehab Staffing	Peyton Pyburn	858-429-7990	peytom@mypreferred.com
Swiger, Dureshehwar	Therapy - OT/PT/SLP	Supplemental Health Care	Rehab Staffing	Morgan Mason	469-708-4005	mmason@shccares.com
Swiger, Dureshehwar	Therapy - OT/PT/SLP	Hearing & Speech Center of Northern California	Speech Therpay Third Party	Emily Smith	(415) 921-7658	esmith@speechhearing.org
Hnin, Aye	Transfer/Transportation	Capital Transit	Medical Transportation - Capital Transit	Shiraz Mir	(916) 470-0476	shirazmir916@gmail.com
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CONTINUITY OF OPERATIONS PLAN

POLICY

Laguna Honda Hospital and Rehabilitation Center (LHH) is linked to the City and County of San Francisco's (CCSF) Emergency Operations Center (EOC) and the Department of Public Health's (DPH)~~DPH's~~ Department Operations Center (DOC) in accordance with ~~the City and County of San Francisco~~CCSF and DPH Emergency Operations Plans through the Standardized Emergency Management System (SEMS).

LHH's role in emergency preparedness is to respond rapidly and effectively to internal and/or external disasters and continue to provide in-patient services to LHH residents. In the event of a major disaster, LHH is also prepared to expand treatment areas to provide basic first aid and temporary shelter to staff, visitors, and a limited number of additional residents requiring skilled nursing or acute (non-surgical) care. LHH works in partnership with Zuckerberg San Francisco General Hospital (ZSFG) to accept additional residents to make room for incoming casualties at ZSFG during an emergency incident. Evacuation of LHH residents from one area of the hospital to another or to an alternate location on or off-site may also occur.

Essential services must be maintained simultaneously with emergency incident mitigation, response, and recovery during and after a disaster impacting operations.

PURPOSE

The purpose of the Continuity of Operations Plan (COOP) is to ensure that LHH continues to provide essential healthcare services that maintain overall resident and staff safety and well-being in keeping with our mission. The plan outlines a systematic, all hazards approach to ensure the continuity of essential services at LHH during any type of event that impacts infrastructure, staffing, or other critical resources.

1. LHH Operations

a. **Mission:** LHH's mission is to provide a welcoming, therapeutic and healing environment that promotes the individual's health and well-being.

b. **Normal Operations:** Consistent with its mission, LHH is comprised of 13~~14~~ resident care units or "neighborhoods" providing skilled nursing and rehabilitation care for up to 769 residents and up to 11 residents requiring acute care. The neighborhoods are listed as follows:

i. Pavilion Mezzanine (11 acute care beds, including one in a negative pressure isolation room; 49 SNF beds)
ii. North Mezzanine (60 SNF beds)
iii. North 1 (~~60~~ 50 SNF beds)
iv. North 2 (~~60~~ 50 SNF beds)

v. North 3 (~~60~~ 50 SNF beds)
vi. North 4 (~~60~~ 50 SNF beds)
vii. North 5 (~~60~~ 50 SNF beds)
viii. North 6 (~~60~~ 50 SNF beds)
ix. South 2 (~~60~~ 50 SNF beds)
x. South 3 (~~60~~ 50 SNF beds)
xi. South 4 (~~60~~ 50 SNF beds, including two in negative pressure isolation rooms)
xii. South 5 (~~60~~ 50 SNF beds, including two in negative pressure isolation rooms)
xiii. South 6 (~~60~~ 50 SNF beds, including two in negative pressure isolation rooms)

c. Clinical Services include: medical services, behavioral health services, nursing services, activity therapy, pharmacy, rehabilitation services, ~~meal service and nutrition consultation~~food and nutrition services, social services, spiritual care, outpatient medical and dental clinics, respiratory therapy, and radiology. LHH also maintains a laboratory staff and courier services to ZSFG for routine and emergency "stat" lab services.

d. Support Services include: Environmental Services (EVS), Facility Services, Food and Nutrition Services (FNS), Health Information Management Services, Security Services, Workplace Safety, and Emergency Management, Central Processing and Distribution (CPD), and Materials Management.

e. Financial Services include: Admissions and Eligibility (A&E), Patient Financial Services, and Accounting, including cashier services for residents.

2. **Activation:** Activation of the LHH COOP shall be considered whenever the Nursing Home Incident Command System (NHICS) is activated according to LHHPP 70-03 Emergency Response Plan, and under one or more of the following circumstances**:**

a. Activation of the DPH Emergency Operations Plan.

b. Activation (partial or full) of the DPH Departmental Operations Center (DOC) for an emergency response.

c. Staff absenteeism is 20% or more than anticipated staffing for hospital operations.

d. When emergency preparedness response activities exceed staffing capabilities.

e. Damage or inoperability of key facility/facilities impedes daily operations.

3. **Leadership Succession:** Management of the LHH section is delegated to the following persons in the order of succession in Table 1 below. This table lists, specifically, the people authorized to act on behalf of the Section Director. If the designated person is unavailable, authority will pass to the next individual on the list. The designated individual retains all assigned obligations, duties and responsibilities until officially relieved by an individual higher on the list of successions. These

individuals are authorized to assume the role of Continuity of Operations Chief (COOP Chief)

Table 1. LHH Leadership Succession (COOP Chief)

LHH Section Title
Chief Executive Officer/Nursing Home Administrator (CEO/NHA)
~~Chief Nursing Officer~~Director of Nursing (~~CNO~~DON)
Chief Medical Officer/Medical Director (CMO)
~~Chief Operations Officer (COO)~~Assistant Nursing Home Administrator (ANHA)
~~Quality Management Director~~Chief Quality Officer (CQO)
Nursing Director, Operations
~~Operations Nurse Manager~~Nursing Operations Supervisor

4. **Essential Services:** The COOP supports the execution of essential functions through all circumstances and in particular during emergencies or situations when normal procedures are not possible. The prioritization of essential services provides guidance for the allocation of resources in order of criticality. This may include reassignment of personnel, priority use of alternate facilities, and directed use of administrative and management support.

The tables below describe LHH's mission critical functions.

Table 2 details Priority 1 activities that must be continued under all circumstances and can be inoperable or delayed for no more than 24 hours. Priority 1 activities include those that must be maintained to protect residents from immediate life safety threats and to comply with regulatory requirements.

Table 2. Priority 1 Essential Services

Essential Service	Systems/Resources Used in Providing Service	Staff (classifications) Providing Service	Staff Qualified to Substitute in a Shortage	Department Providing Service
Medical Care	Computers, all medical supplies, medications	2232, 2230	CMO	Medical Services
Behavioral Health and Psychiatry Services	Computers, medications	2574, 2588, 2232, 2920, 2930, 2576	2230	Psychiatry Services
Radiology Services	Radiology equipment	2468, 2469		Medical Services
Respiratory Therapy Services	Respiratory therapy supplies	2536	2320, 2230, 2323, 2322, 2324, 2312, Director of Clinical Support Services	Medical Services
Laboratory Services	Laboratory supplies	2430	2320, 2230, 2323, 2322, 2324	Medical Services
Assist residents with ADLS	ADL supplies (towels, soap, shampoo, toothbrush, toothpaste, lotions), EZ Lift, Angel Lift, wheelchairs, hospital bed, linens, shower gurneys, shower chairs	2303, 2302	2320, 2323 2322, 2324, 2312, 2583	Nursing Services
Administer Medications and Treatments	Omnicell, med carts, IV pumps, feeding pump, wound care supplies, specialized beds and surfaces, ostomy supplies, glucose machine, alcohol wipes,	2320, 2312	2454, 2450, 2232, 2230, 2323, 2322, 2324	Nursing Services

Essential Service	Systems/Resources Used in Providing Service	Staff (classifications) Providing Service	Staff Qualified to Substitute in a Shortage	Department Providing Service
	lancets, test strips, medication refrigerators, EHR			
Assessment of Residents	Stethoscopes, BP Machines, Bladder Scans, Thermoscans, Pen Light, Reflex Hammer, Otoscopes, EHR	2320, 2322, 2324, 2323	2230, 2232, CMO, CNO	Nursing Services
Delivery of Emergency Interventions	Crash carts, emergency supply box, O2 tanks, O2 tubings and supplies, phone	2320, 2323	2320, 2230, 2323, 2322, 2324, 2312, CMO, CNO, CEO, COO	Nursing Services
Documentation of Resident Conditions	EHR	RCT	2320, 2230, 2323, 2322, 2324, 2312, CMO, CNO, CEO	Nursing Services
Monitoring for Resident Safety	Mobile View, Aeroscout, Temptrak, VoIP Phones, Computers	2320, 2312, 2322, 2324, 2303, 2302, 2323, 2583, 1428, 7334	7335, 7205	Nursing Services
Provide Nursing Staffing	ONE STAFF, Desktop, Phone	2322, 2324, 1429	CNO, CEO	Nursing Services
Provide medication	EHR; Automated Medication Packager; Omnicell	2450; 2409; 2406; 2454; 2453	Pharmacy Director	Pharmacy Services
Complete/submit ePASRRs	ePASRR database, ~~-~~and EHR	UM Nurse (2322, 2320, 2312)	~~QM Director~~DOCC Nurse Director	~~QM~~DOCC

Essential Service	Systems/Resources Used in Providing Service	Staff (classifications) Providing Service	Staff Qualified to Substitute in a Shortage	Department Providing Service
Provide Administrative Services/Administrative Leadership and Support		1406, 1827, 1822, 2818, 0931, 0941, 0942, 0943, 1165, 2324, 2322, 2320 (also refer to LHH Staff List)		Administration
Develop and/or revise the resident menu for appropriate therapeutic management	CBORD, EHR, PC's, laptops, printers	2626, 2624		Clinical Nutrition
Provide food and water to residents	Gas, electricity, clean dishes and serving utensils, chemical sanitizers	2604,2606,2618, 2650,2654,2656	2819, 2820, 0922	Food Services
Clean Patient Rooms	Cleaning supplies	2736	2738, 2740, 2785	EVS
Remove Trash/biohazard	Elevators, trash bin	2736	2738, 2740, 2785	EVS
Provide essential medical equipment and supplies to Neighborhoods	Elevators, PeopleSoft	2390	7524	CPD
Provide facilities and utilities essential for safe resident care	Sound building and infrastructure, utility services	3417, 7120, 7203, 7205, 7334, 7335, 7342, 7344, 7345, 7346, 7347, 7524		Facility Services
Protect residents and staff from security threats	Radios, weapons, vehicles, telephones, computers, cameras	8302, 8304, 8300, 8306, 8308		SFSD

Table 3 details Priority 2 services that can be inoperable or delayed for no more than 72 hours. Priority 2 activities include those that must be maintained to ensure the continuity of government and activated emergency operations (if applicable).

Table 3: Priority 2 Essential Services

Essential Service	Systems/Resources Used in Providing Service	Staff (classifications) Providing Service	Staff Qualified to Substitute in a Shortage	Department Providing Service
Cash disbursement for residents	Trust Accounting system, cash register	Cashiers	0922	Accounting
Purchase of emergency supplies	Cash or credit card (P-card)	CFO, Emergency Manager	0931 (Finance Director)	Accounting
Sterile compounding	EHR; Compounding aseptic isolator	2450; 2409; 2406; 2454; 2453	Pharmacy Director	Pharmacy Services
Conduct admission reviews	Database, EHR, computer	UM Nurse (2322, 2320, 2312)	2324	~~QM~~DOCC
Complete/submit eTARs	Database, EHR, computer	UM Nurse (2322, 2320, 2312)	2324	~~QM~~DOCC
Notify team, staff and other disciplines of patient's admission and the payor coverage	Email, computer	UM Nurse (2322, 2320, 2312)	2324	~~QM~~DOCC
Triage UO's	UO system in intranet, computer	RM Nurse (2322, 2320)	2324	QM
Infection control surveillance	EHR	Infection Control Nurse 2320	2322, 2324	QM
Screen & assess residents	CBORD/EHR/, PC's, laptops, printers	2624, 2622	2626	Clinical Nutrition
Provide food and water to staff	gas, electricity, clean dishes and serving utensils, chemical sanitizers	2604, 2606, 2618, 2650, 2654, 2656	7524	Food Services
Deliver clean linen	elevators, linen carts	2736	7524	EVS

Table 4 details Priority 3 services that can be inoperable or delayed for no more than one week. Priority 3 activities include those that should be maintained to ensure the continuity of government and that are revenue generating.

Table 4: Priority 3 Services

Essential Service	Systems/Resources Used in Providing Service	Staff (classifications) Providing Service	Staff Qualified to Substitute in a Shortage	Dept
Resident laundry	Laundry machines, laundry soap, carts	2583, 2303, 2302		Nursing Services
Hazardous drug compounding	Compounding aseptic containment isolator	2450; 2409; 2406; 2454; 2453	Pharmacy Director	Pharmacy Services
Complete and store UM worksheets	Network drives	UM Nurse (2322, 2320, 2312)	2324	~~QM~~DOCC
Milieu management on the neighborhoods	Staff, leisure and activity supplies and equipment	2320, 2302, 2303, 2583, 2312, 2322, 2323, 2324, 2587, 2588, 2591	2920, 2922, 2924, 2930	AT, Nursing Services
Provide food and water to visitors	Gas, water, electricity, clean dishes and serving utensils, chemical sanitizers	2604, 2606, 2618, 2650, 2654, 2656	7524	Food Services

5. Systems and Resources Needed for Provision of Essential Services

Table 5 lists the resources & systems that are used in providing the essential services listed in Tables 2-4. Each department who uses these resources and systems for an essential service shall implement downtime procedures when these resources or systems are unavailable or limited. These downtime procedures are incorporated into department emergency response plans.

Table 5: Resources and Systems Critical to Providing Essential Services

Category	Resource/System	Department(s) requiring resource
Equipment, Software, Utility	LHH Network	All
Equipment, Supplies	Crash Carts	Nursing, Medical Services
Equipment	Angel Lift	Nursing Services
	Automated Medication Packager	Pharmacy Services
	BP machines	Nursing Services
	Compounding aseptic containment isolator	Pharmacy Services
	Compounding aseptic isolator	Pharmacy Services
	Cameras	SFSD
	Computers	All
	Elevators	CPD, EVS, Nutrition
	EZ Lift	Nursing Services
	Feeding Pumps	Nursing Services
	Glucose Machines	Nursing Services
	Hospital Bed	Nursing Services
	IV Pumps	Nursing Services
	Laundry Machines (washer and Dryer)	Nursing Services
	Linen Carts	EVS
	Med Carts	Nursing Services
	Medication refrigerators	Nursing Services
	Omnicells	Pharmacy Services, Nursing Services
	Printers	Clinical Nutrition
	Radiology Equipment	Medical Services
	Radios	SFSD
	Specialized Beds	Nursing Services
	Telephones	All
	Thermoscans	Nursing Services
	Vehicles	SFSD
	Weapons	SFSD
Supplies	ADL Supplies	Nursing Services
	Chemical Sanitizers	Food Services

Category	Resource/System	Department(s) requiring resource
	Clean dishes and utensils	Food Services
	Cleaning Supplies	EVS
	Emergency Supplies	Nursing Services
	Laboratory Supplies	Medical Services
	Linens and Towels	Nursing Services
	Medical Supplies	Medical Services
	Medications	Pharmacy Services, Medical Services, Psychiatry Services, Nursing Services
	Trash Bins	EVS
Software	ADL System	Accounting
	Aeroscout	Nursing Services
	Automated medication packaging	Pharmacy Services
	CBORD	Clinical Nutrition, Food Services
	EHR	Clinical Nutrition, Medical Services, Nursing Services, QM, Clinics, Rehab, AT, Social Services
	Email	QM
	JCI (Fire)	Facility Services
	EHR	Clinical Nutrition, QM, Nursing Services, Medical Services, Laboratory, Clinics, AT
	McKesson PMM	Pharmacy
	PeopleSoft	CPD
	QS/1	Pharmacy
	PAC (Radiology software)	Medical Services
	Siemens (Fire)	Facility Services
	Incident Reporting System	QM
	Westcall (Nurse Call)	Nursing
Utility	Electricity	All*
	Generator Power	All*
	Natural Gas Supply	Nutrition
	Water	All*
Staff	Staff	All

*Downtime procedures for these utilities are addressed in separate hazard-specific plans.

6. Alternative Care Facilities and Emergency Communications

Plans for alternative care locations, emergency transportation, and communications are detailed in LHHPP 70-01 B1: Emergency Response Plan.

ATTACHMENT:
Attachment A: Job Classifications and Titles

REFERENCE:
LHHPP 70-01 B1: Emergency Response Plan

Revised: 13/05/28, 17/11/14, 19/03/12, 19/07/09, 22/11/08, 26/08/18 (Year/Month/Day)

Attachment A: Job Classifications and Titles

0922	Manager I
0923	Manager II
0931	Manager III
0932	Manager IV
0933	Manager V
0941	Manager VI
0942	Manager VII
0943	Manager VIII
1165	Manager, Dept Public Health
1222	Sr Payroll & Personnel Clerk
1244	Senior Human Resources Analyst
1404	Clerk
1406	Senior Clerk
1408	Principal Clerk
1428	Unit Clerk
1429	Nurses Staffing Assistant
1430	Transcriber Typist
1440	Medical Transcriber Typist
1630	Account Clerk
1632	Senior Account Clerk
1634	Principal Account Clerk
1636	Health Care Billing Clerk 2
1637	Patient Accounts Clerk
1652	Accountant II
1654	Accountant III
1657	Accountant IV
1663	Patient Accounts Supervisor
1664	Patient Accounts Manager
1708	Senior Telephone Operator
1820	Junior Administrative Analyst
1822	Administrative Analyst
1823	Senior Administrative Analyst
1824	Pr Administrative Analyst
1825	Prnpl Admin Analyst II
1827	Administrative Services Mgr
1934	Storekeeper
1942	Asst Materials Coordinator
1944	Materials Coordinator
2105	Patient Svcs Finance Tech
2106	Med Staff Svcs Dept Spc
2110	Medical Records Clerk
2112	Medical Record Technician
2114	Medical Records Tech Sprv
2230	Physician Specialist
2232	Senior Physician Specialist
2302	Nursing Assistant
2303	Patient Care Assistant
2312	Licensed Vocational Nurse
2320	Registered Nurse
2322	Nurse Manager
2323	Clinical Nurse Specialist
2324	Nursing Supervisor
2390	Sterile Processing & Dist Tech
2392	Sr Cent Proc & Dist Tech
2406	Pharmacy Helper
2409	Pharmacy Technician
2424	Diagnostic Imaging Assistant
2430	Medical Evaluations Assistant
2450	Pharmacist
2453	Supervising Pharmacist
2454	Clinical Pharmacist
2468	Diagnostic Imaging Tech II
2469	Diagnostic Imaging Tech III
2536	Respiratory Care Practitioner
2542	Speech Pathologist
2548	Occupational Therapist
2550	Senior Occupational Therapist
2554	Therapy Aide
2555	Physical Therapist Assistant
2556	Physical Therapist
2558	Senior Physical Therapist
2574	Clinical Psychologist
2583	Home Health Aide
2585	Health Worker 1
2586	Health Worker 2
2587	Health Worker 3
2588	Health Worker 4
2591	Health Program Coordinator 2

2593	Health Program Coordinator 3
2604	Food Service Worker
2606	Senior Food Service Worker
2608	Supply Room Attendant
2618	Food Service Supervisor
2619	Senior Food Service Supervisor
2620	Food Service Mgr Administrator
2622	Dietetic Technician
2624	Dietitian
2626	Chief Dietitian
2650	Assistant Cook
2654	Cook
2656	Chef
2736	Porter
2738	Porter Assistant Supervisor
2740	Porter Supervisor 1
2818	Health Program Planner
2903	Hospital Eligibility Worker
2908	Sen Hospital Eligibility Wrkr
2909	Hospital Elig Wrk Supervisor
2920	Medical Social Worker
2922	Senior Medical Social Worker
2924	Medical Social Work Supervisor

2930	Behavioral Health Clinician
2931	Marriage, Family & Child Cnslr
3417	Gardener
4321	Cashier 2
5502	Project Manager 1
5504	Project Manager 2
6138	Industrial Hygienist
6139	Senior Industrial Hygienist
7120	Bldgs & Grounds Maint Supt
7203	Bldg & Grounds Maint Sprv
7205	Chief Stationary Engineer
7324	Beautician
7334	Stationary Engineer
7335	Senior Stationary Engineer
7342	Locksmith
7344	Carpenter
7345	Electrician
7346	Painter
7347	Plumber
7355	Truck Driver
7524	Institution Utility Worker
9910	Public Service Trainee
P103	Special Nurse

RESIDENT EVACUATION PLAN

POLICY:

In order to provide care ~~for~~ to the residents in a safe location, Laguna Honda Hospital and Rehabilitation Center (LHH) has a plan for a partial or full evacuation in the event of an emergency.

PURPOSE:

The purpose of this policy is to set forth procedures for moving residents to a safe location for their continued care in the event of a disaster or other circumstance that renders any portion of the hospital unsafe for such care.

PROCEDURE:

1. Decision to Evacuate

Any time any resident care area(s) of the hospital becomes unsafe for residents, Nursing Home Incident Command System (NHICS) shall be activated.

a. Residents whose emergency plan indicates that evacuation may be harmful shall be evaluated by their physicians to determine the best course of action for the individual resident's well-being.

b. All residents for whom evacuation is indicated shall be moved out of the unsafe area(s) and into an alternate care site.

c. Alternate care sites shall be selected by ~~the NHICS Team~~NHICS using the information in Appendix A.

d. A binder that includes a list of equipment, ~~and~~ supplies, and standard work instructions for the setup of each alternate care location is located in the emergency command center.

e. If there is no safe area for care on the LHH campus, Public Health Emergency Preparedness and Response (PHEPR) will be notified of the need to move residents to another facility.

   i. LHH resident evacuation and transportation shall align with PHEPR. For PHEPR protocols on evacuation or extended closure refer to the San Francisco Department of Public Health (SFDPH) Emergency Response Activation and~~&~~ Notification Protocol.

ii. Care at alternate sites shall align with PHEPR. For PHEPR care at alternate sites protocols refer to SFDPH Continuity of Operations Plan (COOP), section 3. 3.1. Phase II.

iii. In the event ~~that~~ the Secretary of Health and Human Services (HHS) declares a waiver in accordance with section 1135 of the Social Security Act, that identifies LHH as an approved 1135 waiver, ~~,~~ LHH will adhere to the policies and procedures for care at alternate sites per PHEPR protocol. For PHEPR care at alternate sites protocols refer to SFDPH COOP, section 3. 3.1. Phase II.

iv. In accordance with section 1135 of the Act, LHH shall adhere to PHEPR processes to inform the community of care operations at alternate care sites. For PHEPR community communication of LHH care operations at alternate sites refer to SFDPH Crisis and Emergency Risk Communication Guide, section I and III.

v. In accordance with section 1135 of the Act, LHH shall provide reporting information as indicated by PHEPR.

2. Horizontal Evacuation

Whenever possible, evacuation shall be done horizontally. The Nurse Manager or designee shall coordinate this process using the following procedure.

a. Move ambulatory residents.

b. Move semi-ambulatory residents and those in wheelchairs.

c. Move residents who are bed-ridden using evacuation devices or emergency carriers.

d. Only exception are bariatric patients on wide beds, who can be moved out of their room on their bed.

e. Check the area to ensure that all residents have been moved out of the unsafe area.

f. Account for all residents, staff, and visitors.

g. If anyone is missing, attempt to locate them and notify the command center, the Nursing Office, and the Sheriff's Department.

3. Vertical Evacuation

a. If horizontal evacuation is insufficient to locate residents in an area that is safe for their care, vertical evacuation shall be initiated. If elevators are operational and safe to use, vertical evacuation shall be completed using a combination of stairs and elevators. In the event of a fire, earthquake, or other disaster that may compromise the safety of the elevators, elevators shall not be used and the procedures for stair evacuation shall be followed.

b. Upon making the decision to evacuate, the command center shall designate a destination location(s) within the facility to which residents will be relocated and staff from the labor pool shall be used to set up the area for resident care.

4. Vertical Evacuation Using Elevators

a. Elevators shall be controlled by staff from the labor pool with a key to override the elevators. These staff members shall remain in the elevators and use each elevator to clear one floor at a time. The order in which ~~neighborhoods~~ units will be evacuated shall be determined by the Incident Commander for NHICS and shall depend on the type and specific location of the emergency.

b. Ambulatory Residents

i. Ambulatory residents who are able to walk up and down stairs shall be escorted to an exit stairwell by a member of the Nursing staff, who shall walk up or down the stairs with groups of 3-5 residents.

ii. The Nursing staff shall go back to the neighborhood to continue evacuation.

iii. Additional staff members from the labor pool will be waiting in the stairwell on the same floor as the designated relocation area and shall escort residents in groups of 5-10 from the stairwell to the relocation area.

c. Residents in Wheelchairs

i. Residents in wheelchairs shall be brought to the ~~great room~~Great Room and then to the elevator in groups of 4-6. The Charge Nurse shall coordinate this process.

ii. If time is of the essence, some of the non-ambulatory residents may be taken down the stairs after the ambulatory residents using evacuation devices, such as Stretchairs. They shall then be carried by waiting staff to the relocation area.

iii. Additional staff shall be available on the same floor as the designated relocation area and shall direct/escort residents to the relocation area as needed.

d. Bed-bound Residents
   i. After the residents in wheelchairs have been evacuated, residents in beds may be brought to the elevators. This shall be coordinated by the charge nurse.

   ii. If time is of the essence, bed-bound residents may be brought down the stairs using evacuation devices or carriers.

   iii. Labor pool staff shall bring residents to the designated care area.

e. Wheelchair Retrieval

   Once necessary evacuation of residents has been completed, staff shall use the elevators to retrieve any wheelchairs left behind if the Incident Commander determines it is safe to do so.

5. Vertical Evacuation Using Stairs Only

a. Ambulatory Residents

   i. Ambulatory residents who are able to walk up and down stairs shall be escorted to the exit stairwell by a member of the Nursing staff, who shall walk up or down the stairs with groups of 3-5 residents.

   ii. The Nursing staff shall go back to the neighborhood to continue evacuation.

   iii. Additional staff members from the labor pool shall be waiting in the stairwell on the same floor as the designated relocation area and shall escort residents in groups of 5-10 from the stairwell to the relocation area.

b. Non-ambulatory Residents

   i. Non-ambulatory residents shall be brought down the stairs using evacuation devices such as Stretchairs, Stryker chairs, and Paraslydes after the ambulatory residents have evacuated. See Appendix B for information about available devices.

   ii. If time is of the essence or there are not enough evacuation devices, staff shall use blanket carries to bring residents down the stairs and to the relocation area. See Appendix C for instructions on make-shift evacuation devices.

   iii. As many staff members as possible shall be provided from the labor pool for this task, which shall be coordinated by the Nurse Manager and/or Charge Nurse.

c. Wheelchair Retrieval

i. Once necessary evacuation of residents has been completed, staff shall retrieve any wheelchairs left behind if the Incident Commander determines it is safe to do so.

6. Shelter in Place Plan

a. Mitigation/Preparedness: During certain emergency situations, particularly chemical/HAZMAT, biological, radioactive events or weather emergencies, it may be advisable for employees to shelter-in-place rather than evacuate the building. Shelter-in-place is a strategy taken to maintain patient care within LHH and to limit the movement of staff and visitors to protect life and property from hazard. Shelter-in-place is an ideal method of self-protection from airborne contaminants, such as a toxic airborne chemical or a person with a weapon. It may be necessary to evacuate certain parts of LHH and shelter-in-place in another part of the facility.

i. Criteria for Implementation: In situations posing an immediate threat to the safety of employees and visitors shelter in place procedures must take priority. Shelter in place will be determined by the Chief Executive Officer/Nursing Home Administrator (CEO/NHA) or the Administrator On Duty (AOD).

ii. Pre-Event Information: Potential terrorist incidents, such as the release of a chemical hazard may be preceded by alerts issued by local or state authorities. Information may be disseminated to LHH via PHEPR. Notification may also be made from law enforcement, HAZMAT teams or fire department via telephone.

iii. Activation of Emergency Response Procedures: Upon notification that a suspected/confirmed airborne chemical/biological hazard is likely to impact LHH the Emergency Response Plan will be activated and “Shelter in Place” will be announced overhead. Notification may be made by Mass Notification system and email.

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors. • Facilities department to shut down hospital Vacuum and Air Conditioning Unit. (HVAC)
Notify employees, visitors and vendors as to nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.

Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

iv. Reassessment of Event: External communication via, news media, California Health Alert Network (CAHAN) notifications, ReddiNet, email notification, landline communication may provide additional information critical to the assessment and reassessment of the shelter in place response activities.

v. Recovery Strategies: Assess staffing requirements and provide an organized reporting structure. Ensure that the HVAC system and ventilator systems have returned to normal operations. Take down signs from all building entrances and exits. Notify employees, patients and vendors of the ability to enter and exit the building. Provide safe reentry pathways to the building in an organized manner.

vi. Education and Training: New employees at LHH receive emergency preparedness training at new employee orientation (NEO). All staff shall receive emergency preparedness training annually with e-learning module (ELM) through the Department of Education and Training (DET).

7. Communication and Coordination

a. Each department shall assign a representative to the Emergency Preparedness Committee (EPC) who is responsible for continuously enhancing and sustaining emergency preparedness.

b. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of the Department of ~~Workplace Safety and~~ Emergency Management.

c. Residents are ~~apprised~~ notified of emergency preparedness and response procedures in the resident handbook, which is reviewed with the resident on admission by a ~~social worker~~staff from Social Services.

d. The department manager shall facilitate continuous updates for the emergency call back lists. The confidential call back lists are kept securely in the NHICS Command Center.

e. Emergency preparedness updates are communicated to the leadership forum, executive committee, ~~neighborhood~~ unit and departmental meetings, community meetings, and residents' council as necessary.

f. ~~-~~LHH participates in a city-wide emergency preparedness healthcare coalition to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.

g. Multiple communication systems are available and practiced ~~to achieve~~achieving redundancy in the event of technology downtime and to achieve coordination city-wide.
   i. Primary methods of communication include regular telephone services.

   ii. Alternate methods of communication include 800 MHz radios and METS phone (Mayors Emergency Telephone System) are tested monthly.

8. Accounting for Residents and Resident Tracking

a. Labor pool staff shall greet residents at the designated relocation area and account for all residents arriving in the area and report to the Command Center.

b. The Command Center shall work with Nurse Managers to account for any missing residents.

   i. If any residents are identified as missing Code Green shall be activated. For Code Green protocol, refer to LHHPP 24-22.

c. For any resident who is evacuated, continuity of care documents (CCD) shall be made available to providers at the receiving facility via the health information exchange. The document shall contain key information including problem list, allergies, medications, recent lab results.

9. Non-Compliant Residents

a. Utilize staff members who are familiar with the non-compliant resident to help persuade cooperation.

b. Speak calmly to the resident using simple, slow language to help them understand the dire need to evacuate the area or facility.

c. Speak in a warm, friendly manner that inspires them to act without fear or panic.

d. Reframe the situation in a way that highlights the benefits of leaving and emphasizes the emergent nature of the situation.

e. Clearly explain to the non-compliant resident the process for evacuation and offer reassurance about the safety and security of evacuation relocation sites.

f. Engage other staff members who are familiar with the non-compliant resident that can demonstrate official authority in a compassionate manner to help coax the resident to cooperate in the evacuation process.

g. Request the assistance of family members or responsible parties to help persuade the resident to cooperate in the evacuation process.

h. Offer snacks or some other type of accommodation (i.e. enhanced level of comfort, change of scenery, etc.) that may incentivize non-compliant residents with behavioral health issues.

i. Enlist the help of local law enforcement if the resident is defiant and non-compliant in the evacuation process.

j. When the urgency of the situation requires, consider physically removing the resident with standard techniques like a blanket-carry or drag, two-person seat carry or utilization of evacuation equipment (evacuation chair, evacuation sled, etc.) to remove and protect the resident from imminent danger.

10. Employee Training

a. All LHH staff shall be made aware of general evacuation procedures in orientation and annual emergency preparedness in-services.

b. A team of staff from Nursing, Rehab, and Activity Therapy shall be trained on the use of evacuation devices annually. This training shall include ~~hands on~~hands-on practice using the equipment.

ATTACHMENT:
Appendix A: Alternate Care Sites
Appendix B: Evacuation Devices
Appendix C: Emergency Carriers

REFERENCE:
LHHPP 24-22 Code Green Protocol
LHHPP 70-01 B1: Emergency Response Plan

Revised: 18/09/11, 19/03/12, 19/09/10, 20/03/17, 22/12/13, 24/12/10, 26/08/18 (Year/Month/Day)
Original Adoption: 14/07/29

APPENDIX A: Alternate Care Sites

Location	HVAC	Generator Power	Water	Lighting	Shelter from Weather	Restroom	Bed Capacity	Able to Quarantine	Med Gases Available	Floor surface
Neighborhood Common Areas	Y	Y	Y	Y	Y	Y		N	N	Terrazzo
Clinic P1	Y	Y	Y	Y	Y		12	Y	Y	Terrazzo
Rehab P3	Y	Y	Y	Y	Y	Y	13	N	N	Terrazzo
Wellness Gym PG	Y	Y	Y	Y	Y	Y	10	N	N	Rubber
Simon Auditorium H1	N	N	N	Y	Y	Y	60	N	N	Concrete
Wellness Hub H3	Y	N	N	Y	Y	Y	50	N	N	Carpet
Moran Hall H3	Y	N	N	Y	Y	Y	50	N	N	Concrete, Carpet
Esplanade & Kanaley P1	Y	Y	Y	Y	Y	Y	40	N	N	Terrazzo
Cafeteria P1	Y	Y	Y	Y	Y	Y	25	N	N	Terrazzo
Horseshoe Outside PG	N	N	N	Minimal	N	N	100	N	N	Grass, Pavement
NW Parking Lot	N	N	N	Minimal	N	N	100	N	N	Pavement

APPENDIX B: Evacuation Devices

Several devices are available to safely evacuate residents, injured staff, or visitors. Call the Command Center at 4-4636 (4- INFO) to deploy staff to bring the evacuation devices to the evacuation site.

a. **Reeves Stretchairs** (approximately 60) are stored in the emergency storage room in H2 and can be made available by request from the Command Center. Each Stretchair has a cover with a shoulder strap to facilitate easy transport of several devices at once. Open the Stretchair and place under the victim either on a flat surface (bed or floor) or on a chair. To use on a flat surface, roll the victim to one side and place the Stretchair beneath them, with the top aligned with the victim's shoulder. Roll the victim to the opposite side and ease the Stretchair beneath them. Secure the shoulder and crotch/ hip straps. To use on a chair, place on a chair with the crotch strap near the edge of the seat and place the victim on the device by having the victim stand up momentarily and then sit down on the Stretchair or transfer the victim via a standing pivot with 1 or 2 assistants or via a mechanical lifting device. Assure that the top of the Stretchair is level with the victims' shoulders. Lift on the count of three ("1-2-3 lift") with 2-4 rescuers each firmly grasping one or two handles, depending upon the weight of the victim and the strength of the rescuers. The Reeves Stretchair is rated up to 1000 lbs.; however you must never lift more than you can easily manage

b. **Medivac chairs** (approximately 30) are also stored in the emergency storage room in H2 and can be made available by request from the Command Center. They are rated at 450 lbs and they do not have a strap. Place under the victim as described above.

c. **Paraslydes** (15) are available through the Command Center and can be used to evacuate down stairs. Pictoral directions appear on the device. Place the victim (500 lb weight limit) on the stair litter by rolling them to the side and placing the device beneath them. Roll the victim onto the device and center them on the device by sliding their shoulders, then legs, then hips to the middle of the litter. Fold the device around the victim and secure the straps, criss-crossing the chest straps. Use 2-4 rescuers to slide the Paraslyde to the stairwell and ease the device safely and slowly down the stairs. An additional harness is provided if needed for added control for lighter rescuers to ease a heavy victim down stairs.

d. **Stryker Evacuation Chairs** (7) are available through the Command Center for evacuation down stairs (weight limit 500 lbs). Pictoral directions appear on the back of the chair. Fold the chair out as pictured, by squeezing the red bar to raise the handle and by squeezing the lower red bar while pulling out the stair track. Transfer the victim onto the chair and fasten the waist, chest, and ankle straps. Wheel the victim to the stairs. Tip the chair back to allow it to descend on the gliders down the stairs with 1 or 2 rescuers holding the handles to safely guide the chair down.

APPENDIX C: Emergency Carriers

Use as a second choice if evacuation devices are not immediately available.

a. Cradle drop and blanket pull – 1 person (heavy resident)

   i. Double a blanket lengthwise on floor parallel to bed. Slide arm nearest resident's head under the neck and grasp shoulder. Slide free arm under knees and grasp firmly. Place knee or thigh, depending on height of bed, against bed close to resident's thigh. Keep both feet flat on floor about six (6) inches from bed. Pull resident from bed; no lifting is necessary. Pull with both hands, push with knee or thigh against bed. The moment resident starts to leave bed, drop on knee nearest the head. When the resident is clear of bed, the extended knee supports knees of resident and the arm under neck supports arm and shoulders of resident. The cradle formed by the knee and arm protects the back. Let the resident slide gently to the blanket and pull blanket from the room.
   ii. Rescuer cannot maintain the balance necessary if rescuer pulls the resident's buttocks instead of the knees or thighs out on rescuer's knee. This removal is for residents too heavy for one person to carry, for low beds and for bed fires.

b. Swing – 2 persons

   i. Carriers grasp wrists under the resident's knees and behind the resident's back. Resident's arms are along the two carriers' shoulders. Carry resident from room to safe place.

c. Extremity – 2 persons

   i. (To carry a person through a burning exit). One carrier grabs resident around knees (carrier's body between the resident's knees). Second carrier grabs resident under the arms and across upper abdomen. Carry resident from room. Use wet cover if possible.

d. Using a gurney – 3 persons

   i. Gurney placed parallel to bed. Three carriers to lift, one at shoulder level and upper back, one below waist and below hip, one at knee and at ankle. Lift resident and place on gurney. Wheel to safety.

e. Without a gurney, using a blanket – 3 persons

   i. First person spreads blanket on floor at right angles to bed. Resident is placed on blanket. First person positions at the head of the resident, placing own hands on blanket above the resident's elbows. Second and third persons

position on the sides of the resident, placing their hands above and below the resident's knees.

REQUESTING TO OPERATE UNDER A CMS 1135 WAIVER

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to comply with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation regulations related to the operations of a hospital under a 1135 Waiver.

SCOPE:

Applies when the City and County of San Francisco is included in a presidential declaration of emergency or disaster and 1135 Waiver scope and when LHH is unable to operate in compliance with CMS requirements due to the impact(s) of that disaster.

PURPOSE:

To provide guidance on how LHH will integrate a 1135 Waiver into emergency operations.

BACKGROUND:

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to their regular authorities. For example, under section 1135 of the Social Security Act, the HHS Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time-periods. This is to ensure that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

1. Examples of these 1135 Waivers or modifications include:

    a. Conditions of participation or other certification requirements

    b. Program participation and similar requirements

    c. Preapproval requirements

    d. Requirements that physicians and other healthcare professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – State law governs whether a non-Federal provider is authorized to provide services in the State without State licensure)

e. Emergency Medical Treatment and Labor Act (EMTALA)

f. HIPAA—Sanctions arising from noncompliance with HIPAA privacy regulations relating to:

   i. obtaining a patient's agreement to speak with family or friends or honoring a patient's request to opt out of the facility directory;

   ii. distributing a notice of privacy practices; or

   iii. the patient's right to request confidential communications.

g. The waiver is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay.

h. Physician self-referral sanctions (Stark).

i. Performance deadlines and timetables may be adjusted (but not waived).

j. Limitations on payment for healthcare items and services furnished to Medicare Advantage enrollees by non-network providers.

2. These waivers under section 1135 of the Social Security Act shall generally end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published. Unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

3. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.

   a. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.

4. While 1135 Waivers can only be authorized by HHS Secretary or their designee, the CMS Regional Offices will report on collected information to determine if an 1135 Waiver is appropriate. This information may include:

   a. Requests by hospitals to provide screening/triage of patients at a location offsite from the hospital's campus.

   b. Hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation for a duration that exceeds regulatory requirements.

c. Hospitals or long-term care facilities requesting increases in their certified bed capacity.

PROCEDURE:

1. Notification of the authorization of an 1135 Waiver shall be received by the Nursing ~~Hospital~~ Home Incident Command System (NHICS), any departments or individuals hearing of an authorization of an 1135 Waiver must notify the NHICS.

2. Under direction from the Hospital Incident Commander, the Liaison Officer will coordinate with the Director of Regulatory Affairs and the Chief Quality Officer (CQO) of the Quality Management (QM) Department to confirm the scope and implementation of the waiver.

3. Upon confirmation of an 1135 Waiver, LHH's NHICS Management Team will assess the need for implementation, and:

   a. In the event that the 1135 Waiver is a "Blanket Waiver," the Liaison Officer or Director of Regulatory Affairs and the ~~Chief Quality Officer~~CQO shall submit notification to the California Department of Public Health (CDPH) or CMS Regional Office that LHH is operating under the waiver, or

   b. Submit to CDPH or CMS Regional Office a request to operate under the waiver, if the waiver is not considered a "Blanket Waiver". This request must include the hospital's justification for implementing the waiver and an expected duration of the modification requested.

   c. Submit email with Request to Operate under an 1135 Waiver authority to the CMS Regional Office and CDPH:

      Email Address for CMS Regional Office for California:
      ROSFOSO@cms.hhs.gov

      Mailing Address & Phone Numbers for California Department of Public Health:
      Department of Public Health
      Licensing & Certification
      San Francisco District Office
      150 North Hill Drive Suite 22
      Brisbane, CA 94005
      Phone:(415)330-6353
      Fax: (415)330-6350

   d. For after-hour reporting or if the local CDPH Licensing and Certification district office is non-operational due to the emergency or disaster, notify the:

i. State Office of Emergency Services Warning Center at (916) 845-8911; and

ii. Ask that they notify the CDPH duty officer.

4. Any requests to operate under an 1135 Waiver must also be copied to CDPH to ensure the waiver does not conflict with any State requirements and to address any concerns.

5. Upon approval to operate under the 1135 Waiver the NHICS Management Team will communicate to ~~hospital administration and the Chief Quality Officer~~the Chief Executive Officer/Nursing Home Administrator and CQO the approval to operate under the waiver.

6. NHICS will notify any departments covered by the waiver (i.e. Medical Staff Office, Emergency Department, Billing, etc.). This notification must include the scope, timeframe, and any restrictions or requirements of the waiver.

7. NHICS will conduct operations throughout the emergency within the scope of the 1135 Waiver.

8. Upon cessation of the 1135 Waiver, LHH will ensure compliance with any waived requirements.

ATTACHMENT:
None

REFERENCE:
CMS 1135 Waiver: http://www.cms.hhs.gov/H1N1/
§ 70129. Program Flexibility
70741 Disaster and Mass Casualty Program

Revised 26/08/18

Original adoption: 24/02/13 (Year/Month/Day)

FIRE RESPONSE PLAN

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. When You See Smoke or Fire

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

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

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

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

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

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

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

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

    - Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name

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

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

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

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

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

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

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

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

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

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

2. Fire Response in the Hospital Buildings

a. Resident Safety

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

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

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

iii. Turn off electrical equipment in the area.

b. Fire Door Closure

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

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

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

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

c. Stairwell Doors

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

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

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

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

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

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

d. Elevators

i. Never use elevators during a fire.

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

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

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

e. Evacuation of Hazardous Area

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

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

iii. Initiate horizontal evacuation in the following order:

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

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

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

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

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

g. Post Fire Procedures

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

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

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

3. Fire Response in the Administration Building

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

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

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

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

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

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

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

vii. If a determination is made by the San Francisco Fire Department (SFFD), ~~SFSD~~the San Francisco Sherrif's Office (SFSO), Engineering, or ~~WSE~~M Emergency Management that there is no fire in the administration building either because the alarm was triggered in error or only in the Pavilion building, "All Clear" will be announced and occupants may re-enter the building.

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

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

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

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

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

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

4. HICS Activation in Response to a Fire

a. Designation of an Incident Commander

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

ii. The AOD and the Nursing Officer will:

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

b. Incident Commander Responsibilities:

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

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

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

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

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

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

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

vii. Schedule a post-fire debriefing as necessary.

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

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

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

Revised: 09/08/24, 11/09/27, 13/05/28, 14/07/29, 14/09/09, 18/03/13, 19/03/12, 19/09/10, 24/03/12 (Year/Month/Day)

~~(Previously numbered as LHHPP 71-02)~~

Appendix A: Nursing Operations Fire Response Procedures

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

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

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

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

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

        i. ~~Executive Administrator~~Chief Executive Office/Nursing Home Administrator

        ii. AOD (Administrator on Duty)

        iii. ~~Chief Operation Officer~~ Assistant Nursing Home Administrator

        iv. Chief Medical Officer

        v. ~~Chief Nursing Officer~~Director of Nursing

        ~~v.~~vi. Chief Quality Officer

        ~~vi.~~vii. Emergency Management Coordinator

    e. Keep telephone lines open to the incident.

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

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

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

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

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

3. Upon Notification of a Code Red Drill:

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

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

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

Appendix B: Watch Engineer Fire Response Procedures

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

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

    b. Initial response to fire shall include the following:

        i. Activate nearest fire alarm pull station if not already done.

        ii. Tell others to close doors and windows.

        iii. Tell others to turn off Oxygen cylinders and wall gases.

        iv. Extinguish fire, if small.

        v. Direct firefighting until SFFD arrives.

        vi. If false alarm, locate source detector and possible causes.

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

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

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

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

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

        i. Notify the Incident Command Center and Nursing Operations of all clear authorization.

        ii. Reset the alarm system.

        iii. Reset the elevators if not damaged by fire.

        iv. Report completion of re-setting to the Command Center.

    h. Secure fire sprinkler valves, if fire sprinklers activated and once fire is extinguished. All watch engineers are responsible for knowing where shut-off valves are located.

Make immediate arrangements to have sprinkler heads replaced and system recharged.

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

Appendix C: San Francisco Sherriff Office Fire Response Procedures

1. Upon fire alarm activation of notification of fire:

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

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

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

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

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

2. Documentation:

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

Appendix D: EVS Fire Extinguisher Discharge Clean-Up Procedures

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

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

   b. Wear the following personal protective equipment during clean up:

      i. Gloves

      ii. Safety google

      iii. Disposable boot covers

      iv. Coveralls/Gown

      v. Use of either an N95 or reusable respirator is optional.

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

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

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

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

   g. After cleaning, wash your hands thoroughly.

   h. Return the HEPA vacuum to EVS after use.

   Note: This vacuum is solely for cleaning fire extinguisher residue and must not be used for any other purpose.

SPILL RESPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to employee and resident safety, and in an effort to prevent injury and illness, will mitigate hazards associated with spills.

PURPOSE:

~~The Spill Response Plan has been established to~~To ensure that spills of both hazardous and non-hazardous materials are cleaned up appropriately and that employee health and safety is not compromised in the process.

DEFINITION:

1. Hazardous Materials – Any material with a hazardous characteristic such as flammable, combustible, oxidizing, or toxic.

2. Non-Hazardous Materials – Any material that does not have a hazardous characteristic (as described above), such as water, food or drink.

3. Body Fluids – Fluids excreted from the human body (ex. ~~B~~blood, urine, feces, vomitus) that may shed pathogens that may result in healthcare associated infections. Body fluids spills require a two-step process of cleaning followed by disinfection. (LHH 72-01 F10).

   Emergency spill kits – Kits of long/narrow absorbent pads, other absorbent materials, PPE, disposal bags and containers, and signage, to help isolate, contain, cover, and remove spill materials. They have been ~~issues~~issued to multiple departments and placed in areas perceived to be at highest risk for emergency spills.

PROCEDURE:

1. CLEAN UP OF NON-HAZARDOUS MATERIAL SPILLS

a. Spills of non-hazardous materials shall be cleaned up as quickly as possible to remove any slip hazard.

b. If you spill something or notice a spill:

   i. Restrict access to the area around the spill, if possible.

   ii. If you can wipe up the spill with available absorbent material such as paper towels, do this as soon as possible.

iii. Where available, utilize emergency spill kits to cordon, cover, remove, and recover spills that are too large and/or complex for personal cleaning.

iv. Dispose spill kits or materials used to clean up spill according to their classification (biohazard, chemical, or general waste).

v. If the spill is too large ~~for you~~ to clean up or ~~you do not have~~the appropriate PPE is not ~~avialable~~available, such as gloves and/or eye protection, report the spill to Environmental Services (EVS):
- EVS mainline: Ext 4-4624 or ~~415~~628-75~~49~~-4624 (7:00 am to 3:30 pm)
- 3:30 pm to 7:00 am: Email DPH-LHH-EVSLeadership@sfdph.org or call Nursing Office.

vi. Make sure that no one enters the area until EVS arrives.

- Please secure the area and place a wet floor signs near the spill. EVS will ~~clean-up~~clean up the spill after receiving the report.

2. RESPONDING TO HAZARDOUS MATERIAL SPILLS

a. Hazardous drug spills will be cleaned up according to LHHPP 25-05 Hazardous Drugs Management.

b. Any employee who spills a hazardous material that they are using will restrict access to the area of the spill and report the spill to the Department of Workplace Safety during the daytime (~~415~~628-75~~49~~-3321) or the Facility Services Watch Engineer during off hours (415-370-8259).

c. The Department of Workplace Safety ~~& Emergency Management (WSEM)~~ or ~~Facilities~~ Facility Services will respond with an emergency spill kit or call the ~~SFDPH~~ San Francisco Department of Public Health (SFDPH) Environmental Health Section at 415-252-3900 for assistance.

d. After an uncontrolled spill or leak of a hazardous material, the Industrial Hygienist, Chief Engineer, or Watch Engineer will call the following agencies, as necessary:

i. SFDPH Environmental Health Section – 311 or 415-252-3800

ii. California Office of Emergency Services - 800-852-7550

iii. National Response Center - 800-424-8802

iv. Toxics Substance Control Division - 1-800-471-7127

e. In addition to calling the agencies listed above, whenever spilled hazardous materials enter the sewer, the Chief Engineer or the Industrial Hygienist will be

responsible for calling: the San Francisco Department of Public Works (DPW) at 311 or 415-695-2020.

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-05 Hazardous Drugs Management.

Revised: 02/03/06, 12/09/25, 15/01/13, 16/07/12 (Year/Month/Day)
~~Approved renumbering from 74-01 to 70-07: 15/01/13~~
~~Approved for renumbering to 70-01 Section A, B, and C: 18/02/23~~

EARTHQUAKE REPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents even while responder to natural disasters such as earthquakes and any resulting challenges.

PURPOSE:

To take appropriate action during and following an earthquake to reduce injury and loss of life, prevent subsequent fires and other secondary effects, and facilitate recovery.

PROCEDURE:

1. Remain as safe as possible while the ground is shaking to prevent injury.

    a. Drop, Cover and Hold On – preferably under a sturdy table or desk and away from windows and other hazards such as tall furniture or heavy items that could fall. Do not stand in doorways.

    b. Stay Inside – many injuries and fatalities occur from people running out of buildings.

    c. If outside, take cover as above and move away from buildings, electrical power lines, and overhanging structures.

2. The Nursing Home Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander ~~(IC)~~ and NHICS team will be responsible for managing the response to the earthquake with the following basic objectives:

    a. Ensure safety and security of all residents, staff, and visitors;

    b. Minimize damage to property; and

    c. Facilitate the recovery of power and return to normal operations.

3. Communication to Stakeholders – After completing immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the incident using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

b. Initiate emergency staff call backs if the response to the earthquake requires extra labor resources not already available on site.

c. Do not disseminate information to the public or the media. Any media or public information inquiries should be routed to the LHH Communications Team via the NHICS team.

4. Staff Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

   a. Employees shall contact the command center to report hazards or to request resources to assist with delivery of care.

5. Staff are to ensure the safety of all persons and continue providing quality care to the residents and patients. ~~Ensure Safety of all Persons and Continue Quality Care of Residents~~

   a. Check for injuries and move residents away from windows or other hazards such as shelves with heavy objects overhead.

   b. Check every space and every person to determine if anyone is trapped or in need of medical attention.

   c. Account for all persons in your ~~neighborhood~~ unit or department (residents and staff).

   d. Complete the Department Operating Status Report (DOSR) and fax it to the command center at 628-754-4671 ~~415-504-8313~~ or deliver to a DOSR bin.

   e. Do not use elevators until advised of their safety.

   f. Check the environment for fire and respond per R.A.C.E. as needed. Notify the command center of any fire safety concerns.

   g. Check for other hazards such as broken glass, electrical shorts, falling objects such as lights, ceiling tiles, wiring and report to the Command Center.

   h. Be prepared for aftershocks. These may be as hazardous as the initial quake.

   i. Facility Services shall assess building damage and will notify the Command Center of findings.

6. Re-establish normal operations according to essential service priorities as outlined in LHHPP 70-01 B2 Continuity of Operations Plan.

7. Follow appropriate procedures for any resulting effects, such as fire, power outage, or water disruption.

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)

Revised: 18/07/10, 23/06/30, 23/10/10, 26/08/18 (Year/Month/Day)
Original adoption:

LAGUNA HONDA HOSPITAL MEDICAL SURGE PLAN FOR NURSING HOME INCIDENT COMMAND ACTIVATION DUE TO PUBLIC HEALTH EMERGENCY / MASS CASUALTY EVENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents in the event of a city-wide or regional medical surge. LHH is also prepared to participate in a system-wide response to medical surge by receiving appropriate patients from other healthcare facilities who need decompression to manage the surge.

PURPOSE:

1. To provide continued quality care and participate in a system-wide response to incidents that result in a medical surge exceeding the capacity of the normal medical infrastructure.

2. To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts during a Nursing Home Incident Command System (NHICS) event when Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) is experiencing an acute surge of patients due to a trauma-based mass casualty incident (MCI) or another public health/medical related emergency (PHE).

3. To identify essential communication and coordination to ensure resident safety.

DEFINITIONS:

ZSFG Hospital status "Condition Yellow" is instituted when ten (10) or more patients are admitted for acute care at the hospital and waiting for an admission bed.

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

PROCEDURE:

1. Any time the San Francisco healthcare system is challenged by an increase in emergency calls or healthcare utilization that goes beyond the capacity to provide adequate care due to a public health emergency or mass casualty event, LHH shall activate NHICS and implement this Medical Surge Plan.

2. The most important goal is the safety and wellbeing of the residents at LHH. ~~care of LHH residents.~~ Therefore, if a medical surge occurs as a result of a disease epidemic that is affecting LHH residents, then triage and care of these residents is the number one priority for LHH ~~-~~and the procedures outlined in LHHPP 70-01 C6 Pandemic Flu Plan or disease specific procedures in LHHPP 72 Infection Control shall be followed.

3. When conditions described in #1 occur:

    a. ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO/Nursing Home Administrator (NHA) or designee (i.e. Assistant Nursing Home Administrator (ANHA), ~~Chief Nursing Officer (~~Director of Nursing (DON)~~CNO)~~, Chief Medical Officer/Medical Director (CMO), and/or Chief Quality Officer (CQO)) when public health emergency conditions exist that require expeditious transfer of appropriate patients from ZSFG to LHH.

    b. LHH CEO/NHA or designee (i.e. ANHA, DON~~CNO~~, CMO, or CQO) shall confer with LHH Executive leaders to activate LHH Nursing Home Incident Command System (NHICS).

4. When a medical surge occurs throughout the San Francisco healthcare system:

    a. LHH will participate in a coordinated response with the possibility of receiving patients from hospitals outside of the San Francisco~~SF~~ Health Network (SFHN) using the protocols that are in place to determine bed availability and ensure appropriate level of care.

    b. NHICS shall be activated to manage a response to a city-wide surge.

    c. The NHICS team shall coordinate activities and communication with hospitals and DPH through the DPH Department Operations Center (DOC) or City Emergency Operations Center (EOC).

5. In the case of a city-wide disaster such as an earthquake, there may be a widespread need for first aid treatment throughout the city. If members of the community present to LHH for first aid:

    a. NHICS shall be activated to triage and treat these patients.

    b. Triage and treatment shall be provided in the medical clinic if the number of patients is manageable. For larger numbers of injured persons, other clinical staff may be deployed to provide care.

    c. If community members arrive to LHH seeking first aid of injuries that surpass the ability of LHH clinicians, 911 will be called to transfer those injured to an acute care facility.

d. For triage and treatment of large numbers of first aid patients, a tent can be set up in the gravel parking lot on the west side of the facility. The tent is stored in storage container #6 in the parking lot and can be assembled if necessary.

Post Response Debrief & Performance Improvement

1. The Incident Commander along with help from the Emergency Manager, shall arrange for post activation debrief/hotwash with LHH staff involved in the incident response.

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

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)
LHHPP 70-01 C5 Emergency Responder Dispensing Plan
LHHPP 70-01 C6 Pandemic Influenza Plan
LHHPP 72 Infection Control

Revised: 18/09/11, 23/08/08, 24/05/14 (Year/Month/Day)

EMERGENCY RESPONDER ANTIBIOTIC DISPENSING PLAN

INTRODUCTION

The San Francisco Department of Public Health (SFDPH) is responsible for developing strategies to deliver mass prophylaxis (preventative medications, e.g., antibiotics or vaccines) to *all* residents of San Francisco in the event of a large-scale infectious disease/public health emergency. Although there are many scenarios where mass prophylaxis may be needed, SFDPH has used an anthrax scenario as the planning target since antibiotics would need to be dispensed to all residents of San Francisco within a 48-hour time frame.

In the event of an infectious disease emergency for which antibiotics can provide protection, SFDPH will provide antibiotics first to emergency responders (public health/public safety agencies, critical infrastructure agencies, and critical officials) and their families. The goal is to enable them to come to work to perform their critical public protection duties knowing that they and their families are protected. To prepare for this, emergency responder agencies have developed dispensing plans to describe how they will dispense antibiotics to employees and their household contacts members.

The Local Cache

During a public health emergency requiring mass prophylaxis, San Francisco will request assets from the Strategic National Stockpile (SNS). The SNS will be deployed to San Francisco, through the California Department of Public Health (CDPH). To ensure emergency responders are properly protected so they can continue their work, San Francisco has purchased and is storing a local cache with enough antibiotics to prophylax emergency responders and their families before the federal SNS supplies are expected to be available.

SFDPH will distribute antibiotics to Laguna Honda Hospital and Rehabilitation Center (LHH) based on the estimated number of employees and household members. In addition to antibiotics, SFDPH will provide drug information sheets. These materials are available in several languages.

Although a 10-day course is the recommended standard course, the local cache contains only enough antibiotics to dispense a 3-day supply for emergency responders and their families, which will be dispensed to ~~Laguna Honda~~LHH employees according to this plan. Once the SNS medication arrives, SFDPH will dispense to the general public at pre-identified Points of Dispensing (PODs). ~~Laguna Honda~~LHH employees and their families will be sent to a public dispensing site for the rest of their 10-day course of medicine.

Emergency Authorization for Antibiotic Dispensing

Declaring a public health emergency involving a mass prophylaxis response is the responsibility of the San Francisco Health Officer (CA Health and Safety Code, Section

101075) and the procedures and authorities set out in the SFDPH Emergency Operations Plan and the City and County's Emergency Operations Plan. When a public health emergency (PHE) is declared, special emergency protocols can be put in place that suspend existing regulations or take whatever other actions are necessary to preserve life and health (CA Health and Safety Code, Section 101040, SF Administrative Code, Section 7.6.b.1and Article 17 of Emergency Services Act). In a declared emergency, ~~the San Francisco Department of Public Health~~ SFDPH, under the authority of the Health Officer, becomes the prescribing authority for mass antibiotic dispensing. Consequently, normal pharmaceutical dispensing rules are lifted and non-licensed/non-medical staff can dispense antibiotics as long as they follow the protocols and procedures set up by SFDPH.

PROCEDURE

I. Program Responsibility

The agency coordinator is the primary ~~Laguna Honda~~LHH point of contact with SFDPH for dispensing operations. This position oversees and coordinates the dispensing of antibiotics to employees and household contacts.

Agency Coordinator@			
Name	Eugenio Ocampo, PharmD ~~Michelle Fouts~~	Title	Director of Pharmacy
Address	375 Laguna Honda Blvd.	Email	Eugenio.Ocampo@sfdph.org ~~Michelle.fouts@sfdph.org~~
Phone	628-217-9983 office	24/7 Phone	Cell: 650-291-4240 ~~415-577-4811~~
Primary back-up agency coordinator			
Name	Mina Nasr ~~Jennie Chuan~~	Title	Clinical Pharmacy Supervisor ~~Pharmacist in~~
Address	375 Laguna Honda Blvd.	Email	Mina.Nasr@sfdph.org ~~jennie.chuan@sfdph.org~~
Phone	415-682-5783~~0~~	24/7 Phone	Cell: ~~415-215-7111~~ 415-274-
Secondary back-up agency coordinator			
Name	Christina Lee	Title~~-~~	Senior Physician Specialist, Clinic
Address	375 Laguna Honda Blvd.	Email	Christina.lee@sfdph.org
Phone	415-682-5669 clinic	24/7 Phone	Pager: 415-327-4871
Additional back up agency coordinators			
Contact ~~Laguna Honda Hospital~~LHH Incident Command Center via direct line or 800 MHz radio. Command staff will assign the most appropriate person available to the coordinator role if above staff are not			628-754-4636

II. Activating the Dispensing Plan

A. NHICS Activation and Staffing

1. If mass prophylaxis is initiated, the SFDPH DOC and EOC will be activated to coordinate the distribution and dispensing of appropriate medical countermeasures. SFDPH DOC will contact the Agency Coordinator to alert and notify ~~Laguna Honda~~LHH to activate and prepare to implement emergency responder dispensing.

2. The Agency Coordinator will notify the ~~Executive Administrator~~Chief Executive Officer/Nursing Home Administrator (CEO/NHA) or the Administrator on Duty (AOD) of the need to activate the Nursing Home Incident Command System (NHICS) according to the Laguna Honda Emergency Response Plan (LHHPP 70-01 B1).

3. The ~~Administrator~~ CEO/NHA or AOD will designate an Incident Commander for NHICS operations. The Incident Commander will activate positions listed in Attachment 1 as needed and the Agency Coordinator will serve as the Operations Section Chief.

4. A template message will be sent by the Command Center or the Nursing Office to all staff using SFDPH Alert notifying all DPH employees assigned to ~~Laguna Honda~~LHH that the Emergency Dispensing Plan has been activated.

5. Emergency call back will be initiated by the NHICS Command Center using the confidential call back lists upon the direction of the Incident Commander.

6. All staff who are activated in a NHICS role or are called back to the Labor Pool will report to the Command Center to sign in and receive their assignment.

B. Activating the Point of Dispensing (POD)

1. The Logistics Section will be responsible for setting up the POD in Gerald Simon Theater according to the floor plan in Attachment 2.

2. Back-up locations for the POD include Moran Hall and the H3 Training Room.

C. Receiving the Local Cache and Tracking Inventory

1. Antibiotics from the local cache will be packaged at a centralized warehouse and delivered by SFDPH. The DOC will coordinate delivery of the medication with the Agency Coordinator.

2. The Medication Staging Team will be responsible for tracking antibiotic inventory from the time they receive the antibiotics until unused antibiotics are returned to SFDPH after the event.

3. The Inventory Control Group Supervisor will conduct inventory upon receipt of the antibiotics using the Inventory Forms provided by SFDPH in Attachment 3. Notify the Agency Coordinator if there are any discrepancies between the amount of antibiotics received and amount stated on the packing slips provided by SFDPH DOC.

4. Each dispenser shall use the Inventory Control Forms in Attachment 3 to track the type and amount of antibiotics dispensed as well as lot numbers.

D. Just in Time Training

All mobile and ~~stationary~~stationery dispensing teams will be provided with just in time training on dispensing procedures and inventory tracking prior to dispensing any medications. This training will be performed by staff familiar with this plan and the inventory tracking forms and may include staff from ~~the~~ Pharmacy Services, Medicine, Nursing, ~~Education~~Department of Education and Training (DET), or Emergency Management.

E. Pre-Screening of Employees

Screening is critical to ensure that people receive the right antibiotic. SFDPH has developed an electronic screening form which people can complete online at www.bayareadisastermeds.org for themselves and their household members. This process only takes a couple of minutes and results in a printable form indicating the medication that each individual in the household should receive, including whether they need to seek additional medical consultation due to a contraindication for both antibiotics dispensed. Employees will be encouraged to complete the screening form before proceeding to the POD for dispensing.

III. Dispensing Antibiotics

During a declared public health emergency, special emergency protocols (CA Health and Safety Code, Section 101040, SF Administrative Code, Section 7.6.b.1 and Article 17 of Emergency Services Act) will be put in place to facilitate getting lifesaving medications to people. Such declarations of emergency will allow antibiotic dispensing by non-licensed and non-medical personnel as actions needed “to preserve life and health” (CA Business and Professions Code, Section 4062.b). During a public health emergency non-licensed and non-medical staff may dispense medication provided they follow protocols developed by SFDPH.

Once a person has been screened to determine the appropriate antibiotic, they shall be dispensed the antibiotic and given a drug information sheet for the antibiotic they receive. For staff who are picking up medications for children who need to have their doxycycline

pills crushed, crushing instructions and oral syringes need to be included.

A. POD Dispensing

1. The ~~command~~ Command Center will coordinate a dispensing schedule by notifying LHH Department Managers when to send their employees to the POD. The schedule will depend on the time of day dispensing occurs and the flow of traffic through the POD, which will be communicated by the Operations Section to the ~~command center~~ Command Center.

2. Antibiotic dispensing will occur at the rapid dispensing line and the screening/dispensing line.

3. Employees who have been pre-screened using the online screening form will receive antibiotics from dispensers at the rapid dispensing line.

4. Those who must be screened will be referred to the screening area where computers and staff will be available to guide them through the process so that they can then go to the rapid dispensing line. If internet access is unavailable, they will fill out the paper screening form (Attachment 4) and will have their form reviewed and antibiotics dispensed by the screener/dispenser in the screening/dispensing line according to the Screening Key and instructions in Attachment 4.

5. Those who are referred to medical consultation will receive either receive doxy or cipro if they can take one of the drugs from the rapid dispensing line or a prescription for an alternative antibiotic from the medical consultant.

B. Mobile Dispensing Team Delivery

1. Mobile Dispensing Teams will deliver antibiotics to staff assigned to patient care units, who may stay on their units to complete and print their prescreening forms from any computer with a printer. Team One dispenses to the North Residences (7 floors at approximately 1 floor per hour); Team Two dispenses to the South and Pavilion Residences (7 floors at approximately 1 floor per hour).

2. ~~Back packs~~Backpacks with all necessary supplies will be provided to the mobile teams by the Logistics Section and the Medication Staging Team.

3. Printed forms must be presented to the Mobile Triage Dispensing Team when they arrive to~~on~~ the unit. Expected arrival times will be announced; one hour per unit is anticipated.

4. Staff will complete label(s) provided by the Mobile Team and affix the label immediately to the baggie of antibiotics dispensed for each person in their household. Drug information sheets will be provided.

5. Those who must obtain a medical consultation will be referred for consultation in the Clinic or via phone to the Medical Consultation hotline, which will be established in the Incident Command Center accessible by dialing 4-INFO.

IV. Communication

A. When employees are given their medications, they will be provided with information about where and when they can receive the rest of their ten-day course of antibiotics, information about the antibiotics they will be receiving (Attachment 5), and information about the public health emergency.

B. Any additional information that must be conveyed to staff after dispensing will be provided through the use of SFDPH Alert notifications. Staff may also continue to call the NHICS command center for information throughout the event, even after dispensing has concluded.

C. NHICS will remain activated with limited staffing until the public health emergency has been eliminated and the command center will remain the point of contact for employees with questions.

VI. Demobilization of POD

When dispensing operations have concluded, the Agency Coordinator is responsible ~~to ensure~~for ensuring that all necessary documentation is completed and will manage demobilization of the POD according to the checklist below. The Inventory Control Group Supervisor will conduct the final inventory for the agency, complete all inventory control forms for the agency and prepare unused antibiotics for return to the SFDPH DOC.

POD Demobilization Check List	
Collect all screening forms	
Take final inventory and complete inventory forms	
Package unused medication for return to SFDPH	
Breakdown POD	
Ensure that POD staff sign out in the command center	
Return all supplies and documentation to command center	

Following POD demobilization, the NHICS command center will remain operational until normal operations are resumed and all NHICS documentation has been completed including forms completed by the Finance Section. Demobilization of the command center will be carried out by the Demobilization Unit of the Planning Section.

ATTACHMENT:
Attachment 1: NHICS Roles
Attachment 2: POD Setup Diagram
Attachment 3: Emergency Dispensing Inventory Receipt and Tracking Forms
Attachment 4: Screening Form, Key, and Instructions
Attachment 5: Antibiotic Information Sheets

REFERENCE:
None.

Revised: 16/09/13, 23/09/12 (Year/Month/Day)

Attachment 1: NHICS Roles

Command Positions

- Public Information Officer – responsible for communicating messages from the command center out to the Laguna Honda Community and the public.
- Safety Officer – responsible for ensuring the safety of responders
- Liaison Officer – responsible for collaboration with outside agencies, such as the DOC, DEM, EMS

Planning Section - Responsible for collecting DOSRs, answering command center phone and gathering information from POD and from departments/neighborhoods, customizing the IAP template for each operational period, and demobilizing.

- Section Chief
- Situation Unit
- Documentation Unit
- Demobilization Unit Leader

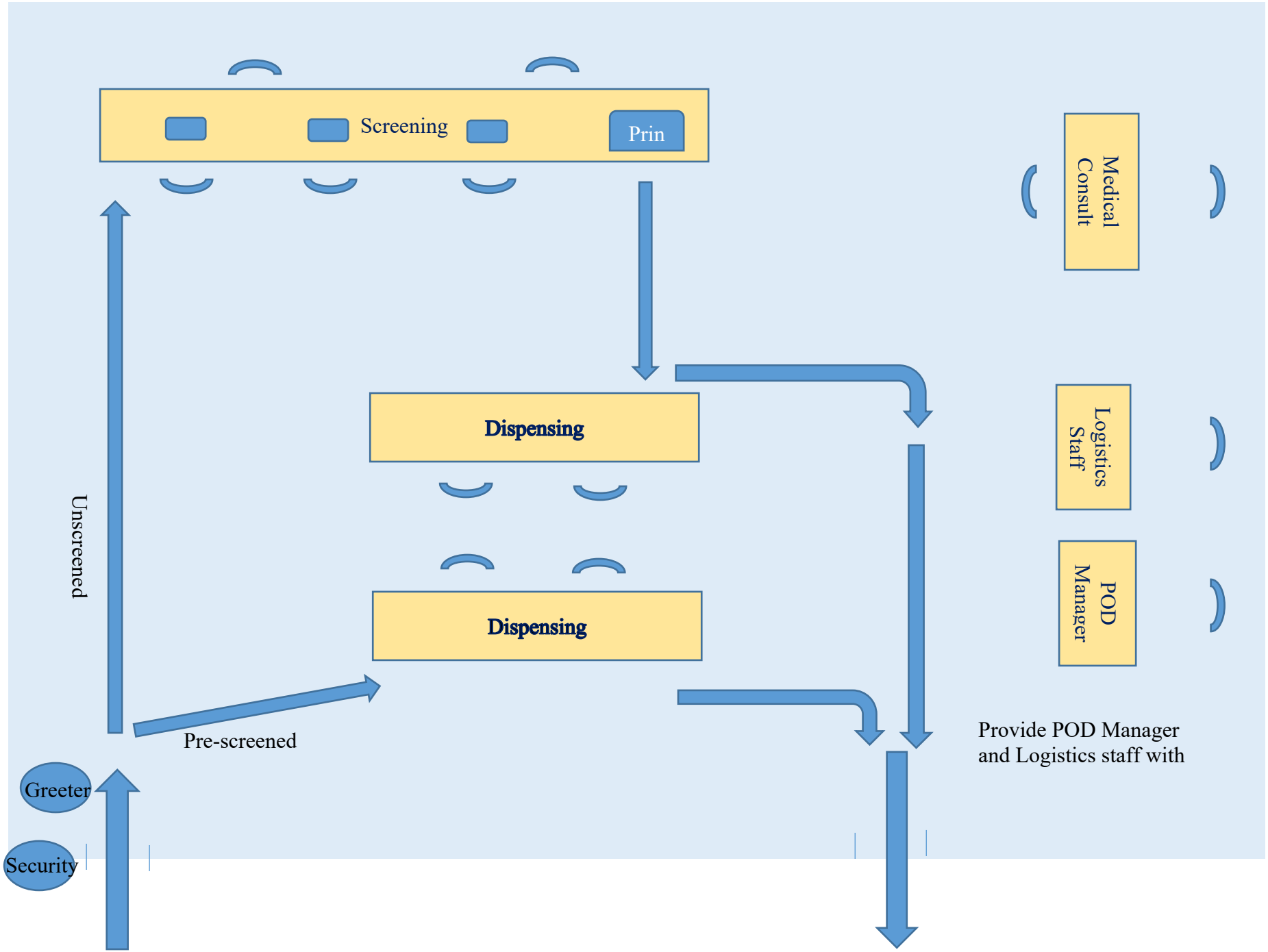
Logistics Section – Responsible for providing all resources required for effective response.

- Section Chief
- Support Branch – Responsible for setting up and providing resources to responders in the command center and the POD
- Labor Pool Unit – Responsible for providing additional staffing for Operations where needed, such as POD staff, dispensing teams, and trainers.

Operations Section (assigned to the POD location) – responsible for carrying out the all objectives laid out in the IAP, most importantly the safe and effective dispensing of medication to staff.

- Section Chief (filled by Agency Coordinator) – responsible for overall coordination of the dispensing operation
- Medical Care Branch – responsible for the well-being of staff, including providing consultation services in the POD and command center hotline
- Medication Staging Team – responsible for inventory and tracking of medications
- Medication Distribution personnel – responsible for handing out medication appropriately
- Security Branch – works with law enforcement to ensure orderly dispensing and crowd control
- Just in Time Trainers – responsible for training dispensing teams
- Runners – collect DOSRs, deliver messages and/or resources between command center and POD.

Attachment 2: POD Setup Diagram


Screening
Prin
Medical Consult
Dispensing
Logistics Staff
Dispensing
POD Manager
Unscreened
Pre-screened
Provide POD Manager and Logistics staff with
Greeter
Security

Attachment 3: Emergency Dispensing Inventory Receipt and Tracking Forms

Emergency Dispensing Inventory Receipt Form

Please verify the information and inventory of supplies received is correct. Sign and date at the bottom of the page.

Agency Name _____ **Designated Representative** _____
Date **Contact number**

Drug/ Supplies	**Quantity** (Boxes)	**Courses Per Box** (unit-of-use bottles)	**Lot Number** (Do not include more than one lot number on a line)	**Comments Notes**

DPH Warehouse staff signature _____ **Agency Representative Signature** _____

Emergency Dispensing Inventory Control Form – Doxycycline

Use one line for each person who picks up medication and record aggregate number of people prescribed Doxy in people prescribed column. Use the Ciprofloxacin Inventory control form to record number of person prescribed Cipro. Return completed form to Inventory Control Personnel.

Drug – Doxycycline	Lot Number	# of People Prescribed	# of Crushing Instructions Given	Notes

Dispenser Name _____ Signature _____

Date _____ Total Courses Given _____

Emergency Dispensing Inventory Control Form – Ciprofloxacin

Use one line for each person who picks up medication and record aggregate number of people prescribed Doxy in people prescribed column. Use the Ciprofloxacin Inventory control form to record number of person prescribed Cipro. Return completed form to Inventory Control Personnel.

Drug	Lot Number	# of People Prescribed	Notes

Dispenser Name _____ Signature _____

Date _____ Total Courses Given _____

Emergency Dispensing Site Total Inventory Control Form

Complete the inventory control form using information from dispenser inventory control forms. Fill in inventory used column as you get completed inventory forms from dispensers. Contact the Operation Lead when remaining inventory is less than 25%

Doxycycline	**Starting Inventory**				**Ciprofloxacin**	**Starting Inventory**		
Lot Number	**Courses Used**	**Courses Remaining**	**Notes**		**Lot Number**	**Courses Used**	**Courses Remaining**	**Notes**

Inventory Group _____ **Signature** _____

Date _____ **Total Courses Given** _____

Emergency Dispensing Agency Final Inventory Close Out Form

Complete once dispensing operations have completed and inventory is ready for return to SFDPH DOC.

Agency Name _____ **Agency Coordinator** _____

Contact Phone number _____ **Date** _____

Drug/ Supply	Lot Number	Quantity Used	Quantity Returned	Notes

SFDPH DOC Staff Signature _____ **Agency Representative Signature** _____

Date Unused Inventory Picked up _____

Attachment 4: Screening Form, Key, and Instructions

MULTI-PERSON ANTIBIOTICS SCREENING FORM*

*Use these forms if unable to access on line screening at www.bayarea disastermeds.org

GENERAL INSTRUCTIONS:

1. In Column B, list each person for whom you are picking up up antibiotics (including yourself).
2. For each person listed, leave columns blank if no conditions apply. ONLY put a check mark ('7) in columns C-H if that person has the condition. If you are picking up for children under age 18, complete columns I and J.
3. Do not write anything in the "For Clinic Use Only" section.
4. Proceed with your completed form to the next Screening station and give this form to the staff person there.
5. Staff will then direct you to the next station.

Use one line for each person.		DOXY CONTRAINDICATIONS		CIPRO CONTRAINDICATIONS				PEDIATRIC INFORMATION					CONSULT		
A	B	C	D	E	F	G	H	I	J	1	2	3	4	5	
		ANTIBIOTIC CONTRAINDICATIONS						AGE	WEIGHT	CIPRO	DOXY				
Person #	Name of each person for whom you are picking up (write your name for person #1)	ALLERGIC TO DOXYcycline or any "CYCLINE" drug?	PREGNANT or BREAST-FEEDING?	ALLERGIC TO CIPROfloxacin or ANY "floxacin" drug?	History of SEIZURES, or EPILEPSY?	Currently taking Tizanidine?	Have Myasthenia Gravis?	AGE (IF under 18)	WEIGHT (IF UNDER 90 POUNDS)	CIPROFLOXACIN	DOXYCYCLINE	SPECIAL INSTRUCTIONS	GO TO CONSULT	CONSULT INITIALS	Consult Notes
1										1					
2										2					
3										3					
4										4					
5										5					
6										6					
7										7					
8										8					
9										9					
10										10					

Date: _____/_____/_____

Site: _____ **Shift:** _____

Screener initials _____

Dispenser initials _____

Multiperson Screening Form -- KEY (Doxy Dominant)*

*Use these forms if unable to access on line screening at www.bayarea disastermeds.org

Match the each person's response on the screening form to the row that corresponds to the checked boxes on the screening form key. Check the corresponding box in the "For Clinic Use" columns.

Complete the Date, Site, Shift and Screener initial section at the bottom of the page

TRUST THE KEY

FOR CLINIC USE

Use one line for each person.		DOXY CONTRAINDICATIONS		CIPRO CONTRAINDICATIONS				PEDIATRIC INFORMATION		CONSULT				
A	B	C	D	E	F	G	H	I		1	2	3	4	5	J
		ANTIBIOTIC CONTRAINDICATIONS						AGE							WEIGHT
Person #	Name of Person for whom you are picking up (include yourself in line 1)	ALLERGIC TO DOXYcycline or any "CYCLINE" drug?	PREGNANT	ALLERGIC TO CIPROfloxacin or ANY "floxacin" drug?	History of SEIZURES, or EPILEPSY?	Currently taking Tizanidine?	Have Mysathenia Gravis?	AGE (IF under 18)		CIPROFLOXACIN	DOXYCYCLINE	CRUSHING INSTRUCTIONS	GO TO CONSULT --	CONSULT INITIALS	
	No to all conditions in column C-D, age >= 18 --> Check Doxy	Blank or "No"		**Doesn't matter what is in column E-H**				Blank or >= 18	Blank or Anything		ü				
	No to all conditions in column C-D, age < 18, weight blank or > 90 lbs --> Check Doxy	Blank or "No"		**Doesn't matter what is in column E-H**				<18	Blank or >= 90		ü				
	No to all conditions in column C-D, age < 18, weight < 90 lbs --> Check Doxy and Crushing Instruction	Blank or "No"		**Doesn't matter what is in column E-H**				<18			ü	ü			<90
	Yes to any condition in column C-D, but no to all conditions in column E-H, age >= 18 --> Check Cipro	**Check/"Yes" in any**		All blank or "no"				Blank or >= 18	Blank or Anything	ü					
	Yes to any condition in column C-D, but no to all conditions in column E-H, age <18, weight >= 62lb --> Check Cipro	**Check/"Yes" in any**		All blank or "no"				<18		ü					>=62
	Yes to any condition in column C-D, but no to all conditions in column E-H, age <18, weight < 62lbs --> Check Go To Consult	**Check/"Yes" in any**		All blank or "no"				<18					ü		<62
	Yes to any condition in column C-D **AND** Yes to any condition in column E- H --> Check Go To Consult	**Check/"Yes" in any**		Check/ "Yes" in any				Blank or Anything	Blank or Anything				ü		

Date: _____/_____/_____
Site: _____ **Shift:** _____

Screener initial _____

Dispenser initials _____

GENERAL INSTRUCTIONS FOR INTERPRETING THE MULTI-PERSON SCREENING FORM

Use the key with the Multi Person Antibiotic Screening Form to determine whether or not the client or the person for whom they are picking up antibiotics should receive doxycycline or ciprofloxacin, based on the contraindications that may be listed. For a minority of people, it should be recommended that they have a conversation with the medical consultant.

All children (less than age 18 AND weighing less than 90 pounds) will receive doxycycline unless they are allergic or are pregnant. Any time doxycycline is dispensed for a pediatric dose, it must be accompanied by crushing instructions and an oral syringe must be given.

Basically, when boxes are checked indicating a contraindication to doxycycline, they should be given cipro. When boxes are checked indicating a contraindication to cipro, they should be given doxy. When there are contraindications to both, they should be sent to Medical Consultation.

For any pediatric patients or patients who cannot swallow pills, indicate on the Multi Person Screening Form that the crushing instructions need to be given, so that the dispenser will know to give instructions and an oral syringe.

Anyone who is 18 years old or older is considered an adult.
The weight cutoff for receiving pediatric doxy is 90 lbs.
The weight cutoff for receiving pediatric cipro is 62 lbs. For the exercise on March 19, 2009, crushing cipro is not an option. Therefore, if a person indicates a contraindication to doxy and is less than 18 years old but weighs more than 62 lbs, they can receive an adult dose of cipro.

If a person is 18 or older and weighing less than 90 lbs, they should still receive an adult dose of doxy.

Trust the Multi-Person Screening form. People may say that they have allergies to other drugs (penicillin, e.g.) or that they are currently taking other medications and wonder about the interactions. All of that information is addressed on the drug information sheets, which they will receive at dispensing. It is important for everyone to read the drug information sheet in its entirety. If they are asking about something that is not addressed on the multi-person screening form directly, then it is not considered an issue worthy of including on the form.

Finally, people who have valid allergies to antibiotics such as doxycycline or ciprofloxacin usually know it. If someone says they do not know if they are allergic, some guiding statements are to say that they should consider themselves allergic if a medical doctor has told them they are allergic or if they have experienced a life-threatening reaction to the drug.

After you have screened all people listed on the form, complete the "Screener Initial" section of the form and refer the patient to either "Dispensing C" line or to "Medical Consultation".

Attachment 5: Antibiotic Information Sheets

A) Doxycycline
B) Ciprofloxacin
C) Doxycycline Crush Sheet

In an Emergency:

How to Prepare Doxycycline for Children and Adults Who Cannot Swallow Pills

Mixing Doxycycline Hyclate 100mg Tablets with Food

Once you have been notified by your federal, state or local authorities that you need to take doxycycline for a public health emergency, it may be necessary to prepare *emergency* doses of doxycycline for children and adults who cannot swallow pills.

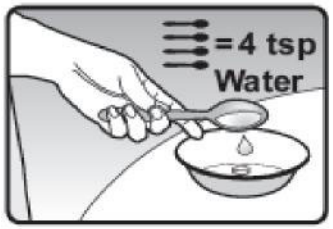
June 2008
Prepared by the U.S. Food and Drug Administration

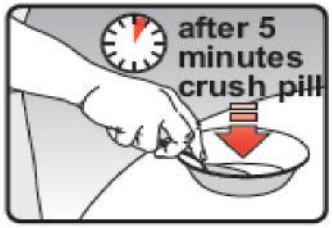
1 Supplies You Will Need

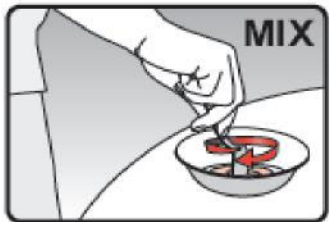
You will need these items to make doses of doxycycline for adults and children who cannot swallow pills:

- 1 doxycycline pill (100 mg) *(Do not take doxycycline if you are allergic to tetracyclines)*
- a metal teaspoon
- 2 small bowls
- Water
- one of these foods or drinks to hide the bitter taste of crushed doxycycline:
  - milk or chocolate milk
  - chocolate pudding
  - apple juice and sugar

Use any metal teaspoon to crush the pill
Use a MEASURING TEASPOON to measure the water. A measuring teaspoon = 5 mL (5 cc) of liquid







2 Crushing the Pill and Mixing with Water

1. Put 1 doxycycline pill in a small bowl.
2. Add 4 full teaspoons of water to the same bowl.
3. Let the pill soak in the water for 5 minutes so it will be soft.
4. Use the back of a metal teaspoon to crush the pill in the water. Crush the pill until no visible pieces remain.
5. Stir the pill and water so it is well mixed.

You have now made the Doxycycline and Water Mixture.

Child's weight: _____

3 Adding Food to the Doxycycline and Water Mixture to Make It Taste Better

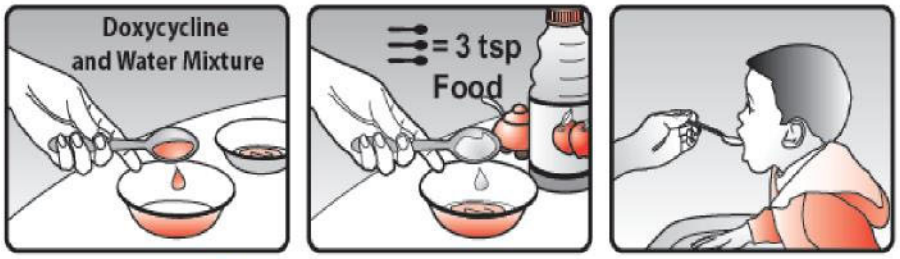
1. Weigh your child.
2. Find your child's weight on the left side of the chart below.
3. Next, look on the right side of the chart to find the amount of the Doxycycline and Water Mixture to mix with food. The chart shows you the amount to give your child for 1 dose. (*For a ½ teaspoon dose, fill the metal teaspoon half way. It is better to give a little more of the medicine than not enough).*

Child's Weight	Amount of Doxycycline and Water Mixture	Teaspoons
12 pounds or less	½ teaspoon	
13 to 25 pounds	1 teaspoon	
26 to 38 pounds	1½ teaspoons	
39 to 50 pounds	2 teaspoons	
51 to 63 pounds	2½ teaspoons	
64 to 75 pounds	3 teaspoons	
76 to 88 pounds	3½ teaspoons	
89 pounds or more and adults	Use the entire mixture	Entire Mixture

4. Add the right amount of the Doxycycline and Water Mixture from the chart above to the second bowl. For adults and children 89 pounds and more, use the entire mixture.

4a. Use a MEASURING TEASPOON to measure out the right amount of the Doxycycline and Water Mixture

5. Add 3 teaspoons of milk **or** chocolate milk **or** chocolate pudding **or** apple juice to the second bowl. If you use apple juice, also add 4 teaspoons of sugar to the second bowl.
   - Stir well.



6. Go to Step 4 for dosing.

4 Dosing the Doxycycline and Water Mixture Mixed With Food

1. Give all of the Doxycycline and Water and food mixture in the second bowl. This is one dose.
2. **Each child or adult should take 1 dose in the morning and 1 dose at night each day.**

5 Storing the Doxycycline and Water Mixture (If There Is Enough for Another Dose)

- **If you have enough leftover doxycycline and water mixture for another dose, you can keep it for the next dose.**
- The doxycycline and water mixture can be stored in a covered bowl or cup. Label and date.
- Keep the mixture in a safe place out of the reach of children.
- Store the Doxycycline and Water Mixture at room temperature for up to 24 hours.
- Throw away any unused mixture after 24 hours and make a new Doxycycline and Water Mixture before the next dose.

Do not take doxycycline if you have an allergy to tetracyclines

Get emergency help if you have any signs of an allergic reaction including hives, difficulty breathing, or swelling of your face, lips, tongue or throat.

Doxycycline may cause diarrhea, skin reaction to the sun, loss of appetite, nausea and vomiting. Birth control pills may not work as well if you take doxycycline.

Report any reaction to the medication to MedWatch at www.fda.gov/medwatch or 1-800-FDA-1088

PANDEMIC RESPIRATORY ILLNESS PLAN

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to minimizing the impact of a pandemic on the health and well-being of its residents and staff.

2. LHH is prepared to provide support to the city-wide health care system in managing a pandemic that results in a medical surge for emergency departments in hospitals throughout San Francisco.

PURPOSE:

To establish procedures by which LHH will collaborate with the San Francisco Department of Public Health (SFDPH), San Francisco Emergency Response services, other emergency response and public health agencies, and other health care facilities in response to pandemic or any other infectious respiratory disease epidemics affecting San Francisco.

LHH does not provide emergency services to the public; its role in responding to pandemic or any other infectious respiratory disease epidemic is limited to the following objectives:

1. Monitoring the scope and spread of respiratory illness in the community for planning purposes.

2. Identifying and reporting cases of illness in residents and/or staff

3. Containing outbreaks of illness in residents and/or staff

4. Participating in a regional response to associated medical surge according to LHHPP 70-01 C4 Medical Surge Plan

DEFINITION:

A pandemic is a global outbreak. Examples of a pandemic include COVID-19 and influenza A virus. Pandemics typically occur when novel (new) viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way.

PROCEDURE:

1. **Case Identification in Residents**

a. Residents who have symptoms characteristic of influenza-like illness (ILI) including fever, fatigue, cough, congestion, sore throat, myalgias and headache shall be considered at risk.

b. Residents and clinic outpatients are also considered to be at risk if they have:

i. ~~h~~Had direct contact with poultry; or

ii. H~~h~~ad close contact with a person with confirmed or suspected novel influenza or coronavirus or other emerging infectious disease.

Laboratory testing will be conducted according to Centers for Disease Control and Prevention (CDC) Guidelines for the specific pandemic using our most current laboratory procedures in the Zuckerberg San Francisco General Hospital (ZSFG) Lab Manual found at http://labmed.ucsf.edu/sfghlab/.

2. Monitoring and Reporting of Influenza Case Rates in Residents:

a. LHH ~~Infection Control and Prevention (ICP)~~Infection Prevention and Control (IPC) staff will review resident incidents/cases of unusual respiratory illness. –Case counts/summaries will include a review of positive rapid test results as often as possible.

b. Initial concerns regarding pandemic respiratory illness with the potential to impact LHH will be reported to LHH ~~ICP~~ IPC staff.

c. The IPC~~ICP~~ Staff or Medical Staff will notify the Chief Executive Officer/Nursing Home Administrator (CEO/NHA) or Administrator on Duty (AOD) of any signs of pandemic respiratory illness affecting the LHH community.

d. Concerns regarding pandemic respiratory illness will be reported to the SFDPH Communicable Disease Branch by the CEO/NHA or AOD and the Nursing Home Incident Command System (NHICS) will be activated according to the LHHPP 70-01 B1 Emergency Response Plan.

3. Identification of Employee Cases

a. Employees who have symptoms including fever, fatigue, cough, congestion, sore throat, myalgias and headache shall be considered at risk for unusual respiratory illness.

b. Employees with symptoms ~~shall~~should not report to work while they have these symptoms and should be medically evaluated.

c. If an employee believes that their illness is caused by workplace exposure to an ill resident or co-worker, they should report the illness to their supervisor according

to the LHHPP 73-01 Injury and Illness Prevention Program. Medical evaluation of occupationally exposed employees will be provided by ZSFG OHS according to the LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

i. During surge situations, NHICS may implement a contact tracing program. If this occurs, the employee will notify their supervisor and the contact tracing team when symptoms/exposure are expected or confirmed.

~~c.~~d. Employees with unusual respiratory illness without a work-related exposure should be evaluated by their primary care provider.

~~d.~~e. Health care workers diagnosed with an unusual respiratory illness (COVID-19/Influenza/RSV/Rhinovirus/etc.) shall report the diagnosis to their supervisor, who will notify the ~~Infection Control Nurse.~~ IPC staff.

4. Response and Containment

a. Residents: Residents with known or suspected respiratory illness shall be managed with a combination isolation precautions approach. ~~-~~This will be driven by the facilities transmission-based precautions policy following guidance from local, state, and federal guidelines.

i. Residents will be placed according to the LHHP 72-01 B5 Transmission-Based Precautions and Resident Room Placement; and isolation rooms will be managed according to the LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

ii. Elective admissions and procedures ~~maybe~~may be deferred until the local outbreak resolves. ~~-~~This decision will be made by NHICS leadership, facility leadership and infection control experts in consultation with local, state, and federal partners.

~~ii.~~iii. LHH has protocols that contain more specific instructions for both Influenza and COVID-19 that should be referenced in the event of an outbreak~~event~~. ~~Links to those documents are included below as attachment 1 and 2.~~

b. Healthcare Workers:

i. Healthcare workers (HCWs) with likely or confirmed respiratory illness must not return to work while ill and should reference policy LHHPP 72-01 D4 Evaluation of Communicable Illness in Personnel. In the event of respiratory pandemic, off-work policies will be reviewed and aligned with the local, state, and federal guidance.

ii. In the event of a suspected pandemic outbreak, ~~ICP~~ IPC staff will communicate with all managers regarding the need to test symptomatic employees.

Depending on the diagnostic tests available, testing may occur in LHH Medical Clinic, ZSFG Occupational Health, ZSFG Urgent Care, the ZSFG Emergency Department, or another venue based on specific circumstances.

iii. HCWs receive ongoing training and education regarding infection control practices during non-pandemic periods. In the event of suspected or confirmed pandemic respiratory illness, HCWs will be provided additional training regarding specific, recommended infection control measures.

iv. If possible, pregnant and other staff at high risk for complications of respiratory illness shall be reassigned to low-risk duties (e.g., non-influenza and/or COVID-19 resident care, administrative duties that do not involve resident care) or placed on furlough.

v. HCW quarantine will be considered according to the specific situation and recommendations from Health and Human Services (HHS), the CDC, California Department of Public Health (CDPH), and local public health authorities.

c. Visitors

i. Visitors with upper respiratory symptoms shall be asked to refrain from visiting LHH until afebrile for 24 hours (without the use of antipyretic medications) and improvement of symptoms. Special considerations may be given to close family members and persons essential for the resident's well-being. Testing may be required but this decision will be driven by recommendations from local, state and federal partners.

ii. Family members who visit residents with respiratory illness shall follow the transmission-based precautions expectations while interacting with the resident. They shall also adhere to hospital hand hygiene practices. Family members should be educated during outbreak to ensure they understand the risks, benefits, and care expectations of residents during an outbreak/surge of unusual respiratory illness.

d. Personal Protective Equipment (PPE):

i. Respiratory protection including N95s and powered air purifying respirators (PAPRs) shall be worn in accordance with the LHHPP 73-09 Respiratory Protection Program and the LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

ii. Surgical masks or procedure masks are not respirators and will not protect staff from airborne exposure to influenza virus but may provide some protection from splashes or droplets. –Decisions regarding the required PPE will be made

based upon the circulating respiratory illness following local, state, and federal guidelines.

iii. Other PPE, such as gloves, gowns, and eye/face protection shall be used for standard, contact, or droplet precautions according to LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement and LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions.

e. Vaccine Use in a Pandemic:

i. Before a vaccine containing the circulating pandemic virus strain becomes available, pre-pandemic vaccine from the hospital supply may be considered if this vaccine contains the pandemic subtype or is partially cross protective to the pandemic virus. These decisions will be driven by local, state, and federal guidelines after consultation with LHH pharmacy and NHICS leadership.

ii. Once a pandemic vaccine becomes available, CDPH will distribute vaccine according to their Pandemic Operations Plan.

iii. Once LHH has received the vaccine from CDPH, the vaccination of designated priority groups will begin. Note that persons who would not likely be protected by vaccination may be excluded. Priority groups include:

- Hospital staff who have direct resident contact and/or are involved in support services essential for resident care.
- Residents that are at most risk of having severe complications from infection including:
  - Those > 65 years with 1 or more high-risk condition
  - Those 18 years to 64 years with 2 or more high-risk conditions
  - Those 18 years or older with a history of hospitalization for pneumonia or influenza or other high-risk condition in the past year
- Residents and health care workers who are pregnant.

iv. Once priority groups have been vaccinated, remaining vaccine will be stored for future use and/or administered to other residents and staff in accordance with CDC recommendations for vaccine use at that time.

f. Antiviral Use:

i. The effectiveness of antiviral medications in the treatment and prophylaxis of disease caused by avian influenza (H5N1) or other potential pandemic strains is unknown.

ii. The use of antiviral drugs for both residents and health care workers will be managed according to availability with guidance from HHS, the CDC, CDPH, and local department of public health officials.

iii. Because of the potential effectiveness of treatment with antiviral drugs and the greater efficiency of treatment in the setting of limited supply, the use of antivirals for prophylaxis will be restricted to maximize health benefits.

g. Surge Procedures:

i. If the total number of LHH residents needing healthcare assessment and treatment exceeds the immediately available resources of the hospital, LHH will activate the Emergency Response Plan and appropriate surge capacity plans and procedures including cancellation of clinics, discharge of less acute residents, activation of alternate care areas, facility lock-down, co-horting of residents as needed, and adjustment of staffing ratios and implementation of austere care if warranted for a healthcare emergency.

- See respiratory illness/COVID-19 surge protocol for additional information.

ii. LHH will work with the SFDPH and other local and regional healthcare providers to direct residents to appropriate alternate care locations whenever possible.

iii. In the event that a pandemic has impacted San Francisco, but has not had a direct effect on LHH residents, LHH will activate its Medical Surge plan (LHHPP 70-01 C4 Medical Surge Plan) and be available to receive admissions from ZSFG to increase the number of beds available for influenza cases coming into their emergency department.

iv. If a surge leads to a shortage of PPE, the procedures for accessing PPE in the LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan, section 6 will be followed.

ATTACHMENT:
None.

REFERENCE:
70-01 B1 Emergency Response Plan
70-01 C4 Medical Surge Plan

72-01 Infection Control Manual
73-07 Aerosol Transmissible Disease Exposure Control Plan
73-09 Respiratory Protection Program
UCSF Departments of Pathology & Laboratory Medicine's Lab Manual for SFGH
CDPH, CID, DCDC Pandemic Influenza Operations Plan

Awaiting Approval: Flu Protocol
COVID-19 Protocol

Revised: 08/08/25, 15/01/13, 17/05/09, 23/06/30, 23/08/08 (Year/Month/Day)
Original adoption: 08/06
~~Approved for renumbering from 72-06 to 70-08: 15/01/13~~
~~Approved for renumbering to 70-01 Section A, B, and C: 18/02/23~~

POWER OUTAGE REPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents in the event of a power outage by using generator power and/or downtime procedures.

PURPOSE:

To take appropriate action during a power outage to prevent injury and loss of life and to facilitate recovery.

PROCEDURE:

1. The Nursing Home Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander and NHICS team will be responsible for managing the response to the power outage with the following basic objectives:

    a. Ensure safety and security of all residents, staff, and visitors, by requesting contracted security and or the San Francisco ~~Sheriffs~~Sheriff's Office (SFSO) to conduct patrols to identify any safety and security hazards.

    b. Minimize damage to LHH property.

    c. Facilitate the recovery of power and return to normal facility operations.

2. Communication to Stakeholders – After immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the outage using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

    b. Initiate emergency call backs if the implementation of any downtime procedures requires extra labor resources not available on site.

    c. Disseminate information to the public or the media ONLY with the approval from~~of~~ the LHH ~~Nursing Home Administrator/~~Chief Executive Officer/Nursing Home Administrator (~~NHA/CEO~~CEO/NHA) or DPH Public Information Officer (PIO).

3. Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

a. All employees shall contact the command center with questions about the power outage, to report hazards, or to request resources to assist with safe, quality delivery of care.

b. Employees shall refer media representatives to the NHICS Command Center at 415-759-4636.

4. ~~Ensure Safety of all Persons and Continue Quality Care of Residents~~Staff shall ensure the safety of all persons and continue to provide quality care to the residents of LHH.

a. ~~Neighborhood~~ Unit staff shall account for all residents, staff, and visitors in the neighborhood.

b. Check for injuries and fall risk. Prioritize checking all bathrooms, which will be very dark, creating a significant fall risk.

c. Each ~~neighborhood~~ unit has a supply of emergency lighting equipment, including flashlights and lanterns that may be used to provide care in poorly lit locations.

d. Complete the Department Operating Status Report (DOSR) and fax it to the command center at ~~415-504-8313~~628-754-4671 or deliver to a DOSR bin.

e. Activate the Continuity of Operations Plan (COOP) 70-01 B2 and follow your department's downtime procedures to continue care without equipment or systems that may be unavailable due to power outage.

5. Mitigate secondary hazards

a. Follow all directions from the command center and report changes in status.

b. Keep essential resident care equipment plugged into red outlets, which are powered by the emergency generators.

c. Turn off unnecessary lights and unplug unnecessary equipment as needed to avoid excess demand when power is restored.

d. SFSO shall notify incoming visitors of the power outage and restrict facility access if directed by the NHICS Team.

6. Once Power Has Been Restored

a. When power is restored, the command center will notify the Nursing O~~o~~ffice, and they shall notify building occupants via overhead page.

b. ~~Watch engineer~~The Facility Services Watch Engineer or Chief Engineer will check all equipment and lights and notify the ~~command center~~ Command Center of negative effects caused by the power outage.
c. The Command Center will notify the IT Help Desk at 4-3577 or dph.helpdesk@sfdph.org.

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)

Revised: 18/05/08, 23/09/12, 24/12/10, 26/08/18 (Year/Month/Day)
Original adoption:

WATER DISRUPTION PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing residents and staff with a sufficient supply of water throughout any emergency event that disrupts the water supply.

PURPOSE:

To effectively manage a disruption in water service.

PROCEDURE:

1. The Nursing Home Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander and NHICS team shall be responsible for managing the response to the disruption in water service with the following basic objectives:

    a. Ensure an adequate water supply for the safety of residents and staff.

    b. Minimize damage to property.

    c. Facilitate the recovery of water service and return to normal operations.

2. Response staff and NHICS team can use the CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities document as a reference for additional response actions.

3. Communication to Stakeholders – After completing immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the disruption using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

    b. Initiate emergency call backs if the provision of an adequate water supply requires extra labor resources not available on site.

    c. Disseminate information to the public or the media ONLY with the approval of the LHH Chief Executive Officer/Nursing Home Administrator (CEO/NHA) ~~CEO~~ or DPH Public Information Officer (PIO).

4. Communication with Command Center (phone: 4-4636, fax: ~~415-504-8313~~628-754-4671)

a. All employees shall contact the command center with questions about the disruption of water service, to report adverse effects, or to request resources to assist with safe, quality delivery of care.

b. Employees shall refer media representatives to the ~~Nursing Home Incident~~NHICS Command Center at 628~~415~~-75~~49~~-4636.

5. Identify sources of potable water

Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount required per day estimated at 1,780 gallons per day for a full census of 780 plus 1,000 staff.

Water for 3 days = 5,340 gallons

Water for 5 days = 8,900 gallons

Water for 7 days = 12,460 gal.

a. There are two 300,000-gallon water tanks east of the east parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed)

b. Bottled water is delivered weekly for office water coolers such that there is between 1200 and 1700 gallons on hand at any given time. We also have an emergency operations MOU in place with the vendor (details with material management).

c. 270 gallons of water stored in Food Service Emergency Storeroom (120 cases of 24 can, 12 ounces per can).

d. 325.5 gallons of juice stored in the Food Service Emergency Storeroom

6. Conserve potable water until service is restored:

a. Do not flush toilets more than necessary~~.~~ only flush for solid waste.

b. Hand hygiene will remain a priority primarily by using alcohol hand sanitizer. If hands are visibly soiled, or staff are caring for a resident with known/suspected CDI infection, hand washing with soap and water should still be performed.

c. Turn off irrigation systems.

d. Use waterless bathing products for resident hygiene as much as possible.

e. Disconnect ice machines.

f. Environmental cleaning will remain a priority. Use commercially prepared wipes as much as possible for disinfecting surfaces.

g. Use alternate methods for sanitary sewage disposal:

   i. Flush toilets with buckets of pool water. Pools have a total of 32,450 gallons of water. A pump is available, via facilities, to fill buckets on a cart that can be transported for cleaning or flushing purposes.

   ii. If pool water runs out, use commodes and bedpans with liners or plastic bags under toilet seats and empty into waste bags. Follow instruction from command center for bag disposal procedures.

h. If the sprinkler system loses pressure, Facility Services shall activate Facility Services P&P LS-12 Fire Watch.

7. When water service is restored:

   a. The Facility Services Department shall check all building systems, including sprinklers to ensure adequate pressure and water flow.

   b. The command center shall notify building occupants that the service is restored, and normal operations can resume.

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
Facility Services P&P US-6: Utility Systems – Plumbing Systems
Facility Services P&P LS-12: Life Safety Management – Fire Watch
Facility Services P&P US-7: Domestic Water System
Food Services 1.03 Disaster Plan
CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities

Revised: 18/09/11, 23/31/05, 23/10/10 (Year/Month/Day)
Original adoption:

HEAT EMERGENCY AND HEAT ILLNESS PREVENTION PLA~~NN~~ : INDOOR AND OUTDOOR HEAT STRESS CONDITIONS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to responding to heat emergencies by providing a safe and healthy environment for its residents, patients, and staff and assisting in a regional response to impacts on the local healthcare system.

PURPOSE:

~~1.~~

~~2.~~ To implement procedures for responding to excessively warm climate conditions that may impact operations and pose a threat to the health and well-being of residents and staff.

1.

2. ~~2.~~ To participate in a coordinated effort to manage any city-wide medical surge resulting from a heat emergency.

3. ~~3.~~ To comply with California Department of Industrial Relations Indoor Heat Stress Program Section 3396 and the Outdoor Heat Stress Standard 3395, both of which require that a heat illness prevention plan be developed.

DEFINITIONS:

1. ~~(1)~~ "Acclimatization" means temporary adaptation of the body to work in the heat that occurs gradually when a person is exposed to it. Acclimatization peaks in most people within four to fourteen days of regular work for at least two hours per day in the heat.

2. ~~(2)~~ "Administrative control" means a method to limit exposure to a hazard by adjustment of work procedures, practices, or schedules. Examples of administrative controls that may be effective at minimizing the risk of heat illness in a particular work area include, but are not limited to: acclimatizing employees, rotating employees, scheduling work earlier or later in the day, using work/rest schedules, reducing work intensity or speed, reducing work hours, changing required work clothing, and using relief workers.

3. ~~(3)~~ "Clothing that restricts heat removal" means full-body clothing covering the arms, legs, and torso that is any of the following:

   a. ~~(A)~~ Waterproof; or

b. ~~(B)~~ Designed to protect the wearer from a chemical, biological, physical, radiological, or fire hazard; or

c. ~~(C)~~ Designed to protect the wearer or the work process from contamination.

d. ~~(D)~~ "Clothing that restricts heat removal" does not include clothing demonstrated by the employer to be all of the following:

i. ~~(1)~~ Constructed only of knit or woven fibers, or otherwise an air and water vapor permeable material; and
ii. ~~(2)~~ Worn in lieu of the employee's street clothing; and

iii. ~~(3)~~ Worn without a full-body thermal, vapor, or moisture barrier.

iv. ~~(4)~~ "Cool-down area" means an indoor or outdoor area that is blocked from direct sunlight and shielded from other high radiant heat sources to the extent feasible and is either open to the air or provided with ventilation or cooling. One indicator that solar blockage is sufficient is when objects do not cast a shadow in the area of blocked sunlight. A cool-down area does not include a location where:

- ~~(A)~~ Environmental risk factors defeat the purpose of allowing the body to cool; or

- ~~(B)~~ Employees are exposed to unsafe or unhealthy conditions; or

- ~~(C)~~ Employees are deterred or discouraged from accessing or using the cool-down area.

v. ~~(5)~~ Effective Heat Illness Prevention Plan. The plan shall be in writing in both English and the language understood by the majority of the employees and shall be made available at the worksite to employees and to representatives of the Division upon request. This Policy on Heat Stress serves as Laguna Honda Hospitals Heat Stress Plan, as required by OSHA. The Heat Illness Prevention Plan shall at a minimum, contain:

- ~~(1)~~ Procedures for the provision of water.

- ~~(2)~~ Procedures for access to cool-down areas.

- ~~(3)~~ Procedures to measure the temperature and heat index, and record whichever is greater; identify and evaluate all other environmental risk factors for heat illness; and implement control measures.

- ~~(4)~~ Emergency response procedures.

- ~~(5)~~ Procedures for acclimatization.

vi. ~~(6)~~ "Heat Wave" means ant day in which the predicted high outdoor temperature for the day will be at least 80 degrees F and at least for the preceding five days, for the purpose of this section only.

vii. ~~(7)~~ "Heat Index" means a measure of heat stress developed by the National Weather Service (NWS) for outdoor environments that takes into account the dry bulb temperature and the relative humidity. For purposes of this section, heat index refers to conditions in indoor work areas. Radiant heat is not included in the heat index. The required NWS heat index chart (2019) in Appendix A to section 3396.F. (1). Also specified in subsections (e)(1)(A), through (e)(1)(D), the employer shall measure the temperature and heat index, and record whichever is greater. The employer shall also identify and evaluate all other environmental risk factors for heat illness.

- ~~(A)~~ The employer shall establish and maintain accurate records of either the temperature or heat index measurements, whichever value is greater. The records shall include the date, time, and specific location of all measurements.

- ~~(B)~~ Temperature and heat index measurements shall be taken as follows: (1) initial measurements shall be taken when it is reasonable to suspect that subsection (e) applies where employees work and at times during the work shift when employee exposures are expected to be the greatest.

- Measurements shall be taken again when they are reasonably expected to be 10 degrees or more above the previous measurements where employees work and at times during the work shift when employee exposures are expected to be the greatest.

- Records, as required, shall be retained for 12 months or until the next measurements are taken, whichever is later. The records shall be made available to employees, or their designated representatives.

viii. ~~(8)~~ "Personal heat-protective equipment" means equipment worn to protect the user against heat illness. Examples of personal heat-protective equipment that may be effective at minimizing the risk of heat illness in a particular work area include, but are not limited to water-cooled garments, air-cooled garments, cooling vests, wetted over-garments, heat-reflective clothing, and supplied-air personal cooling systems.

ix. ~~(9)~~ "Personal risk factors for heat illness" means factors such as an individual's age, degree of acclimatization, health, water consumption, alcohol

consumption, caffeine consumption, and use of medications that affect the body's water retention or other physiological responses to heat.

x. ~~(10)~~ Provision of Water. Employees shall have access to potable drinking water including but not limited to the requirements that it be fresh, pure, suitably cool, and provided to employees free of charge. The water shall be located as close as practicable to the areas where employees are working and in indoor cool-down areas required by subsection (d). Where drinking water is not plumbed or otherwise continuously supplied, it shall be provided in sufficient quantity at the beginning of the work shift to provide one quart per employee per hour for drinking for the entire shift. Employers may begin the shift with smaller quantities of water if they have effective procedures for replenishment during the shift as needed to allow employees to drink one quart or more per hour. The frequent consumption of water shall be encouraged.

PROCEDURE:

1. Recognizing a Heat Emergency

a. When the temperature outdoors at LHH reaches 85 degrees F, the Facility Services Director, Chief Engineer, or Watch Engineer shall notify the Nursing Office, particularly for potential problems in residents~~.~~

b. When the interior temperature in any care area reaches 80 degrees F or higher, the Facility Services Director, Chief Engineer, or Watch Engineer shall notify the Chief Executive (CEO), designee, or Administrator on Duty (AOD) and Nursing Office, primarily for concern to the residents.

c. The CEO or AOD shall activate HICS in order to manage the heat emergency for residents. For HICS activation process, refer to LHHPP 70-01 B1 Emergency Response Plan.

~~a.~~d. In accordance with Cal OSHA Heat Illness Prevention in Indoor Spaces, when the temperature equals or exceeds 82 degrees Fahrenheit in any work space, a Heat Stress Plan must be developed which (1) sets forth procedures for measuring and recording the greater of temperature and the heat index in the workplace; and (2) procedures for providing water, acclimation, cool down areas, and emergency response measures. Department heads and supervisors should encourage their employees to take preventive cool-down breaks and ascertain whether employees are exhibiting symptoms of heat illness. Responding to heat

illness, including monitoring, first aid, and emergency responses, acclimatizing new workers or employes, including supervisors, and effective training on heat illness prevention requirements

~~b. The CEO or AOD shall activate HICS in order to manage the heat emergency. For HICS activation process, refer to LHHPP 70-01 B1 Emergency Response Plan.~~

e. The ~~The Workplace Safety Officer,~~ LHH CEO, or AOD shall notify Public Health Emergency Preparedness and Response (PHEPR) of high temperatures in patient care areas.

f. When the Indoor Temperature reaches 87 F or higher:
Additional requirements are imposed when the indoor temperature reaches 87 F or higher, or if the indoor temperature reaches 82 F and the employee is wearing clothing that restricts heat removal (such as a protective suit), or if the employee works in a high radiant heat area (as defined by statue). In those circumstances, the employer must additionally do all of the following:

i. Measure and maintain records of temperatures or heat index measurements (whichever is higher) for 12 months;

ii. Identify and evaluate all other non-temperature related environmental risk factors for heat illness;

iii. Obtain active employee or union involvement in measuring the temperature and identifying and evaluating environmental risk factors;

iv. Implement “engineering controls” (as defined by the statue) when feasible to reduce the temperature and heat index below 87 F, or below 82 F when employees wear heat-restrictive clothing or work in high-radiant heat areas. When engineering controls are not feasible, implement administrative controls such as rotating employees, rescheduling work, and reducing work intensity to minimize the risk of heat illness. If both feasible engineering and administrative controls are not enough to decrease the temperature and minimize the risk to heat illness, then “personal heat-protective equipment” should be provided (e.g. cooling vests or other similar cooling equipment).

2. Recognizing Heat-related Illnesses

a. When the Nursing Office receives notification of high temperatures, the Nursing Department shall begin monitoring high risk residents’ vital signs hourly and follow procedure 4.

b. If there is a suspicion of heat-related illness in a resident, the physician will evaluate the resident to determine the need for transfer to an acute care setting or movement to a cooler location.

c. All cases of confirmed or suspected heat-related illness in any building occupant shall be reported to the command center at 415-759-4636 (4-4636).

d. In the event of an immediate medical emergency, staff at the location of the emergency shall call 911 and then notify the command center at 415-759-4636 (4-4636).

Table 1: Symptoms and First Aid for Heat-Related Illness

Illness	Symptoms	First Aid
Heat stroke	▪ Confusion ▪ Fainting ▪ Seizures ▪ Excessive sweating or red, hot, dry skin with lack of sweating ▪ Very high body temperature	▪ **Call 911** ▪ Place affected person in shady, cool area ▪ Loosen clothing, remove outer clothing ▪ Fan air on affected person; cold packs in armpits ▪ Wet affected person with cool water; apply ice packs, cool compresses, or ice if available ▪ Provide fluids (preferably water) as soon as possible ▪ Stay with affected person until help arrives
Heat exhaustion	▪ Cool, moist skin ▪ Heavy sweating ▪ Headache ▪ Nausea or vomiting ▪ Dizziness ▪ Light headedness ▪ Weakness ▪ Thirst ▪ Irritability ▪ Fast heart beat	▪ Have affected person sit or lie down in a cool, shady area ▪ Give affected person plenty of water or other cool beverages to drink ▪ Cool affected person with cold compresses/ice packs ▪ Affected residents shall be evaluated by the medical staff ▪ Affected employees should seek medical treatment if signs or symptoms worsen or do not improve within 60 minutes ▪ Do not return to work that day
Heat cramps	▪ Muscle spasms ▪ Pain ▪ Usually in abdomen, arms, or legs	▪ Have affected person rest in shady, cool area ▪ Affected person should drink water or other cool beverages ▪ Wait a few hours before allowing affected person to return to strenuous work ▪ Have affected person seek medical attention if cramps don't go away
Heat rash	▪ Clusters of red bumps on skin ▪ Often appears on neck, upper chest, folds of skin	▪ Try to work in a cooler, less humid environment when possible ▪ Keep the affected area dry

Adapted from: www.osha.gov/SLTC/heatstress/heat_illnesses.html

3. Status Reports and Communication

a. Department Operating Status Reports (DOSRs) shall be used to determine whether there has been any potential impact on services or the health of residents or staff.

b. Any change in the DOSR status shall be reported to the command center at 415-759-4636.

c. Any neighborhood or department needing resources to manage the heat emergency shall request assistance from the command center.

d. The HICS Command Center shall establish and maintain regular communication with the Department of Public Health.

4. Maintaining Comfortable Temperatures for Residents and Staff

a. Provide plenty of water to both residents and staff for adequate hydration.

b. Close all windows in the new hospital buildings to ensure the ventilation system can provide the coolest environment possible~~.~~

5. Cooling Centers

a. Cooling centers with air conditioning, ice, and water dispensers shall be set up in various locations throughout the campus to provide relief for anyone experiencing early symptoms of heat stress.

b. Conference rooms B-102, B-104, and A-100 shall be available as cooling centers for staff in the administration building.

6. Regional Medical Surge

a. During a heat emergency, San Francisco's health care system may be impacted with an increase in emergency calls.

b. LHH shall be prepared to receive admissions from ZSFG or other acute care hospitals in accordance with the LHH Medical Surge Plan.

7. Training

a. ~~(1)~~ Employee training. Effective training in the following topics shall be provided to each supervisory and non-supervisory employee before the employee begins work that should reasonably be anticipated to result in exposure to the risk of heat illness:

i. ~~(A)~~ The environmental and personal risk factors for heat illness, as well as the added burden of heat load on the body caused by exertion, clothing, and personal protective equipment.

ii. ~~(B)~~ The employer's procedures for complying with the requirements of this section, including, but not limited to, the employer's responsibility to provide water, cool-down areas, cool-down rests, control measures, and access to first aid as well as the employees' right to exercise their rights under this section without retaliation.

iii. ~~(C)~~ The importance of frequent consumption of small quantities of water, up to four cups per hour, when the work environment is hot and employees are likely to be sweating more than usual in the performance of their duties.

iv. ~~(D)~~ The concept, importance, and methods of acclimatization pursuant to the employer's procedures.

v. ~~(E)~~ The different types of heat illness, the common signs and symptoms of heat illness, and appropriate first aid and/or emergency responses to the different types of heat illness, and in addition, that heat illness may progress quickly from mild symptoms and signs to serious and life-threatening illness.

vi. ~~(F)~~ The importance of employees immediately reporting to the employer, directly or through the employee's supervisor, symptoms or signs of heat illness in themselves, or in co-workers.

vii. ~~(G)~~ The employer's procedures for responding to signs or symptoms of possible heat illness, including how emergency medical services will be provided should they become necessary.

viii. ~~(H)~~ The employer's procedures for contacting emergency medical services, and if necessary, for transporting employees to a point where they can be reached by an emergency responder.

ix. ~~(I)~~ The employer's procedures for ensuring that, in the event of an emergency, clear and precise directions to the worksite can and will be provided as needed to emergency responders. These procedures shall include designating a person to be available to ensure that emergency procedures are invoked when appropriate.

b. ~~(2)~~ Supervisor training. Prior to supervising employees performing work that should reasonably be anticipated to result in exposure to the risk of heat illness, effective training on the following topics shall be provided to the supervisor:

i. ~~(A)~~ The information required to be provided as detailed in the above training section.

ii. ~~(B)~~ The procedures the supervisor is to follow to implement the applicable provisions in this section.

iii. ~~(C)~~ The procedures the supervisor is to follow when an employee exhibits signs or reports symptoms consistent with possible heat illness, including emergency response procedures.

iv. ~~(D)~~ Where the work area is affected by outdoor temperatures, how to monitor weather reports and how to respond to hot weather advisories.

ATTACHMENT:
None.

REFERENCE:
70-01 B1 Emergency Response Plan
70-01 C4 Medical Surge Plan
California OSHA's Indoor Heat Illness Prevention Standard, Title 8, Section 2296, effective July 2024

Revised: 20/01/14, 22/11/08 (Year/Month/Day)
Original adoption: 17/11/14

CODE SILVER – ACTIVE SHOOTER

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to the prevention of workplace violence when at all possible. LHH is also committed to providing a response plan for an active shooter situation.

PURPOSE:

The purpose is to provide guidance for responding to the presence of an active shooter at LHH.

DEFINITION:

An active shooter is defined as any person or persons who is/are actively engaged in killing or attempting to kill people in the hospital or on the hospital campus. The weapon(s) typically involve use of firearms but may include other weapons such as knives or explosive devices.

PROCEDURE:

1. Situation

This plan applies to situations in which an active shooter is on the LHH campus. An active shooter may have a target victim~~,~~ but often displays no pattern or method for selection of their victims.

2. Employee Responsibility

All employees shall take responsibility for their own survival in the event of an active shooter entering their work area. You can prepare yourself to maximize your chance of survival by:

a. Being familiar with the work area

b. Knowing the route to all nearest exits

c. Having a plan for barricading in place

3. General Response

In the event of an active shooter, there is no single method that is guaranteed to be effective. –LHH has chosen to use the “Four Outs” process for Active Shooter response: Get Out, Hide Out, Keep Out, Take Out. This process includes the actions

of "Run, Hide, Fight"~~.~~, a commonly used response tactic. Those who find themselves in an active shooter situation should choose whichever option is best in their respective environment. In a hospital setting, response will vary depending on the mobility of residents and the area affected by the shooting.

4. Four Outs Resident & Personal Safety Protocol:

If the active shooter is close to your location, remember the **Four Outs:**

- **GET OUT**: Evacuate if opportunity allows you to safely leave the facility.
- **HIDE OUT:** If unable to evacuate because of the active shooter's position - hide
- **KEEP OUT**: ~~.~~If you are hiding, barricade your position by utilizing door locks, furniture, etc. to prevent the active shooter from breaching your position.
- **TAKE OUT:** ~~.~~As a LAST resort, prepare to fight the active shooter by utilizing weapons such as heavy objects, chairs or anything else in the area, surprise, diversion and committed actions.

5. If a Shooter Enters Your Work Area

a. Run to safety if possible.

b. If you cannot escape, focus on your survival.

c. Hide or get behind something that will provide some concealment if shots are fired in your direction.

d. Try not to do anything that will provoke the shooter(s).

- If there is no possibility of escaping or hiding, as a last resort and only if your life is in imminent danger, attempt to overpower the shooter(s). If you choose to fight:

  i. Commit to your decision and act as aggressively as possible toward the shooter.

  ii. Improvise weapons using things like fire extinguishers or sharp instruments.

  iii. Yell and throw things at the shooter.

If the shooter leaves the area, barricade the room or get to a safer location and call the Sheriff's Office 415-759-2319 (from LHH phone 4-2319).

6. If You Are ~~I~~in a Location Distant ~~F~~from the Shooter

a. If you can get out of the building to escape the shooter, take care of yourself and get out, even if it means leaving others behind.

b. Convince others to come with you if possible. Do not let anyone convince you to stay.

c. Leave your belongings.

d. Call the Sheriff at 415-759-2319 (from LHH phone 4-2319), or 9-1-1, when you are safely out of the building.

e. If you cannot get out of the building, close doors and barricade yourself and others in a room if possible.

f. Hide or get behind something that will provide cover or concealment if shots are fired in your direction.

g. Turn off the ringer on your cell phone and other sources of noise.

h. Call the Sheriff's Office at 415-759-2319 (from LHH phone 4-2319), or 9-1-1, if it is safe to do so (see procedure 6a for information to provide).

   i. If speaking will reveal your hiding place, leave the line open so the Sheriff can hear.

i. Do not open the door or leave your hiding place until you hear that Code Silver is all clear.

7. Notification and Incident Command

During any active shooter incident, it is important to notify all hospital occupants of the situation and alert law enforcement as quickly as possible.

a. Call the San Francisco Sheriff's Office (SFSO) 415628-~~759~~754-2319 (from LHH phone 4-2319), if you are able to do so safely. Provide as much information as possible to the dispatcher, including:

   i. Location and description of the shooter(s)

   ii. Number of shooters and number and type of weapons

   iii. Movement of shooter

   iv. Number of victims and/or hostages

b. ~~The Sheriff's Office~~SFSO will call 911 to report incident.

c. ~~The Sheriff's Office~~SFSO will notify Nursing Operations for a hospital wide overhead page.

d. ~~The LHH Sheriffs' Office~~SFSO will establish the Incident Command Post and the ranking officer on duty will be the Incident Commander.

e. ~~The Sheriff's~~SFSO Operations Center will send a templated message to all staff via Everbridge.

f. All other staff shall attempt to communicate the Code Silver situation with others.

g. Staff are to follow the SFSO staff's directions.

h. When the shooter is apprehended or leaves the campus, the Sheriff will announce overhead that Code Silver is all clear.

i. The ~~Executive Administrator~~Chief Executive Officer/Nursing Home Administrator (CEO/NHA) or AOD will activate the Nursing Home Incident Command System (NHICS) to manage the recovery, in a unified command with Law Enforcement, until resumption of regular operations.

8. Law Enforcement (SFSO) Response

Law Enforcement officers responding to an active shooter are trained to proceed immediately to the area in which shots were last heard, to stop the shooting as quickly as possible.

a. The first responding officers may be in teams. They may be dressed in normal patrol uniforms, plain clothes with a visible law enforcement badge or other insignias, or they may be wearing external ballistic vests and Kevlar helmets or other tactical gear. The officers may be armed with rifles, shotguns, and handguns.

9. How to react when law enforcement arrives.

a. Remain calm, and follow officers' instructions

b. Put down any items in your hands (i.e., bags, jackets)

c. Immediately raise hands and spread fingers

d. Always keep hands visible

e. Avoid making quick movements toward officers such as attempting to hold on to them for safety

f. Avoid pointing, screaming and/or yelling

g. Do not stop to ask officers for help or directions when evacuating, just proceed in the direction from which officers are entering the area.

h. **Do exactly as the team of officers instruct**. The first responding officers will be focused on stopping the active shooter and creating a safe environment for medical assistance to be brought in to aid the injured.

j. When the shooter is apprehended or leaves the campus, the Sheriff Office will notify the appropriate hospital administrator when the building has been cleared for re-entry. The ~~Executive Administrator~~CEO/NHA or AOD will activate NHICS to manage the recovery until resumption of regular operations.

k. Sheriff officer to notify Nursing Operations to announce all clear via the overhead paging system.

ATTACHMENT:
None.

REFERENCE:
75-10 Security Services Standard Operating Procedures
Laguna Honda Hospital Code Silver Active Shooter Response Guide *(pocket guide)*
The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Partnership's "Active Shooter Planning and Response in a Healthcare Setting", Draft January 2014.

Revised: 07/06/23,16/01/12, 16/07/12, 23/09/12 (Year, Month, Day)
Original adoption: 15/07/14
~~Approved for renumbering to 70-01 Section A, B, and C: 18/02/23~~

INFORMATION YOU SHOULD PROVIDE TO LHH SFSD OPERATOR 759-2319 (4-2319) OR 911 AND ARRIVING LAW ENFORCEMENT:

Location: Building – Floor - Room
Number of shooters
Descriptions – Race, Gender, Age & Height, Weight, Hair Color
Type(s) of weapon(s)
Carrying backpack or duffel bag?
Where is the shooter now?
Where was shooter last seen?
Direction of travel
Do you recognize the shooter? If so, provide name.
Any explosions besides gunshots?
Number of people at your location.
Any injuries? Number & types.

Code Silver = Active Shooter → Run to Safety or Immediately Barricade in Place.

No Hospital Command Center Activation & No DOSRs Until Shooter Apprehended

Remain Barricaded Until You Are Given Further Instructions.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Laguna Honda Hospital

Code Silver

Active Shooter Response Guide

BE PREPARED TO DEAL WITH AN ACTIVE SHOOTER SITUATION:

Be aware of your environment.
Be vigilant regarding any unusual or suspicious activities.
Be familiar with your usual work area. Know where and how you could barricade in place to protect yourself and your patients.
Look for the two nearest exits in any facility you visit.

IF A SHOOTER ENTERS YOUR VICINITY:

Remain calm.
Try not to provoke the shooter.
Escape or hide if you can.
ONLY AS A LAST RESORT WHEN YOUR LIFE IS IN IMMINENT DANGER, attempt to negotiate with or overpower the shooter.
If you choose to take action, be decisive, quick and physically aggressive trying to incapacitate the shooter.
If the shooter leaves the area, barricade in place or escape to a safer location.

IF THE ACTIVE SHOOTER IS NOT AT YOUR LOCATION:

Remain calm.
Warn others to immediately take cover and barricade in place.
Lock and barricade or block doors and windows.
Keep everyone out of sight. Take cover behind concrete walls, heavy desks, or filing cabinets.
Silence your cell phone & pager.

IF YOU ARE OUTSIDE:

Remain calm.
Move away from the shooter or the sound of gunshots.
Take cover behind thick walls or parked vehicles.

WHEN POLICE ARRIVE:

Remain calm.
FOLLOW OFFICERS' INSTRUCTIONS EXACTLY.
Drop anything you are holding, raise your hands and spread your fingers. Keep your hands visible.
Don't point, scream, yell or make any quick movements towards officers.
When evacuating, don't stop to ask for help or directions.
Medical assistance will be provided after the scene is safe.

Expect to be held in a safe location until the situation is under control and all witnesses have been identified and questioned.

AFTER A SHOOTING INCIDENT:

Account for all patients, staff and visitors.
Ensure everyone's safety, and provide medical care as needed.
Report anyone missing or injured along with your department's status to the Hospital Command Center / NHICS Team.
Follow instructions from Law Enforcement and the NHICS Team.
Assess the mental health needs of patients, visitors and staff and refer them for support as directed by the NHICS Team.

LAGUNA HONDA HOSPITAL MAIN/INTERMEDIATE DISTRIBUTION FRAME SUPPORT – ~~FACILITIES~~FACILITY SERVICES

PURPOSE:

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

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

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

PROCEDURE:

1. Notification Procedure for Facility Systems outages

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

a. Department of Public Health (DPH) IT Service Desk (6-7378) (24/7) – use appropriate language if IT escalation is required (e.g. “cooling system is off”, “server room is offline”, “temperatures are rising in the following critical areas: _____”).

b. ~~AOD~~Administrator on Duty (AOD)/Nursing Operations (4-2999) to inform them of a potential problem.

c. The Watch Engineer will contact Service Desk (ext. 6-7378) when key indicators are present:

   i. Temperature in the MDF reaches 80 degrees.

   ii. Temperature in the BDF/IDFs reaches 90 degrees

d. Service Desk will inform the various IT OPS teams with hardware residing in the affected area via email for awareness.

e. Once Service Desk receives an all clear from the Watch Desk, Service Desk will send out a follow up email to the potentially impacted teams so the teams can check on their hardware.

~~e.~~f. If Service Desk was informed of any possible hardware damage, Service Desk will open a ServiceNow incident and call the On Call staff for the impacted team(s).

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

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

REFERENCE:
None.

Revised: 24/04/09 (Year/Month/Day)
Original adoption: 2020/09/08 (Year/Month/Day)

Appendix 1:

Glossary

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

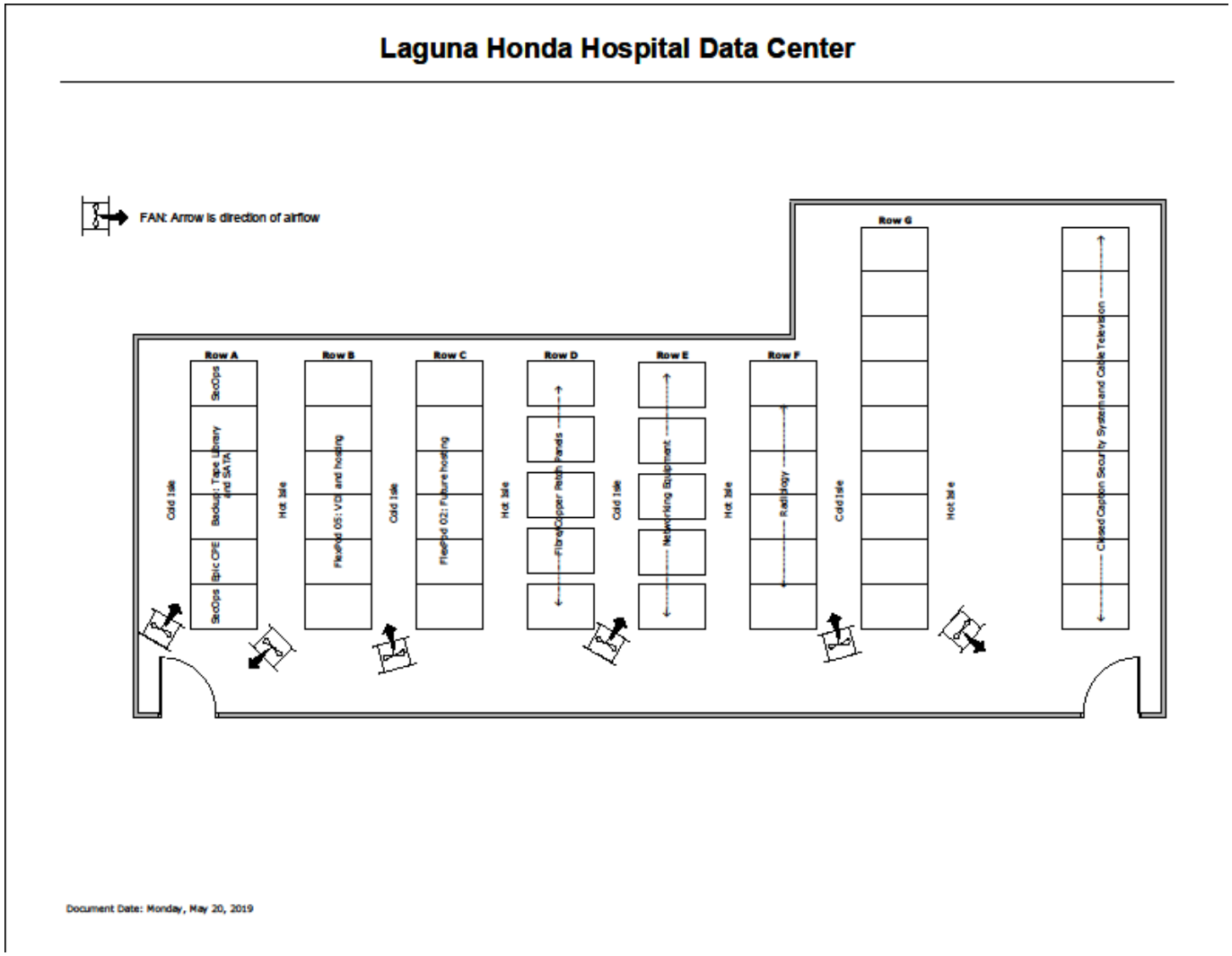
Types of Systems Operated by Facilities

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

Contact List

Name	Role	Number
~~Facilities~~ Facility Services Watch Engineer	Direct access to Watch Engineer 24/7	415-370-8259
IT Service Desk	24/7 Service Desk for IT	628-206-7378
~~Mark Cantor~~	~~Chief Engineer - LHH~~	~~415-759-3571~~

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



Revised Nursing Policies and Procedures

DOCUMENTATION OF RESIDENT CARE/STATUS by the LICENSED NURSE - SNF

POLICY:

The Licensed Nurse (LN) is responsible for documenting assessment/observations findings, developing care plans based on identified needs, implementing or supervising nursing interventions, and evaluating and revising the resident care plan.

PURPOSE:

To communicate relevant information regarding assessment, interventions, and outcomes to Resident Care Team (RCT) to promote continuity and quality care for our residents.

BACKGROUND:

Documentation of resident care includes the resident's physical, emotional, spiritual, recreational status, functional capabilities, attainment of care plan goals and/or other changes in status and reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.

PROCEDURE:

A. Refer to Laguna Honda Hospitalwide Policy and Procedure (HWPP) File: #21-05 Medical Record Documentation

B. Frequency of Nursing Documentation

Documentation frequency varies as the resident's condition changes. The licensed nurse is responsible for ensuring that documentation in the electronic health record (EHR) reflecting assessment, planning, interventions, outcomes, and evaluation are completed in a timely manner. Any written documentation must be legible with licensed nurse name and title.

1. Skilled Nursing Neighborhoods

   a. Admissions, relocations, and post procedures – document a minimum of once per shift for at least 72 hours until condition is stable, and resident has made the adjustment to the new environment. Summaries are completed weekly.

   b. Medicare designation – Document a daily note at minimum, for the duration of coverage as indicated. Nursing documentation will specifically describe aspects of skilled nursing care designated as the focus of coverage, in addition to routine physical assessment data. When no longer covered by Medicare, progress to weekly documentation ~~scheduled~~.

   c. Unanticipated c~~C~~hange in resident condition or potential/actual decline – Document a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change. Then document daily until condition stabilizes or resolves. Some examples of changes in resident condition may include, but are not limited to, change in

cognitive function or unusual behavior, abnormal vital signs, meal intake of less than 50%, infectious processes requiring antimicrobials, loss of functional ability, new incontinence, and exacerbation of a chronic condition.

a. Infectious processes requiring antimicrobial therapy: Complete a nursing note and document vital signs at a minimum of once per shift for the entire course of antimicrobial therapy and as often as clinically indicated.
b. Antimicrobials prescribed for prophylaxis, including ointments for ongoing skin conditions should be monitored and documented on once per shift for 72 hours and then as needed.

d. Pavilion Mezzanine SNF – Document a minimum of once weekly for duration of rehabilitation. Documentation should reflect detailed description of the outcome of interventions, with an emphasis on degree of independence, resident education, and progress towards discharge planning goals.

e. Long Term SNF residents - ~~-~~Comprehensive weekly summaries will be documented for all residents. This summary is an evaluation of the resident's response to care provided. Data collection for the summary includes physical assessment, review of the care plan, activities of daily living, progress notes in EHR, vital signs, height and weight, medication and treatment records. If the resident has an unanticipated change in condition, frequency of documentation will increase as often as condition warrants and until stabilized.

f. Discharge – Refer to NPP C 1.3 Discharge Procedure to Acute and LHHPP 20-04 Discharge Planning.

g. The Care Area Assessment (CAA) - Documentation will be done after completion of a comprehensive MDS assessment and care planning (Refer to LHHPP #23-02 Completion of Resident Assessment Instrument/ Minimum Data Set).

C. Weekly Summary

1. Licensed Nurse consults with resident care team for any pertinent information regarding resident over the past week
2. Review EHR and prior weekly summaries for comparison
3. Review and update Care Plan prior to completion of the weekly summary
4. Create a progress note using the smartphrase "LHH NSG WEEKLY SUMMARY:

~~C.~~ D. Documentation other than Progress Notes

1. Admission documentation (Refer to Nursing P&P)
   a. NPP C 1.0 Resident Admission and Readmission for SNF
   b. NPP C 1.2 Relocation Between Laguna Honda SNF Neighborhoods
   c. NPP C 1.3 Discharge Procedure to Acute

2. The EHR contains the Nursing Admission Assessment and other nursing assessments.

3. Licensed nurse documentation includes completion of specific assessment and evaluation tools in the EHR.

4. Medication and Treatment Administration Documentation in the EHR

a. For medication administration, refer to LHHPP 25-15 Medication Administration.

b. Documentation for treatments includes the time, the treatment as ordered, pain assessment, and pertinent observations.

c. When PRN medications or treatments are administered, the reason and result of intervention are documented on the EHR.

5. Activities of Daily Living (ADL) in the EHR

   a. The Licensed Nurse, in collaboration with the resident care team develops a plan of care to meet the resident's/patient's needs, while promoting as much functional independence as possible. Licensed Nurse is responsible for creating individualized resident-specific tasks and interventions in the care plan (e.g., restorative interventions or assistance during meals).

   b. Licensed Nurse will document if the LN provides direct assistance with resident's ADL.

   c. Refer to NPP C 3.2 Documentation of Resident Care by Nursing Assistant.

   d. Licensed Nurses are responsible for reviewing the documentation on the EHR to ensure that care is provided as per care plan.

6. Medication orders, vital signs, height, weight, labs, immunization, and point of care testing are documented in the EHR.

7. Allergies: Nurses and physicians review allergies upon admission. Residents should be observed for allergic reactions and adverse drug reactions throughout their stay. For any new reactions, notify the physician. The physician adds new allergies and/or adverse drug reactions to the EHR allergy section.

~~**APPENDICES:**~~

~~NONE~~

REFERENCES:

Centers for Medicare & Medicaid Services. (2025, September 24). *Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) User's Manual* (Version 1.20.1; effective October 1, 2025). U.S. Department of Health and Human Services. https://www.cms.gov

~~CMS's RAI Version 3.0 Manual v1.17.1 (2019)~~

CROSS REFERENCES:

Hospitalwide Policy and Procedure
20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
20-04 Discharge Planning

21-05 Medical Record Documentation
23-02 Completion of Resident Assessment Instrument/ Minimum Data Set
25-15 Medication Administration

Nursing Policy and Procedure
B 5.0 Resident Identification and Color Codes
C 1.0 Admission and Readmission Procedures for Skilled Nursing Facility
C 1.2 Relocation Between Laguna Honda SNF Neighborhoods
C 1.3 Discharge Procedure to Acute
C 3.2 Documentation of Resident Care by the Nurse Assistant
C 4.0 Notification and Documentation of a Change in Resident Status

APPENDICES:

NONE

Adopted: 8/2002

Revised: ~~2009/~~09/2009; ~~2015/~~06/16/2015; ~~2015/~~09/08/2015, ~~2019/~~03/12/2019; ~~2022/~~12/13/2022; ~~2024/~~04/09/2024; ~~2024/~~09/19/2024; 04/29/2026

Reviewed: ~~2024/~~12/10/2024

Approved: ~~2024/~~12/10/2024

DOCUMENTATION OF RESIDENT CARE BY THE NURSING ASSISTANT

POLICY:

1. Nursing Assistant (Certified Nursing Assistant ~~and/~~ Patient Care Assistant) documents activities of daily living (ADL) ~~every shift~~ in the appropriate ADL section of the electronic health record (EHR).

2. Daily Cares and Safety precautions are completed ~~near the end of each shift~~ by the nursing assistant at least once every shift (~~CNA~~CNA/ ~~and~~ PCA).

~~3.~~ Nursing Assistant documents intake and output (I/O) in the I/O Flowsheet Activity Tab of the EHR. ~~{[~~Refer to Nursing Policy & Procedure (NPP) G 3.0 Intake & Output~~]}~~.
3.

~~4.~~
~~5.~~ Nursing Assistant ~~documents change in condition in the Notes section of the EHR and~~ notifies the charge nurse or the licensed nurse and documents change in condition and notification in the Notes section of the EHR. ~~.~~
4.

PURPOSE:

Concise and accurate documentation and monitoring of daily care provided.

~~**INTRODUCTION:**~~

~~**A.** Intake/Output (I/O) Flowsheet~~
~~Activities of Daily Living (ADL)s~~
~~Daily Cares~~
~~Flowsheet~~
- ~~PCA Vitals, I/O~~
- ~~PCA Daily Cares/Safety~~
  - ~~i. Do NOT document restorative minutes unless the resident is receiving restorative care for ROM~~

~~Coach Doc~~
~~Notes~~

PROCEDURE:

A. Vitals Signs~~I/O FLOWSHEET~~ (or PCA Vitals, I/O LHH/4A Flowsheet)
~~(Refer to NPP G3.0 Intake and Output for details on documentation)~~
Vital Signs – Refer to NPP G 1.0 Vital Signs for details on documentation
Weight – Refer to NPP G 7.0 Obtaining, Recording, and Evaluating Resident Weight
Height - Refer to NPP G 4.0 Measuring the Resident's Height

B. I/O Flowsheet (or PCA Vitals, I/O LHH/4A Flowsheet)

Refer to NPP G 3.0 Intake and Output for details on documentation
~~Document resident's intake and output for the following:~~

- ~~Percent Meals Eaten (%)~~
- ~~Urine Incontinence/Urine Amount/Unmeasured Urine Occurrence~~
- ~~Bowel Incontinence/Unmeasured Stool Occurrence/Stool Amount/Stool Appearance:~~
- ~~Colostomy/Ileostomy~~

Activities of Daily Living ~~**NOTE**: Licensed Nurse must document output for nephrostomy.~~

C. ~~ACTIVITIES OF DAILY LIVING ACTIVITY TAB~~

Documentation is required every shift for the following ADL activities:

~~**ADL Activities:**~~

- **Eating**: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient/resident
- **Oral Hygiene:** The ability to use suitable items to clean teeth. {Dentures (if applicable): The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment.}
- **Personal hygiene**: The ability to maintain hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes bathes, showers, and oral hygiene.)
- **Toileting Hygiene**: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment. (Takes place before and after use of the toilet, commode, bedpan, or urinal.)
- **Shower/Bathe Self**: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in or out of the tub or shower.
- **Upper Body Dressing:** The ability to dress and undress above the waist, including fasteners, if applicable.
- **Lower Body Dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
- **Putting on/Taking off Footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
- ~~**Roll Left and Right**: The ability to roll from lying on back to left and right side, and return to lying on back on the bed~~
- **Sit to Lying:** The ability to move from sitting on side of bed to lying flat on the bed
- **Lying to Sitting on Side of Bed:** The ability to move from lying on the back to sitting on the side of the bed and with NO back support
- **Sit to Stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair). If using a mechanical lift, document as dependent even if resident assists with any part of the transfer.
- **Toilet Transfer**: The ability to get on and off a toilet or commode (does not apply to use of urinal, bedpan, or other elimination devices).
- **Tub/Shower Transfer:** The ability to get in and out of a tub/shower

- **Walk 10 Feet:** Once standing, the ability to walk at least 10 feet in room, corridor, or similar space
- **Walk 50 Feet with Two Turns:** Once standing, the ability to walk at least 50 feet and make two turns
- **Walk 150 Feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space
- **Picking Up Object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. (If the resident is unable to stand, use the appropriate "not attempted" code
- **Wheel 50 Feet with Two Turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
- **Wheel 150 Feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space

A. DAILY CARES Activity (or PCT Daily Cares/Safety Flowsheet) ACTIVITY TAB
A.D.

Document at least only once every shift:

- Safe Environment: Document applicable sections
- Fall Risk Interventions: Document applicable sections
- Mobility: Document applicable sections
    - Head of Bed Elevated: Indicate the degrees of elevation in bed. **NOTE:** For residents on tube feeding, a minimum of 30 degrees is needed and head of bed documentation needs to be completed twice during shift.
    - Repositioned: Select all positions provided during the shift
    - Positioning Frequency: Select "Able to Turn Self" if resident self turns or "Every 2 Hours," unless otherwise ordered by the physician.
- Repositioned: Select all positions provided during the shift
- Positioning Frequency: Select "Able to Turn Self" if resident self turns or "Every 2 Hours," unless otherwise ordered by the physician.
- Hygiene: Select all hygiene care provided during the shift
- Restorative Nursing Programs: Do NOT document restorative minutes unless the resident is receiving Restorative care for range of motion. **Note**: Restorative Care Flowsheet tab (within the Flowsheet Activity) is for Restorative Nursing Assistants.
-
- Miscellaneous Devices: Document application, removal, in place, device monitoring and refusals of devices
-
- Devices Monitoring: Document applicable sections

B. FLOWSHEET ACTIVITY TAB

- **PCA VITAL SIGNS, I/O** (Refer to NPP G3.0 Intake and Output for details on documentation):
    i. Document:
        - Vital Signs
        - Measured Intake/Output
        - Meal Percentage
        - Supplements
- **GG Care ADL or CARE Tool Performance (Flowsheet)**
    i. Functional abilities of the resident/patient
- **PCA Daily Cares/Safety**

~~i. PCA/CNA documents restorative interventions in this section. Document the following:~~

- ~~Type of restorative activity under the appropriate section~~
- ~~Minutes spent on each restorative category under Restorative Nursing Program~~

~~C. RESTORATIVE INTERVENTIONS~~

~~To qualify for restorative, the resident must have an individualized and measurable restorative goal and individualized restorative interventions. The restorative program must be evaluated at regular intervals and with care conferences. (Do NOT document restorative minutes unless the resident is receiving Restorative care for Range of Motion (ROM).~~

~~D.~~E. NOTES ACTIVITY ~~TAB~~

Use the Notes section to document any supplemental data not noted in other areas (e.g., licensed nurse notifications, changes in condition).

NOTE: There may be additional flowsheets to document in as needed (e.g., Coach Use for close observation, ~~close supervision,~~ restraints, etc) ~~(e.g., Coach Documentation, Restraints, etc.)~~

REFERENCES:

Centers for Medicare & Medicaid Services. (2025, September 24). *Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) User's Manual* (Version 1.20.1; effective October 1, 2025). U.S. Department of Health and Human Services. https://www.cms.gov

~~RAI/MDS Manual~~

CROSS REFERENCES:

Nursing Policies & Procedures
- G 1.0 Vital Signs
- G 3.0 Intake & Output
- G 4.0 Measuring the Resident's Height
- G 7.0 Obtaining, Recording, and Evaluating Resident Weight

ATTACHMENTS:

None

Adopted from Policy Number Changed from C 3.1 to C 3.2, September~~,~~ 2009

Revised: ~~2002/~~08/2002; ~~2009/~~03/2009; ~~2014/~~07/22/2014, ~~2019/~~03/12/2019, ~~2020/~~06/23/2020; ~~2024/~~12/16/2024; 05/26/2026

Reviewed: 2025/03/10

Approved: 2025/03/10

ORAL HYGIENE

POLICY:

1. All residents will be encouraged to participate with their own oral hygiene, as appropriate to their functional and cognitive status.

2. Any member of the nursing staff~~, except Home Health Aides,~~ may perform oral hygiene.

3. Oral hygiene is to be completed after breakfast and lunch, and as needed. Residents who are nothing by mouth (NPO) will have oral hygiene completed each shift, and as needed.

4. Residents should wear dentures if they have them, unless contraindicated.

5. The certified nursing assistant or patient care assistant may use a Yankauer suction tip or a suction toothbrush under the supervision of the licensed nurse (LN).

6. Non-medicated personal oral hygiene items such as toothbrushes and non-medicated toothpaste may be stored in a bag and placed in a closed drawer at the resident's bedside. Keep separate from topical personal hygiene items (Refer to B 6.0 Items Allowed at The Bedside and D1 2.0 Resident Activities of Daily Living)

7. The LN will communicate to the nursing care givers which residents are on any medication that can affect oral health (e.g., medications that can increase the risk of bleeding, chemotherapy agents that can cause mucositis, and any medicine that causes gum disease, so extra caution can be used during oral hygiene).

PURPOSE:

1. To promote resident comfort, nutrition, and verbal communication.

2. To cleanse and refresh the resident's mouth, teeth and gums.

3. To stimulate the circulation of the gums, to keep them healthy, and to prevent the development of caries and accumulation of plaque.

4. To assist in preventing chronic disease and infection.

PROCEDURE:

A. Equipment: Obtain oral hygiene supplies that are appropriate to resident's needs.

B. Oral Hygiene: ~~(~~Refer to ~~Skills (elsevierperformancemanager.com)~~Elsevier Skills: Oral Hygiene

C. Oral Hygiene for Unconscious or Debilitated Residents (Refer to ~~Skills (elsevierperformancemanager.com)~~Elsevier Skills: Oral Hygiene for Unconscious or Debilitated Patients ~~for procedures on Oral Hygiene for Unconscious or Debilitated Patients)~~

D. Care of Dentures: (Refer to Skills (elsevierperformancemanager.com)Elsevier Skills: Denture Care for procedures on Denture Care)

1. When not worn, place dentures in the resident's labeled denture container, soaking in water. Store container with dentures inside the drawer of the bedside stand.

2. If resident's dentures are loose or wiggly, refer to the Licensed Nurse for follow-up/communication with primary care physician.

3. For missing or broken dentures, refer to HWPP 24-27 Denture Replacement and HWPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.

E. Special Circumstances for Oral Hygiene

1. Some residents may be on specialized oral hygiene routines, as determined by the Dental Clinic. Follow physician orders as indicated.

F. Reporting and Documentation

1. Report to licensed nurse any abnormal signs or reports from the resident such as swollen gums, bleeding, dryness and sores.

2. Report to the LN if the resident refuses oral hygiene.

3. Document the resident's level of dependency and ability to perform oral hygiene in the electronic health record.

4. Document unexpected outcomes and related interventions

REFERENCES:

Elsevier (20254) Oral Hygiene https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhhhttps://point-of-care.elsevierperformancemanager.com/skills/343/extended-text?skillId=GN_14_2&virtualname=lhh#scrollToTop – electronic access on March 26, 2025June 9, 2026

Elsevier (20254) Oral Hygiene for the Unconscious or Debilitated Patients https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhhhttps://point-of-care.elsevierperformancemanager.com/skills/598/extended-text?skillId=GN_14_3&virtualname=lhh#scrollToTop – electronic access on March 26, 2025June 9, 2026

Elsevier (20245) Denture Care https://point-of-care.elsevierperformancemanager.com/skills/440/extended-text?skillId=GN_PG14_1&virtualname=lhh#scrollToTop – electronic access on March 26, 2025June 9, 2026

Adapted from Perry, A.G. and others (Eds.). (2025). *Clinical nursing skills & techniques* (11th ed.). St. Louis: Elsevier.

CROSS-REFERENCES:

Hospitalwide Policies & Procedures
22-05 Handling Resident's Property and Prevention of Theft and Loss
24-27 Denture Replacement

Nursing Policy & Procedure
B6.0 Items Allowed at the Bedside
D1 2.0 Resident Activities of Daily Living

ATTACHMENTS/APPENDICES:

~~None~~NONE

Revised: ~~2000/~~08/2000, ~~2009/~~09/2009; ~~2014/~~03/25/2014; ~~2022/~~11/08/2022; ~~2025/~~04/08/2025; 06/09/2026

Reviewed: 2025/06/09

Approved: 2025/06/09

BATTERY OPERATED LIFT TRANSFER (C-625 Ceiling Lift & EZ Way Smart Lift)

POLICY:

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

2. The licensed nurse will assess each resident to be transferred by the battery-operated lift to determine the most appropriate material, style and size of sling. The results of their assessment will be entered in the electronic health record (EHR).

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

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

5. For residents ~~with~~ demonstrating aggressive behavior, ~~lacking the ability to~~unable or unwilling to follow directions, or ~~whenever otherwise clinically indicated~~has other conditions that might place resident and/or staff at risk, ask for additional nursing staff assistance and/or do not proceed with transfer until resident is calm.~~additional nursing staff will assist with lift transfer (see also #2)~~.

6. Each resident will have his/her own sling(s). Sling tags are to be labeled, using a permanent marker, with resident's full name and the month/year first opened.

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

8. Each staff using the sling must inspect sling's seams, loops, straps, and fabric for any loose threads, fraying, and holes prior to use and after laundry.

9. Battery operated lift is to be turned off and charged when not in use to prolong battery life and assure readiness for use at any time.

10. Never use damaged or broken lifts. Broken/damaged ceiling lifts must be tagged and reported to Facility Services as soon as identified. The lift must not be used until repair and inspection is complete.

11. Do not exceed maximum weight capacity of sling or of patient lift, whichever is lower.
    a. Weight restriction for C-625 ceiling lift model is less than or equal to 625 pounds
    b. Weight restriction for EZ Way Smart Lift model is 500 pounds

PURPOSE:

To provide residents with safe transfers.

BACKGROUND:

The C-625 Ceiling Lift is a battery-operated ceiling lift which lifts, positions and transfers residents. The C-625 is a fixed lift and can carry up to 625 pounds. Lift tracks are securely mounted to the ceiling of the residents rooms, in the bathroom, in the tub rooms, and in the therapy areas of the ground floor Pavilion. The ceiling lift can move a resident from bed to chair, bed to toilet, chair to tub, and vice versa; or from floor to bed. In some rooms, a ceiling turn table changes track lift direction.

Components of the Ceiling Lift System
Tracks
Lifting straps
Emergency stop/lowering feature
Carry bar
Pneumatic hand control

The EZ Way Smart Lift is a battery-operated lift which lifts patients from the bed, chair, toilet and floor. The lift can carry up to 500 lbs. The EZ Way Smart Lift should not be locked when lifting or lowering a patient, except when lifting resident from the floor while using the Repositioning Sling.

PROCEDURE:

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

1. Resident factors to be considered regarding type of sling:
   - Resident's weight
   - Resident's measurements (Refer to Appendix 1: Medline Sling Sizing Guide):
     i. General Transfer Slings
        a. Measure resident's shoulder circumference
     ii. Toileting Slings
        a. Measure resident's chest circumference
     iii. Resident's ability to support and control his/her head
     iv. If the resident has an amputation(s) above the knee or contractures
     v. If the resident has large fleshy thighs or delicate skin or sores on the legs
     vi. Difficulty or refusal to follow directions

   NOTE: Selection of sling 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.

2. Types of Slings: (Refer to Appendix 2 for Sling Application and individual sling tag for weight capacity)
   - Positioning Sling (Max weight 1000 lbs.)
     i. Used with a lift to turn the resident from side to side, transfer from floor, and/or lifting resident to conduct bed stripping on an occupied bed
   - General Transfer Sling: (optional head support is available)
     i. 2 Point Sling (Max weight 700lbs.)
        a. Used for transfers

b. Padded wings for comfort and support

ii. Seated U-Shaped Padded Sling (Max weight 450 bls. For sizes S-L, Max weight 700 lbs. for size XL)
   a. Softer material than 2-point sling for comfort

iii. Seated U-Shaped Mesh Sling (Max weight 450 lbs.)
   a. Made of mesh for bathing/toileting and quick drying

iv. Hammock Sling
   a. Used for residents with
      i. Lower body contractures
      ii. Amputation
      iii. Large fleshy thighs
      iv. Delicate skin

B. Before ~~u~~Using the Lift

1. Prepare environment and clear path for lift to be used safely; ensure lift can fit under or around receiving surface and through doorways
2. Demonstrates proper ergonomic position while maneuvering the lift ensures staff work as close to the resident as possible to avoid stress of leaning.

C. Positioning the Sling: (Refer to Appendix 2 for Sling Application)

1. Position sling under the resident with the handles facing outward from the resident's skin.
2. Check that the resident is centered on the sling.
   - If sling has head support, align top of sling with top of ears or head
   - If sling does not have head support, align top of sling with top of the shoulders

~~C.~~ **Lift Operation**

~~D.~~**A.** ~~Position sling under the resident with the handles facing outward from the resident's skin.~~

~~1. Check that the resident is centered on the sling.~~

~~• If sling has head support, align top of sling with top of ears or head~~

~~If sling does not have head support, align top of sling with top of the shoulders~~

~~A. **Positioning the Lift:**~~

~~EZ Way Smart Lift: Wheel must be unlocked during the transfer. (Except if lifting resident from the floor using the repositioning sling)~~

~~Ceiling Lift: Lift should be positioned directly over the resident~~

~~Position the lift cradle vertically 6-12 inches above patient.~~

~~**Placement on the Lift:**~~

~~Upon application of sling to lift, lift the resident ~2 inches off the surface and confirm resident is secure with weight spread evenly between sling straps; long straps are secured and will not disengage; resident will not slide out of the sling or tip backward or forward~~

~~Confirm sling does not pinch resident's skin, and resident is not demonstrating any nonverbal and verbal signs of discomfort~~

~~**During and Immediately After the Lift:**~~

~~Slowly lift resident and only as high as necessary to complete the transfer, confirms again resident is still comfortable and sling does not hurt resident's skin~~

~~Ensure lifting strap is straight and not twisting when using the UP or DOWN function~~

~~E.~~**D.** ~~Remove sling correctly from the resident~~ **[Refer to Appendix 3: Operating the Battery-Operated Lifts (Ceiling & EZ)]**

~~F.~~**E. Care and Maintenance of Lift and Sling**

1. Wipe down all hard surfaces of the equipment until visibly wet with facility approved disinfectant. Use caution when applying cleaner around the control box to ensure liquid does not enter the control box.
2. Ensures the surface is wet (for the 2 point sling, remove two plastic support inserts when laundering)
   - After laundering:
     i. Check all seams, loops, straps and fabric for any damage from laundering
     ii. Check the loops if damaged, torn or frayed
     iii. Check for loose stitching
     iv. Check for heat damage (puckering or crumpling)
     v. Check for significant staining
     vi. Check for tears in the fabric
     vii. Reapply plastic support inserts for 2-point sling

~~G.~~**F. Documentation**

1. Care Plan/Kardex
   - Document the type of transfer technique used.
   - Document type of sling, size, color of straps to apply for resident.

REFERENCES:

EZ Way Smart Lift Operating Instructions [Manufacturers Manual]. (2023). Clarinda, IA: EZ Way, Inc.

Medline: Safe Patient Handling Slings

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

CROSS-REFERENCES:

Nursing Policies & Procedures
D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

Appendix 1: Sling Sizing Guide
Appendix 2: Sling Application
Appendix 3: Operating the Battery-Operated Lifts (Ceiling & EZ)

(D6 1.1 Battery-Operated Lift Transfer and D6 1.4 Battery-Operated Ceiling Lift C-625 combined into D61.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift) on 2025/06/09)

Revised: ~~2008/~~01/2008, ~~2010/~~04/2010, ~~2010/~~06/2010, ~~2010/~~08/2010, ~~2011/~~02/14/2011; ~~2014/~~07/22/2014; ~~2016/~~09/23/2016; ~~2019/~~09/10/2019; ~~2023/~~09/12/2023; ~~2024/~~03/12/2024; ~~2025/~~03/06/2025; 06/08/2026

Reviewed: 2025/06/09; 05/28/2026

Approved: 2025/06/09

SLING SIZING GUIDE

Sizing Tool

1. Choose your preferred sling style.
2. Weigh the patient to determine the needed capacity.
3. Measure the patient for a proper fit using the chart below.

General Transfer Slings

Measure the patient's shoulder circumference (A):			
Small	Medium	Large	X-Large
28"–45" (71–114 cm)	37"–57" (94–145 cm)	47"–67" (119–170 cm)	57"–80" (145–203 cm)

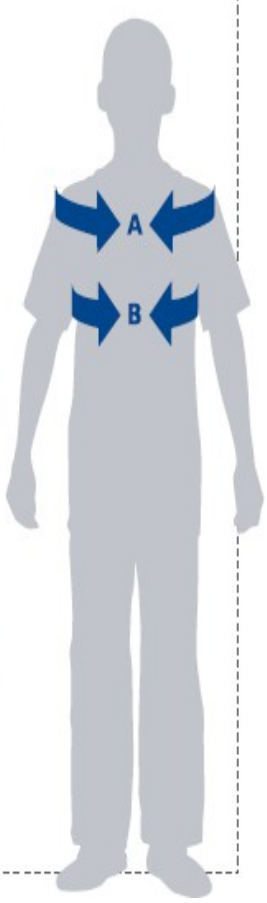
Toileting Slings

Measure the patient's chest circumference (B):			
Small	Medium	Large	X-Large
26"–42" (66–107 cm)	30"–48" (76–122 cm)	38"–60" (97–152 cm)	58"–73" (147–185 cm)

Stand-Assist Slings

Measure the patient's chest circumference (B):			
Small	Medium	Large	X-Large
28"–42" (71–107 cm)	30"–48" (76–122 cm)	36"–60" (91–152 cm)	50"–79" (127–201 cm)

Sizing tool is a guideline only.



The above sizing guide is only intended as a guide and is an approximation. Patient width and body proportions should also be considered when selecting the correct size of Medline sling. If a patient is between sizes, choose the smaller size.

If the patient's bottom is hanging considerably out of the opening in a seated sling, the sling is likely too big.

New: 2025/05/12
Reviewed: 2025/05/12
Approved: 2025/05/12

Attaching the 2 Point Low Back Sling to the lift

- 2 straps on each side:
  - i. Align top of sling with top of the shoulders and top of "U" shape at the base of the sling at the tailbone. When applying sling under resident, ensure the resident is positioned in the middle of the sling.
  - ~~i.~~ii. Place wings under the thighs and cross when attached to the lift hanger spreader bar/cradle.
  - ~~ii.~~iii. Shorter loops for top strap, longer loops for bottom straps to obtain a seated position.
  - ~~iii.~~iv. Make sure that the color loops match, left to right, when attaching to lift hanger spreader bar/cradle

Attaching the Seated U Shape Padded/Mesh Slings to the lift

- 4 straps on each side
  - i. Align top of sling with top of the shoulders and top of "U" shape at the base of the ~~sling at~~sling at the tailbone. When applying sling under resident, ensure the resident is positioned in the middle of the sling
  - ~~i.~~ii. Place wings under the thighs and cross when attached to the lift hanger spreader bar/cradle
  - ~~ii.~~iii. Top two straps attach on the top sling hanger on the hanger bar spreader/cradle, bottom two straps attach on the lower sling hanger on the hanger spreader bar/cradle
  - ~~iii.~~iv. Shorter loops for top two straps, longer loops for bottom two straps to obtain a seated position
  - ~~iv.~~v. Make sure the color loops match on each side when attaching to lift cradle

Attaching the Amputee Hammock Sling to the lift:

- 2 straps on each side with additional slit for bottom straps to go through
  - i. Configuration 1: Each leg wing goes under both resident's thighs and bottom straps go through the slits to make a hammock. The resident's legs are not separated.
  - ii. Configuration 2: Left leg wing goes under left thigh and lower strap goes through the slit. Right leg wing goes under right thigh and lower strap goes through the slit. The resident's legs are separated
  - iii. Make sure the color loops match on each side when attaching to lift cradle.

~~**Attaching the Seated U Shape of Mesh Sling to the lift**~~

- ~~4 straps on each side~~
  - ~~of sling with top of the shoulders and top of "U" shape at the base of the sling at the tailbone. When applying sling under resident, ensure the resident is~~

~~positioned in the middle of the sling~~

~~i. Place wings under the thighs and cross when attached to the lift hanger spreader bar/cradle~~

~~ii. Top two straps attach on the top sling hanger on the hanger bar spreader/cradle, bottom two straps attach on the lower sling hanger on the hanger spreader bar/cradle~~

~~iii. Shorter loops for top two straps, longer loops for bottom two straps to obtain a seated position~~

~~iv. Mak sure that the color loops match, left to right, when attaching to lift cradle~~

Attaching the Seated U Shape Sling with Head Support to the lift

- 4 straps on each side
  i. Align top of sling with top of ears or head, and top of "U" shape at the base of the sling ~~-~~at the tailbone. When applying sling on resident ensure the sling is positioned in the middle of the sling
  ii. Place wings under the thighs and cross when attached to the lift hanger spreader bar/cradle
  iii. Top two straps attach on the top sling hanger on the hanger bar spreader/cradle, bottom two straps attach on the lower sling hanger on the hanger spreader bar/cradle
  iv. Shorter loops for top two straps, longer loops for bottom two straps to obtain a seated position
  v. Make sure that the color loops match, left to right, when attaching to lift cradle

Attaching the Repositioning Sling to the lift

- Align top of the sling to top of the head.
- Do NOT use sling on Low Air Loss Mattress. Apply sling with green side down. You may leave the repositioning sling under the resident: place Ultrasorb in between resident and sling. When using on EZ/Ceiling Lift you can bunch up the lower portion of the sling
- 5 straps on each side
  i. Top two straps attach on the top sling hanger on the hanger bar spreader/cradle, bottom three straps attach on the lower sling hanger on the hanger spreader bar/cradle
  ii. Make sure that the color loops match on each side when attaching to lift hanger spreader bar/cradle

New: ~~2025/~~03/13/2025
Revised: 06/08/2026
Reviewed: ~~2025/~~05/12/2025
Approved: ~~2025/~~05/12/2025

Operating the Battery-Operated CEILING Lift

(NOTE: Two nursing staff members are always required for operation of battery-operated lift)

A. Turning the Lift On and Charging the Lift Battery

1. To turn on the lift on, press any button on the hand control. The indicator light on the underside of the lift will turn **GREEN** and the display screen will turn on. If the lift fails to turn on, ensure that the Emergency Stop/Lowering Cord has not been pulled and that the plastic clip at the end of the cord has not come out.

2. The battery has to be charged or returned to charger at the end of the track to sustain the longest life for the batteries. The lift can remain on the charger until the next time it is needed.

3. In the event of power outage, fully charged batteries will last between 80-100 lifts.

4. If the batteries are low, the indicator light will turn **ORANGE** on the underside panel. The display screen will indicate a low battery and a slow beeping audible alarm will sound. If the battery is low and in the middle of transfer, complete the lift in progress, and then move the lift to the end of the track where the charger is located.

5. If the batteries are completely discharged/fully drained, the indicator light will turn **red** on the underside panel and a fast beeping audible alarm will sound. The lift will not raise or lower and the display will indicate 0% battery. **EMERGENCY LOWERING** will still function. The lift requires four (4) hours of charging when batteries are depleted.

6. The indicator light on the charge turns **GREEN** when the batteries are fully charged and will indicate 100% on the screen on the underside panel.

7. **Emergency stopping** - This allows the staff to shut off the power completely. To activate this feature, the red cord is pulled once. The lift immediately stops and its functions will be disabled. To restore the power back to the lift, the white plastic tab that popped out when the cord was pulled, needs to be reinserted into the lift and pushed back in to turn the lift on.

8. **Emergency lowering –** In the event that the DOWN button on the hand control does not function or in the event of power failure, the carry bar can be lowered by pulling down and holding the RED emergency cord. Continue to pull down the cord until the carry bar (or resident) is safely lowered to the desired position. The unit will continue to beep as long as the cord is pulled down and it will not stop until the cord is released. The EMERGENCY lowering button does not provide a raising function.

9. **Emergency manual raising and lowering –** When the above emergency procedures do not work, contact Facility Services to perform the manual emergency interventions.

B. Resident's Transfer Using Ceiling Lift

1. Prepare the chair/bed/gurney to which the resident is to be transferred. Position the chair against a solid surface. Ensure that all bed and chair brakes are locked.

2. Move the lift away from the charging station close to the resident who is being transferred. Move the lift along the tracks using the bar.

3. Prepare the resident being transferred with the appropriate sling.

4. Once the resident is fitted with the sling, move the lift so that it is positioned directly over the resident. Lower the carry bar to a height so that the straps of the sling can be easily attached to the carry bar. Check to ensure that the lift is correctly positioned directly above the resident to be lifted.

5. Attach the straps of the sling to the hooks of the carry bar. ~~The straps on each side of the sling are generally attached to the corresponding side of the carry bar.~~ Double check to ensure that the straps are properly attached to the carry bar and that the resident being lifted is properly positioned in the sling prior to lifting. (Refer to Appendix 2: Sling Application)

6. Ensure that the resident's arms are in the sling. Raise the resident by pressing the UP button of the hand control. When there is tension and resident is ~2 inches off the mattress, confirm that loops are secure in hooks, and sling is smooth and not pinching residents skin, before lifting further. Observe for verbalizations and/or signs of discomfort.

7. Always use caution when lowering/raising a resident who is on the sling of the lift and when moving the lift along the tracks. Watch out for and avoid any obstructions that may cause injury to the resident, or damage to the lift.

8. Once at the correct height the resident can be moved along the track to the desired location. Move the lift along the track by gently pushing the carry bar or individual in the sling. Never pull the lift along the track.

9. Once at the desired location the resident in the sling can be lowered / raised to the correct height in order to complete the transfer. ***Prior to removing the straps of the sling from the carry bar, be sure to check that the resident being lifted is securely supported in the final desired position.***

10. Lower the carry bar sufficiently to allow the straps of the sling to be easily removed from the carry bar. Ensure that the carry bar does not come in contact with the resident in the sling. Remove the straps from the carry bar. Raise the carry bar and move it away so it does not interfere with the removal of the sling from the resident.

11. The sling can now be gently removed from the resident and stored.

12. The lift can now be moved to a safe location or its original location. It is recommended that the lift be left on charge when not in operation.

Operating the Battery-Operated EZ Lift

(NOTE: Two nursing staff members are always required for operation of battery-operated lift)

A. Turning the Lift On and Charging the Battery

1. To turn the unit on, push the ON/OFF button. The EZ Way Smart Lift will display a greeting message.

2. Make sure the battery charge level is showing on the screen.

3. Red emergency stop button must be in the UP position. Unit will not operate if button is in the DOWN position, and display will indicate EMERGENCY STOP.

B. Resident's Transfer Using the Lift

1. Prepares environment and clears path for the lift to be used safely; ensures lift can fit under or around receiving surface and through doorways.

2. Prepare the chair/bed/gurney to which the resident is to be transferred. Position the chair against a solid surface. Ensure that all bed and chair brakes are locked.

3. Once the resident is fitted with the sling, move the lift so that the green nose cone is about 2 inches in front of the resident's head. Lower the carry bar to a height so that the straps of the sling can be easily attached to the carry bar. If needed, raise the head of the bed to ease application of top loops Check to ensure that the lift is correctly positioned directly above the resident to be lifted.

4. Attach the straps of the sling to the hooks of the carry bar. ~~The straps on each side of the sling are generally attached to the corresponding side of the carry bar.~~ Double check to ensure that the straps are properly attached to the carry bar and that the resident being lifted is properly positioned in the sling prior to lifting. (Refer to Appendix 2: Sling Application)

5. Ensure that the resident's arms are in the sling. Raise the resident by pressing the UP button of the hand control. When there is tension and resident is ~2 inches off the mattress, confirm that loops are secure in hooks, and sling is smooth and not pinching resident's skin, before lifting further. Observe for verbalizations and/or signs of discomfort.

6. Always use caution when lowering/raising a resident who is on the sling of the lift and when moving the lift along the tracks. Watch out for and avoid any obstructions that may cause injury to the resident, or damage to the lift.

7. Maneuver the lift away from bed. Maneuver the lift by using the lift handles.

8. Adjust the legs of the lift to go around wheelchair/toilet/chair by using the spreader bar

9. Position the wheelchair under the resident. If transferring the resident to a chair or toilet, position the resident so he/she is properly aligned to be lowered onto the chair, toilet or wheelchair.

10. Push the DOWN button on the hand control

11. Stand behind the resident and hold onto the center handle located on the back of the sling. When resident is nearly seated, gently pull up on the center handle of the sling to ensure the resident will be seated in an upright position

New: ~~2025/~~05/12/2025
Revised: ~~2025/~~05/12/2025; 06/08/2026
Reviewed: 2025/05/12
Approved: 2025/05/12

ASSESSMENT AND MANAGEMENT OF URINARY INCONTINENCE

POLICY:

1. Residents/patients are assessed for urinary incontinence (UI) by a registered nurse within 7 days of admission, quarterly, annually and when a significant change occurs as part of the MDS / RAI process.

2. Licensed nurse shall develop ~~A~~an individualized ~~program~~ plan to manage UI ~~is developed by a licensed nurse~~ for each resident/patient who is assessed as incontinent.

3. Any resident/patient assessed as incontinent is regularly checked for wetness and changed promptly.

4. Any resident/patient admitted for palliative/end-of-life care will have individualized urinary function assessment and management.

PURPOSE:

To enhance quality of life and functional status by identifying urinary incontinence ~~UI~~ and developing and implementing individualized plans of care to manage urinary incontinence, and minimize or avoid negative consequences of incontinence~~manage UI.~~

PROCEDURE:

~~A.~~ **Continence Status and Assessment**
A.
~~**A. Assessment**~~

1. Continence Assessment is completed on admission/readmission, quarterly, annually, and when a significant change occurs.

2. Continence Status is documented every hour for four days by nursing staff. Documentation should reflect the exact time of bladder occurrence.

3. Upon completion of the four-day Continence Status period, the Registered Nurse (RN) will review intake/output (I/O) documentation for the assessment period for trends and patterns, and if urinary continence has been identified.

4. Registered Nurse will conduct a genitourinary assessment and document on the following sections of the resident's/patient's Electronic Health Record (EHR)
    a. Genitourinary Assessment
    b. Urine Assessment

5. Registered Nurse shall determine if a toileting program is appropriate based upon documentation and determine what type of incontinence the resident/patient has (if any) and if bladder and bowel training is needed.

6. Registered Nurse will initiate or update care plan.
    ~~a. Initial admission and readmission assessment for UI includes items listed in the genitourinary section of the admission assessment, customary voiding habits listed on the MDS, items on the MDS assessment continence in the last 7 days, and "Toilet use".~~

2. If urinary incontinence has been identified, a four (4) day Cactus, completed by CNA or PCA on the shift(s) the incontinence occurs, is used to determine the resident's usual voiding pattern.

3. Once the Cactus is completed, the licensed nurse completes the continence assessment to include symptoms, type of incontinence, post void residual (if done) and bladder assessment conclusion/ plan of care.

7. A post void residual (PVR) may be done as part of the continence assessment to identify urinary retention, which is commonly asymptomatic in older adults and is also common after spinal cord injury and in men with enlarged prostate

4.8. A bladder scanner is preferred to catheterization as a non-invasive method to determine PVR.

5. The Care Area Assessment (CAA) for UI is used in conjunction with relevant documentation in the medical record. (Refer to Centers for Medicare & Medicaid Services RAI Version 3.0, 2025) chart to further assess the type and cause of urinary incontinence and includes such factors as:

6.
7. delirium
8. Urinary tract infection
9. Atrophic vaginitis in postmenopausal women
10. Medications
11. Psychological or psychiatric problems
12. Constipation/impaction
13. Caffeine use
14. Excessive fluid intake
15. Pain
16. Environmental factors (i.e., restricted mobility, lack of access to a toilet, other environmental barriers, restraints)
17. Excessive or inadequate urine output
18. Urinary urgency AND need for assistance in toileting
19. Bladder cancer
20. Spinal cord or brain lesions
21. Tabes dorsalis
22. Neurogenic bladder diseases and conditions such as benign prostatic hypertrophy, congestive heart failure, pulmonary edema, stroke, transient ischemic attack, diabetes, depression, Parkinson's disease, dementia, prostate cancer
23. Medications such as diuretics, sedative hypnotics, anticholinergics, drugs that stimulate or block sympathetic nervous system
24. Calcium channel blockers
25.9.

26.10. Functional assessment of the resident's/patient's ability to use the toilet/, (or commode, /bedpan, or /urinal), transfer on/-off toilet, clean self, change pad, adjust clothing, or manage an ostomy/ or catheter is done by the licensed nurse as part of the quarterly and full MDS assessment. Referral to Occupational Therapy for further evaluation may be requested as needed.

B. B. Problem Identification and Interventions

1. Licensed nurses identify the possible cause of chronic UI based on their assessment, and consult with the physician and other members of the Rresident cCare tTeam (RCT) as needed.

1.
~~2.~~
~~**3.**~~ When additional consultation and testing is needed to complete the assessment for UI, a physician's referral for genitourinary (GU) services is obtained.

2.
~~4.~~
~~**5.**~~ **Problem identification** for UI includes ~~stress,~~ urge, stress, mixed, overflow, ~~transient, and~~ functional~~,~~ and transient incontinence.
~~(See attached: Urinary Incontinence Guidelines.)~~
3.
~~6.~~
~~**7.**~~ **Interventions** include individualized toileting plans across all shifts unless otherwise specified

4.
~~8.~~
~~9.~~5. **Supportive interventions** that do not treat urinary incontinence but may protect the resident/patient from urine leakage and embarrassment include pads, briefs, and external male drainage devices (condom catheter).

a. A **trial toileting program** is appropriate for most residents/patients with urinary incontinence and some cognitive ability and the ability to cooperate and such a trial should be done prior to resorting to a keep dry program using urinary incontinence products alone.
b. A **combined program** of toileting during waking hours plus use of incontinence products at specified times, such as during hours of sleep may be appropriate and preferred by some residents/patients.
c. When **incontinence products** are deemed appropriate, the resident/patient ~~resident~~ is checked for wetness at a minimum of every 2 hours or on a regular, individualized schedule.
d. **During hours of sleep** residents/patients ~~residents~~ are checked and changed on an individualized schedule to avoid sleep disruption yet preserve the resident's/patient's ~~resident's~~ skin condition.

~~**10.**~~ **Intermittent catheterization** may be ordered for urinary retention and overflow incontinence.
6.

~~11.~~7. **For indwelling catheter use refer to NPP F 5.0 Nursing Management of Urinary Catheter** ~~**Indwelling catheters** interfere with continence retraining and carry the risk of infection, but may be necessary/ ordered by the physician for various conditions such as: acute urinary retention, bladder outlet obstruction, need for accurate measurements of urinary output, to assist in healing of open sacral or perineal wounds in incontinent patients, patients requiring prolonged immobilization, to improve comfort for end of life care if needed.~~

~~12.~~8. **Goals** for continence programs include improving or preventing the decline of the current degree of continence and preventing complications (e.g., skin breakdown, moisture-related skin damage).

~~13.~~9. **Restorative continence programs** for bladder retraining and scheduled toileting (as defined in the LTC RAI user's manual) are generally appropriate for residents/patients ~~residents~~

with some bladder control. Restorative programs require an individualized care plan, licensed nurse oversight, and periodic evaluation by a licensed nurse. (See NPP D 1.0 Restorative Nursing Program)

C. Evaluation / Documentation

1. **Admission assessment:** The licensed nurse completes the genitourinary section of the Initial Nursing Assessment.

2. **MDS and CAA summary:** The RN completes sections pertinent to UI.

~~a. "Customary Routine"~~
~~b. Initial / annual/ quarterly MDS - "Toilet Use", and continence in last 7 days~~

3. ~~**Cactus sheet /Bladder diary**~~**Continence Status** ~~C~~completed by the CNA or PCA, evaluated by a licensed nurse.

4. **Continence Assessment**: Completed by the licensed nurse after analysis of the bladder diary data.

5. **Plan of Care:** The registered~~licensed~~ nurse initiates or updates the resident's/patient's ~~resident's~~ plan of care on the electronic health record

6. **Activities of Daily Living:** The CNA or PCA completes "toilet use", "bladder" sections. The licensed nurse initiates restorative bladder interventions and reevaluates monthly.

7. **Weekly / monthly summary:** The licensed nurse notes progress in relation to continence retraining goals and changes from baseline.

8. **Electronic Health Record:** The licensed nurse notes acute changes in urinary symptoms and related interventions.

APPENDIX:

~~Appendix 1: Continence Assessment – Cactus Sheet/Bladder Diary~~None

REFERENCES:

Centers for Medicare & Medicaid Services. (2025, September 24). Chapter 4: Care Area assessment process and care planning. Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) user's manual (Version 1.20.1). U.S. Department of Health & Human Services. https://www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf-1

Centers for Medicare & Medicaid Services. (2005, June 28). *Appendix PP: Guidance to surveyors – urinary incontinence (F-Tag 315)* (CMS Transmittal 8). In *State Operations Manual* (Pub. 100-07). U.S. Department of Health & Human Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R8SOM.pdf

~~Johnson, T. Ouslander, J, "The Newly Revised F Tag 315 and Surveyor Guidance for Urinary Incontinence, JAMDA, 2006~~

~~Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins~~

~~Long-term Care Resident Assessment Instrument 3.0 User's Manual, 2017 edition~~

~~MDS 3.0 CMS RAI Version 1.15 October 2017~~

CROSS REFERENCES:

Hospitalwide Policy & Procedure
23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference

Nursing Policy and Procedure
C 1.0 Admission and Readmission Procedures
C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
D 1.0 Restorative Nursing Program
F 1.0 Assistance with Elimination
F 4.0 Application and Management of Condom Catheters
F 5.0 Nursing Management of Urinary Catheters

Revised: ~~2001/~~06/2001, ~~2005/~~03/2005, ~~2008/~~09/2008, ~~2011/~~02/01/2011, ~~2017/~~11/04/2017, ~~2019/~~07/09/2018; 04/27/2026

Reviewed: ~~2019/~~07/09/2019

Approved: ~~2019/~~07/09/2019

Behavior Therapy	Definition	Resident Type	Type of Incontinence
● **Bladder Rehabilitation/ Bladder Retraining**	Residents to resist or inhibit the sensation of urgency, to postpone or delay voiding, and to void according to a timetable rather than to the urge to void	Independent, cognitively intact, has occasional incontinence, motivated to maintain highest level of continence, & able to sense urinary urge.	Urge and Mixed
● **Pelvic floor Muscle Rehabilitation**	Strengthening the voluntary muscles that contribute to the closing force of the urethra and support of the pelvic organs	Able and willing to participate	Urge and Stress
● **Prompted Voiding**	Resident is regularly monitored with encouragement to report continence status, prompted to toilet on a scheduled basis, praise and feedback received when continent and attempts to toilet. (e.g., reminded every 2 hours if toileting is needed & is toileted if assistance is needed.)	Cognitive impaired; caregiver dependent; motivated and continuous effort	Urge or Mixed
● **Habit Training /Scheduled Voiding**	Resident toileted, offered bedpan/urinal at regular intervals based on resident's voiding habits, usually q3-4hrs while awake.	Cognitively impaired; Caregiver dependent	Stress, Urge or Mixed

Behavior Therapy	Definition	Resident Type	Type of Incontinence
Urge Suppression	Bladder relaxation techniques used to control involuntary bladder contraction & suppress the urge to void	Able to respond to verbal prompts, cognitively intact; or mild/moderate cognitive impairment. Can be resident/ caregiver dependent	Urge
Bladder Retraining	Urge suppression: resident voids on a schedule, which is modified over time to increase time between voids.	Motivated, cognitively intact & able to sense urinary urge.	Urge
Scheduled Toileting/Habit Training	Resident toileted, offered bedpan/urinal on a fixed schedule, usually q 2-3hrs	Cognitively impaired; Caregiver dependent	Stress, Urge & Functional
Individualized Scheduled Toileting	Resident toileted on schedule that matches voiding pattern determined from bladder diary.	Cognitively intact or mild/moderate cognitive impairment. Either resident or caregiver dependent	Stress, urge & Functional
Prompted Voiding	Resident is asked on a regular schedule/ q 2 hrs if toileting is needed & is toileted if assistance is needed.	Cognitive impairment; caregiver dependent; low # of incontinent episodes per day; can control urination until toilet /bedpan/urinal is reached/ in place.	Urge & Functional
Double Voiding	Double attempts to empty bladder at each voiding. Resident voids normally then waits 1 minute and attempts to void again	Cognitively intact	Overflow

Adapted from: Williams, M., Borgenicht, K. "Behavioral Therapies in Urinary Incontinence" handout
References: Newman, D.K., (2002). *Managing and Treating Urinary Incontinence*
Doughty, D.B., (2000). *Urinary & Fecal Incontinence: Nursing Management*

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
12:00am					
1:00am					
2:00am					
3:00am					
4:00am					
5:00am					
6:00am					
7:00am					

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1:00pm					
2:00pm					
3:00pm					

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
4:00pm					
5:00pm					
6:00pm					
7:00pm					
8:00pm					
9:00pm					
10:00pm					
11:00pm					

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
12:00am					
1:00am					
2:00am					
3:00am					
4:00am					
5:00am					
6:00am					
7:00am					

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1:00pm					
2:00pm					
3:00pm					

Date _____ Signature: _____

Time	Incontinent-Leak	Incontinent-Lrg.	Dry	Voided	PO Fluid(cc)
4:00pm					
5:00pm					
6:00pm					
7:00pm					
8:00pm					
9:00pm					
10:00pm					
11:00pm					

Instructions

1. Reposition / check resident for wetness.
2. DO NOT offer to toilet; monitor residents' usual pattern. Toilet only if resident requests to be toileted.
3. Circle the symbol that represents your findings.
4. "Voided" means used bedpan, toilet, urinal, or commode.
5. Record the amount of fluid consumed if applicable.
6. Inform resident when he/she can expect you back.(q2hr or more often PRN.)

MR 348
08/05

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

CONTINENCE ASSESSMENT
Page 1
CACTUS SHEET/BLADDER DIARY

Addressograph

F 2.0 Assessment & Management of Urinary Incontinence, Appendix I

Revised 10-2017

Laguna Honda Hospital and Rehabilitation Center

CONTINENCE ASSESSMENT

Page 2

Addressograph

A) Licensed Nurse Assessment
Symptom Assessment (check all that apply):

□ Aware of urge to void
□ Unaware of urge to void
□ Strong uncontrollable urge to void
□ Leaks urine on way to bathroom
□ Urine loss with exertion such as any of the following: coughing, sneezing, change of position, or laughing
□ Difficulty starting urine stream
□ Post void dribbling
□ Sensation bladder is not emptying completely
□ Receving diuretics
□ Other (see comments)

Types of Incontinence

Stress: Involuntary loss of small amounts of urine due to effort or physical exertion.

Urge: Involuntary loss of urine associated with sudden uncontrollable urge to void.

Mixed: Both stress & urge symptoms of incontinence

Overflow: Involuntary loss of urine associated with incomplete bladder emptying, urinary retention and over distension of the bladder. Dribbling or leakage as small amounts of urine may occur.

Functional: Incontinence caused by factors outside the urinary tract such as immobility, inability to get to toilet or cognitive impairment.

B) What type of incontinence do these symptoms describe?

□ Stress
□ Urge
□ Mixed
□ Overflow
□ Functional

C) Documented post void residual (PVR)_____

D) Bladder Assessment Conclusion & Plan of Care (check all that apply):

□Scheduled Toileting: habit training or individualized (stress, urge, functional)
□ Bladder Retraining (urge)
□ Urge Suppression (urge)
□ Prompted Voiding
□ Double Voiding (overflow)
□ Bedside Commode
□ Pelvic floor exercises (Kegel)
□ Use of absorbent pads/ briefs/ product
□ Not a candidate for toileting program (see comments)
□ GU clinic referral by MD
□ Incontinence Care per LHH policy
□ Documented on care plan □ Document on DNCR
□ Other (see comments)

Comments:

Date: _____ RN signature:_____

Assessment and Management of Bowel Function

POLICY:

1. Registered Nurse shall assess, document and monitor bowel function upon admission within 7 days, quarterly, annually and when a significant change occurs as part of the MDS/RAI process.

2. Nursing Assistant [Certified Nursing Assistant (CNA) or)/Patient Care Assistant (PCA)] will monitor and recorddocument bowel movements each shift. Nursing Assistant will alert Licensed Nurse if no bowel movement for > 3 days (or per physician order), or for new incontinence.

1. License Nurse shall evaluate all residents for bowel function at admission and whenever clinically indicated.
   Licensed Nurse shall administer prn laxatives and/or stool softeners per physician bowel regimen, and monitor and document effects. If ineffective, notify physician for further orders.
3. After other interventions for constipation relief have been unsuccessful, licensed nurses may remove a fecal impaction with a physician's order.

2.4. Invasive elimination procedures that Bowel management procedures that are considered invasive and require insertion/removal of a finger or device into the resident's rectum (e.g., rectal tubes, suppositories, digital rectal stimulation) may only be performed by a licensed nurse.

3.1. After other interventions for constipation relief have been unsuccessful, licensed nurses may remove a fecal impaction with a physician's order.

4.1. Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) will monitor and record bowel movements each shift.

PURPOSE:

To enhance quality of life and functional status by maintaining or restoring healthy bowel continence and preventing complications.

PROCEDURE:

1. For fecal impaction removal, refer to Elsevier Skills: Fecal Impaction Removal

1. For use of enema, refer to Elsevier Skills: Enemas Upon admission and as needed, the licensed nurse will observe the following:
2.

3. For use of rectal tube, refer to manufacturer's instructions for the particular brand/product to be used
   Inspect, palpate and auscultate abdomen
   Indications of tenderness
   Verbal and nonverbal signs or symptoms of gas, pain and/or discomfort
   Characteristics of stool
   Frequency of bowel movements
   Presence of blood or mucus
   Presence of continence
   Mode of elimination (e.g., commode, toilet)
   Last bowel movement
   Licensed nurse will complete bowel and bladder assessment.
   Refer to Elsevier for procedures related to enemas and rectal tubes: https://point-of-care.elsevierperformancemanager.com/skills/616/quick-sheet?skillId=GN_33_3&virtualname=lhh
   Refer to Elsevier for fecal impaction removal: https://point-of-care.elsevierperformancemanager.com/skills/11034/quick-sheet?skillId=HC_058&virtualname=lhh

DOCUMENTATION:

1. The licensed nurse completes the bowel ~~and bladder~~ assessment in the electronic health record
2. The CNA or PCA records bowel function in the Activities of Daily Living section each shift.
3. The licensed nurse documents rectal tube use in the electronic health record (EHR).
4. Licensed nurse develops, evaluates and revises related care plans when indicated for actual or potential bowel problems.

REFERENCES:

Centers for Medicare & Medicaid Services. (2025, September 24). *Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) User's Manual* (Version 1.20.1; effective October 1, 2025). U.S. Department of Health and Human Services. https://www.cms.gov

Elsevier (2025) Fecal Impaction Removal https://point-of-care.elsevierperformancemanager.com/skills/615/extended-text?skillId=GN_33_2&virtualname=lhh#scrollToTop – electronic access on June 9, 2026

Elsevier (2025) Enemas https://point-of-care.elsevierperformancemanager.com/skills/616/extended-text?skillId=GN_33_3&virtualname=lhh#scrollToTop – electronic access on June 9, 2026

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CROSS REFERENCES:

Nursing Policy and Procedure
F 1.0 Assistance with Elimination
F 2.0: Assessment and Management of Urinary Incontinence

ATTACHMENTS/APPENDICES:

NONE

Revised: ~~2006/~~07/2006;~~,~~ ~~2008/~~09/2008;~~,~~ ~~2010/~~10/2010;~~,~~ ~~2016/~~12/2016;~~,~~ ~~2018/~~07/10/2018;~~,~~ ~~2019/~~03/12/2019; ~~2024/~~06/11/2024; 06/09/2026

Reviewed: 2024/06/11

Approved: 2024/06/11

REPLACEMENT AND CARE/MAINTENANCE OF AN EXISTING SUPRAPUBIC CATHETER

POLICY:

1. Initial replacement of a suprapubic (SP) catheter is performed by a physician. Thereafter, a registered nurse (RN) may replace the existing SP catheter with a physician order specifying the size of catheter, catheter type, balloon volume, type of dressing (if any), and indication for the catheter.

~~1.~~2. Suprapubic ~~(SP)~~ catheters are changed by an RN ~~on a~~ quarterly ~~basis~~, unless otherwise specified by the physician's order, ~~by the Registered Nurse (RN)~~ to prevent clogging of the catheter and to aid in the prevention of catheter acquired urinary tract infections (CAUTI). If catheter is dislodged prior to 4 weeks upon initial placement, the physician shall be notified.

3. The Licensed Nurse (LN) will provide site care for an existing SP catheter daily, and as needed.

4. All SP catheters must be secured to the abdomen with an anchoring device to prevent accidental removal.

5. Drainage bags will be changed based on clinical indication such as infection, obstruction, or when the closed system is compromised

~~2. Initial replacement of a SP catheter is performed by a physician. Thereafter, only a RN with demonstrated competency of SP catheter insertion may replace the existing SP catheter, with a physician order specifying the catheter type, size, balloon volume, type of dressing, and indication for the catheter.~~

~~3. The Licensed Nurse will provide site care of an existing SP catheter daily and as needed.~~

~~4. All SP catheters must be secured to the abdomen with an anchoring device to prevent accidental removal.~~

~~5.~~6. Intake and output will be measured every shift for residents with a suprapubic catheter. [Refer to Nursing Policy & Procedure (NPP) G 3.0 Intake and Output]~~For additional applicable policy statements, refer to the Nursing Policy and Procedure, F5.0 Nursing Management of Urinary Catheters.~~

PURPOSE:

To prevent CAUTI, ~~to~~ maintain S~~S~~P catheter patency, and ~~to~~ provide a guide for safe aseptic replacement of an existing SP catheter.

~~Background~~BACKGROUND:

~~SP catheters are used when urethral catheterization is not possible or desirable due to; urethral stricture, prostatic enlargement, urethral trauma, postoperative drainage after lower urinary tract or bowel surgery, and the management of neurogenic bladder. Residents with neurologic conditions such as multiple sclerosis, spinal cord injury, or other, may choose the use of a SP catheter to simplify their long-term catheter management and reduce urethral trauma due to the need for repeated urethral catheterizations (Lamont, et. al, 2011). These catheters are also changed for catheter blockage and leakage around the catheter (usually a sign of impending blockage).~~ Suprapubic catheters are inserted directly into the bladder through the lower abdominal wall, allowing urine to drain from the catheter into a urinary drainage bag. Suprapubic catheters decrease the risk of urethral injury from indwelling catheter use.

PROCEDURE:

A. ~~FOR RR~~EPLACEMENT OF AN EXISTING SU~~S~~PRAPUBIC CATHETER:

I. Equipment

- Non-sterile gloves and additional personal protective equipment if needed per precautions
- Drape or blanket
- Catheter Supplies
  - Closed System: (16 French or 18 French):
    - Total One Layer Tray Select Silicone Closed System Foley Catheter with Drainage bag
  - Open System: {Other Sizes (i.e., 20 French)}
    - Coude Tip Foley Catheter (if ordered)
    - Individually Packed Catheter
    - Catheter Insertion Tray
    - Drainage Bag

~~Clean gloves~~

~~II. **Sterile gloves**~~

~~III. **Two (2) 12mL syringes;**~~

~~IV. **One syringe to deflate balloon**~~

~~V. **One syringe filled with 10mL (or other volume as specified by physician order) of sterile water for replacement SP catheter balloon inflation**~~

~~VI. **Catheter tray (comparable-sized catheter to size resident has currently, unless ordered otherwise)**~~

~~VII. **Three (3) 4x4s**~~

~~VIII.**New leg bag or bedside bag**~~

~~IX. **Irrigation set**~~

~~X. **250 mL of normal saline**~~

~~XI. **Water soluble lubricant**~~

~~XII. **Catheter anchoring device**~~

~~XIII.~~

II. Replacement of an ~~e~~Existing S~~P~~uprapubic Catheter Procedure (Refer to Elsevier Skills: Suprapubic Catheter - Replacement)

Review the manufacturer's instructions for the type of urinary catheter to be used, and how much balloon volume is needed

- If using Closed System:

- Remove kit from outer packaging and set on clean surface close to resident
- Using aseptic technique, unfold first layer of outer wrapper to expose absorbent drape
- Doff gloves
- Unfold next later of wrapper to expose hand sanitizer and sterile gloves
- Perform hand hygiene with hand hygiene packet
- Don sterile gloves
- Unwrap final fold to expose inner sterile field
- Prepare kit left to right
  - Attach sterile water syringe to inflation port (do NOT pre-test balloon)
  - Dispense lube jelly into lube tray
  - Remove catheter protective sheath and place catheter along the lube tray lubricate at least 3" – 5" of catheter tip
  - Open povidone-iodine (PVP) swab sticks and place pre-saturated swab sticks on the bottom right side of tray
  - Place fenestrated drape over the resident, leaving only the procedure site exposed

- If using Open System:
  - Place unopened catheter insertion tray, foley catheter, and drainage bag on a clean surface close to resident
  - Open the package of the drainage bag, check to see if drainage bag clamp is closed, and set bag aside
  - Open sterile catheter insertion tray
  - Open outer wrapper of the foley catheter while maintaining sterility of the inner wrapper and place catheter together with the opened, sterile catheter insertion tray
  - Perform hand hygiene and don sterile gloves
  - Place fenestrated drape over the resident, leaving only the procedure site exposed
  - Arrange supplies on sterile field
  - Squeeze sterile water-soluble lubricant onto the tip of the new catheter

~~1. Perform hand hygiene; apply clean gloves.~~
~~2. Inspect the SP catheter where it enters the suprapubic tract (stoma) for encrusted material or drainage. Also inspect the tissue around the catheter.~~
~~3. Using a cleansing/hygiene product, cleanse gently around the SP catheter, working outward. Remove all exudate and dry completely.~~
~~4. Place 4x4s near the site to catch any urine leakage when the existing SP catheter is removed.~~
~~5. Instill 30mL normal saline into the established catheter prior to removing the catheter. This will establish patency when the new SP catheter is inserted.~~
~~6. Gently deflate the balloon of the existing SP catheter with the appropriate size syringe.~~
~~7. Remove catheter by gently pulling it straight out in a slow steady manner. Note the approximate length of the SP catheter. This will assist in estimating the length when inserting the replacement SP catheter.~~
~~o If the SP catheter cannot be withdrawn easily, notify the physician.~~
~~8. Remove gloves, use hand sanitizer before applying sterile gloves.~~
~~9. Immediately apply 5mL to 10mL of water-soluble lubricant onto the suprapubic tract (stoma) and insert new SP catheter.~~
~~10. Once urine returns, insert the SP catheter approximately 2 inches further to ensure the SP catheter is in the bladder and not the suprapubic tract.~~
~~o If urine flow does not occur within a minute or so of SP catheter insertion, use a syringe and irrigate, freeing the SP catheter lumen of the lubricant.~~
~~11. Inflate the balloon with prescribed amount of sterile water and attach the SP catheter to the appropriate drainage system.~~

12. Apply dressing per MD order.

- Established sites (5-7 days) that are not draining may not require a dressing.

13. Secure catheter to resident's abdomen with catheter anchoring device, approximately 6-8 cm from insertion site. Do not pull catheter taut and allow enough room to insert 2 fingers under the catheter.

A. Documentation

B.

C. Document date and time of SP catheter change, size of SP catheter, amount of sterile water in balloon, note ease of removal of previous SP catheter, condition of site, type of dressing applied, and resident's tolerance of procedure, on the Treatment Administration Record (TAR).

D.

E.

B. PROCEDURE FOR CARE OF AN EXISTING SUPRASPUBIC CATHETER PROCEDURE:

I. Equipment

- Clean gloves
- Catheter securement device
- Tape
- Sterile cotton-tipped applicators
- Sterile Washcloth or ggauze dressing or washcloth auze
- Sterile normal saline/water
- Sterile split gauze
- Usual cleansing/hygiene product
- 4x4 dressing or other dressing as specified in MD order
- Catheter plug with cap for aquatics therapyPlastic bag for disposal

II. Care and Maintenance of an Existing SuprapubicP Catheter Procedure (Refer to Elsevier Skills: Suprapubic Catheter - Care)

1. Gather supplies
1. Perform hand hygiene, don .
2. Apply clean gloves and appropriate Personal Protective Equipment (PPE).
3. Check old dressing for drainage and intactness
4. Cleanse the skin around the catheter site gently with a gauze slightly moistened with disposable sterile normal saline/water. Use a circular motion, starting at the catheter site and going outward
5. Dry completely
6. Check catheter site for signs of inflammation or infection (e.g., redness, swelling, discharge) and urine leakage
7. Doff gloves, hand hygiene, don clean gloves
8. Apply new dressing, if any, as ordered
9. Loop the catheter on the resident's abdomen and secure it to the abdomen with a catheter securement device to reduce tension on the catheter site.

10. Check the bag and tubing placement. Secure the catheter drainage tubing with a securement device. Coil excess tubing on the bed and fasten it to the bottom sheet with a clip
11. Dispose of all soiled dressings, supplies, or single-use equipment in a plastic bag and into appropriate receptacle.
12. Remove PPE and perform hand hygiene

~~***A.*** Daily, and as needed, cleanse exit site gently with washcloth using warm water and usual cleansing product. Use a circular motion starting at the SP catheter exit site and going outward.~~

C. SUPRAPUBIC CATHETER MAINTENANCE FOR AQUATIC SERVICES (Refer to Hospitalwide Policy & Procedure 28-03 Aquatic Services)

~~Dry completely.~~
~~Inspect for signs of infection (redness, exudate, and swelling) and signs of urine leakage.~~
~~Apply daily dressing as ordered.~~
~~Check that the drainage bag is secured to the SP catheter.~~
~~Ensure that the SP catheter is secured to resident's abdomen with a catheter anchoring device, approximately 6-8 cm from insertion site. Do not pull catheter taut and allow enough room to insert 2 fingers under the catheter.~~
~~For applicable routine maintenance of an indwelling urinary catheter, refer to Nursing Policy and Procedure, F5.0 Nursing Management of Urinary Catheters.~~

DOCUMENTATION:

A. Upon receiving resident with a suprapubic catheter, Registered Nurse shall add an Avatar for Suprapubic Catheter and create a nursing assistant worklist task for intake/output. Complete a nursing note documenting the following:
- Indication of use based on physician's order
- Indication for catheter insertion/reinsertion
- Date and time of insertion/reinsertion
- Catheter size, amount of fluid used to inflate catheter balloon
- Volume and urine characteristics
- Resident's tolerance of the procedure, including pain assessment
- Any untoward events encountered during the procedure and related interventions
- Specimen collection, if performed

B. Document for daily charting and/or weekly summary:
- Any unexpected events encountered during the specific period such as obstruction or leakage, bladder distention, change in urine output from baseline, clinical signs and symptoms that may indicate infection or other complications. (Refer to Nursing Policy and Procedure C4.0 Notification and Documentation of Change in Resident Status)
- Any interventions performed and evaluation and outcome of intervention

C. Care Plan ((~~Done~~Completed by LN): Refer to HWPP #23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference
- Diagnosis requiring suprapubic catheter
- Initial date of insertion, type and size of the catheter used, any unique management or approaches to resident when inserting catheter
- Address possible risk for complications and infections from use of suprapubic catheter.
- 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 care plan.

D. At least once every shift, the licensed nurse documents the following in the EHR flowsheet:
- Suprapubic Catheter (LN only, except for Urine Output)
  - Urine Output/Assessment
    - Urine Color
    - Urine Appearance
    - Urine Odor
  - Site Assessment
  - Dressing Status
  - Dressing Type
  - Dressing Change Due (document date of when next dressing change, if any, is due)
  - Collection Container
  - Catheter Bag (yes or no) – Catheter bags are only changed when indicated, see policy statement
  - Urine Output – volume of suprapubic output (LN, PCA/CAN cand document)

E. Under progress notes:
- Pertinent observations of catheter insertion site
- Resident's tolerance of catheter replacement
- Resident's tolerance of dressing change, if any
- Unexpected outcomes and related interventions

~~**III. SUPRAPUBIC CATHETER MAINTENANCE FOR AQUATIC SERVICES**~~

~~IV.~~

~~1. Perform hand hygiene and apply clean gloves,~~
~~2. Empty the drainage bag completely.~~
~~3. Obtain a catheter plug with cap from Central Supply, disconnect drainage bag from the SP catheter and discard and cap the end of SP catheter to prevent urine backflow and to stop drainage.~~
~~4. Conceal catheter tubing inside resident's swimsuit/swim trunk.~~
~~5. After aquatics therapy and return to the unit, reconnect to a new drainage bag using aseptic technique.~~

~~**DOCUMENTATION**~~

~~A. Document dressing change on the Treatment Administration Record (TAR) and document pertinent observations of catheter insertion site in the Integrated Progress Notes.~~

REFERENCES:

Centers for Disease Control and Prevention. (2024). *Guideline for prevention of catheter-associated urinary tract infections (CAUTI)*. https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf - electronic access on April 22, 2026

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Society of Urologic Nurses and Associates. (2005). *Clinical practice guidelines: Suprapubic catheter replacement*. Pitman, NJ: Society of Urologic Nurses and Associates.
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~~Healthcare Infection Control Practices Advisory Committee (2009). Guideline for prevention of catheter-associated urinary tract infections. Accessed at: http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf~~

~~Lamont, T., Harrison, S., Panesar, S., & Surkitt-Parr, M. (2011). Safer insertion of suprapubic catheters: Summary of a safety report from the national patient safety agency. *BMJ, 342, 546-548*.~~

~~Excerpted and adapted from Perry AG, Potter PA: *Clinical nursing skills & techniques,* ed 7, St. Louis, 2010, Mosby. Accessed via SFGH net: http://mns.elsevierperformancemanager.com/NursingSkills/ContentPlayer/SkillContentPlayerIFrame.aspx?KeyId=407&Id=GN_32_7&IsConnect=False&bcp=SearchOp~0~suprapubic~False&Section=1~~

CROSS REFERENCE:

Hospitalwide Policies and Procedures
28-03 Aquatic Services

Nursing Policy & Procedure
~~NPP~~ F5.0 Nursing Management of Urinary Catheters

Revised: ~~2014/~~05/27/2014; ~~2016/~~11/08/2016; 04/22/2026

Reviewed: ~~2016/~~11/08/2016

Approved: ~~2016/~~11/08/2016

OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS AND TREATMENTS

POLICY:

1. The charge nurse or team leader is responsible ~~to have~~for having a continuous supply of prescribed medications available 24 hours a day, seven days a week through Department of Pharmacy Services, or automated medication dispensing cabinets.

2. The medication room, medication cart, treatment cart, and medication refrigerator are ~~to be locked~~locked when not in use or attended.

3. Complete an Incident Report if there is an error in the medication dispensed, or labeling error. Return any drug dispensed in error to the Pharmacy immediately and obtain a replacement. If Pharmacy is closed, notify the nursing supervisor who can return the medication to the pharmacy.

4. Licensed ~~nurse~~nurses ~~adheres~~adhere to relevant policies and procedures outlined by the Department of Pharmacy Services.

5. Unless otherwise stated in this policy, the licensed nurse does not need to date products with opened date.

PURPOSE:

Correct medications will be available, handled and stored properly.

PROCEDURES:

A. Pharmacy Accessibility: ~~(~~Refer to Pharmacy Policy & Procedure (Pharm P&P) 01.01.01 Accessibility to Medications~~)~~

B. Obtaining ~~m~~Medication from Pharmacy: Refer to Pharm P&P 02.01.00b Distribution of Medications and Order Processing

1. New medication orders will be transmitted to Pharmacy as an electronic prescription via the electronic health record (EHR). Medications will be available via automated dispensing cabinet or resident/patient specific supply delivered by pharmacy.

2. Medications needed prior to the next Pharmacy delivery may be picked up at the pharmacy window by unit staff with hospital identification.

~~1.~~3. ~~New medication orders will be transmitted to pharmacy as an electronic prescription via the electronic health record. Medications will be available via automated dispensing cabinet or patient specific supply delivered by pharmacy. Medications needed prior to the next pharmacy delivery may be picked up at the pharmacy window by a licensed nurse or licensed psychiatric technician.~~Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room.

~~2.~~4. Maintenance Medications:

a. Pharmacy will deliver a resident/patient specific supply of maintenance medications to the neighborhood for cart fill exchange~~with scheduled oral medications~~.
b. For newly ordered medication, pharmacy will dispense the amount of medication up to the next cart fill exchange.

~~3.~~5. Pass Medications (~~S~~Short-~~t~~Term Medications): Refer to Pharm P&P 02.01.04 Pass Medication
a. Pharmacy will dispense only the amount of medication that was specified in the order.
b. Bulk medications (topicals, eye/ear drops, inhalers, insulin) taken from the unit for use while on pass will be relabeled with an outpatient label
~~a.~~c. Licensed nurse will review the directions and check the number and appearance of the drug with the resident or responsible person
~~PRN or "As Needed" Medications (Refer to Pharmacy Policy 09.01.00).~~

6. Medication Refills: If refill is needed before routine date of replacement,~~.~~ ~~-~~request the refill via the EHR.

~~4.~~7. Stock Items: ~~(~~Refer to Pharm P&P ~~Pharmacy Policy~~ 09.01.00 Automated Medication Dispensing Cabinets~~).~~

~~5.~~8. Controlled Substances~~ Medications~~: ~~(~~Refer to Pharm P&P~~Pharmacy Policies~~ 09.01.00 Automated Medication Dispensing Cabinets, and Pharm P&P 02.02.00 Controlled Substances~~).~~

C. Labeling Medications

1. ~~The l~~Licensed nurse inspects the condition and legibility of labels. ~~All prescription drugs that do not have a clearly legible label are to be returned to Pharmacy for replacement.~~ If having difficulty scanning barcode of medication label, notify pharmacy of issue.

2. Label Changes:
a. If label of medication that is already dispensed ~~label~~ becomes soiled, illegible, or if change is made in dosage or frequency of an existing medication, the licensed nurse will contact the main pharmacy or bring the medication to the main pharmacy window for relabeling during pharmacy hours~~drug container is to be placed in a relabel zip lock bag and placed in the pharmacy pick up tray.~~.
~~a.~~b. If medication is removed during off pharmacy hours and requires labeling, pharmacy will coordinate by either contacting the unit requesting the item to be returned to pharmacy for labeling or arranging a delivery technician to retrieve medication at the next unit delivery.
~~In the event that the correct dose for the resident involves more than one strength of the medication to achieve the dose, multiple strengths of medication will be sent to achieve dose. It is the responsibility of the LN to confirm dose prescribed with amount to be administered.~~

D. Storage of Medications

1. Condition of Medication Container and Contents
a. Medications are to be kept in the containers received from Pharmacy. If containers become cracked, soiled, or do not have secure closures, return to Pharmacy for replacement.
b. If drug contents become outdated, contaminated or show deterioration, then~~,~~ ~~return~~ discard in appropriate waste container and ~~to~~request refill from Pharmacy ~~for replacement~~.

2. ~~Orderliness of~~ Medication and Treatment Carts

a. Medication Cart:
   i. Medication cart stores ~~the~~ resident~~'~~s/patients ~~supply of internal~~ medication including injectables, ophthalmic preparations, otic preparations and inhalation preparations (nebulizer/aerosol).
      - Otic and ophthalmic medications are stored in separate bags labeled with route
      - Inhalers and insulin vials/pens or other injectables are stored separately
      - Topical medications for skin condition may be stored in a separate drawer of medication cart
   ii. ~~Licensed nurse checks e~~Expiration dates of medications are checked before administering medication, and on a weekly basis (Refer to Standard Work on LHH Nursing Process to Prevent Expired Medication on Units and Reaching Patients).
   iii. All unlabeled and expired medications are to be discarded in appropriate medication waste bin. ~~(Refer to HWPP 25-05 Hazardous Drugs Management).~~

b. Treatment cart:
   i. Ointments and creams are labeled with resident's/patient's name and are legible.
   ~~i.~~ii. All medication tubes and bottles are to have covers.
   iii. Irrigating ~~s~~Solutions ~~are checked for expiration date labeling:~~
      - Normal saline, sterile water and isopropyl alcohol are ordered from Central Supply and are single use only~~,~~. ~~and a~~After single use, ~~remainder of solution~~remaining solution is discarded into appropriate waste bin.
      - Other irrigation solutions are ordered from Pharmacy ~~and are labeled with expiration dates~~. When bottles of irrigation solution supplied by Pharmacy are first opened, licensed nurse labels bottle with the date/time opened and nurse's initials. Irrigation solutions supplied by pharmacy are not to be used 24 hours after opening.
      - Unlabeled or expired solutions are to be returned to Pharmacy. (Refer to Pharmacy Policy 02.01.06 Expiration Dating of Pharmaceuticals for expiration policies and practice.)~~Unlabeled or expired solutions are to be returned.~~
      - ~~When bottles of irrigation solution supplied by pharmacy are first opened, write the date, time and nurse's initials on the label. Refer to Pharmacy Policy 02.01.06 Appendix 1 for expiration policies and practice.~~
      - ~~Irrigation solutions supplied by pharmacy are not to be used 24 hours after opening.~~
      -

~~c. Medication Room~~

~~The following items are stored in locked medication room, locked carts or the automatic dispensing cabinet(s). Internal, external, and injectable items must be stored separately. Approved ward stock supplies or medications.~~
~~i. Emergency drug box, Emergency I.V. bag, I.V. solutions and tubing.~~
~~ii. Test reagents, Chemstrips, or hemoccult tests.~~

3. Medication Refrigerator - used only for medications requiring refrigeration.
   a. Medication refrigerator temperature is monitored continuously via wireless refrigerator monitoring system. [Refer to Nursing Policy and Procedure (NPP) D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerators/Freezers via TempTrak Cleanliness of Refrigerators]
   b. Licensed nurses check temperature of medication refrigerators twice a day by logging into TempTrak. (Refer to Standard Work on Checking Temperature of Medication/Nourishment Refrigerators and Freezers via Temptrak)

c. Store oral medications together in one area, injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.
d. No food or specimens are to be placed in the medication refrigerator.

4. The following items are stored in a locked medication room, locked carts or the automatic dispensing cabinet(s)
   a. Approved ward stock supplies or medications,
   b. Emergency Drug Box w/ content listed on exterior
   c. Emergency intravenous (IV) bags, solutions, and tubing.

~~2. Medication refrigerator - is used only for drugs needing refrigeration.~~
~~a. Refrigerator temperature is monitored continuously via wireless refrigerator monitoring system. The temperature log is checked by nursing staff (Refer to LHHPP 31-01: Wireless Refrigerator and Freezer Temperature Monitoring System).~~
~~b. Store oral medications together in one area, refrigerated injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.~~
~~c. No food or specimens are to be placed in the biological refrigerator.~~

E. Handling Medications

1. Liquid Medications:
   a. Shake the liquid medication before measuring if directed by medication label and/or MAR administration instructions.
   b. A calibrated medicine cup or ~~O~~oral ~~Liquid S~~syringe ~~Dispenser i~~as~~r~~re used to ~~accurately~~ measure and administer liquid medications from multidose containers.
      i. Calibrated Medicine Cup: Pour medication at eye level on a level surface. Measure at the bottom of the meniscus. Do not pour excess back into medication container.
      ii. Oral Syringe: Use new oral syringe for each administration. For accurate measurement of medications, a ~~such as Dilantin suspension. Shake the suspension medication well and be sure the~~ssure syringe plunger is fully depressed before inverting the bottle to fill the syringe. ~~-~~Use the inside edge of ~~the~~ black measurement ring to ~~read~~ measure volume at eye level~~volume~~. ~~-~~ The syringe may be attached to an enteric tube or put into the mouth between the teeth and cheek to administer medication. ~~-~~Discard oral syringe~~dispenser~~ after ~~each individual~~ dose.

2. Hazardous Medications (formerly known as antineoplastic~~-~~/cytotoxic medications):
   a. Special precaution needs to be applied when preparing and handling hazardous medication administration. ~~n~~ (Refer to LHHPP 25-05 Hazardous Drugs Management).
   ~~a.~~b. Instructions for administering the medication can be found in administration instructions on the EHR Medication Administration Record (MAR)

3. Controlled Substances: ~~Medications (~~Refer to Pharm P&~~Pharmacy P~~olicy 02.02.00 Controlled Substances, Pharm P&P 09.01.00 Automated Medication Dispensing Cabinets, and Standard Work on Cycle Count and Medication Refrigerator Check)~~.~~

4. ~~Multidose~~ Injectables:

   a. Insulin and Insulin Analogs:
      i. Expiration dates are written on insulin vials and pens when dispensed by Pharmacy.

ii. If insulin is needed when Pharmacy is closed, licensed nurse shall retrieve new vial from PMA refrigerator and vial label with expiration date (expiration date is 28 days upon opening). Store insulin in the resident/patient cassette and contact pharmacy for re-labeling when Pharmacy opens.
iii. Store insulin in individual resident's/patient's cassette. Only insulin in Pavilion Mezzanine Acute (PMA) are stored in refrigerator.
iv. Visually inspect prior to use and discard if any of the following occur:
- Change in appearance of the solution
- Damage or loss of integrity of the closure
- Known or suspected to be contaminated
- Expired

~~Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.~~

b. Multiple dose ~~injectables~~vials that contain a preservative (non-insulin)
i. Refrigerated for stability, if recommended by the manufacturer
ii. S ~~s~~hall be visually inspected prior to use and discarded if any of the following occur:
- Change in appearance of the solution
- Damage or loss of integrity of the closure
- Improperly stored
- Known or suspected to be contaminated
- Empty or expired
- ~~There is a change in appearance of the solution.~~

~~There is a change in appearance of the solution.~~
~~There is damage or loss of integrity of the closure.~~
~~i. The drug has been improperly stored.~~
~~ii. The vial is known or suspected to be contaminated~~
~~The vial has met the expiration date~~

c. Injectables that do not contain preservatives shall be used immediately and any remaining contents shall be discarded
d. PPD vials shall be given a 28-day expiration date upon opening
e. Expiration Dating: ~~(~~Refer to ~~Pharmacy Policy~~Pharm P&P 02.01.06 ~~Appendix 1~~Expiration Dating of Pharmaceuticals~~).~~
~~b.~~f. Multiple Packaged Intravenous (IV) Fluids – Once the iv fluid overwrap is torn or removed, any remaining unused iv fluid bag(s) will be labeled with a sticker (obtained from Central Supply) and given a 15-day expiration date for 25 and 50 ml bags and 30-day expiration date for 100 ml or larger iv bag(s)

~~c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.~~

~~d. Insulin vials shall be:~~
~~i. Dated upon initial entry~~
~~ii. Open vials may be kept in individual resident cassettes or in the refrigerator.~~
~~iii. Open, in-use vials shall be discarded after 28 days. Pharmacy assigns expiration date.~~
~~iv. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.~~

~~e. Injectables that contain preservatives shall be:~~

~~i. Refrigerated for stability, if recommended by the manufacturer.~~
~~ii. Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).~~

REFERENCES:~~Monthly Pharmacy Ward Survey~~

NONE

~~1. The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered to the resident to ascertain that medications are given accurately and with acceptable infection control measures employed.~~

~~2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.~~

CROSS REFERENCES:

Hospitalwide Policies & Procedures
25-01 High Risk - High Alert Medications
25-02 Safe Medication Orders
25-05 Hazardous Drugs Management

Nursing Policies & Procedures
D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerators via TempTrak & Cleanliness of Refrigerators

~~31-01 Wireless Refrigerator and Freezer Temperature Monitoring System~~

Pharmacy Policies & Procedures
01.01.01 Accessibility to Medications
02.01.00b Distribution of Medications and Medication Order Processing
02.01.04 Pass Medications~~01.02.02 Stop Orders~~
~~01.08.00 Extern Students~~

02.02.00 Controlled Substances
02.01.06 Expiration Dating of Pharmaceuticals
09.01.00 Automated Medication Dispensing Cabinets ~~09.01.00 Automated Medication Dispensing Cabinets~~
~~02.01.00a Acute Care Order Processing and Med Distribution~~

~~Nursing Policies & Procedures~~
~~B 6.0 Items Allowed at the Bedside~~

~~Emergency Equipment/Refrigeration Monitoring Sheet~~
~~Emergency Equipment Monitoring Sheet for Wellness Center Only~~
Standard Work on Checking Temperature of Medication/Nourishment Refrigerators and Freezers via Temptrak

Standard Work on LHH Nursing Process to Prevent Expired Medication on Units and Reaching Patients

APPENDIX/APPENDICES:

NONE

Adopted from NPP J 1.0 12/2006

New: ~~2010/~~04/2010

Revised: ~~2011/~~03/17/2011; ~~2015/~~07/14/2015; ~~2017/~~01/10/2017; ~~2019/~~05/14/2019; ~~2020/~~05/19/2020; ~~2023/~~11/14/2023; ~~2024/~~11/08/2024; ~~2025/~~04/18/2025; 04/30/2026

Reviewed: 2025/05/12

Approved: 2025/05/12

INTRAVENOUS (IV) THERAPY MAINTENANCE

POLICY:

1. The Registered Nurse (RN) is responsible for the administration, monitoring~~, maintenance~~, and maintenance of intravenous (IV) therapy.

2. If the purpose of the IV infusion is to maintain IV-line patency, the order must specify the desired infusion rate. An IV designated only as "to keep vein open (TKO)" or "keep vein open (KVO)" should be infused at 30 mL per hour unless otherwise ordered. Use an IV pump for all IV infusions.

3. Peripheral IV (PIV) site is to be changed or rotated every ninety-six (96) hours or earlier if necessary. If the IV line is not changed in 96 hours, notify MD and document reason (i.e., poor vein access, resident refused IV site change). If venous access is limited, request physician order to extend use of the current site.

4. An RN may restart peripheral IV site as needed without a physician's order if the IV site is expired, infiltrated, ~~inflamed~~phlebitic, problematic or has dislodged.

5. Physician order is required for placement of PIVs in the foot or ankle and have a maximum duration of 24 hours. ~~All IV bags are changed every 24 hours and PRN according to physician's orders. If the IV line is not changed in 96 hours, notify MD and document reason (i.e., poor vein access, resident refused IV site change), and notify the physician. If venous access is limited, request physician order to extend use of the current site~~

~~3.~~

4.~~6.~~ Aseptic "no touch" technique is used throughout the procedure. ~~Standard~~ Appropriate precautions must be observed. Gloves are worn to perform venipuncture and other vascular access procedures. Used IV equipment will be disposed of accordingly.

5.~~7.~~ Intake and output are monitored and documented every shift for a resident who is on IV therapy.

6.~~8.~~ Extended dwell or midline PIV catheters are **not** inserted at LHH.

7.~~9.~~ The maximum recommended dwell time for an extended dwell or midline PIV is <30 days. The RN is responsible for monitoring dwell time.

8.~~10.~~ Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.

9.~~11.~~ The RN will assess for continued necessity of the extended dwell or midline PIV, which should be removed when no longer necessary.

10.~~12.~~ No blood pressures will be obtained on the arm with an extended dwell or midline PIV.

PURPOSE:

To provide guidelines for licensed nurses with management of IV therapy.

RELEVANT DATA:

1. Peripheral venous catheter is usually inserted in veins of forearm or hand using a small flexible cannula. The end catheter of a peripheral IV line does not end in a great vessel.

2. Internal Jugular (IJ), External Jugular (EJ), Peripherally Inserted Central Catheter (PICC) lines are to be managed as central lines. {Refer to NPP J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Central Catheters (PICC) Management.}

3.2. Extended Dwell or Midline PIVs are inserted into the peripheral vascular system in the arm for short-term use. These catheters are longer (8cm-18cm) enabling the deeper veins in the arm to be safely accessed. They may be used for the administration of IV fluids, medications and blood products, and blood sampling (but may not always be possible depending on where the tip of the catheter resides).

- Extended dwell or midline PIVs may be indicated for patients requiring repeated replacement of PIVs, with poor or limited peripheral access, requiring larger vessel access to decrease the risk of phlebitis and infiltration, or for administration of prolonged antibiotic therapy.
- Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.
- The maximum recommended dwell time for an extended dwell or midline PIV is <30 days.
- Do not use extended dwell or midline PIVs to obtain blood cultures.
-

3. Internal Jugular (IJ), External Jugular (EJ), Peripherally Inserted Central Catheter (PICC) lines are to be managed as central lines. [Refer to NPP J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Central Catheters (PICC) Management.]

PROCEDURE:

A. Preparation for Peripheral Intravenous (PIV) Insertion

1. 1. Check physician orders prior to initiation initiating ofan IV therapy. The order must include the type of IV solution, rate of administration and/or duration of administration and must specify medication additives (i.e., name of drug, dosage, and specific fluid amount).insertion.

3. Perform hand hygiene prior to palpationng, inserting, replacing, or dressing any IV. Wear Don clean gloves.

4. Prepare IV fluids and medications in designated medication room; cleanse preparation site with antiseptic pads prior to each preparation.

5. Label IV tubing and fluid bag with the date time, type of additives, and the initial of the RN preparing the admixture.

Select an appropriate site for insertion. PIV insertion should be avoided on a limb with an AV fistula/graft or on the limb on the same side as a mastectomy/partial mastectomy, on an arm with edema or known blood clot, on an arm affected by stroke or on the same arm with a PICC in place.

5.

6.5. Obtain physician approval prior to insertions in the lower extremities.

6. Peripheral IV insertion procedure: ~~(Saline lock without extension tubing)~~ (Refer to ~~Skills (elsevierperformancemanager.com)~~Elsevier Skills: Intravenous Therapy - Short Peripheral Catheter Insertion ~~for IV insertion)~~

~~B.~~
B. Administering Medications

1. Refer to HWPP 25-15 Medication Administration.

2. Check physician orders prior to initiation of IV therapy. Physicians order must include:
   - Type of IV solution
   - Rate of administration and/or duration of administration
   - Medication additives (i.e., name of drug, dosage, and specific fluid amount).

3. Prepare IV fluids and medications in designated IV preparation site in medication room; cleanse preparation site with facility-approved disinfectants prior to each preparation.

4. Label IV tubing and fluid bag with the date/time of preparation, type of additives, and the initial of the RN preparing the admixture.

~~2.~~5. Ensure that IV fluids and additives are compatible by referring to compatibility chart, Lexicomp (online formulary) or verifying with the Pharmacy.

   - Pharmacy: ~~https://in-dphsp01.in.sfdph.net/lagunanet/pharmacy/SitePages/Home.aspx~~Pharmacy Home: https://sfdphintranet/sites/LHH-Pharmacy/SitePages/Home.aspx

   - Online drug formulary: https://online.lexi.com/lco/action/home

~~3.~~6. Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.

C. Access and Maintenance of IV Site

1. Accessing the PIV
   - Perform hand hygiene and don clean gloves
   - Scrub the access hub/injection port in a 'juice the orange" technique, which involves cleaning a needleless port by scrubbing it firmly with an antiseptic swab in a twisting, circular motion to effectively disinfect the port.
     - For 70% isopropyl alcohol swabs, scrub for 15 seconds and allow to dry
     - For CHG/alcohol swab, scrub for 5 seconds and allow to dry before accessing
   - Attach and instill prepared medications/fluids without recontamination of the prepped port.

2. Flushing the PIV
   - Flush all PIV catheters with 10 mL syringe of 0.9% Normal Saline (NS) for the following:
     - ~~P~~pre and post each administration of medication
     - a~~A~~fter the administration of blood products
     - for extended dwell or midline, flushing with 20 mL NS is recommended after a blood draw or blood transfusion.

- ~~W~~when converting a continuous infusion to an intermittent device
- e~~E~~very ~~8~~8 hours when catheter is not in use (locked)

~~Peripheral IV site may be in place up to 96 hours. If the IV line is not changed in 96 hours, notify MD and document reason (i.e., poor vein access, resident refused IV site change), and notify the physician. If venous access is limited, request physician order to extend use of the current site.~~

3. Dressing Change
   - Peripheral IV: Refer to Elsevier Skills: Intravenous Therapy - Dressing Change
     - The PIV should be covered with a transparent dressing and labeled with the date of IV insertion (DOI)
     - The PIV dressing should be changed if the dressing is not intact, loose, damp, soiled, or if the dressing does not adequately cover the site.
       - If only the dressing needs to be changed, ensure the label is dated with the DOI, not the date of the dressing change.
   - Extended dwell or midline ~~PIV maintenance and dressing change~~PIV: ~~(Refer to Skills (elsevierperformancemanager.com)~~Elsevier Skills: Midline Catheter - Dressing Change ~~for dressing change)~~
     - The extended dwell catheter that has a CHG (chlorhexidine gluconate) impregnated sponge should be changed every 7 days and PRN (if moist or not intact)
     - PPV should be changed with every dressing change

Field Code Changed

~~1. The maximum recommended dwell time for an extended dwell or midline PIV is <30 days.~~

~~2. All catheters used as intermittent devices are flushed:~~

- ~~Pre and post each administration of medication~~
- ~~After the administration of blood products~~
- ~~When converting a continuous infusion to an intermittent device~~
- ~~Every 8 hours when catheter is not in use (locked)~~

~~3.~~4. Evaluation of ~~IV~~ IV Site

- If complications are evident, notify the physician~~,~~. If a peripheral IV site, change the site. Refer to Visual Infusion Phlebitis Scale (VIPS) under Section ~~F~~ E Discontinuing IV site.

~~SUMMARY OF IV CHANGES~~ ~~*New tubing is required for new PIV site~~		
~~TUBING TYPE~~	~~DEFINED AS~~	~~WHEN CHANGED~~
~~IV bag~~		~~Q24 hours~~
~~Maintenance tubing~~	~~**Continuous** infusion, not disconnected~~	~~Q96 hours and with every site change~~
~~Primary IV administration set~~	~~Connected **intermittently** to infuse medications (e.g., antibiotics & electrolytes)~~	~~Daily and with every site change~~
~~Secondary tubing (attached to maintenance tubing)~~	~~If connected to primary tubing that is not disconnected from patient~~	~~Q96 hours and with every site change~~
~~Secondary tubing (attached to intermittently attached tubing or using multiple secondary tubing)~~	~~If disconnected from primary tubing or if primary tubing is only attached intermittently~~	~~Q24 hours and if site is changed~~

~~Continuous medication drips~~	~~If not disconnected~~	~~Q96 hours and if site is changed~~
~~TPN tubing~~		~~Daily – along with positive pressure valve (PPV) change when new bag is hung~~
~~Blood and blood products~~		~~Change with every unit~~

D. IV Administration Set Changes

1. Label all IV administration sets (bag and tubing) with date and time changed, and initial of RN who changed set

2. Definitions
   - Maintenance Tubing: IV tubing that is continuously connected and infusing at an hourly rate
   - Primary Intermittent Tubing: a primary administration set that is used intermittently and not connected/infusing continuously. Changed daily.
   - Secondary Tubing: a short administration set connected to the set is attached to the primary administration set
     - If secondary set is left attached to continuously infusing maintenance tubing and primed by back priming and not disconnected, then that secondary tubing is to be changed along with the maintenance tubing.
     - If secondary tubing is disconnected from the primary tubing, change tubing daily.

SUMMARY OF ADULT FLUIDS/MEDICATIONS AND TUBING MAINTENANCE ***New tubing is required for new PIV site**		
Solution/Medication Type	***Bag/Container Change Frequency***	***Tubing Change Frequency***
IV Fluids and Medications	• Every **96 hours** if running continuously (no disconnections) • Every **24 hours** if running intermittently • By beyond use date (expiration date) • With tubing changes • With newly placed vascular access device (VAD) placement	• **With medication concentration changes** • Q4 days if running continuously (i.e., no disconnections) • Daily if tubing is not continuously connected • When connecting to a newly placed vascular access device
Parenteral Nutrition (TPN) and Lipid Emulsions	• Daily	• Daily with new bag- including a new PPV and new filter
Blood and Blood Products	• Administration must start within **30 min** or release from blood bank, OR refrigerator, or certified blood bank cooler • All blood or plasma units must be transfused within **4 hours** of start	• Change with every unit

General IV Tubing		
Tubing Type	***Defined as***	***Tubing Change Frequency***
Maintenance tubing	**Continuous** infusion, not disconnected	Q 4 Days hours and with every site change
Primary Intermittent Tubing	Connected **intermittently** to infuse IV fluids or medications (e.g., antibiotics & electrolytes)	Daily and with every site change
Secondary tubing	Not disconnected from primary tubing and if using back-prime method to prime	Q 4 Days hours and with every site change
Secondary tubing	If disconnected from primary tubing or if primary tubing is only attached intermittently	Daily and with every site change

~~**Extended dwell or midline PIV maintenance and dressing change:** (Refer to Skills (elsevierperformancemanager.com) for dressing change)~~

E. Discontinuing Peripheral IV site: ~~(~~Refer to ~~Skills (elsevierperformancemanager.com)~~Elsevier Skills: Intravenous Therapy - Discontinuation ~~for discontinuing IV site)~~

1. Remove the PIV if there are signs of infection, infiltration, phlebitis, or if the catheter is no longer necessary

2. For any signs and symptoms of phlebitis and infiltration/extravasation:
   - STOP infusion and disconnect infusion from PIV
   - Attempt aspiration of the residual drug from the IV device prior to removal

3. When phlebitis is noted on assessment:
   - Use the Visual Infusion Phlebitis Scale (VIPS) to determine severity and notify the physician. Perform nursing interventions listed below to treat the phlebitis.
   - Document: degree of phlebitis, interventions performed, resident response, provider notification, and site reassessments.

- Reassess site routinely for changes during and after nursing interventions.
-

VISUAL INFUSION PHLEBITIS SCALE (VIPS)		
For any signs and symptoms of phlebitis and infiltration/extravasation: • Stop infusion immediately and disconnect from PIV • Attempt aspiration of the residual drug from the IV device prior to removal		
SITE OBSERVATION	**SCORE**	**STAGE/ACTION**
IV site appears healthy	0	**No sign of phlebitis**
ONE of the following signs are evident: • Slight pain near IV site • OR • Slight redness near IV site	1	**Possible first signs of phlebitis** **Action:** continue to use PIV and routinely assess
Both of the following are evident or one is significant: • Pain at IV site • Redness	2	**Mild phlebitis** **Action:** Remove and if necessary, replace PIV
ALL of the following are evident: • Pain along path of cannula • Redness around site • Swelling	3	**Moderate phlebitis** **Action:** Remove and if necessary, replace PIV **Consider treatment**: See interventions below
ALL of the following are evident and extensive: • Pain along path of cannula • Redness around site • Swelling • Palpable venous cord	4	**Advanced phlebitis OR early thrombophlebitis** **Action:** Remove and if necessary, replace PIV **Initiate treatment:** See interventions below
ALL of the following are evident and extensive: • Pain along path of cannula • Redness around site • Swelling • Palpable venous cord • Pyrexia (fever)	5	**Advanced thrombophlebitis** **Action:** Remove and if necessary, replace PIV **Initiate treatment:** See interventions below
Administer the following nursing interventions and document the response: • Elevate the extremity for 24-48 hours to aid in reabsorption • Thermal application: o Warm compress: aids in vasodilation, enhancing dispersion of the vesicant agent and decreasing drug accumulation in the local tissue; used for non-DNA binding vesicants such as vancomycin, nafcillin, and penicillin o Cold compress: aids in vasoconstriction, limiting drug dispersion in the extended tissue; used for contrast media, hyperosmolar fluids, and most DNA-binding vesicants. Consult pharmacy for treatment recommendations for chemotherapy extravasation. o Thermal applications should be applied for 15-20 minutes every 4 hours for 24-48 hours until symptoms resolve o Notify provider		

Visual Infusion Phlebitis Scale (V.I.P. Scale)

Observation	Score	Stage *Action / Intervention*
I.V. site appears healthy	0	**No sign of phlebitis** *Continue to use PIV and routinely assess*
ONE of the following signs are evident: • Slight pain near IV site OR • Slight redness near IV site	1	**Possible initial signs of phlebitis** *Continue to use PIV and routinely assess*
TWO of the following are evident: • Pain at IV site • Swelling • Erythema	2	**Mild phlebitis** *Remove and, if necessary, replace IV*
ALL of the following signs are evident: • Pain along path of cannula • Induration	3	**Moderate phlebitis** *Remove and, if necessary, replace IV* *Consider treatment interventions*
ALL of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Palpable venous cord • Induration	4	**Advanced phlebitis OR early thrombophlebitis** *Remove and, if necessary, replace IV* *See nursing interventions below*
ALL of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Palpable venous cord • Induration • Pyrexia (fever)	5	**Advanced thrombophlebitis** *Remove and, if necessary, replace IV* *See nursing interventions below*

Nursing Interventions for V.I.P. Scale > 3

- Elevate the extremity for 24-48 hours to aid in reabsorption
- Apply thermal compress for 15-20 minutes every 4 hours for 24-48 hours until symptoms resolve

- Cold compress: aids in vasoconstriction, limiting drug dispersion in the extended tissue; used for contrast media, hyperosmolar fluids and most DNA-binding vesicants.
- Warm compress: aids in vasodilation, enhancing dispersion of the vesicant agent and decreasing accumulation in the local tissue; used for non-DNA binding vesicants (e.g., vancomycin, nafcillin, penicillin)

- Refer to IV Extravasation (non-chemo) Guidelines for further guidance
- Consult pharmacy for treatment recommendations for chemotherapy extravasation

F. Reporting and/or Documentation

1. Electronic Health Record (EHR):

- Peripheral IV Insertion Pprocedure:
  - Document date, time, location, catheter gauge, number of insertion attempts, and name of the inserter.
  - Document the Peripheral IV properties under Lines, Drains and Airways (LDA)
  - Document the Peripheral IV assessment under LDA
  - Document the resident's tolerance, including pain assessment, of the procedure and any difficulty or complications encountered, interventions implemented and physician notification.
- Extended Ddwell or ~~m~~Midline PIV ~~insertion~~:
  - Continue documenting the Midline/Extended Dwell Peripheral IV properties
  - If receiving the patient without the insertion documented in LDA, initiate the Midline/Extended Dwell Peripheral IV properties with information received in report and/or transfer documents
- Peripheral IV, ~~and e~~Extended ~~d~~Dwell or ~~m~~Midline PIV Removal ~~p~~Procedure:
  - Document the removal in the Peripheral IV properties under LDA, including the removal date, time, VIPS and reason.
  - Document pain assessment, any difficulty or complications encountered, interventions implemented and physician notification.
- Peripheral IV, ~~and e~~Extended ~~d~~Dwell or ~~m~~Midline PIV Site ~~a~~Assessments every shift:
  - Document the Peripheral IV assessment under LDA
  - Document the resident's tolerance of the procedure and any difficulty or complications encountered, interventions implemented and physician notification.
- Intake and Output every shift, including all IV fluids, medications and flushes

REFERENCE:

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- ~~Midline Catheter: Removal~~
- ~~Midline Catheter: Maintenance and Dressing Change~~
- ~~Intravenous Therapy: Short Peripheral Catheter Insertion~~
- ~~Intravenous Therapy: Maintenance and Dressing Change~~
- ~~Intravenous Therapy: Discontinuation~~

Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Clinical Review: Martha Beck, MA, BSB, RN, CNOR, June 2021

CROSS REFERENCE:

Hospital-wide Policy and Procedure
25-05 Hazardous Drugs Management
25-15 Medication Administration

Nursing Policy and Procedure
J 7.0 Central Venous Access Device (CVAD) Management
J 7.1 Peripherally Inserted Central Catheters (PICC) Management

Zuckerberg Nursing Policies and Procedures
16.1 Management and Care of Peripherally inserted Central Catheters (PICC)
16.3 Extended Dwell/Midline Peripheral Intravenous Catheters
16.7 Placement and Maintenance of Peripheral Intravenous Catheters
16.9 Management and Care of Central Venous Access Device (CVAD)

APPENDIX/APPENDICES:

NONE

Revised: ~~2000/~~08/2000, ~~2010/~~06/2010; ~~2015/~~03/10/2015; ~~2019/~~03/12/2019; ~~2024/~~05/01/2024; 03/30/2026

Reviewed: 2024/12/10

Approved: 2024/12/10

CENTRAL VENOUS ACCESS DEVICE (CVAD) CARE AND MANAGEMENT

POLICIES:

1. A physician's order is required for administration of medications/, fluids or /blood products, and withdrawal of blood, to and fromfrom a central venous access device (CVAD).
1.

2.
2. Registered Nnurses (RN) perform all aspects of CVAD care including assessment, accessing, flushing, blood withdrawal, dressing change, needleless connector change, and disinfecting cap changes.
3. : administration of fluid, blood and medication; dressing and cap change; blood withdrawal; and assessment for complications.

3. A registered nurse will assess the condition of CVAD site every shift. Any evidence of inflammation or infection will be documented and the physician will be notified as soon as possible.

4. All CVADs are assessed for positive blood return every shift. Notify physician if unable to obtain blood return.

4. Licensed Vocational Nurse (LVN) may monitor infusions via CVAD that the RN has initiated, including notification of a RN or MD of medication side effects or of problems with the CVAD line.

5. All blood work from the CVAD must be drawn by the RN. Phlebotomists and LVNs are not permitted to withdrawal blood from a CVAD.

6.5. Hands are to be washed beforeAlways perform hand hygiene and don clean gloves just prior to palpating, accessing or removing the dressing of any CVAD. palpating, inserting, changing or dressing any intravascular device and gloves are to be worn when changing dressings.

6. The dressing at the catheter site must be dry, sterile and air occlusive and is changed every 4 days, and PRN if soiled, loose or wet [except for PICC line dressings which are changed every 7 days (refer to Nursing Policy and Procedure 7.1 Management of Peripherally Inserted Central Catheters Management)]. Each lumen of a multi-lumen central venous catheter is to be labeled to identify its use, preferably by tracking previous use or manufacturer's recommendations for use, when known.

7. Use a maximum positive pressure valve (PPV) needleless connector on all lumens. Clamp the lumen **after** disconnecting the flush syringe to properly engage the positive pressure feature. This reduces the risk of lumen clotting at the catheter tip. A needleless system is to be used to decrease potential blood borne pathogen exposure to staff.

8. Positive pressure valves are changed routinely with dressing changes. Clamp all lumens prior to changing PPV. [**Exception**: If the line is being used for total parenteral nutrition (TPN), the RN will change the PPV daily with each new TPN tubing change.]

9. All lumens of a CVAD must be clamped when not in use in order to reduce the risk of air embolus if end cap falls off.

10. When flushing a CVAD do not use a syringe smaller than 10 mL. Using a 10 mL syringe provides the appropriate pounds per square inch (PSI) to minimize risk of catheter blowout and perforation. Slow

injection of intravenous medications in a smaller pre-filled syringe can be appropriate but always follow with 10 mL of 0.9% Normal Saline (NS) flush syringe in a push-pause technique to create a turbulent flow within the lumen to promote lumen patency.

~~7.~~

~~8. I.V. tubing is to be changed at least every 72 hours and more frequently as needed. The I.V. solution bag is to be changed every 24 hours and is to be labeled to identify date, time and RN's initials. When medications are added to the bag, a medication added sticker is to be completed and attached to the bag. Label dressing with date of change and nurse's initials.~~

~~The dressing at the catheter site must be dry, sterile and air occlusive and is changed every 3 days, (except for PICC line dressings which are changed every 7 days) and PRN if soiled, loose or wet. Use a central line dressing tray and Biopatch.~~

~~9.~~

~~10. Positive pressure valve/hub is changed every 72 hours with the dressing change unless the cap has already been replaced during blood withdrawal.~~

~~11.~~

~~12. Each lumen of a multi-lumen central venous catheter is to be labeled to identify its use, preferably by tracking previous use or manufacturer's recommendations for use, when known.~~

~~13. CVAD patency is maintained by flushing with 0.9% saline.~~

~~If physician orders "Flush central line per protocol", for:~~

11. No Heparin is needed for the MaxPlus™ ~~positive pressure valve~~PPV.

12. **Groshong**: Heparin is not used in general. Flush used lumens with 5 m~~l~~L of 0.9% ~~normal saline~~NS in a 10 m~~l~~L syringe before and after each use, and unused lumens every 7 days. Flush with 20 m~~l~~L of 0.9% ~~normal saline~~NS after blood withdrawal.

13. For administration of parenteral nutrition, refer to Hospitalwide Policy & Procedure 25-08 Management of Parenteral Nutrition.

14. An accidentally expelled or broken catheter is an emergency. Activate Code Blue. Apply firm pressure with sterile gauze. Keep patient/resident calm.

15. Discontinuation of CVAD can only be done by a Laguna Honda Hospital (LHH) physician.

~~**Unused lumens**: Flush with 10 or 12 ml of 0.9% normal saline utilizing the push – stop – push – stop technique once every shift~~

~~**Intermittently Used Lumens**: Flush with 10 or 12 ml of 0.9% normal saline utilizing the push – stop – push – stop technique before and after any I.V. medication is given.~~

~~No Heparin is needed for the MaxPlus positive pressure valve.~~

~~Groshong: Heparin is not used in general. Flush used lumens with 5 ml of 0.9% normal saline in a 10 ml syringe before and after each use and unused lumens every 7 days. Flush with 20 ml of 0.9% normal saline after blood withdrawal.~~

~~Intake, output and vital signs are to be obtained every shift until stabilized and as needed.~~

~~A registered nurse will assess the condition of CVAD site every shift. Any evidence of inflammation or infection will be documented and the physician will be notified as soon as possible.~~

~~An accidentally expelled or broken catheter is an emergency. Apply firm pressure with sterile gauze. Keep resident calm. Have 2nd staff member notify physician STAT.~~

~~IV fluids must be administered by an infusion pump.~~

~~All ports must be clamped when not in use to prevent potential air embolus.~~

~~13. Discontinuation of CVAD can only be done by LHH physician.~~

PURPOSE:

To ensure standards for assessment, accessing and maintenance of CVADs are met while ensuring safety and education of the patient/resident and staff.~~effectively administer intravenous fluids, medications, and blood products, or withdraw blood specimen through a central venous access device (CVAD).~~

BACKGROUND:

CVADs are intravenous lines that terminate at or near the heart or in one of the great vessels.

- CVADs are inserted when peripheral access is not appropriate (for the chemical composition/pH of IV meds prescribed) or not obtainable.
- CVADs are inserted and managed aseptically.

~~Percutaneously inserted central venous catheters (excluding PICC lines) are used for therapy lasting less than 4 weeks. These catheters are inserted at bedside and sutured in place by MD.~~

~~RNs and MDs who have been oriented to withdraw blood from CVADs may withdraw blood specimens for laboratory tests as ordered by the physician.~~

~~Blood cultures may **NOT** be drawn from CVADs. This includes peripherally inserted (PICC) or subcutaneously implanted (IVAD) lines.~~

~~Tunneled catheters have a Dacron cuff under the skin and must be inserted in an operating room removed by a physician. Tunneled catheters (e.g. Hickman, Groshong) are used for long term therapy. RNs may **not** discontinue tunneled catheters.~~

PROCEDURES:

I. ~~FLUSHING~~ACCESSING CVAD AND FLUSHING
(note: implanted ports that are not used or accessed are flushed every 4 weeks) ~~THE CVAD~~

A. Prior to every access of a CVAD lumen, port, or connection to IV tubing; the hub surface or lumen end, and threads, must be disinfected using the following "**Accessing Bundle**" steps:
   a. Perform hand hygiene

b. Don clean gloves
c. "Juice the Orange" is to apply aggressive friction to all exposed hub surfaces and ends of lumens before applying new PPV. Use either;
   - 70% alcohol swabs with the 'Juice the Orange' technique for 15 seconds
     OR
   - PDI device swab (CHG = 70% alcohol swab) for 5 seconds scrub and 5 seconds dry
d. Access the hub using aseptic technique to avoid re-contamination of the prepared surfaces

B. Flush CVAD with 10 mL syringe of 0.9% NS for the following:
a. Before and after intermittent medication(s)
b. Before starting an infusion and resuming continuous IV fluid
c. After the administration of blood products (flush with 20 mL 0.9% NS total)
d. After blood draw (flush with 20 mL 0.9% NS total)
e. Every 8 hours when catheter is not in use (locked)

~~**Equipments**~~

C. Use the **"SAS"** method when administering intermittent or IV push medications:
- **S. Saline** = Saline flush with 10 mL to assess patency
- **A. Administer =** Administer the IVP/IVPB medication.
- **S. Saline =** Saline flush with 10 mL to clear the medication from the catheter.

~~(2) 10 or 12 ml syringes with 0.9% normal saline~~
~~Alcohol wipes~~
~~Clean Gloves~~

~~Procedures~~

~~Identify resident and check armband. Explain procedure to resident.~~

~~Wash hands before and after procedure and use gloves. Clean the access hub with alcohol using friction each time you access the line ("Juice it like an orange") to get adequate friction.~~

~~Always use a 10 or 12 ml syringe to flush using the push – stop – push – stop technique. (Firm pressure to push followed by a pause, then firm pushing again will help keep the line patent).~~

~~If a resident receives intermittent I.V. therapy such as antibiotics, flush the line with normal saline before and after its use.~~

~~S. Saline - flush with 10ml 0.9% normal saline to access patency.~~
~~A. Administer - administer the IVP/IVPB medication.~~
~~S. Saline - flush with 10ml 0.9% normal saline to clear the medication from the catheter.~~

~~To flush when no medications/ antibiotics are ordered (or between medication administration times): Flush each lumen *at least* once each shift and PRN with 10 or 12 ml of 0.9% normal saline.~~

~~MEDICATION AND FLUID ADMINISTRATION~~

~~Equipments~~

~~I.V. pump~~
~~I.V. solution/medication~~
~~I.V. tubing~~
~~Clean gloves~~
~~(2)10 or 12 ml syringes with 0.9% normal saline~~
~~Alcohol wipes~~

~~Procedures~~

~~Identify resident and check armband. Explain procedure to resident.~~

~~Wash hands before and after procedure and use gloves. Follow all applicable medication and infection control policies.~~

~~The largest lumen of a multi-lumen central line is reserved for blood administration or withdrawal. Label each lumen for fluid or medication administration, and only use the lumen for its labeled use.~~

~~Prepare I.V. fluids on a clean surface such as the portion of the treatment room counters designated "I.V. Prep Area". Clean work area before and after use with 70% ethyl alcohol.~~

~~To safely add medications to I.V. fluids, use appropriate pharmacy drug compatibility resources.~~

~~Bolus I.V. medications are given only by a registered nurse in emergency situations under a physician's supervision.~~

~~Prime I.V. tubing.]~~

~~Thread I.V. tubing unto the infusion pump and set the desired rate.~~

~~Use clean gloves and clean the access positive pressure valve/hub with alcohol using friction each time you access the line. "Juice it like an orange" to get adequate friction. .~~

~~Flush the catheter with a 10 or 12 ml syringe of 0.9% normal saline using the push – stop – push – stop technique.~~

~~For an I.V. infusion, connect the I.V. tubing to the central venous line via the positive pressure valve/hub. For injection, attach syringe directly to the venous line via the positive pressure valve/hub.~~

~~Start the infusion.~~

~~To discontinue the infusion, use clean gloves to disconnect the I.V. tubing from the injection port. Cleanse the cap with alcohol (juice it like an orange) and flush with 10 or 12 ml syringe of 0.9% normal saline using the push – stop – push – stop technique. For intermittent medication administration, "S.A.S." is used to maintain patency. Please refer to the procedure for flushing a CVAD.~~

~~I.~~II. BLOOD WITHDRAWAL (Refer to Elsevier Skills: Blood Specimen Venous Catheter)

A. ~~Equipments~~Equipment

- ~~-~~Completed lab requisition and labels
- ~~-~~Clean gloves
- ~~-(2)10 ml or 12 ml syringes with 0.9 % normal saline~~Sterile syringe and transfer adaptor
- Discard specimen tube (5-10 mL)

~~(2) 10 ml or 12 ml syringe~~

- ~~-~~Appropriate ~~vacutainer~~ specimen tubes
-
- ~~-~~70% alcohol swab or PDI device (CHG + 70% alcohol swab) swabs~~- Transfer set (i.e. Angel wing, pink indicator outside packaging)~~
-
- ~~-~~10 mL syringes of NS flush
- New PPV primed with NS
- ~~Vacutainer tubes~~

Procedure~~Positive pressure valve/hub (MaxPlus)~~

B.

~~Alcohol wipes~~
~~Chux or pad~~

~~**Procedures**~~

~~1. Identify resident and check armband. Explain procedure to resident.~~

~~2. Clean bedside table with hospital approved disinfectant and paper towel.~~

~~3. Wash hands and lower forearms with soap and water, and then open supplies using aseptic technique.~~

~~4. For double or triple lumen CVAD, dedicate 1 lumen for blood draw. The other lumen is to be used for IV medication and IV fluid maintenance.~~

~~5. If an IV infusion is running stop/pause IV infusion for at least one minute to allow the fluid to be carried further into the resident's circulation, prior to withdrawing blood. Clamp all lumens (except the one for blood withdrawal) if multi-lumen catheter.~~

~~6. Put on clean gloves.~~

~~7. Clean the positive pressure valve/hub with alcohol wipe ("Juice it like an orange") to remove any debris.~~

~~8. Flush the designated port with 10 ml 0.9 % normal saline, withdraw 10 ml and discard in the sharp disposal container.~~

~~9. Using 10-12ml syringe, withdraw specimen needed.~~

~~10. After obtaining the specimen attach the syringe to the transfer set to transfer the specimen to vacutainer tube. Then flush catheter with10ml 0.9% normal saline using the push – stop – push – stop technique.~~

~~11. Cleanse the injection port with an alcohol wipe and replace positive pressure valve /hub. Restart the IV infusion, if ordered.~~

~~12. Dispose of equipment and supplies according to Body Substance Precautions. Discard blood tube in sharps container.~~

~~13. Send labeled specimens in plastic bag with requisition to laboratory. Follow the Stat Chemical Lab Protocol on page H 10.0 if needed.~~

1. Perform positive patient/resident identification using two identifiers
2. Explain procedure to patient/resident.
3. Clean bedside table with hospital approved disinfectant and allow to air dry
4. Perform hand hygiene
5. Gather and prepare supplies using aseptic technique
6. Prepare saline flush syringes (expel air and maintain content and tip sterility).
7. Stop/Pause all infusions prior to withdrawing blood
   - Clamp all lumens (except the one for blood withdrawal) if multi-lumen catheter.
   - Do not withdraw blood from central line lumens designated for TPN
8. Follow the **"Accessing Bundle"**
9. Attach 10 mL NS flush syringe and push-pause to clear lumen and use the same syringe to withdraw 5 mL of blood and discard.
10. Decontaminate hub after disconnecting waste syringe using "Juice the Orange" prior to connecting sterile syringe for specimen collection. Keep control of PPV at all times to avoid re-contamination.
11. Draw back gently, slowly and steady on the syringe until enough blood has been acquired for sampling.
12. Disconnect sample syringe. Use needless transfer adaptor to aspirate blood from syringe to the lab tubes. Lab tubes should be labeled at bedside to ensure positive patient/resident identification.
13. Decontaminate hub used for blood draw using "Juice the Orange"
14. Flush with 10 mL NS syringe twice (20 mL NS total) to clear PPV and lumen of blood.
15. Disconnect flush syringe. Decontaminate hub used for blood draw. Connect and resume infusions, if applicable.
16. Dispose of equipment and supplies
17. Remove gloves and perform hand hygiene.

***** Unless ordered by the physician,~~,~~ blood cultures may NOT be drawn from CVADs ~~avoid drawing blood cultures from CVADs (microbial colonization will often result in a false positive result).~~**

~~II.~~III. ~~CENTRAL VENOUS~~ DRESSING CHANGE

A. ~~Equipments~~Equipment

- ~~————~~Central Line Dressing Kit - includes sterile gloves and CHG impregnated dressing
- Optional: Sterile Glove (sized per preference)
- Face mask for patient/resident
- Clean gloves
- Adhesive-backed securement device (if needed)

- Needleless Connector (PPV) (quantity = number of lumens)
- 0.9% Normal Saline flushes (2 per lumen)
- Absorbent pad or towel

~~Central Line Tray #DYNDC1217B (with Chloraprep and Biopatch)~~
~~Clean gloves~~
~~Extra mask for resident if unable to reliably turn head away from CVAD~~

~~B.~~ Procedure~~s~~
B.

1. Evaluate the access site for complications, including infection, catheter migration, mechanical damage of leaking, catheter-associated deep vein thrombosis, and phlebitis
2. Explain procedure to the patient/resident

~~C.~~ Clean bedside table with hospital-approved disinfectant and
~~Identify patient and check armband. Explain procedure to patient.~~

~~Clean bedside table with hospital approved disinfectant and paper towel.~~

~~Place chux under resident's shoulder on catheter side as needed.~~

~~Wash hands and lower forearms, and then apply clean gloves.~~

~~Prior to removal of old dressing, palpate for tenderness. Do not touch site after the dressing has been removed and maintain a "no touch" technique and clean gloves throughout the procedure. (Use sterile gloves if the situation warrants touching the site directly).~~

~~Ask patient to turn head away from site during procedure. Mask resident if unable to turn head away from CVAD. Remove old dressing by pulling towards the insertion site, taking care not to dislodge or separate catheter and its attachment.~~

~~Inspect insertion site for any changes in catheter or suture position, skin irritation or breakdown, bleeding or edema, redness, swelling, tenderness and odor; observe for leaking connections or kinks in catheter, or any drainage.~~

~~Wash hands and apply new clean gloves and open central line dressing kit.~~

~~To break the seal of Chloraprep, hold and squeeze the handle of the swab until chlorhexidine fill up the sponge pad. Cleanse the insertion site using friction and let air dry.~~

~~Apply Biopatch (making sure the **Blue** side up and the **White** foam side is next to the resident's skin) over the insertion site. The antimicrobial patch is used to cover the CVAD insertion site and to absorb exudates. The catheter should rest upon the slit portion of the antimicrobial dressing.~~

~~Apply bio-occlusive transparent dressing over the area, pressing on the dressing from the center and working out to sides to prevent bubbles and loss of dressing occlusion. Do not frame dressing with tape. Benzoin may be used to secure dressing at outer edge.~~

~~**NOTE:** If patient is allergic to the bio-occlusive transparent dressing, cover site with a sterile 4X4 dressing, tape and change every 48 hours. Do not routinely apply antimicrobial ointments to CVAD insertion sites.~~

~~Central line dressing should be changed every 7 days and prn. Change dressings when they become damp, loose, or soiled, or whenever they must be removed for visual inspection of the catheter insertion site.~~

~~Avoid submerging insertion site/ dressing in water or spraying water over site. Plastic (i.e. clear plastic wrap) may be placed over the CVAD during tub bath or shower but dressing must be changed if it becomes wet accidentally.~~

~~Notify physician if a central line or a peripheral I.V. that has been anchored by a suture appears infiltrated or phlebitic.~~

~~Record the date of the next dressing change in the treatment record.~~

3. allow to air dry
4. Perform hand hygiene
5. Open Central Line Dressing Kit on prepared bedside table using aseptic technique
6. With tips of fingers remove the sterile gloves and facemask from the kit after opening. Lay gloves on clean surface.
7. Apply mask to patient/resident. Instruct patient/resident to turn the head away from the site during the procedure if no mask applied.
8. Open the adhesive-backed securement device and drop the device onto the dressing kit tray using aseptic technique (if needed)
9. Hand hygiene and apply clean gloves.
10. Look at the skin around the CVAD access site for signs and symptoms of skin injury
11. Prior to the removal of the old dressing, palpate the site for tenderness or induration
12. Stabilize the catheter with the nondominant hand
13. Remove the old dressing by lifting the corner of the dressing and gently pulling the dressing out and parallel to the skin. Repeat on all sides until the dressing is removed.
14. If an adhesive-backed securement device is present, unlatch the catheter from the stabilization device and remove the device.
15. Discard the dressing and securement device in the appropriate receptacle
16. Remove gloves, perform hand hygiene and apply sterile gloves
17. Using the non-dominant hand to secure the catheter from being dislodged, use the dominant sterile hand to cleanse skin with Chloraprep using gentle friction for 30 seconds and let it completely air dry for 1-2 minutes (to prevent skin reaction). **NOTE:** ensure that Chloraprep is completely dry before continuing
18. Using No Sting barrier film, prep skin under catheter wings and outer edge of where the transparent film dressing will be. NOTE: This skin prep acts as a skin protectant to the adhesive. Allow to completely dry.
19. Apply adhesive-backed securement device if needed
20. Using your sterile dominant hand only – apply CHG impregnated sponge (BIOPATCH®), blue side up or the patch states “This Side Up” over the insertion site with opening facing the wings of the line (to make it easier to remove BIOPATCH® on next dressing change).
21. Apply transparent dressing over the insertion site, pressing on the dressing from the center and working out to sides to prevent bubbles and loss of occlusion. Apply “No Sting Barrier Film” to edges of the dressing to enhance adhesion and to reduce the risk of rolling up
22. Label the dressing with initials and date of dressing change
23. Remove gloves and perform hand hygiene
24. Apply clean gloves and using aseptic technique, prime new PPV and change:
    i. Prime new PPV with 10 mL NS while maintaining the sterility of the tip until ready to connect to lumen
    ii. Clamp lumen
    iii. Remove old PPV and discard
    iv. Scrub hub for 15 seconds with alcohol pad and allow to air dry for 15 seconds

25. Apply new primed PPV and flush in remaining 10 mL NS (ensure there is blood return on each lumen).
26. Notify physician if site has exudate, redness, swelling, or if patient/resident complains of pain.
27. Dispose of equipment and supplies in appropriate receptacle
28. Remove gloves and perform hand hygiene
29. Document appearance of insertion site in electronic health record and enter the date of the next scheduled change in the Kardex

~~**D.**~~

~~III.~~IV. DISCONTINUATION OF CVAD – *Can only be done by LHH physician.*

~~**A. Equipments**~~

- ~~Suture removal kit~~
- ~~Alcohol wipes or Chloraprep~~
- ~~Clean Gloves~~
- ~~2X2 gauze~~
- ~~Tape~~

~~**B. Procedures**~~

~~1. Identify patient and check armband. Explain procedure to patient.~~

~~2. Wash hands and lower forearms with soap and water, and then open supplies using aseptic technique.~~

~~3. Prepare tape and dressing, wash hands and apply clean gloves. Swab the site with Chloraprep or alcohol wipes. If indicated, use a suture removal kit to cut sutures and remove with tweezers.~~

~~4. Instruct/coach the resident to take a deep breath and then exhale. Assist the physician while she/he removes the catheter during exhalation while assisting the physician; Apply pressure with gauze sponges in dressing kit.~~

~~5. Instruct resident if appropriate, to promptly report bleeding or swelling.~~

~~6. Assess site for continued bleeding, swelling or hematoma, and instruct patient to promptly report any bleeding or swelling.~~

~~7. Dispose of used equipment according to Body Substance Precautions.~~

~~IV.~~V. DOCUMENTATION

A. ~~Treatment Record: RN to document~~Document procedure performed on the appropriate Nurse's Notes; include the following information: date/time of dressing change or catheter discontinuation, appearance of site and condition of catheter tip

1. Document procedure (e.g., dressing changes, blood withdrawal, arm circumference) performed on EPIC Avatar
2. Document assessment of site every shift.
3. Document notification of physician for any unexpected complications and any action taken in the Nurse's Notes
4. Document when education is provided to the patient/resident and/or responsible party in the Nurse's Notes. If education handouts were provided, include the name of the handout in the

patient/resident education documentation. Include a verification statement of patient/resident and/or responsible party of the education provided.

5. Document medication administration on the EPIC Medication Administration Record (MAR)
6. Document intravenous fluid administration on the appropriate medical record.
7. Document appearance of the CVAD site in the electronic health record every shift.

Document in the care plan the need for a CVAD and individualized interventions for prevention of infection.~~:~~

8.

9. Weekly summary documentation on progress towards care planned goal(s)

~~1. CVAD dressing change procedure performed (every 7 days and PRN).~~

~~2. Positive pressure valve/hub changed (every 72 hours and PRN).~~

~~3. Blood withdrawal, if regularly scheduled (i.e. CBC every Monday).~~

~~**B. Medication Record:** RN to document:~~

~~1. Medication / antibiotic administration, as ordered.~~

~~**C. IV Flow Sheet:** RN to document:~~

~~1. Fluid administration.~~

~~2. General condition of line ("o.k."), at least each shift.~~

~~**D. Resident Care Plan**~~

~~Indicate that resident has a PICC line and individualized interventions for prevention of infection.~~

~~**E. Integrated Progress Notes**~~

~~1. Licensed nurse documents the weekly / monthly summary progress toward or away from the care planned goal.~~

~~2. RN documents emergent problems, such as notification of physician for any PICC problems (exudates, tenderness, redness, swelling, if the catheter has been dislodged, the inability to flush or the inability to withdraw blood).~~

~~3. RN documents blood withdrawal, if not already documented as regularly scheduled blood work on the Treatment Record.~~

~~**Venous Access Device Care Chart**~~

	Multilumen	**Port**	**Groshong**	**PICC**	**Peripheral IV**
	10 ml	10 ml	10 ml	10 ml	3 ml
	Flush all lines with NS before and after each use				
	10 ml	10ml	20ml	10ml	10ml
	Q 24 hrs	Q 4 wks	Q 7 days	Q 24 hrs	8 hrs
	Q 72 hrs & PRN	Q wk & PRN	Q 72 hrs & PRN	Q wk & PRN	Q 3 days & PRN
	Change 3 days				
	72 hrs & PRN	N/A	72 hrs	72 hrs & PRN	72 hrs & PRN
	N/A	Q 7 days	N/A	N/A	N/A
	Q 24 hrs	Q 24 hrs if being used	N/A	Q 24 hrs	Q 24 hrs
	Q 3 days	Q 3 days if being used		Q 3 days	Q 3 days

ATTACHMENT/ATTATCHMENTS:

NONE

REFERENCES:

Elsevier (2025) Central Venous Catheter: Dressing Change https://point-of-care.elsevierperformancemanager.com/skills/77/extended-text?skillId=CC_065&virtualname=lhh#scrollToTop – electronic access on June 11, 2026

Elsevier (2025) Venous Catheter: Flushing and Locking https://point-of-care.elsevierperformancemanager.com/skills/24407/extended-text?skillId=CCMS_175&virtualname=lhh#scrollToTop – electronic access on June 11, 2026

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MMWR, Aug. 9 2002. Guidelines for the Prevention of Intravascular Catheter-Related Infections [available] http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5110a1.htm.
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multicenter study. *Medical Science Monitor*, 15(3): CR107-110. [available] http://www.medscimonit.com/fulltxt.php?ICD=869585.

CROSS REFERENCES:

Nursing Policies and Procedures:
C 9.0 Transcription and Processing of Orders

Nursing Policies and Procedures: E 6.0 Parenteral Nutrition
Nursing Policies and Procedures: J 1.0 Medication Administration
Nursing Policies and Procedures: J 6.0 Intravenous Therapy Maintenance

Nursing Policies and Procedures: J 7.1 Peripherally Inserted Central Catheters (PICC) Care and Management

Zuckerberg Nursing Policies and Procedures
16.1 Management and Care of Peripherally inserted Central Catheters (PICC)
16.2 Management and Care of Ports (Portacaths and Mediports)
16.9 Management and Care of Central Venous Access Device (CVAD)

Revised: 08/2000; 11/29/2011; 06/11/2026

Reviewed: 11/29/2011

Approved: 11/29/2011

PERIPHERALLY INSERTED CENTRAL CATHETERS (PICC) MANAGEMENT

POLICY:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) Patient Flow Coordinator will note the type of Central Venous Access Device (CVAD) that the patient/resident has, determine any unique/special requirements for care or supplies prior to admission, and communicate any needs to the receiving neighborhood Clinical Nurse Specialist (CNS) and the Department of Education and Training (DET) prior to the patient/resident's arrival at LHH.

2. The Registered Nurse (RN) who is skilled and knowledgeable in the care of the Peripherally Inserted Central Catheter (PICC) is responsible for the management of PICCs including assessment, accessing, flushing, blood withdrawal, dressing change, needleless connector change, and disinfecting cap changes.

3. Upon admission to LHH with a PICC line, with each dressing change, and prn the RN will measure and document the length of the PICC line in "cm out" from the insertion site to the wings, and the mid arm circumference.

~~1. The Registered Nurse (RN) who is skilled and knowledgeable in the care of the Peripherally Inserted Central Catheter (PICC) is responsible for the management of PICCs, including assessment, accessing, flushing, blood withdrawal, dressing change, connector change, and alcohol cap changes.~~

4. The RN will immediately report to the covering physician at the first sign of the PICC line becoming sluggish or partially occluded, to evaluate the need for further assessment and/or the need for de-clotting with Cathflo® Activase (Alteplase).

5. Only RNs who are skilled and knowledgeable in the de-clotting procedure of Central Venous Access Devices (CVAD), may administer Cathflo® Activase (Alteplase) to the PICC line.

~~2.~~1. ~~Only RNs who have been trained by the PICC nurse, or designee, will discontinue PICC lines.~~

~~3.~~6. PICC line intravenous (IV) medications (not including flushes, push medications, or heparin lock), parenteral nutrition, and IV fluids must always be administered via pump.

~~4.~~7. Laguna Honda (LHH) defines To-Keep-Open (TKO) IV fluid, as delivering at least 30 mL per hour via pump when utilizing a PICC line.

~~5. The RN will assess the PICC site every shift for signs of redness, exudate, and catheter migration. The RN will immediately report to the covering physician at the first sign of the PICC line becoming sluggish or partially occluded, to evaluate the need for further assessment by a PICC Nurse and/or the need for de-clotting with Cathflo® Activase (Alteplase).~~

~~6. Only RNs who are skilled and knowledgeable in the de-clotting procedure of Central Venous Access Devices (CVAD), may administer Cathflo® Activase (Alteplase) to the PICC line (refer to CVAD de-clotting policy and procedure).~~

~~7.~~ In collaboration with the healthcare team, ~~Blood cultures should not be drawn from a PICC line or from the PICC arm.~~

~~8. No blood pressure, peripheral blood draws, or peripheral IVs will be done in the PICC arm.~~

~~9.~~
~~The RN will assess the PICC site every shift for signs of redness, exudate, and catheter migration.~~

~~PICC dressing changes will be completed every 7 days, and as needed if there is evidence of bleeding, moisture, or the dressing integrity has become compromised.~~

~~10. The RN will change the PICC StatLock® with every dressing change.~~

~~11. The RN will apply a new BIOPATCH® with each new dressing change.~~

~~12. The RN will change positive pressure connectors once per week and PRN for non-TPN lines. If the line is being used for TPN, the RN will change the positive pressure connector daily with each new TPN tubing change.~~

~~13. The RN will change single-use alcohol caps attached to the positive pressure connector with each access, or weekly if the line is not in use.~~

~~14. The RN will adhere to the PICC Line Flushing Maintenance Protocol, as described in the procedure section of this policy.~~

~~15. To assist in preventing central-line blood stream infections, LH will adhere to the Institute for Healthcare Improvement (IHI) central line bundle (see general guidelines section).~~ t

~~16.~~8. ~~To reduce the number of unnecessary central line catheter days in order to reduce the risk of infection and venous thromboembolism, the~~he RN will assess the need for continued use of the PICC line on a weekly basis for long-term care including Pavilion Mezzanine SNF (PMS), or daily for medical-surgical level of care in Pavilion Mezzanine Acute (PMA), ~~in collaboration with the healthcare team~~ and document accordingly.

~~17. Upon admission to LH with a PICC line and during each dressing change, the RN will measure and document the length of the PICC line in "cm out" from the insertion site to the wings.~~

~~18. Upon admission to LH, and weekly, the RN will measure the mid upper arm circumference (see procedure section for instructions).~~

~~19.~~9. Patient/Resident's ~~Residents~~ who are discharged home with a PICC will receive education from the primary RN regarding management prior to discharge.

10. Only RNs who have been trained by the PICC nurse, or designee, will discontinue PICC lines.

~~20. The LH Admission/Transfer Coordinator will note the type of CVAD that the resident has, determine any unique/special requirements for care or supplies prior to admission, and communicate any needs to the receiving neighborhood Clinical Nurse Specialist and the Education and Training Department prior to the resident's arrival at LH.~~

PURPOSE:

To ensure that standards for access and maintenance of PICC lines are met, while ensuring the safety and education of the patient/resident ~~resident~~ and staff.

BACKGROUND

"A PICC is a radiopaque central vascular access device (CVAD) that is inserted peripherally, usually into the basilic, brachial, or cephalic vein above the antecubital fossa and threaded up the vein until the tip of the catheter is in the cavoatrial junction. It is used for administration of fluids and medications, prolonged antibiotic therapy, central parenteral nutrition, blood products, and chemotherapy.

The catheter may have a single-, double-, or triple-lumen configuration. PICCs are reliable alternatives to short-term central venous catheters and are frequently used for patients in all types of health care settings. The placement of a PICC with the least amount of lumens needed for the anticipated infusions is recommended to reduce device complications such as catheter-related bloodstream infection.

Typically, the catheter hubs are covered with a needleless connector that allows venous access without removing the cap. There are several needleless connectors available; generally, they are categorized as positive-displacement, negative-displacement, or neutral-displacement devices."

(Refer to Skills: (elsevierperformancemanager.com) for procedures on Peripherally Inserted Central Catheter: Insertion)

~~A PICC is a type of Central Venous Access Device (CVAD), and is a very small-gauge catheter inserted percutaneously into an upper extremity vein and then threaded into the superior vena cava. The tip of the PICC line is located in the superior vena cava, approximately 2 cm from the right atrium. The PICC line is used for continuous, or intermittent intravenous (IV) infusions, or highly concentrated fluids such as parenteral nutrition (e.g., TPN). PICC lines can also be used for blood draws (excluding blood cultures). PICC lines are used for short or long term intravenous therapy, usually from seven days to months. The type of PICC device selection (how many lumens, etc.) is guided by the principles of least invasive, fewest lumens, and smallest gauge catheters that are appropriate for the type of therapy and for the anticipated duration of the therapy (Weinstein & Hagle, 2014).~~

~~Preventing catheter-related bloodstream infections is of utmost importance in the management of the PICC line, through adherence of the five components of care included the **Institute for Health Improvement (IHI) Central Line Bundle**;~~

- ~~Hand hygiene~~
- ~~Maximal barrier precautions upon insertion~~
- ~~Chlorhexidine skin antisepsis~~
- ~~Optimal catheter site selection, with avoidance of using the femoral vein for central venous access in adult patients~~
- ~~Daily review of line necessity, with prompt removal of unnecessary lines.~~

GENERAL PICC MANAGEMENT GUIDELINES

1. The following safety measures must be followed when providing care for a patient/resident ~~resident~~ with a PICC line:
   - ~~i. When migration of the catheter is noted, the line may not be used until a CXR is completed to assess for proper placement of the catheter.~~
   - ~~ii.~~i. DO NOT draw blood cultures from a PICC line
   - ~~iii.~~ii. DO NOT use vacutainers when obtaining blood for lab tests from a PICC line
   - ~~iv.~~iii. DO NOT use the patient/resident's ~~resident's~~ arm with the PICC line for blood pressure checks, peripheral blood draws, or peripheral IVs.

2. ~~Every r~~Patient/Resident ~~esident~~ with a PICC line will have ~~is given~~ a patient/resident~~resident~~-specific poster alert alerting medical personnel ~~that states~~to the presence of a PICC line, arm restrictions, date of insertion and ~~proper~~ external catheter length ~~{(~~centimeters (cm) out~~)}~~. This poster will remain with the patient/resident ~~resident~~ through their entire hospital stay while their PICC is in place. The poster will be prominently displayed at the head of the patient/resident's ~~resident's~~ bed ~~(see Appendix A)~~.

3. The RN will assess the PICC site every shift for signs of redness, exudate, and catheter migration.

~~3.~~4. ~~For a D~~double ~~l~~Lumen PICCs, dedicate and label one lumen for blood draw/IV maintenance/medications, etc., and the other lumen for TPN (if the PICC was placed for parenteral nutrition).

~~4.~~5. Triple L~~l~~umen PICCs have only one lumen that is "Power Injectable" (i.e., supports 5-7 mL of fluid per second). This lumen is marked "Power Injectable" and meant to be used for contra~~c~~st injection. This lumen should NOT be dedicated for TPN (either of the other two remaining lumens may be dedicated for TPN). *Note: A Power PICC can be used for contrast injection in radiology. Only the red port on a triple lumen is power injectable*.

6. DRESSING CHANGES: Peripherally Inserted Central Catheter dressing, BIOPATCH®, and StatLock® shall be changed every 7 days, and as needed if there is evidence of bleeding, moisture, compromised dressing integrity, or whenever it must be removed for visual inspection of the catheter insertion site.

~~5. Single-use alcohol caps will be attached to each positive pressure port connector to decrease the risk of infection and changed after each access (single-use only) to the particular port. If the ports are not in use, the alcohol caps will be changed weekly and PRN.~~

~~6. PICC DRESSING CHANGE: Change the PICC dressing when it becomes damp, loose, or soiled, or whenever it must be removed for visual inspection of the catheter insertion site, otherwise the PICC dressing and StatLock® should be change every 7 days.~~

7. The RN will change the needleless connector [positive pressure connector valve (PPV)] of the PICC weekly with each dressing change, and PRN for NON-Total Parenteral Nutrition (TPN) lines.
   Exception: If the line is being used for TPN, the RN will change the PPV daily with each new TPN tubing change.

8. The RN will change single-use disinfecting caps attached to the PPV with each access, or weekly if the line is not in use.

9. SECUREMENT DEVICES: PICCs will be secured in place by 1 of three methods:

i. Adhesive Securement (Statlock) – must be changed with every dressing change
ii. Securacath – subcutaneous device placed at time of insertion that remains in place for duration of PICC line, or
iii. Sutured – least common way of securing a PICC and only done in special cases

~~7.~~10. SIZE OF SYRINGE: ~~-~~Use ONLY a 10~~-~~ or 12 mL syringe to access the PICC lumens to reduce the chance of rupturing the line or dislodging a clot (e.g., during administration of push medications, flushing line).

~~8. PICC Line FLUSHING Protocol: PICC lines should be flushed with 10 mL of normal saline (NS), whether in continuous use or not, using only a 10-12 mL syringe, and per the schedule below;~~

~~i. Before and after intermittent medication(s) and blood draw.~~
~~ii. Before resuming continuous IV fluid~~
~~iii. Single lumen PICC-flush every 12 hours~~
~~iv. Dual lumen PICC-flush both lumens every 8 hours~~
~~v. Triple lumen PICC-flush all three lumens every 6 hours for maintenance~~
~~EXCEPTION: Do not stop TPN infusion for routine flushing, flush with routine tubing and change every 24 hours.~~

~~9.~~ Accidental Partial Removal: NEVER push PICC back into the body if it comes out further than the initial cm out noted at placement time (usually 1 cm). If this happens with only a few cm further removed the RN should complete dressing and report new 'cm out' to PICC service. Inform provider and a CXR may be deemed necessary to confirm PICC tip position for on-going use for infusions.

~~10.~~11. **NOTE**: to calculate the external length of a PICC note that there is an ink mark every 1 cm and a number is noted every 5 cm

PROCEDURES

I. ACCESSING PICC LINE AND FLUSHING PROTOCOLS: {Refer to Skills: (elsevierperformancemanager.com) for procedures on Venous Catheter: Flushing and Locking}

A. Prior to every access to PICC line, the needleless connector (PPV) or hub of the PICC must be disinfected using the following "**Accessing Bundle":**
1. Perform hand hygiene
2. Don clean gloves and appropriate PPE
3. Disinfect the PPV or hub surface of the PICC, including the threads of the hub, with alcohol wipes and aggressive friction for 15 seconds = "Juice the Orange" and allow to air dry for 15 seconds. **Note:** The phrase "Juice the Orange" and IV access bundle steps are used to help emphasize this concept
4. Access the PPV or hub using aseptic technique to avoid re-contamination of the prepared surface

B. PICC LINE Flushing Protocol: PICC lines should be flushed with 10 mL of normal saline (NS), whether in continuous use or not, per the schedule below:
- Before and after intermittent medication(s) and blood draw (flush with 10 mL NS syringe twice (20 mL NS total) after blood draw to flush PPV clear).
- Before starting an infusion and resuming continuous IV fluid
- Single lumen PICC - flush every 12 hours;
- Dual lumen PICC - flush both lumens every 8 hours;
- Triple lumen PICC - flush all three lumens every 6 hours for maintenance.
- **EXCEPTION**: Do not stop TPN infusion for routine flushing, flush with routine tubing change every 24 hours.

~~I.~~**II. ADMINISTERING MEDICATIONS OR FLUSH VIA PICC**

A. To administer push medications or NS flushes via PICC;
~~1. Perform hand hygiene~~
~~2. Apply clean gloves~~
~~3. Always use a 10-12 mL syringe to administer ordered medication or flush~~
~~4. Remove the alcohol cap which is connected to the positive pressure valve~~
~~5.~~1. ~~Scrub the hub of the positive pressure valve (juice it like an orange) for at least 15 seconds~~Follow the **Accessing Bundle**
~~6.~~2. Connect the syringe
~~7.~~3. Unclamp the clamp on the PICC line
~~8.~~4. If administering a push medication, administer medication with a gentle push/pause/push/pause technique, per medication guidelines
~~9.~~5. Flush line with 10 mL of ~~normal saline~~NS ~~using a gentle push/pause/push/pause technique~~
~~10.~~6. Remove syringe and apply new single-use ~~alcohol~~ disinfecting cap
~~11.~~7. Re-clamp the clamp on the PICC line
~~12.~~8. Document medication administration and PICC flush per facility protocol.

B. To administer intravenous fluids, TPN, or intravenous medications via pump;

~~1. Perform hand hygiene~~
~~2. Apply clean gloves~~
~~3. Determine which line is designated for medications/fluids or which line is dedicated for TPN~~
~~4. Remove the alcohol cap which is connected to the positive pressure valve~~
~~5.~~1. ~~Scrub the hub of the positive pressure connector valve (juice it like an orange) for at least 15 seconds~~Follow the **Accessing Bundle**
~~6.~~2. Attach 10mL NS filled syringe to flush line
~~7.~~3. Unclamp clamp on the PICC line
~~8.~~4. Flush line with 10 mL of ~~normal saline~~NS using a gentle push/pause/push/pause technique
~~9.~~5. Attach IV tubing to ~~port~~line
~~10.~~6. Program IV pump per MD order
~~11.~~7. When the IV fluid or IV medication is complete, disconnect tubing from the port
~~12.~~8. Use alcohol wipe to scrub the ~~hub~~hub~~.~~
~~13.~~9. Flush the ~~port~~ line with 10 mL NS
10. Remove syringe and apply new single-use disinfecting cap
~~14.~~11. Re-clamp the clamp on the PICC line
~~15. Attach new single-use alcohol cap~~
~~16.~~12. For TPN infusions, the ~~positive pressure connector~~PPV must be changed with each TPN tubing change.

III. PICC DRESSING CHANGE PROCEDURE {Refer to Skills: (elsevierperformancemanager.com) for procedures on Peripherally Inserted Central Catheter: Dressing Change}

A. EQUIPMENT

- Central ~~l~~Line ~~d~~Dressing Kkit ~~which contains -~~ includes sterile gloves and Chlorhexidine-gluconate (CHG) impregnated sponge dressing (BIOPATCH®)
- Optional: Sterile Glove (sized per preference)
- Face mask for patient/resident
- Clean gloves
- Adhesive anchoring device (StatLock® PICC Plus), unless PICC secured with Securacath
- Needleless Connector (PPV) (quantity = number of lumens)
- Normal Saline flushes (2 per lumen)
- ~~Chux~~ Absorbent pad or towel

~~**FREQUENCY**~~

~~Change dressings when they become damp, loose, or soiled, or whenever they must be removed for visual inspection of the catheter insertion site, otherwise the PICC dressing and STAT Lock should be change every 7 days.~~

~~i. If dressing is loose or non-adherent, change dressing, and do not just reinforce with tape.~~

B. PROCEDURE

1. Gather supplies
2. Perform positive patient/resident identification using 2 identifiers
~~2.~~3. Explain procedure to the patient/resident
~~3.~~4. Clean bedside table with hospital-approved disinfectant and allow to air dry
~~4.~~5. Place an absorbent pad~~a chux~~ or towel under patient/resident's ~~resident's~~ arm as needed
6. Perform hand hygiene
~~5.~~7. Apply mask to patient/resident~~resident~~. Instruct patient/resident to turn face away from PICC line if no mask applied.
~~6.~~8. Perform hand hygiene using alcohol based waterless sanitizer unless hand are visibly soiled. If hands are visibly soiled, then wash hands and lower forearms with soap and water
9. Open ~~sterile~~ Central Line Dressing Kit on prepared bedside table using aseptic technique
10. With tips of fingers remove the sterile gloves and facemask from the kit after opening. Apply facemask and lay gloves on clean surface.
~~7.~~
11. Open the StatLock® PICC Plus Package and drop the PICC StatLock® onto the dressing kit tray using aseptic technique (StatLock® not needed if Securacath in place)
~~8.~~
12. ~~Apply clean gloves and mask~~Hand hygiene and apply clean gloves.
~~9.~~
~~10.~~13. Prior to the removal of the old dressing, palpate the site for tenderness or induration
~~11.~~14. Remove the old dressing by stretching the sides of the dressing and pulling slowly from s~~S~~outh to ~~N~~north direction (to reduce risk of catheter dislodgment) while using your finger on top of PICC dressing to prevent accidental dislodgment of the PICC catheter.
~~12. Use alcohol pads to help loosen the adherence of the StatLock® dressing to be removed.~~
~~13.~~15. Remove the StatLock® dressing by opening "doors", lifting catheter wings (taking care not to piston the catheter in/out), and remove the StatLock®
~~14.~~16. Inspect PICC insertion site for any changes in external catheter length (original cm out will be noted on signage above bed)~~length~~, skin irritation or breakdown, bleeding or edema, redness, swelling, tenderness, and odor. Observe for any leaking connections or kinks in the catheter, or any drainage. Report any/all of the above to provider.
~~15.~~17. ~~The PICC catheter has visible markings at each centimeter~~Observe the "cm out" from the insertion site to wings with each dressing change using a disposable measuring tape.
    ~~i. Note the "cm out" from insertion site to wings during each dressing change.~~
    ~~ii.~~i. The "cm out" should be the same as the one noted on the poster above the bed.
    ~~iii.~~ii. If the catheter is out farther than the noted length (catheter migration), notify the physician ~~and PICC RN ASAP (**ZSFG PICC line nurse at (415) 206-6766 or pager (415)327-4945.**~~ **DO NOT attempt to push the catheter back into the patient/resident.**

18. Make sure unsecured catheter is stable (use a helper if necessary to secure catheter while changing gloves if patient/resident is restless).
~~16.~~19. Remove and discard clean gloves
~~17.~~20. Perform hand hygiene ~~again~~ using an alcohol based waterless sanitizer and apply sterile gloves ~~contained in the dressing kit~~
~~18.~~21. Using the non-dominant hand to secure the catheter from being dislodged, use the dominant sterile hand to ~~C~~cleanse skin ~~using the~~with ~~-~~Chloraprep ~~swab contained in the dressing kit,~~ using gentle friction for 30 seconds and let it completely air dry for 1~~-~~2 minutes (to prevent a skin reaction). **NOTE:** ensure that Chloraprep is completely dry before continuing
~~19.~~22. Using No Sting barrier film, prep~~Apply~~ skin ~~prep prior to protect skin~~under catheter wings and outer edge of where the transparent film dressing will be. ~~. Do not apply skin prep to the site.~~NOTE: This skin prep acts as a skin protectant to the adhesive. Allow to completely dry. ~~Skin prep only to around the borders of the dressing and under the StatLock®.~~
~~20.~~23. Apply ~~the~~ StatLock® under the wings of the PICC and secure wings by **first** locking both doors and then adhering StatLock® to skin (unless Securacath is the anchoring device)
~~21.~~24. Using your sterile dominant hand only – ~~A~~apply CHG impregnated sponge (~~pply~~ BIOPATCH®), ~~"b~~blue side up" or the patch states "This Side Up" over the insertion site with opening facing the wings of the PICC line (to make it easier to remove BIOPATCH® on next dressing change). ~~over the insertion site with opening facing the wings of the PICC line.~~
~~22.~~25. Apply transparent dressing over the insertion site, pressing on the dressing from the center and working out to sides to prevent bubbles and loss of occlusion. Apply "No Sting Barrier Film" to edges of the dressing to enhance adhesion and to reduce the risk of rolling up.
26. Label the dressing with initials and date of dressing change
27. Remove gloves and perform hand hygiene
28. Apply clean gloves and using aseptic technique, prime new PPV and change
    i. Prime new PPV with 10 mL NS while maintaining the sterility of the tip until ready to connect to PICC lumen
    ii. Clamp lumen of PICC
    iii. Remove old PPV and discard
    iv. Scrub hub for 15 seconds with alcohol pad and allows to air dry for 15 seconds
    ~~i.~~v. Apply new primed PPV and flush in remaining 10 mL NS (ensure there is blood return on each lumen).
29. Notify physician if PICC insertion site has exudate, redness, swelling, or if patient/resident ~~resident~~ complains of pain.
~~23.~~30. Dispose of equipment and supplies according to Body Substance Precautions
31. Remove gloves and perform hand hygiene
~~24.~~32. Document appearance of insertion site in electronic health record and enter the date of the next scheduled change in the Kardex
~~25.~~1. ~~Notify physician if PICC insertion site has exudate, redness, swelling, or if resident complains of pain.~~

~~II.~~IV. ASSESSING MID UPPER PICC ARM CIRCUMFERENCE

A. EQUIPMENT

- Permanent marker
- Disposable tape measure

B. PROCEDURE

1. Mark the patient/resident's ~~resident's~~ mid upper PICC arm (between the elbow and axilla) with a permanent marker where the measurement will be taken in order to maintain consistency among staff performing the measurements.
2. Measure the mid upper PICC arm circumference (between the elbow and axilla) upon admission, weekly, and PRN if the arm appears visibly swollen or the patient/resident ~~resident~~ complains of pain or tenderness.
    i. If there is an increase in the circumference or new symptoms, notify the physician immediately.
3. Document measurement in the electronic health record

~~III.~~V. ASSESSING THE NEED FOR CONTINUED USE OF PICC LINE

~~A.~~ Access PICC necessity: ~~Regular review of central line necessity will prevent unnecessary delays in removing lines that are no longer needed (IHI, 2012). The risk of infection increases over time as the line remains in place and the risk of infection decreases if the line is removed when it is no longer needed (IHI, 2012).~~

~~B.~~

~~C.~~A. ~~The defined timeframe for regular review of central line necessity at LH will be;~~

- Weekly for long-term care including Pavilion Mezzanine SNF (PMS)
- Daily for medical-surgical level of care in Pavilion Mezzanine Acute (PMA)

~~IV.~~VI. BLOOD WITHDRAWAL VIA PICC

A. EQUIPMENT

1. Completed lab requisition order, patient/resident labels, specimen tubes (DO NOT USE VACCUTAINER)
2. Clean gloves and appropriate PPE
3. Alcohol wipes

~~3.~~4. ~~1~~One or more 10 mL syringes depending on sample amount needed

~~4.~~1. ~~Alcohol wipes~~

5. Three prefilled 10~~3 syringes with 10~~ mL ~~of n~~normal ~~s~~saline (NS) syringes

~~5.~~6. Needleless female transfer adaptor to deliver blood with syringe to lab tubes

B. PROCEDURE ~~for BLOOD WITHDRAWAL~~

1. Gather and prepare supplies (open flushes/remove air, open packages of sterile syringes for sampling while maintaining sterility until ready to connect).
2. Perform positive patient identification using two identifiers

~~2.~~3. Explain procedure to patient/resident.

4. Clean bedside table with hospital approved disinfectant and allow to air dry

~~3.~~

~~4.~~5. Stop/Pause all infusions prior to withdrawing blood
    i. ~~For double lumen catheter, clamp off the lumen that is not being used for the blood draw~~ Clamp all lumens (except the one for blood withdrawal) if multi-lumen catheter.
    ii. NOTE: TPN port should not be disconnected to reduce risk of CLABSI. To avoid blood sample contamination with TPN – turn off infusion and close clamp (only

while drawing the blood). Do not draw blood from lumen designated for TPN. After sample has been obtained, unclamp other lumens and restart infusions/TPN.

5.6. Straighten out ~~the arm which has the~~ PICC arm~~line~~

6. ~~Perform hand hygiene using alcohol-based waterless sanitizer unless hands are visibly soiled. If hands are visibly soiled, then wash hands.~~

7. ~~Open supplies using aseptic technique~~

8. ~~Put on clean gloves~~

9. ~~Disinfect the positive pressure valve or hub of the PICC using an alcohol swab and aggressive friction to the hub surface, including the threads of the hub, for 15 seconds (e.g., juice the orange) (Step 3 of the IV access bundle). **Note: You do not need to remove the positive pressure valve to withdraw blood to do blood sampling.**~~

10.7. ~~Access the hub using aseptic technique to avoid re-contamination of the prepared surface (Step 4 of IV access bundle).~~Follow the **Accessing Bundle**

11.8. Flush lumen with 10 mL of Normal Saline (NS~~), and~~) and use the same syringe to withdraw 5~~3~~ mL of blood and discard.

9. Detach waste syringe and take 10 mL sterile syringe and attach to the PPV for blood draw while ~~K~~keeping ~~a hold~~control of PPV at all times to avoid re-contamination

10. Draw back gently, slowly and steady on the syringe until enough blood has been acquired for sampling. ~~of the hub to prevent re-contamination and use a sterile 10-12 mL syringe and withdraw blood sample.~~

11. Disconnect sample syringe. Use needless transfer adaptor to aspirate blood from syringe to the lab tubes. Lab tubes should be labeled at bedside to ensure positive patient/resident identification.

12. Decontaminate hub used for blood draw using “Juice the Orange”

13. Flush with 10 mL NS syringe twice (20 mL NS total) to clear PPV and lumen of blood.

14. Disconnect flush syringe. Decontaminate hub used for blood draw. Connect and resume infusions, if applicable.

~~12.~~

~~13. Set the hub down while transferring blood from the syringe into the blood sample vials to reduce clotting of sample.~~

~~14. Pick up the hub and prior to flushing with saline or accessing the port again, scrub the hub with alcohol for 15 seconds (because it touched the skin and requires decontamination).~~

~~15. Without recontamination, use a 10 mL normal saline syringe x 2 and flush blood out of the PICC until the positive pressure valve is clear of blood using the push-pause technique.~~

~~16. You do not need to change the positive pressure valve after a blood draw.~~

~~17.~~15. Dispose of equipment and supplies ~~according to Body Substance Precautions.~~

~~18.~~16. Remove gloves and perform hand hygiene.

~~V.~~VII. PATIENT/RESIDENT EDUCATION

A. To reduce the chance of PICC line complications or migration, educate patient/resident ~~resident~~ regarding the importance of not touching PICC dressing site or tubing due to risk for infection.

B. Educate the patient/resident ~~resident~~ about proper hand hygiene practice to reduce the chance of infection.

C. Educate patient/resident ~~resident~~, as appropriate, to promptly report any symptoms of new or worsened pain or tenderness to the PICC site, or any symptoms of fever or chills.

D. Before initiating, explain all PICC procedures to the patient/resident ~~resident~~, as appropriate, such as dressing changes, flushing of lines, and assessment of insertion site.

E. Educate patient/resident ~~resident~~ to not get the PICC dressing wet, and if the dressing becomes damp or wet, to promptly alert the RN.
F. Educate patient/resident ~~resident~~, as appropriate, regarding the importance of not tampering with the PICC or instilling anything into the PICC line due to the risk of infection or emboli.
G. Educate patient/resident ~~resident~~, as able, to remind caregivers to perform hand hygiene if not already completed.
H. Educate patient/resident ~~resident~~, as able, to make sure providers scrub the hub (e.g., juice ~~it like an~~the orange) with an alcohol swab before instilling anything into the PICC.

~~VI.~~VIII. DOCUMENTATION

A. Document procedure (e.g., dressing changes, blood withdrawal, arm circumference) performed on EPIC Avatar
B. Document assessment of site every shift.
C. Document notification of provider for any unexpected complications and any action taken in the Nurse's Notes
D. Document when education is provided to the patient/resident and/or responsible party in the Nurse's Notes. If education handouts were provided, include the name of the handout in the patient/resident education documentation. Include a verification statement of patient/resident and/or responsible party of the education provided.
E. Document medication administration on the EPIC Medication Administration Record (MAR)
F. Document intravenous fluid administration on the appropriate medical record.
~~A.~~**G.** Document appearance of the insertion site in the electronic health record every shift.
~~B. Document weekly, and PRN, dressing changes in the electronic health record.~~
~~C.~~**H.** Document the continued need for the central line (PICC) in the electronic health record weekly (~~day~~ DAY shift).
~~D. Document weekly, and PRN, mid upper arm circumference in the electronic health record.~~
~~E. Document any resident education in the electronic health record.~~

ATTACHMENT/ATTATCHMENTS:

NONE

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CROSS REFERENCES:

Nursing Policies and Procedures
- J 6.0 Intravenous Therapy Maintenance
- J 7.1 Peripherally Inserted Central Catheters (PICC) Management

Zuckerberg Nursing Policies and Procedures
- 16.1 Management and Care of Peripherally inserted Central Catheters (PICC)
- 16.9 Management and Care of Central Venous Access Device (CVAD)

~~ZSFG Nursing Department Policy No: 16.1, Management and Care of Peripherally Inserted Central Line Catheters (PICC).~~

Revised: ~~2007/~~03/2007; ~~2009/~~09/2009, ~~2010/~~10/2010; ~~2018/~~11/13/2018; 6/11-/2026

Reviewed: 2018/11/13; 2025/01/17

Approved: 2018/11/13

PREVENTION AND TREATMENT OF SKIN TEARS

POLICY:

1. Licensed Nurse is responsible for identifying residents/patients at risk for skin tear development and implementing intervention strategies to minimize the occurrence of avoidable skin tears.

2. Licensed Nurse is responsible for notifying and obtaining a treatment order from the physician when a resident/patient develops and/or is admitted with minor skin tears that are not related to pressure.

3. Registered Nurse (RN) is responsible for wound assessment, dressing application and notifying for presence of wound infection, wound deterioration and non-healing wound.

4. The Licensed Vocational Nurse, under the supervision of the RN, may collect wound assessment data and perform dressing application as ordered by the physician.

PURPOSE:

To prevent the occurrence of avoidable skin tears and promote the healing of skin tears.

BACKGROUND:

~~Skin tears are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces including blunt trauma, fall, poor handling, equipment injury or removal of adherent dressings. Skin tears do not extend through the subcutaneous layer. In already fragile or vulnerable skin (e.g., in aged or very young skin), less force is required to cause a traumatic injury, meaning that incidence of skin tears is often increased.~~

~~Skin tears can occur on any part of the body but are often sustained on the extremities such as upper and lower limbs or the dorsal aspect of the hands.~~

~~When a resident/patient presents with a skin tear, the initial assessment should include a full, comprehensive assessment of the resident/patient as well as the wound. It is also important to establish the cause of the injury.~~

Skin Tear Categories ~~{[~~International Skin Tear Advisory Panel (ISTAP)~~]}~~:

Type 1 skin tear — No skin loss
Linear or flap tear where the skin flap can be repositioned to cover the wound bed.

Type 2 skin tear — Partial flap loss
The skin flap cannot be repositioned to cover the whole of the wound bed.

Type 3 skin tear — Total flap loss
Total skin flap loss that exposes the entire wound bed.

PROCEDURE:

A. Prevention of Skin Tears
~~**A. Prevention of Skin Tears**~~

1. Review history of previous skin tears and identify risk factors for accidental trauma (e.g., fragile skin, dryness)
2. Consider medications that may directly affect skin (e.g. topical and systemic steroids)
3. Manage dry skin and use emollients to moisturize
4. Consider the use of protective clothing (e.g. shin guards, long sleeves or retention bandages)
~~5. Staff should not have jewelry in resident/patient contact~~
~~6.~~5. Exercise caution ~~when~~ during resident/patient care~~repositioning and transferring resident/patient~~ to prevent their skin from catching onto objects (e.g., jewelry, bed frames, etc.) and ~~avoid~~ reduce risk of~~any surface that can cause skin tearing~~ injury.
   a. Use transfer techniques that prevent friction or shear
   b. ~~Pad~~ Encourage use of protective clothing/devices and/or equipment (e.g, ~~bedrails,~~ long sleeves, stockinette, ~~wheelchair arms, and leg supports~~padding for wheelchair armrests)
   c. Support dangling arms and legs with pillows or blankets
6. Provide adequate lighting in environment
7. Encourage meal and fluid intake
8. Initiate/update an individualized skin care plan

B. Management and Treatment of Skin Tears

1. Control bleeding
2. Follow physician's orders for skin tear treatment
~~1.~~
3. Cleanse skin tears with facility approved wound cleanser~~and debride per order~~
4. Use non-adherent dressings, if possible
5. Use gauze wrap, stockinette, or flexible netting to secure dressings
6. If dressing requires use of tape, use paper tape
7. If adherent dressings are required, use caution when removing the dressing or use adhesive remover pad prior to prevent further skin tearing
~~2.~~
~~3.~~8. Monitor for signs and symptoms of infection
~~4.~~9. Monitor wound edge/closure; skin typically follows a closure trajectory of 14-21 days.
10. Consider and address factors affecting wound healing (e.g., diabetes, poor nutrition, ~~circulation~~ circulatory issues)

11. Skin tears with flap present:

~~**C. Treatment of Skin Tears**~~

~~1. Basic care for skin tears~~
~~a. Cleanse skin tears with Vashe. DO NOT USE PEROXIDE.~~
~~b. Use non-adherent dressings, if possible.~~
~~c. Apply skin protective barriers or a non-adherent wound dressing with gauze or secondary dressing such as silicone.~~
~~d. Use gauze wraps, stockinettes, flexible netting to secure dressings rather than tape. If you must use tape, use paper tape.~~
~~If adherent dressings are required, use caution when removing the dressing or use adhesive remover pad prior to removing the dressing to prevent skin tearing.~~

~~Skin tears with skin flap present~~

~~e.~~a. ~~The t~~Treatment goal ~~should be to avoid dislodging the flap~~is to preserve skin flap and prevent dislodging.~~.~~

~~f.~~b. Carefully ~~Repositionplace~~ the torn flap over ~~the~~ wound ~~so that there is a chance of it~~to promote reattach~~ing~~ment to the wound bed.

c. Approximate edges together by using a sterile cotton tip applicator to gently ~~sliding~~ slide flap over exposed wound ~~with sterile cotton tip applicator~~.

~~g. Cover with moist wound dressing, such as hydro gel, foam, petroleum-based protective ointment (Vaseline gauze), or Steri-strip.~~

~~h. Secure non-adherent dressings with a gauze or tubular non-adhesive wrap (tubi pad or tubular stockinet).~~

~~i. Change dressing daily~~

~~j. Monitor for signs and symptoms of infection and, if present, notify the physician for new treatment.~~

C. Documentation

~~Skin tears without flap or with hematoma~~
~~Cover with non-adherent dressing and foam dressing. Change daily.~~
~~Monitor for signs and symptoms of infection, notify physician if any~~
~~Continue with skin tear prevention protocols when tear heals~~

~~**Documentation**~~

1. Changes in resident's/patient's skin condition (e.g., new skin tear, worsening wound) must have a Resident Care Plan and documentation for a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change
2. Add "LDA Wound" in the Avatar to monitor and document wound progression.
   a. Under **Primary Wound Type,** select "**Skin Tear"**
3. Weekly Wound Assessment
   a. Include: Site assessment; peri-wound assessment; drainage with description, shape and margins; treatment and dressing performed
   b. Create a worklist task to notify staff of weekly assessment and dressing changes as ordered
   c. Complete a full wound assessment if the wound shows significant change
4. LDA or Wound documentation EVERY shift
   a. If the dressing change is not due
      - Document **Dressing Status** such as "Clean, Dry, Intact"
      - Document **Site Assessment** as "UTA" for "unable to assess" and specify in comment section the reason
   b. If the dressing change is due (i.e., scheduled changes or soiled dressing)
      - Document **Site Assessment** and **Peri-Wound Assessment**
      - Document **Dressing Change** and **Dressing Status**
   c. If no dressing is ordered
      - Document **Site Assessment** and **Peri-Wound Assessment**

   If you chart Unable to Assess (UTA), document explanatory comment (example: dressing change not due)

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CROSS-REFERENCES:

Hospitalwide Policy and Procedure
23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference

Nursing Policy and Procedure
K 2.0 Wound Assessments and Management

APPENDIX/APPENDICES:

NONE

Revised: ~~2002/~~01/2002; ~~2005/~~02/2005; ~~2008/~~04/2008; ~~2014/~~05/27/2014; ~~2023/~~05/09/2023; ~~2025/~~05/05/2025; 05/06/2026

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