List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on March 14, 2023

Revised Hospital-wide Policies and Procedures

Dept.	Policy #	Title	Notes
_LHHPP	01-12	Compliance Program	1. Added Office of Compliance and Privacy Affairs (OCPA) throughout policy 2. Added language regarding reporting violations without the fear of retribution, the privacy and rights of the reporter will be protected and retaliation is prohibited. 3. Added substantiated allegations may result in disciplinary or corrective action. 4. Added the Compliance Officer will be the designated contact person and provided contact information 5. Added documentation will be filed and maintained by OCPA for a minimum of 7 years after the investigation has been close. 6. Added staff with knowledge of violation or suspected violations are required to report and there will be disciplinary actions if failing to report. 7. Added investigation will start within 7 days of receipt of report 8. Added Compliance Officer will hold ultimate supervision of investigation but may delegate responsibilities to others 9. Added items investigation may include 10. Added a corrective action plan is required for significant compliance violations. 11. Added steps to after compliance violation is found.
_LHHPP	01-14	Compliance Program Discipline	1. Added investigation shall start within 7 days of receipt and the Compliance Officer holds ultimate supervision of compliance investigations 2. Added Office of Compliance and Privacy Affairs (OCPA) throughout document 3. Added Compliance Officer will recommend discipline to the DPH Human Resources Labor Division who will determine and impose appropriate discipline. 4. Added corrective action plan is required for significant compliance violations 5. Added investigation must be documented and supporting documents must be attached to all reports 6. Added unsubstantiated and substantiated violation findings process

_LHHPP	22-01	Abuse and Neglect Prevention, Identification, Investigation Protection, Reporting and Response	1. Added required reporting timeframes 2. Added Seton 1150B of the Social Security Act and reporting of any reasonable suspicion of a crime 3. Updated definitions 4. Added LHH will screen employees for history of abuse and maintain documentation 5. Added training details to The Abuse Prohibition/Prevention Program 6. Removed mentions of other LHH policies 7. Removed DET and QM will collaborate on abuse in-service and trainings 8. Removed periodic drills 9. Added retaliation statement 10. Added prevention guidelines and details 11. Added LHH will work with SFSO in investigation 12. Added Coordination with QAPI
_LHHPP	22-03	Resident Rights	1. Updated policy to reflect Phase 3 updates: -Resident has the right to dignity, self-determination, and communication -Language interpretation will be provided to residents where English may not be the predominant language. -The facility shall have written translation of rights and responsibilities -Large text of resident statement rights will be available -The receipt or acknowledgement of residents right shall be placed in the resident's medical chart. 2. Updated CEO information in Appendix A
_LHHPP	23-02	Completion of Resident Assessment Instrument/Minimum Data Set (RAI)MDS)	1. Updated Resident Care Team notification from "of the month through email" to "by the end of each month" 2. Added MDS discussion and care planning process during the RCC and/or individual RCT members prior to the scheduled RCC 3. Added new section on Submission of required data to Centers for Medicare and Medicaid Services.
_LHHPP	24-28	Behavioral Health Care and Services	1. Added section on residents with SUD receiving specialty SUD treatment requires resident consent. 2. Added if resident's condition or behavior needs cannot be met at LHH or safety of induvial are endangered, RCT can seek alternative placement for the resident.
_LHHPP	29-04	Cremation Assistance	Minor grammar updates
_LHHPP	31-02	Hospital Equipment and Supplies Budget and Procurement	1. Replaced Laguna Honda with LHH 2. Minor grammar updates
_LHHPP	35-04	Inventory and Disposal of Hospital Property	Minor grammar updates
_LHHPP	45-05	Molly's Fund - Assistive Technology Program	Minor grammar updates
_LHHPP	50-04	Enteral Nutrition Charge Procedures	Minor grammar updates

_LHHPP	60-01	Quality Assurance Performance Improvement	1. Updated policy section to include QAPI program to developed and focused on the outcomes of care and quality of life and addresses services that are unique to our facility. 2. Removed education and facilitation from Purpose and Leadership Principles 3. Added definitions 5. Replace Patient/Resident Safety Officer, Hospital Administrator for Strategic Performance Management with Regulatory Affairs, Director of Risk Management, and Director of Performance Improvement. 6. Under PIPS Functions: -updated biannual to annual for review of LHH QAPI Program -removed "ensures integration of PI recommendations", "provides patient safety even reviews and evaluating results" and "oversees the work of OPEX" 7. Removed PIPS Subcommittees and Patient/Resident Quality and Safety Plan sections 8. Removed Director of Regulatory Affairs and Risk Management will serve as Vice Chair of Event Analysis and Systems Improvement Committee 9. Updated Manager of Education and Training to Nurse Director of Education and Training. 10. Under Use of Data: -Added performance monitoring and improvement activities are data driven drawn from multiple sources and presented to the QAA committee for their analysis. -Added QAA will use systemic approach to create corrective action to remedy the problem -Added facility assessment, grievance logs, minimum data set, quality measures and survey outcomes to data sources 10. Under Performance Improvement Methology, added continual performance improvement tracking after corrective action 11. Removed Patient Safety section 12. Added new Feedback section
_LHHPP	65-01	Procedures for Grant Application, Acceptance and Expenditures	Minor grammar updates
_LHHPP	72-01 C21	MRSA Testing	Updated Appendix A URL
_LHHPP	72-01 F2	Disinfection for Isolation Room	1. Updated title from Isolation Room Disinfection to Disinfection for Isolation Room 2. Added only EPA disinfectants and cleaners will be used
_LHHPP	72-01 F11	Classification of Reusable Medical Devices and Processing Requirements	1. Updated revised date
_LHHPP	72-01 F13	Cleaning and Disinfecting Non-Critical Resident Care Equipment	New attachment 1 - LHH Non-Critical Resident Care Equipment Disinfectant Exceptions

Deletion Policies and Procedures			
Dept.	**Policy #**	**Title**	**Notes**
_LHHPP	72-01 B6	Intravascular Device Guidelines	Request to delete and refer to NPP Category J: Medication and Intravascular Therapy section
_LHHPP	72-01 B8	Medication Handling/Dispensing Guidelines	Request to delete and refer to NPP J-01.1 Obtaining, Handling and Storage of Medication
_LHHPP	72-01 B11	Respiratory Care Guidelines	Request to delete and refer to NPP Category I: Respiratory Care section
_LHHPP	72-01 B13	Urinary Catheterization Guidelines	Request to delete and refer to NPP F-05.0 Nursing Management of Urinary Catheter
_LHHPP	72-01 C19	West Nile Virus	Request to delete

New Nursing Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	C 3.X	Documentation of Care - Acute Unit	New Policy 1. The Laguna Honda Hospital (LHH) Acute Unit are defined as the Acute Medical Acute Rehab units. The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF) 2. The responsible Physician, Nurse Manager (NM), Charge Nurse, and the Nursing Director (ND) will be notified of any new admissions 3. The Registered Nurse (RN) implements and documents the nursing process in the delivery of care to the patient in the electronic health record (EHR); assessments, nursing diagnoses, outcomes and planning, implementation and evaluation 4. Each nursing role (e.g., RN, Licensed Vocation Nurse (LVN), Patient Care Assistant (PCA), or Home Health Aide (HHA) will perform and document care delivered that is within the scope of their practice 5. If no PCA is available, the RN will perform PCA tasks and documentation 6. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse 7. Float LVN or RN assigned to the Acute Unit will receive a unit-specific orientation to the environment of care and unit routine from a training acute staff or Nursing Supervisor prior to providing care. They may perform and document task within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g., medication administrations, wound dressing changes, etc.) They may not perform Acute specific tasks which require training or competencies, such as blood transfusion. Refer to Policy Acute 01.0 Nursing Staff Education - Acute Unit

Revision Nursing Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	J 5.0	Oxygen Administration	Cleansing of O2 tank after use: Generalized to wipe down tank (did not specify cleansing product)

Revision Medical Services Policies and Procedures			
Dept.	**Policy #**	**Title**	**Notes**
Medical Services	D08-07	Laguna Honda Psychiatry Substance Treatment and Recovery Services (STARS)	1. Added documentation for non-specialty services for residents with SUDs shall be entered into the EHR and accessed by RCT. 2. Added if residents who are willing to participate in the DMC program, the resident will be referred to and enrolled in the DMC program. 3. Added resident will be asked to sign ROI form for permission to sharing treatment records and share with special SUD treatment information with the RCT. 4. Added consent for ROI section. -Provider will document summary information of SUD treatment in EHR -SUD treatment incorporated in resident's care plans - Provider will document detailed SUD treatment information in EHR -ROI can be revoked at any time and provider will cease to document SUD treatment in EHR 5. Added If resident wants to participate in SUD but does not consent for ROI section -Provider will not document SUD treatment in EHR -SUD treatment will be documented in behavioral health EHR only and LHH SUD provider will note in the behavioral health EHR that resident does not consent -RCT may ask the resident about how the SUD treatment is doing and document in EHR -Resident can change their mind and consents to ROI, ROI documentation will be followed -SUD providers will periodically ask residents whether if they want to consent to ROI. 6. Added reference to 75-05 Illicit or Prohibited Drugs Policy for other aspects involving resident active substance use and contraband presence.

Revised Hospital-wide Policies and Procedures

COMPLIANCE PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) maintains a Compliance Program consistent with the Department of Public Health (DPH) ~~Compliance Office's~~Office of Compliance and Privacy Affairs (OCPA) policies and procedures and with federal and state regulations, including the Federal and California False Claim Acts.

2. The Compliance Program at the LHH campus applies to LHH employees, and LHH campus contractors and agents who, on behalf of LHH, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, or monitor the provision of health care services.

3. LHH works with ~~the DPH Office of Compliance and Privacy Affairs~~OCPA to meet LHH's compliance objectives.

4. ~~The facility~~LHH consistent with DPH implements and publicizes a reporting system that allows anyone to report compliance violations anonymously without fear of retribution and that ensures the integrity of the reports.

5. All complaints regarding improper or unethical business practices, violations of the law or ~~company~~DPH or City policies (including harassment, fraud, retaliation, and discrimination), ~~will~~ shall be taken seriously, addressed promptly, and handled in a manner that protects the privacy of the caller.

6. No retaliation against employees who report concerns in good faith ~~will~~shall be permitted.

~~3.~~7. Disciplinary or corrective action in response to substantiated allegations ~~will~~shall be an integral part of the Compliance Hotline.

PURPOSE:

1. To ensure the integrity of LHH campus clinical and business activities by adhering to the following goals:

   a. To promote an understanding of and compliance with Medicare, Medi-Cal, and other applicable federal and state laws and regulations;

   b. To use education and training to improve compliance with documentation, coding, billing and reimbursements rules and regulations;

   c. To work with providers, managers, and staff to integrate compliance into the daily operations of LHH and promote patient safety and quality of care; and

d. To promote compliance with the CMS Value-Based Purchasing, including accurate and timely reporting of clinical assessments.

2. ~~This facility~~LHH supports an "open door policy" in which anyone may discuss concerns or report compliance violations to any supervisor, manager, HR representative, or compliance professional at any time.

PROCEDURE:

1. LHH is committed to comply with all applicable federal and state statutes and regulations related to billing for services and reimbursement programs. To this end, it maintains a Compliance Program that includes procedures 2 through 8.

~~2.~~3. Compliance Officer

The facility has a designated contact person to which anyone may report suspected violations. This person is ~~(insert job title)~~ the Compliance Officer and may be reached directly at 415-759-3374, email or interoffice mail: LHH Compliance Officer, Administration.

The Compliance Officer is responsible for the daily operation of the Compliance Program at the LHH campus that includes:

a. Overseeing and monitoring the implementation and maintenance of the Compliance Program.

b. Reporting on a regular basis to the LHH Compliance Steering Committee (no less than quarterly) to review and conduct compliance activities.

c. Periodically reassessing the Compliance Program to identify necessary changes due to findings from compliance activities, changes in business practices or processes, and new regulations and risks.

d. Coordinating internal compliance review and monitoring activities.

e. Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.

~~3.~~4. Compliance Committee

The LHH Compliance Steering Committee, chaired by the Compliance Officer, is responsible for ensuring integrity in the clinical and business operations of LHH. The Committee, through the Compliance Officer, shall report to the LHH Executive Quality Council at least once a year, and function as an oversight committee with sub-

committees and work groups tasked to research/resolve particular issues as they arise. This includes ensuring that the Compliance Program is effective at identifying and mitigating risks by:

a. Approving Compliance Program policies and procedures, annual risk assessments, and the annual work plan, including periodic updates of those documents.

b. Monitoring compliance program activities through regular reports from the Compliance Officer and compliance monitoring project owners.

c. Allocating adequate resources to address compliance risks, including designating department staff to partner with the Compliance Office on compliance monitoring projects, and tasking work groups as necessary.

d. Support value-based quality initiatives and reporting.

4. **Compliance Training**

LHH, through its Compliance Officer and its Department of Education and Training, shall ensure that all staff receive compliance training upon hire and annually.

a. Training and education are key components of the Compliance Program. Training ensures the LHH workforce and governing bodies receive information about the Compliance Program when they begin employment and at least annually as “refreshers” that reinforce the culture of compliance.

b. The Compliance Officer is responsible for developing, coordinating and participating in education and training efforts to ensure that staff are knowledgeable about the Compliance Program. Additionally, the Compliance Officer shall recommend that targeted training is provided to specific audiences when warranted due to identified compliance risks.

5. **Compliance Standards and Policy and Procedures**

LHH, through its Compliance Officer, shall ensure that LHH has developed and distributed written policies and procedures that establish Compliance standards. Policies and procedures are also created and/or updated in response to new laws and regulations that affect the Compliance Program.

a. DPH Code of Conduct: The DPH Code of Conduct applies to LHH employees and volunteers. The Code of Conduct is provided by Human Resources to new employees at the time of hire with signed acknowledgment. Staff are also required to review with signed acknowledgement annually through the annual compliance training module. Training and education are key components of the Compliance Program.

b. Compliance Program Policies: In addition to adherence to the DPH Compliance Policies, LHH maintains specific compliance policies and procedures for issues that may be pertinent to LHH campus operations.

   i. Departments within the LHH campus shall also maintain their own department-specific policies and procedures for ensuring proper controls and monitoring of activities that impact billing and reimbursement such as documentation of medical necessity, selection of procedure (CPT) and diagnosis (ICD-10) codes, accuracy of data submitted to government agencies for claims reimbursement, etc.

6. Reporting Compliance Issues

~~Information related to reporting compliance violations is posted (insert locations). Training shall be provided on a regular basis, not less than upon orientation and annually, to remind individuals of the reporting system, what to report, timeframes for reporting, and how to report.~~

~~Procedure:~~

- ~~The intake call and/or report will be received by the Chief Compliance Officer or designee, which may be a third party vendor.~~
- ~~The Chief Compliance Officer or designee will be responsible for maintaining confidential records of all calls and/or reports and responses.~~
- ~~Compliance Hotline cases will be handled in a manner which protects the privacy of the caller.~~
- ~~Individuals, including employees reporting to the Compliance Hotline may choose to remain anonymous or give their name. If an employee chooses to remain anonymous, the call and/or report will be investigated and resolved in the same manner and with the same diligence as all others.~~
- ~~Appropriate action will be taken in response to each call and/or report. In most cases, appropriate action will include an investigation into the allegations of the complaint or concerns, an action plan to resolve the issues, and communication back to the caller, if applicable.~~
- ~~Complaints that do not raise a potential compliance issue will be referred to the appropriate department (e.g., risk management, Human Resources, facility management, or other departments as appropriate).~~
- ~~Investigations shall be handled by persons having a sufficient level of expertise/knowledge with regard to the issue presented by the call and/or report.~~
- ~~The Compliance Officer shall identify who, if anyone, should be notified of the existence of the call and/or report.~~
- ~~These individuals should determine whether the conduct alleged is of such a nature that it should be reported to any applicable outside agency or regulatory board.~~

a. LHH, through its Compliance Officer, shall make lines of communication available for employees to report fraud and compliance concerns with the option of remaining anonymous. This includes a confidential Compliance and Privacy Hotline at 855-729-6040.

b. LHH also maintains a strict non-retaliation policy for employees who report compliance violations. Staff are expected to report concerns by first discussing with their supervisor or manager, then either through the Compliance and Privacy Hotline or by contacting the Compliance Officer directly at 415-759-3374, email or interoffice mail: LHH Compliance Officer, Administration.

c. Documentation regarding the Compliance Hotline will be filed and maintained by OCPA and the Compliance Officer or designee for a minimum of seven (7) years after the investigation has closed~~, and will be subject to the requirements of the facility's *Compliance and Ethics Program Policy*~~.

d. Employees with knowledge of a violation or suspected violation of the compliance program's standards, policies, and procedures are required to report it immediately. Staff who knowingly fail to report a violation shall be subject to disciplinary action, up to and including termination.

7. Investigating Compliance Issues

a. LHH, through its Compliance Officer, shall promptly investigate reports of violations of the Compliance Program or federal or state laws and regulations related to billing for health care services**.**

b. LHH shall implement corrective measures up to and including ~~dismissal~~ termination for employees who are out of compliance with the Compliance Program or any federal or state law related to billing for health care services.

c. The Compliance Officer or designee shall begin and/or oversee investigations on all compliance-related matters within seven (7) days following receipt of the report indicating a matter warranting investigation.

~~b.~~e. The Compliance Officer may delegate the investigation responsibilities but will hold ultimate supervision and responsibility for all compliance investigations.

~~c.~~f. The investigation may include, but is not limited to:

i. Reviewing and preserving documents related to the matter;

ii. Interviewing appropriate individuals;

iii. Reviewing policies and procedures applicable to the matter;

iv. Collaborating with an internal facility authority, as needed;

~~iv.~~v. Engaging an outside consultant, authority, law enforcement, or regulatory entity to assist in the investigation, as needed.

~~d.~~g. If a significant compliance violation is found, the Compliance Officer and/or facility management shall develop and implement a corrective action plan.

~~e.~~h. If the investigation findings do not substantiate the allegation or matter:

i. The investigation will be closed by the Compliance Officer.

ii. Documentation regarding the investigation will be filed and maintained by the Compliance Officer and ~~the Facility Compliance Department~~ OCPA for a minimum of seven (7) years after the investigation has closed.

~~f.~~i. If a compliance violation is found:

i. All documentation related to the investigation will be maintained as an "open" investigation until a corrective action plan has been completed and the matter has been resolved, at which time the investigation will be closed by the Compliance Officer.

ii. Once closed, the investigation file will be filed and ~~the applicable Facility Compliance Department~~ OCPA for a minimum of seven (7) years after the investigation has been closed.

~~6.~~8. Auditing and Monitoring Activities

LHH, through its Compliance Officer, shall conduct periodic auditing and monitoring of potential risk areas.

a. The Compliance Officer monitors and coordinates responses to external billing audit requests to ensure that documentation is submitted timely in accordance with the various auditors' timelines and protocols, and corrective steps are taken as necessary in response to audit denials.

b. LHH, through its Compliance Officer, also conducts monitoring and auditing activities to proactively ensure on-going compliance with federal and state regulations and guidelines related to billing and reimbursement for healthcare services. An internal monitoring plan is developed as part of the annual compliance work plan and includes areas of potential risk that have been identified through the annual risk assessment.

c. Any findings of improper billing identified through the internal monitoring process shall be refunded as required by law to the payer, assessed for the root cause, and take corrective actions to resolve the matter.

d. The Compliance Officer monitors corrective actions to ensure that improvements are sustained.

~~The compliance and ethics program contact person shall follow up with those individuals making a report, except in those instances where the report was made anonymously.~~

~~d. All reports will be tracked for purposes of QAPI and evaluating the effectiveness of the compliance and ethics program. Documentation shall be maintained for a minimum of three years by (insert job title).~~

ATTACHMENT:
None.

REFERENCE:
DPH Compliance Program
DPH Compliance Program – Relevant Federal and State Compliance Related Statutes and Regulations
DPH Compliance Policy – Operation of a Compliance Program
DPH Compliance Program Code of Conduct
DPH Compliance Program – Employee Compliance Hotline
DPH Compliance Program – Employee Non-Retaliation Policy
DPH Compliance Program – Guide to Government Interviews and Investigations
Section 6102 of the Affordable Care Act

Revised: 15/05/12, 16/03/08, 17/11/14, 18/11/13, 20/03/17 (Year/Month/Day)
Original adoption: 13/03/26

COMPLIANCE PROGRAM DISCIPLINE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide notification to its employees on compliance with San Francisco Department of Public Health (DPH) Code of Conduct, DPH and/or LHH compliance policies and procedures, and applicable laws and regulations relating to federal and state health care programs, including but not limited to the Federal and California False Claims Acts, the Anti-kickback statute and Stark law, and all other compliance related laws, regulations, and policies (collectively "compliance standards").

2. LHH will provide notification to employees on established procedure for investigation and evaluation to be followed in circumstances where corrective, remedial, or disciplinary action is appropriate to address an employee's failure to comply with compliance standards.

3. LHH seeks to adhere to all compliance standards. Violations of compliance standards shall result in appropriate remedial and disciplinary action and shall be applied consistently throughout LHH regardless of job class or position.

PURPOSE:

To establish a consistent procedure to be followed in circumstances where corrective, remedial, or disciplinary action is appropriate to address an employee's failure to comply with compliance standards.

PROCEDURE:

1. The Compliance Officer or designee shall begin and/or oversee investigations on all compliance-related matters within seven (7) days following receipt of the report indicating a matter warranting investigation.

2. The Compliance Officer may delegate the investigation responsibilities but will hold ultimate supervision and responsibility for all compliance investigations.

3. Discipline Procedure

   a. An employee who commits a violation of any compliance standard or who becomes aware of information regarding any violation or potential violation by an employee or contractor of any compliance standard has a duty to report the[H(1)][T(2)][L(3)][H(4)] violation or potential violation to the ~~DPH~~ Office of Compliance and Privacy Affairs (OCPA) Compliance and Privacy Hotline, to the Compliance Officer, or to a supervisor or manager.

b. The Compliance Officer or designee shall investigate all alleged violations of compliance standards. If the allegation is substantiated, the Compliance Officer shall present the findings to the appropriate LHH supervisors with a recommendation on corrective measures to address the violation ~~which shall include a recommendation on discipline~~.

c. Any activity or practice that violates any compliance standard shall be immediately ceased.

d. The Compliance Officer's discipline recommendation shall be based on the DPH Uniform Disciplinary Guidelines ("Disciplinary Guidelines"). ~~The Compliance Officer will recommend discipline to the~~ DPH Human Resources Labor Division, which will have the ultimate responsibility for determining and imposing the appropriate discipline.

e. If a significant compliance violation is found, the Compliance Officer and/or facility management shall develop and implement a corrective action plan.

~~d.~~f. All investigation methods and findings pursuant to the investigation must be documented.

g. Copies of supporting documents should be attached to all reports.

4. Recommendations of discipline for violations of the following compliance standards shall be made considering the Disciplinary Guideline of "Stealing/Dishonesty:"

a. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment to any payer.

b. Failing to disclose known excluded status on any regulatory sanctions list.

c. Failing to disclose known pending or confirmed disciplinary actions by a licensing body.

d. The Compliance Officer shall follow the Disciplinary Guideline of "any reasonable cause not listed" for recommendations of discipline for all other compliance standards violations.

e. ~~Final determination on any recommended discipline shall be made by the employee's supervisor and/or appointing authority in consultation with Human Resources.~~ Nothing in this policy shall abridge an employee's union and/or civil service rights.

5. If the investigation findings do not substantiate the allegation or matter:

a. The investigation will be closed by the Compliance Officer.

b. Documentation regarding the investigation will be filed and maintained by the Compliance Officer and ~~the Facility Compliance Department~~ OCPA for a minimum of seven (7) years after the investigation has closed.

6. If a compliance violation is found:

a. All documentation related to the investigation will be maintained as an "open" investigation until a corrective action plan has been completed and the matter has been resolved, at which time the investigation will be closed by the Compliance Officer.

~~a.~~b. Once closed, the investigation file will be filed and ~~the applicable Facility Compliance Department~~OCPA for a minimum of seven (7) years after the investigation has been closed.

7. Prohibition on Retaliation against Whistleblowers

a. DPH has a strict non-retaliation policy and will not tolerate or condone any form of retaliation against any employee who reports a known or suspected violation of a compliance standard in good faith. Any employee who commits or condones any form of retaliation shall be subject to discipline up to termination.

ATTACHMENT:
None.

REFERENCE:
LHHPP 01-12 Compliance Program
LHHPP 01-13 Fraud, Waste, and Abuse
DPH Compliance Program – Employee Non-Retaliation Policy
DPH Uniform Disciplinary Guidelines

Original adoption: 19/05/14 (Year/Month/Day)
Revised: 22/06/14

ABUSE AND NEGLECT PREVENTION, IDENTIFICATION, INVESTIGATION, PROTECTION, REPORTING AND RESPONSE

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse, neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

POLICY:

1. LHH employees, contractors, and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.

2. All LHH employees, contractors, and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

3. LHH employees, contractors, and volunteers shall immediately respond to ~~and report~~ observed or suspected incidents of abuse ~~to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations~~.

~~3.~~4. LHH employees, contractors, and volunteers shall report alleged violations to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations within specified timeframes:

   a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

   b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

~~4.~~5. The LHH Department of Education and Training (DET) shall be responsible for developing curricula for and training all employees, volunteers, and contractors on abuse prevention and timely reporting.

~~5.~~6. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.

~~6.~~7. LHH shall not employ or otherwise engage individuals who:

   a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or

c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

8. LHH will promote a culture of safety and open communication where r~~R~~etaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

~~7.~~9. Pursuant to Section 1150B of the Social Security Act, LHH employees, contractors, and volunteers shall report any reasonable suspicion of a crime committed against a resident of this facility.

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.

3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

4. To provide clinical intervention to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

5. To meet reporting requirements as mandated by federal and state laws and regulations.

~~5.~~6. To establish coordination with the QAPI program.

DEFINITION:

1. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services

that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. ~~is defined at 42 CFR §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psycho-social well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology." All residents, even those in a coma, may experience physical harm, pain or mental anguish.~~

a. "Verbal Abuse" means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

b. "Sexual Abuse" is non-consensual sexual contact of any type with a resident.

c. "Physical Abuse" includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.

d. "Mental Abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s).

e. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.

~~1.~~2. "Willful," means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.~~as defined at 42 CFR §483.5 and as used in the definition of "abuse" "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."~~

~~a. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.~~

~~b. "Sexual abuse" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."~~

~~c. Physical abuse, includes but is not limited to hitting, slapping, punching and kicking. It also includes controlling behavior through corporal punishment.~~

~~d. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.~~

~~e. Mental abuse includes, but is not limited to humiliation, harassment, teasing, taunting, and threats of punishment or deprivation.~~

2. "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.~~as defined at 42 CFR §483.5 means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."~~

3. "Exploitation" means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.~~Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion~~.

4. "Misappropriation of Resident Property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. ~~Misappropriation of resident property means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."~~

~~5. Mistreatment means inappropriate treatment or exploitation of a resident.~~

~~6.~~5. "Involuntary S~~s~~eclusion" refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs as long as the least restrictive approach is used for the minimum amount of time.~~is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room (with or without roommates) against the resident's will, or the will of resident representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs.~~

6. "Injuries of unknown source" should be classified as an "injury of unknown source" when all of the following criteria are met:

a. The source of the injury was not observed by any person; and
b. The source of the injury could not be explained by the resident; and
c. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

~~"Injury of unknown source/origin" is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point in time or the incidents of injuries over time are suspicious in nature.~~

7. "Crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

8. "Serious Bodily Injury" means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.~~Serious bodily injury [as defined in Section 6703 (b) (3) of the Affordable Care Act] is defined as an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation~~.

9. "Criminal sexual abuse" is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.~~Criminal sexual abuse is defined in section 2011(19)(B) of the Act (as added by section 6703(a)(1)(C) of the Affordable Care Act), serious bodily injury/harm shall be considered to have occurred is the conduct causing the injury is conduct described in section 2241(related to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or ay similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act~~.

~~"Immediately" means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.~~

~~Crime Section 1150B(b)(1) of the Social Security Act provides that a "crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.~~

~~Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social and activity programs.~~

~~"Screening" means reviewing a potential employee's history of abuse, neglect, or mistreating residents.~~

~~10.~~

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

i. Applicants for employment at LHH must submit to fingerprinting by federal authorities and must have a clear background check prior to processing of any appointments for hire at LHH. This is required in addition to the existing bi-annual fingerprinting and background check process in the State of California for initial certification and continued CNA certification as a condition of employment.

ii. LHH will screen employees for a history of abuse, neglect or mistreating residents by attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries.

~~i.~~iii. LHH will maintain document of proof that screening ~~occured~~occurred.

b. Experience and References

i. Applicants for employment shall provide a photocopy of certification and verification (including references) of qualifying experience. The facility will make reasonable efforts to verify previous employment and to obtain information from previous and/or current employers.

2. Education

a. Employee and Volunteer Education

i. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement" shall be kept in the employee's/volunteer's personnel file.

ii. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, participate in "The Abuse Prohibition/Prevention Program", which includes the following:

- Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;
- Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;
- Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;
- Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources;
- Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:
  - Aggressive and/or catastrophic reactions of residents;
  - Wandering or elopement-type behaviors;
  - Resistance to care;
  - Outbursts or yelling out; and
  - Difficulty in adjusting to new routines or staff.
- Facility orientation program on residents' rights, including confidentiality, preservation of dignity, identifying what constitutes abuse, and recognizing and reporting abuse without fear of retaliation;
- Nonviolent safety management and prevention of challenging behaviors;

- ~~Review of the following policies and procedures that support the overall program:~~
  - ~~LHHPP 22-03 Resident Rights~~
  - ~~LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss~~
  - ~~LHHPP 22-07 Physical Restraints Including Bed Rails~~
  - ~~LHHPP 22-08 Threats of Physical Violence to Residents~~
  - ~~LHHPP 24-06 Resident Complaints/Grievances~~
  - ~~LHHPP 22-10 Management of Resident Aggression~~
  - ~~LHHPP 73-05 Workplace Violence Prevention Program~~

- Annual in-service education provided by the Department of Education and Training (DET) to all employees, which includes a review of residents' rights, abuse and neglect prohibition/prevention, mandated reporting, and resident and employee freedom from retaliation when reporting abuse allegations.

- DET shall provide additional abuse and neglect prevention training to nursing and other staff annually, including recognition of psychological, behavioral, or psychosocial indicators of abuse, recognition of environmental factors that could potentially lead to abuse, and other pertinent abuse and neglect prevention and response educational topics.

- ~~DET and Quality Management will collaborate on abuse in-services and trainings to ensure that gaps in knowledge of abuse prevention are addressed. In addition, prior to the start of each abuse inservice, a pre-test will be administered to assess the current state of learners' abuse prevention knowledge. Comparison of the pre and post tests can help assess the effectiveness of the in-services.~~

- Annual performance appraisals will include a competency to assess knowledge of employee's abuse prevention.

~~Periodic drills across all levels of staff, contractors, or volunteers across all shifts to assure that the individual understand the reporting requirements.~~

~~Training topics will include:~~

- ~~Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;~~
- ~~Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;~~
- ~~Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;~~
- ~~Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources;~~
- ~~Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:~~
- ~~Aggressive and/or catastrophic reactions of residents;~~
- ~~Wandering or elopement-type behaviors;~~
- ~~Resistance to care;~~
- ~~Outbursts or yelling out; and~~
- ~~Difficulty in adjusting to new routines or staff.~~

iii. ~~Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident during the New Employee Orientation (NEO) and annually during residents' rights, abuse and neglect prevention in-services. Annual notification shall also include a description of the fines and Federal health care program sanctions associated with the failure to report an abuse within the mandated time frames, as determined by the nature of the abuse.~~

b. Employees shall be informed of their rights during NEO and through posted information in the Human Resources Department. This shall include the right to file a complaint with the State Survey Agency if anyone at LHH retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident to a law enforcement agency (such as the San Francisco Sheriff's Department (SFSD) at 4-2319).

i. Information on employee rights related to reporting a crime or retaliation shall be posted in HR.

ii. Retaliation includes but not limited to ~~discharge,~~ demotion, suspension, threats, harassment, denial of promotion or other employment-related benefit, or discrimination in the terms and conditions of employment.

iii. LHH shall not file a complaint or a report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the nurse or employee.

c. Resident Education

i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting

advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

ii. A listing of Residents' rights shall be posted on each unit.

iii. Resident education topics such as reporting abuse, neglect, exploitation and/or mistreatment shall be reviewed at the neighborhood/unit community meetings at least twice a year or more frequently as determined by the Resident Care Team (RCT).

3. Prevention

~~LHH will follow policies regarding employees, contractors, and volunteers treatment of residents to assure LHH is doing all that is within its control to prevent occurrences of resident abuse, neglect, exploitation, mistreatment, and misappropriation of property. The includes policies for reporting such instance.~~

a. LHH shall Identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.

b. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

c. LHH shall ensure the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions.

~~a.~~d. Staff shall be trained in nonviolent safety management and prevention of challenging behaviors, which includes assessment, response techniques, and tools to prevent and identify potential crisis and/or de-escalate challenging behaviors. Training includes:

i. Nonverbal communication

ii. Para verbal communication

iii. Verbal communication

iv. Precipitating factors, rational detachment and the integrated experience

v. Staff fear and anxiety

vi. Decision making

vii. Physical interventions (disengagement skills) as a last resort

viii. Debriefing

~~b.~~e. Staff and families shall be provided with information on how and whom they may report concerns, incidents and grievances, as well as feedback regarding their expressed concerns (see procedure 2.a. Employee and Volunteer Education).

f. RCT members and clinical staff shall conduct ongoing resident assessments, revise care plans as needed, and monitor resident's needs and behaviors that may lead to conflict or neglect (see procedure 9 Resident Assessment and Care Planning).

~~LHH shall establish a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.~~

~~LHH shall Identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.~~

~~LHH will assure an assessment of the resources needed to provide care and services to all residents is included in the facility assessment.~~

~~The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.~~

~~LHH shall ensure the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions.~~

~~LHH will provide residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed.~~

~~LHH will address features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur.~~

~~LHH shall assign responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.~~

4. Identification: Signs of Possible Abuse, Neglect, Misappropriation of Resident Property, or Exploitation

a. Abuse may result in psychological, behavioral, or psychosocial outcomes. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate reporting, response, and investigation:

i. Statements from a resident alleging abuse, neglect, misappropriation of resident property, or exploitation (including involuntary seclusion and unreasonable confinement) by staff, another resident, or visitor;

ii. Sounds and/or utterances that suggest physical or verbal abuse, neglect, misappropriation of resident property, or exploitation, chemical or physical restraints;

iii. Injuries, abrasions, falls, or bruises of unknown or suspicious origin and/or location;

iv. Illogical accounts given by resident or staff member of how an injury occurred;

v. Sudden or unexplained changes in resident's personality or behavior(s) such as aggressive or disruptive behavior, running away, fear of being around a certain person or being in a particular context, withdrawal, isolating oneself, expressions of guilt and/or shame, depression, crying, talk of suicide and/or attempts, disturbed sleep;

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;

vii. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning

~~vi.~~viii. Resident-to-resident altercations;

~~vii.~~ix. Visitor-to-resident altercations;

~~viii. Discovery or observation of illicit photographs and/or recordings of residents being taken;~~

x. Unexplained contraction of sexually transmitted diseases, vaginal or anal bleeding, or torn and/or bloodied underclothing.

xi. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status.

~~ix.~~xii. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.

b. These signs may indicate that mental and/or verbal, sexual, or physical abuse, and/or the deprivation of goods and services has occurred; in the event that an indicator becomes apparent, LHH staff should immediately respond to and report the potential abuse.

5. Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer

i. Observes abuse,

ii. Suspects that abuse has occurred,

iii. Observes resident–to-resident or visitor-to-resident altercation,

iv. Identifies an injury of unknown source/ origin,

v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident or visitor-to-resident altercation, that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:

i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall reassign the employee who is being investigated to non-patient care duties or place the employee on administrative leave if non-patient care duties are not available at the point the manager was notified of the allegation. These measures shall be in place until the investigation is completed.

ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

c. The responsible manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

d. Upon receiving a report of alleged abuse, neglect or exploitation, the licensed nurse shall assess the resident for any potential change in condition. If the resident is noted to have a change in condition, the attending or on-call physician shall be promptly notified and shall complete a physician assessment of the resident.~~perform a physical exam~~.

i. The physician shall ~~record in the progress notes of the resident's medical record~~ document ~~-~~the history of abuse as relayed, any findings of ~~physical examination~~the assessment and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated. [IM(1]

~~d.~~e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

~~The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".~~

6. Reporting Protocol

a. All LHH employees, volunteers, and contractors are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

i. The mandated reporter shall immediately respond to the observed or suspected incident(s).

ii. Reporting shall be completed within the specified timeframes:~~and report observed or suspected incidents of abuse by contacting the following designees within 2 hours:~~

- Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or
- Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

iii. Reporting shall to the following agencies in the above specified timeframes:

- CDPH (415) 330-6353

- Ombudsman (415) 751-9788
- Nursing Operations (415) 327-1902

iv. Designees will assist the staff, contractor, or volunteer with reporting requirements and ensure specified timelines are me accordingly for both the initial and follow-up investigation reports, and any other State level required reporting.

~~ii.~~v. The mandated reporter may report anonymously to each internal and/or external agency.

b. LHH mandates suspected abuse to be reported to the local Ombudsman office as required by State law.

c.

~~d.~~ LHH shall report to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.

d. LHH also requires any reasonable suspicion of a crime committed against a resident of LHH be reported to SFSO~~D~~.

i. LHH will work with SFSO annually to determine which crimes are reportable.

ii. Examples of crimes that are reportable include but are not limited to the following:

- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery
- Drug diversion for personal use or gain;
- Identity theft; and
- Fraud and forgery.
- Certain cases of abuse, neglect, and exploitation

e. Notification requirements:

i. Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

ii. Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.

iii. The mandated reporter shall report the incident to CDPH, the Ombudsman and Nursing Operations.

iv. Nursing Operations shall notify the Chief Executive Officer (CEO), Administrator on Duty (AOD), SFSOD, and QM.

f. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall:

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker.

g. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

h. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify HR and the staff person's immediate supervisor within 24 hours.

i. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician.

j. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a

reasonable suspicion of a crime, and determine, if an incident is reportable to SFSOD. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.

k. In cases of alleged or factual rape the following steps must be taken:

i. LHH staff must immediately notify SFSOD (Ext. 4-2319).

ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

iii. At the San Francisco Rape Treatment Center, the resident shall be interviewed, specimens shall be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

iv. In all cases of rape, the attending physician shall request a psychiatric consultation for the resident.

v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

l. The results of the investigation shall be reported to CDPH within five working days of the incident by QM. If the alleged violation is verified, appropriate corrective actions shall be taken.

m. The respective department head, in consultation with HR, shall report cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards.

Federal Regulation (F-Tags)	Suspicion of a Crime 42 CFR 483.12(b)(5) and Section 1150B of the Social Security Act	Alleged Violations 42 CFR 483.12(c)
	F-609 Report of Alleged Violations~~F608 Reporting Crimes~~~~F609 Reporting Allegations of Abuse, Neglect, Exploitation or Mistreatment~~	
What to Report	Any reasonable suspicion of a crime against a resident or an individual receiving care from the facility~~Any reasonable suspicion of a crime against a resident.~~	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all [IM(2)][TN(3)]investigations of alleged violations~~All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation~~

		~~of resident property.~~
~~Who to Report Abuse Allegations or Crime Suspicion To~~Who is Required to Report	Every Employee (Mandated Reporter) shall report to: CDPH, the Ombudsman, and Nursing Operations. ~~Employees shall report immediately.~~	
Who Will Report to CDPH and the Ombudsman	Employee (Mandated Reporter)	
Who Will Report to SFSO~~D~~, QM, CEO~~/AOD~~	Nursing Operations	
When to Report to CDPH, Ombudsman and SFSO~~D~~	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury – not later than 24 hours*~~Within two (2) hours of forming the suspicion of crime.~~	All alleged violations- 1) Immediately but not later than 2 hours*- if the alleged violation involves abuse or results in serious bodily injury 2) Not later than 24 hours*- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury Results of all investigations of alleged violations- within 5 working days of the incident~~Within two (2) hours of knowledge of the allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.~~ [IM(4)][TN(5]

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse, neglect or exploitation allegation involves a LHH employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or place the employee on administrative leave, pending completion of the investigation. The interim reassignment or administrative leave will be in place until the Nursing and HR Departments complete their investigations and confer on their findings. The employee shall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation, neglect or exploitation involves a LHH employee and the conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:

i. Severity of the allegation,

ii. Circumstances of the case per the investigation, and

iii. Prior disciplinary and employment history.

d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to the LHH HR. The LHH HR shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.

e. Once a suspected crime has been committed, caution will be exercised when handling materials that may be used for evidence or for a criminal ~~investigate~~investigation. LHH will ~~referenc~~reference applicable State and local laws regarding preserving evidence.

~~d.~~f. LHH HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

~~e.~~g. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact SFSD. The nursing supervisor or manager shall initiate action to protect the resident and the SFSD and or San Francisco Police Department shall carry out the investigation.

h. The nurse manager or nursing supervisor shall inform the resident and responsible party of the findings of the investigation and provide a feedback to the employee who reported the criminal incident or abuse allegation.

8. Forms Completion and Submission

a. The Charge Nurse or designee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.

b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the designation of Nursing Operations. The staff person may be the Nurse Manager, Charge Nurse, Medical Social Worker or Nursing Operations

Nurse Manager. The completed SOC 341 shall be submitted to QM. (Refer to LHH SharePoint Forms page for an electronic form).

c. The investigating supervisor/manager conducting the investigation into resident abuse, neglect or exploitation shall verify that the Unusual Occurrence and the SOC 341 forms have been completed and submitted to QM.

d. The SOC 341 shall be faxed to 415-751-9789 by Nursing Operations or designee and the fax verification submitted to QM.

e. The investigating supervisor/manager shall complete the Investigation of Alleged Abuse form and submitted to QM with attachments in cases of:

   i. Resident-to-resident
   ii. Visitor-to-resident
   iii. Staff-to-resident
   iv. Injury of unknow origin
   v. Neglect
   vi. Misappropriate of resident's property

f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the final conclusion shall be determined by the Nursing Director, after conferring with the Chief Nursing Officer.

g. QM staff shall submit the SOC 341 form to the Ombudsman Office via fax (415-751-9789) if the fax verification was not received by Nursing Operations or designee[IM(6)][TN(7)].

h. QM staff shall provide a copy of the SOC 341 form to SFSD.

i. QM staff shall provide employee (mandated reporter), if not reported anonymously and staff information known, with a *Mandated Reporter Response Form* to acknowledge receipt of report and provide pertinent finding(s)/conclusion(s) as appropriate in accordance with HIPPA.

9. Resident Assessment and Care Planning

a. In cases of allegations of abuse, neglect or exploitation or resident-to-resident or visitor-to-resident altercation, the nurse manager or charge nurse, with input from the RCT and the resident(s) themselves (if possible) shall take the lead in assessing and updating the residents care plan(s). Considerations for care planning may include the following:

   i. Short-term and long-term measures to provide the resident with a safe and secure environment.

ii. Measures to mitigate the psychological impact of the incident.

iii. Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.

iv. Physiologic factor(s) involved in this incident. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain? Did the resident have signs of an infection or delirium?)

v. Treatment that may have contributed to or induced the resident's behavior.

vi. Need for psychiatric evaluation.

vii. Environmental stimulus/factor(s) contributing to this incident (excessive noise, crowded room).

viii. Staff action and/or inaction that may have contributed to the resident's behavior

ix. Ability to modify environment.

x. Likelihood of a repeat incident.

xi. Interventions to minimize the risk of recurrence.

xii. Need for frequent check-ins

xiii. Need for relocation or transfer to another level of care.

10. Coordination with QAPI

~~b.~~a. LHH will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.

i. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining:

- If a thorough investigation is conducted;
- Whether the resident is protected;
- Whether an analysis was conducted as to why the situation occurred;

- Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and
- Whether there is further need for systemic action such as:
  - Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,
  - Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about,
  - Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions,
  - Measures to verify the implementation of corrective actions and timeframes, and
  - Tracking patterns of similar occurrences.

ATTACHMENT:
Appendix A: Investigation of Alleged Abuse Form

REFERENCE: [IM(8)][TN(9]
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-07 Physical Restraints Including Bed Rails
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Complaints/Grievances
LHHPP 73-05 Workplace Violence Prevention Program
SOC 341 Form

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08, 18/09/11, 19/05/14, 19/07/09, 19/09/10, 20/01/14, 21/02/09 (Year/Month/Day)

Original adoption: 05/20/92

Appendix A: Investigation of Alleged Abuse Form

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

☐ Injury of Unknown Origin ☐ Misappropriation of Resident's Property ☐ Neglect ☐ Other to Resident
☐ Resident to Resident ☐ Staff to Resident ☐ Other _____

Occurrence of Incident

Date of Incident: _____ Time of Incident: Location of Incident:

Brief Description of Incident
PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

Date of Report: _____ Name of Reporter: Job Class/Title: _____

Reporter is: ☐ LHH Staff ☐ Other (specify): Contact Number: _____

Reported to: _____ Job Class/Title:

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Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

☐ Involved parties were separated and counseled. If not, please explain why:

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

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Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

***Notification Requirements** to CDPH, CEO/AOD, Ombudsman, QM Staff and SFSD based on criteria below:*

***Within 2 hours:** Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.*

***Within 24 hours:** Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.*

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

- ☐ Charge Nurse, Nurse Manager, and Nursing Director
- ☐ Physician
- ☐ Director of Social Work or Designee
- ☐ Urgent Psych for Evaluation (415-327-5130)
- ☐ Administrator/AOD
- ☐ Quality Management Department
- ☐ UO Documentation Complete
- ☐ Other _____

External Notification Checklist *(Check appropriate boxes)*

- ☐ Sheriff's Department (415-759-2319)
- ☐ SFSD Notification Form Faxed (415-759-3019)
- ☐ SOC-341 Completed and Faxed (415-751-9789)
- ☐ Rape Treatment Center (415-821-3222)
- ☐ Other _____
- ☐ CDPH Office (415-330-6353)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____
- ☐ Local Ombudsman Office (415-751-9788)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____

Sample call to CDPH:

This is ___ (your name and title) at Laguna Honda Hospital. This call is to notify you that on___ (date and time), a report of alleged resident abuse involving ____ (name of resident) was received.

Please spell the resident's name(s) and give the resident's date of birth when reporting the incident. Specify if there was any resident injury that occurred. State that an investigation of the incident has been initiated.

If there are any questions, please contact Quality Management at ext. 4-3055, ext. 4-3057, ext. 4-3575, or ext. 4-3530.

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s) ☐ N/A

Please complete ONLY if incident is Resident to Resident.

	Resident A	Resident B
Behavior Risk Assessment current and complete.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Care plan discusses problem behavior or risk of being a target of aggression.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any scheduled psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any PRN psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Received PRN psychotropic medications within 6 hours prior to incident.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
History of problem behaviors within the last 3 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Prior psych consult completed within the last 12 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Additional psych consult necessary.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A

Resident Interview

Resident MUST be interviewed unless comatose, discharged, or expired.

Resident A: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Resident B: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Analysis

Was this a deliberate act? ☐ Yes ☐ No If no, please explain: _____

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

Describe any physical injury, pain, and/or mental anguish:

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Investigation of Alleged Abuse

PART VII: CONCLUSION

Based on the interviews and other information available at this time, and in the exercise of my clinical judgment:

☐ I conclude that the abuse is substantiated.
☐ I conclude that the abuse is NOT substantiated.
☐ I conclude that the theft occurred.
☐ I conclude that the theft did NOT occur.

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

Resident/responsible party has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Resident/responsible party was satisfied with the outcome of the investigation.	☐ Yes	☐ No	☐ N/A
Employee(s) has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Reporter of alleged abuse has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Human Resources has been notified when staff to resident alleged abuse is substantiated.	☐ Yes	☐ No	☐ N/A

Additional Required Documents

(Check appropriate boxes)

I have attached a copy of the staff reassignment/ send home letter.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the resident's current and revised care plan.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the staff assignments.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the RCT special review and revised/reviewed the resident's care plan.	☐ Yes	☐ No	☐ N/A

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

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Investigation of Alleged Abuse

ADDITIONAL SPACE

Please use space as needed. Indicate the section additional detail is being provided for.

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RESIDENT RIGHTS

POLICY:

1. Patient/Resident rights are honored without regard to cultural, economic, educational, religious background, sexual orientation, gender identity, disability or the source of payment for his/her care.

2. The resident ~~also~~ has a right to a dignified existence, self-determination, and communication and access to person and services inside and outside ~~the facility~~Laguna Honda Hospital and Rehabilitation Center (LHH).

    a. The facility ~~will~~shall treat each resident with respect and dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

    b. The facility ~~will~~shall protect and promote the rights of the resident.

    c. The facility ~~will~~shall provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.

    ~~The facility willshall establish and maintain identical policies and practices regarding transfer, discharge and the provision of services under the State plan of all residents regardless of payment source.~~

3. The facility ~~will~~shall ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Training topics ~~will~~shall be appropriate to the individual's role.

~~2.~~4. LHH upholds patient/resident's rights to confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

~~3.~~5. Patient/residents are not to be required to perform services for the facility that are not included for therapeutic purposes in the plan of care.

~~4.~~6. ~~Laguna Honda Hospital and Rehabilitation Center (LHH)~~LHH staff collaborates with the San Francisco Ombudsmen Office in their role as residents rights advocate.

~~5.~~7. All residents of LHH are informed of their rights and responsibilities, and are further required to acknowledge receipt of having received a copy of those rights and responsibilities, as well as an explanation if requested.

~~6.~~8. A list of residents' rights is posted or available in appropriate places within LHH.

PURPOSE:

To assure that each resident is knowledgeable about his/her rights and the methods and circumstances by which those rights can be withheld. These rights comply with Title 22, California Code of Regulations Section 70707 and 72527, and Code of Federal Regulations, Title 42, Section 483.10.

PROCEDURE:

1. Prior to, or upon admission to LHH, the (a) Admitting Clerk or (b) a member of the Admission & Eligibility staff ~~will~~shall give to the resident, or her/his representative or responsible relative, a copy of the resident's rights form and ~~will~~shall have a receipt acknowledged by the signature of the receiving party.

2. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident ~~will~~shall be made available ~~and implemented~~.

3. The facility ~~will~~shall have written translations of its statements of rights and responsibilities in commonly encountered foreign languages, if/as applicable.

4. Large print texts of the facility's statement of resident rights and responsibilities should be available.

5. The receipt (acknowledgement) is placed in the resident's medical chart.

6. Discrepancies regarding these procedures should be brought to the attention of the Director of Admissions and Eligibility.

ATTACHMENT:
Appendix A: List of Residents' / Patients' Rights
Appendix B: LGBTQ+ Long-Term Care Facility Bill of Rights

REFERENCE:
LHHPP 24-06 Resident Complaints/Grievances
Resident Rights Web address:
http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph327-Attachment-A.pdf
Prohibiting Discrimination Against Lesbian, Gay, Bisexual, and Transgender Residents by Long-Term Care Facilities:
http://sfbos.org/ftp/uploadedfiles/bdsupervrs/ordinances15/o0047-15.pdf

Revised: 02/09/06, 08/09/30, 10/04/27, 15/11/09, 17/09/12, 19/03/12, 19/05/14, 19/07/09, 20/03/17 (Year/Month/Day)
Original adoption: 98/01/22

Appendix A:

LIST OF RESIDENTS' / PATIENTS' RIGHTS

I. Exercising Your Rights

1. You have the right to a dignified existence, self-determination, and communication and access to people and services both inside and outside of Laguna Honda. You have the right to be free of interference, coercion, discrimination, and retaliation from Laguna Honda in exercising your rights as a resident of Laguna Honda and as a citizen or resident of the United States, and Laguna Honda shall support you exercising your rights. You have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

2. You have the right to designate a representative if you are competent to do so, who may exercise your rights, in accordance with, and to the extent provided by state law.

    a. Your representative has the right to exercise your rights to the extent you have delegated those rights to your representative.

    b. You retain the right to exercise any right not delegated to your representative, including the right to revoke a delegation of rights, except as limited by state law.

    c. Laguna Honda shall treat the decisions of your representative as your decisions to the extent required by either a court or as delegated by you.

    d. Laguna Honda shall not extend to your representative the right to make decisions on behalf of you beyond the extent required by either a court or as delegated by you. Laguna Honda shall report, as required by law, if it has reason to believe that your representative is not acting in your best interest.

3. Residents adjudged incompetent by a court with jurisdiction to do so, shall have their rights devolve to and exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative shall exercise your rights to the extent judged necessary by the court with jurisdiction, and in accordance with state law.

    a. In cases where a representative's decision-making authority is limited by state law or court appointment, you retain the right to make those decisions outside of the representative's authority.

    b. Your wishes and preferences must be considered in the exercise of your rights by the representative, and to the extent possible, you shall be provided with the opportunity to participate in the care planning process.

4. You have the right to exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care. The same-sex spouse or a resident shall be afforded treatment equal to that of an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

II. Planning and Implementing Your Care

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you, and to be informed of the care to be furnished to you and the type of care giver that will furnish that care. You have the right to be informed and participate in your treatment.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in language you can understand. You have the right to be informed in advance of treatment of the risks and benefits of the proposed care, alternatives or options to the proposed treatment, and to choose the alternative or option if you prefer.

5. You have the right to effective communication and to participate in the development and implementation of your plan of care, and the right to receive the services and/or items included in the plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

6. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

7. Participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. You have the right to identify individuals or roles to be included in the

planning process, the right to request meetings, and the right to request revisions to the plan of care.

8. Choose your attending physician, provided that the physician meets the requirements of Code of Federal Regulations, Title 42.

9. See the plan of care and be informed in advance of any changes to the plan of care.

10. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

11. Self-administer medications if your care team has determined that this practice is clinically appropriate.

12. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

13. Reasonable responses to any reasonable requests made for service.

14. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

15. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

III. Respect and Dignity

You have the right to:

1. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

2. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

3. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

4. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

5. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

6. Know which hospital rules and policies apply to your conduct while a patient.

7. A safe, clean, and homelike environment including receiving treatment that supports your safe daily living. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Laguna Honda shall exercise reasonable care for the protection of your property from loss or theft.

8. Reside and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or other residents.

9. Share a room with your spouse if your spouse also resides at Laguna Honda and you both consent to the arrangement.

10. Share a room with the roommate of your choice when practicable, and only when you are both residents at Laguna Honda and consent to the arrangement.

11. Receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

12. Refuse to transfer to another room in the facility, if the purpose of the transfer is to relocate you from a skilled nursing unit to a non-skilled nursing unit within Laguna Honda, or if the transfer is solely for the convenience of Laguna Honda. This right shall not affect your eligibility or entitlement to Medicare or Medi-Cal benefits.

IV. Self-Determination
You have the right to:

1. Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, and

plan of care; and to make choices about aspects of your life at Laguna Honda that are significant to you.

2. Interact with members of the community and participate in community activities both inside and outside of Laguna Honda.

3. Organize and participate in resident groups within Laguna Honda. You have the right to participate in social, religious, and community activities provided that doing so does not interfere with the rights of other residents.

4. Receive visitors of your choosing at the time of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

    a. Laguna Honda reasonably determines that the presence of a particular visitor would endanger the health or safety of you, other residents, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

    b. You have told Laguna Honda staff that you no longer want a particular person to visit.

    c. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

5. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

6. Participate in family groups and have family members or other representatives' meet with the families or representatives of other residents of Laguna Honda.

7. Choose to or refuse to perform services for Laguna Honda. You may perform services for Laguna Honda when:

    a. Laguna Honda has documented your need or desire for work in the plan of care;

    b. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid;

    c. Compensation for paid services is at or above prevailing rates; and

    d. You agree to the work arrangement described in the plan of care.

    e. At no time shall you be required to perform services for Laguna Honda.

8. Manage your own financial affairs, including the right to know in advance, what charges Laguna Honda may impose against your personal funds.

9. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

V. Information, Communication, Privacy, and Confidentiality

You have the right to:

1. Be informed of your rights and the rules and regulations governing resident conduct and responsibilities during your stay at Laguna Honda.

2. Access your personal and medical records; and to secure and confidential treatment of all communications, personal records, and medical records pertaining to your care and stay in the hospital. You have the right to refuse the release of personal and medical records unless federal or state law requires the release of those records. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

3. Receive notices both orally and in writing in a format and language that you understand.

4. Have reasonable access to the use of a telephone in a place where you cannot be overheard, including the right to retain and use a cellular phone at your expense. You have the right to communicate with individuals and entities within and outside of Laguna Honda with reasonable access to the internet, to the extent available within Laguna Honda.

5. Send and receive mail, including letters, packages, and other materials delivered to Laguna Honda; and to have those communications be received and sent promptly and in private. You have the right to access stationery, postage, and writing implements at your expense.

6. Have access to, and privacy in, your use of electronic communications such as email and video communications, and internet research to the extent that it is available at Laguna Honda.

7. Privacy in your medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.

8. Examine the results of the most recent survey of Laguna Honda conducted by Federal or State surveyors and any plan of correction in effect, and to receive information from agencies acting as client advocates including the right to contact such agencies.

9. Voice grievances to Laguna Honda or other agencies that hear grievances without retaliation or discrimination, and without the fear of retaliation or discrimination, including grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and any other concern regarding your stay at Laguna Honda.

   If you want to file a grievance with this hospital, you may do so by writing or calling:

   ~~Michael T. Phillips, MHA, FACHE~~Roland Pickens
   Interim Chief Executive Officer
   Administration Department
   Laguna Honda Hospital
   375 Laguna Honda Boulevard
   San Francisco, CA 94116
   (415) 759-4510~~2363~~

   You have the right to prompt resolution of grievances. The grievance committee will review each grievance and provide you with a written response within 10 business days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

10. File a complaint with the state Department of Public Health regardless of whether you use the hospital's grievance process. The state Department of Public Health's phone number and address is:

    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

COMPLETION OF RESIDENT ASSESSMENT INSTRUMENT/MINIMUM DATA SET (RAI/MDS)

POLICY:

1. The assessments of the Resident Care Team (RCT) members are the primary data sources used by the RAI/MDS coordinator to complete the RAI/MDS assessments.

2. Respective members of the RCT are responsible for the timely completion of MDS assessments i.e. Admission, Quarterly, Annual, Significant Changes, Medicare and other required assessments.

3. The RCT shall utilize the RAI/MDS assessments to develop, review and revise each resident's comprehensive plan of care.

PURPOSE:

To successfully use the RAI/MDS process to enhance resident care, increase resident's active participation in care, and to promote the quality of life of the resident(s).

To utilize the RAI/MDS during care planning process.

To ensure accurate and timely completion of the Resident Assessment Instrument/ Minimum Data Set.

BACKGROUND:

The RAI/MDS is a tool used to identify resident problems, strengths, weaknesses and preferences and provides information for the development of an individualized plan of care.

PROCEDURE:

1. RAI/MDS Accuracy and Completion

a. The MDS Coordinator notifies Resident Care Team members by the end of each month~~every 21st of the month through e-mail~~ identifying those residents who are scheduled for assessments the following month. ~~If the 21st of the month falls on a weekend or holiday, the schedule shall be sent on the following business day~~. The MDS Coordinators may send an updated list after the initial notification~~e-mail~~ to reflect schedule revisions and additions.

b. The RAI/MDS Coordinator shall approve changes to the individual resident's schedule of RAI/MDS completion.

c. The Resident Care Team and the Department of Admissions and Eligibility are responsible for completing respective MDS sections as specified in Attachment C.

d. The team member whose area of assessment is triggered shall complete the Care Area Assessments (CAA). CAA that are triggered during completion of the comprehensive MDS shall be evaluated and discussed during RCC whether or not a comprehensive care plan needs to be developed for the triggered care areas (See LHHPP 23- 01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC).

e. The MDS Coordinator shall access the MDS in the electronic health record (EHR) during the scheduled Resident Care Conference for final review.

f. The MDS Coordinator shall facilitate discussion of the MDS, care areas (CAA) triggered and prompt the care planning process during the RCC and/or individual RCT members prior to the scheduled RCC.

g. All staff who complete any portion of the MDS shall enter their signatures, titles, sections or portion(s) of section(s) they completed, and the completion date in the EHR.

2. The RAI/MDS Assessments

A RAI/MDS assessment (CAA process and utilization guidelines) shall be completed for all residents at LHH.

Assessment Types:

a. Tracking Records

i. Entry- completion of an Entry tracking Record during admission and reentry.

ii. Death in facility- refers to when a resident dies in the facility or dies while on leave of absence (LOA).

b. OBRA Assessments

i. Admission- comprehensive assessment for a new resident or a returning resident.

ii. Annual- comprehensive assessment completed on an annual basis (at least every 366 days).

iii. Significant Change in Status Assessment- comprehensive assessment is completed if RCT determined that a resident meets the significant change

guidelines for either improvement or decline (see Standard Work for Significant Change in Status Assessment)

iv. Quarterly- an OBRA non-~~-~~comprehensive assessment completed every 92 days following the previous OBRA and is used to track resident's status between comprehensive assessments.

v. Significant Correction to Prior Comprehensive Assessment- completed when the RCT determines that a resident's prior Comprehensive assessment contains a significant error.

vi. Significant Correction to Prior Quarterly Assessment- completed when the RCT determines that a resident's prior Quarterly assessment contains a significant error.

vii. Discharge ~~(~~return not anticipated or return anticipated)- must be completed within 30 days when resident is discharged from the facility either return anticipated or return not anticipated.

c. Medicare Assessment- assessment of clinical condition of the resident receiving Part A SNF- level care.

Submission of required data to Centers for Medicare and Medicaid Services (CMS)

a. The facility must report data to meet the SNF Quality Reporting Program (QRP). The MDS 3.0 is transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES).
    a. The MDS 3.0 data is generated for the Certification and Survey Provider Enhanced Reporting system (CASPER) which provides the quality measures indicating the facility's star rating.
        i. List of Quality Measures
            1. High-Risk/Unstageable Pressure Ulcers (L) • Physical Restraints (L) • Falls (L) • Falls with Major Injury (L) 09/2020 v1.05 Certification And Survey Provider Enhanced Reports MDS 3.0 QM 11-4 CASPER Reporting MDS Provider User's Guide • Residents Who Newly Received an Antipsychotic Medication (S) • Residents Who Received an Antipsychotic Medication (L) • Prevalence of Antianxiety/Hypnotic Medication Use (L) • Antianxiety/Hypnotic Medication Use % (L) • Behavior Symptoms Affecting Others (L) • Depressive Symptoms (L) • Urinary Tract Infection (L) • Catheter Inserted and Left in Bladder (L)* • Low-Risk Residents Who Lose Bowel/Bladder Control (L) • Excessive Weight Loss (L) • Need for Help with ADLs Has Increased (L) • Percent of Residents Whose Ability to Move Independently Worsened (L)* • Percent of Residents Who Made Improvements in Function (S)* •

Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF Only)

b. The facility is required to submit staffing information through the Payroll Based Journal (PBJ) on a quarterly basis.

ATTACHMENT:
Attachment A: Required OBRA Assessment Schedule for the MDS
Attachment B: Medicare MDS Assessment Schedule
Attachment C: MDS 3.0 Section by Section

REFERENCE:
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
MDS 3.0 User's Manual, MED-Pass
Standard Work for Timely Submission and Accuracy of MDS
Standard Work for Significant Change in Status Assessment RCC

Revised: 10/01/20, 12/05/22, 19/05/14, 19/07/09 (Year/Month/Day)
Original adoption:

Attachment A: Required OBRA Assessment Schedule for the MDS

ADMISSION	Refer to RAI Manual page 2 - 8
~~Annual~~ANNUAL	Refer to RAI Manual page 2 - 19
SIGNIFICANT CHANGE IN STATUS	Refer to RAI Manual page 2 - 22 to 2- 27
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	Refer to RAI Manual page 2 - 30
QUARTERLY	Refer to RAI Manual page 2 - 31 to 2- 33
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	Refer to RAI Manual page 2 - 34
ENTRY	Refer to RAI Manual page 2 - 34 to 2 - 35
DEATH IN FACILITY	Refer to RAI Manual page 2 - 36
DISCHARGE	Refer to RAI Manual page 2 - 36 to 2 - 37

Attachment B: MEDICARE MDS Assessment Schedule

5 Day NPE (Medicare Last Covered Day) IPA (Interim Payment Assessment) Interrupted Stay ~~14 Day~~ ~~30 Day~~ ~~60 Day~~ ~~90 Day~~ ~~Other Medicare Required Assessment (OMRA)~~	Refer to RAI Manual ~~Page 2 - 29~~

Attachment C: MDS 3.0 Section by Section

SECTION	RESPONSIBLE DISCIPLINE(S)
A	
A0050	MDS
A0100 - A0200	IS
A0200	MDS
A030~~0010~~ – A0410	MDS
A0500 – A0900	A&E - autoflow
A1000	MDS - SS autoflow
A1100 - A1300	SOCIAL SERVICES -
A1200 – A1550	SOCIAL SERVICES and MDS
A1600 – A1700	MDS
A1800 – A2400	MDS
B	
B0100 – B1200	~~LICENSED NURSE~~MDS
C	
C0100 – C0500	~~LICENSED NURSE~~MDS
C0600 – C1000	~~LICENSED NURSE~~MDS
C1310	~~LICENSED NURSE~~MDS
D	
D0100 – D0350	~~LICENSED NURSE~~ MDS
D0500 – D060050	~~LICENSED NURSE~~ MDS
E	
E0100 – E600	~~LICENSED NURSE~~MDS
E800 – E1100	
F	
F0300 – F0400	ACTIVITIES
F0500 – F0700	ACTIVITIES
F0800	ACTIVITIES
G	
G0110 – G0120A	MDS
- G0300 – G0900	~~LICENSED NURSE~~MDS
GG GG0100-GG0170	MDS
H	
H0100 – H0600	MDS
I	
I 0100 – I 8000	MDS
J	
J0120 – J2000	MDS
J2100 - J500	MDS
K	
K0100 – K0710	DIETITIAN (RD)

L	
L0200	MDS
M	
M0100 – M1200	MDS~~LICENSED NURSE~~
N	
N0300 – N2005 0450	MDS
O	
O 0100 - O 0300	MDS
O 0400 - O0430 ~~A thru C~~	MDS (in collaboration with Rehab)
O 0400 D & E	MDS
O 0400 F	ACTIVITIES
O 0500 – O 0700	MDS
P	
P0100- P0200	MDS
S	
S9040A- S9040H	MDS
Q	
Q0100	MDS
Q0300 – Q0600	SOCIAL SERVICES
V	
V0100	MDS
V0200	RCT
V0200 B&C	MDS
X	
X0100 – X1100	RAI
Z0100	SOFTWARE CALCULATION
Z0400	RCT
Z0500 A&B	~~————~~MDS COORDINATOR

BEHAVIORAL HEALTH CARE AND SERVICES

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to ensure all residents receive necessary behavioral health care and services to assist them in reaching and maintaining their highest level of physicial, mental and psychosocial functioning.

PURPOSE:

To establish Policies and Procedures to ensure that LHH provides necessary behavioral health care and services which include[CMS DHHS SOM (§483.40)]:

a. Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;
b. Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being;
c. Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;
d. Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;
e. Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated.

DEFINITIONS:

1. **Highest practicable physical, mental, and psychosocial well-being**
   This is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

2. **Mental Disorder**

   Mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

3. **Substance Use Disorder (SUD)**

Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school, or home. (Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA) definition found at http://www.samhsa.gov/disorders/substance-use).

4. **Trauma**
   Trauma is defined as results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

5. **Post-traumatic stress disorder (PTSD)**
   Post-traumatic stress disorder occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD.

6. **Depression:**
   Depression (major depressive disorder) is a common and serious medical illness that negatively affects how an individual feels, the way they think and act. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home.

   Although people experience losses, it does not necessarily mean that they will become depressed. Depression is not a natural part of aging, however, older adults are at an increased risk. Symptoms may include fatigue, sleep and appetite disturbances, agitation, expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation. Late life depression may be harder to identify due to a resident's cognitive impairment, loss of functional ability, the complexity of multiple chronic medical problems that compound the problem, and the loss of significant relationships and roles in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

7. **Anxiety and Anxiety Disorders**
   Anxiety is a common reaction to stress that involves occasional worry about circumstantial events. Anxiety disorders, however, include symptoms such as excessive fear and intense anxiety and can cause significant distress. Anxiety disorders are prevalent among older adults and may cause debilitating symptoms. The distinction between general anxiety and an anxiety disorder is subtle and can be difficult to identify. Accurate diagnosis by a qualified professional is essential. Anxiety can be triggered by loss of function, changes in relationships, relocation, or medical illness. Importantly, anxiety may also be a symptom of other disorders, such as dementia, and care must be taken to ensure that other disorders are not inadvertently misdiagnosed as an anxiety disorder (or vice versa).

6 . Non-pharmacological Intervention:
Non-pharmacological intervention refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.

BACKGROUND:

Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment.
3. The facility will ensure that necessary behavioral health care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.
4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.
5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to:
   a. Depression – It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.
   b. Anxiety and Anxiety Disorders – There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder.
   c. Schizophrenia – It is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
   d. Bipolar Disorder – It is a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly.

6. All LHH staff have the responsibility to help residents meeting their behavioral health care needs.

PROCEDURE:

1. Assessment and Reassessment

a. LHH utilizes the comprehensive assessment and reassessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes, but is not limited to:
   i. PASARR screening.
   ii. Obtaining history and prior level of functioning from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health.
   iii. Ongoing monitoring of mood and behavior, including identifying individual resident responses to stressors
   iv. Care plan development and implementation.
   v. Evaluation.

b. The resident, and as appropriate the resident's family, are included in the comprehensive assessment and reassessment process along with the interdisciplinary team and outside sources, as indicated.

2. Care Planning

The care plan shall:

a. Have interventions that are person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.

b. Provide for meaningful activities which promote engagement and positive, meaningful relationships. Residents living with mental health and SUDs may require different activities than other nursing home residents. The facility will ensure that activities are provided to meet the needs of these residents.

c. Reflect the resident's goals for care.

d. Account for the resident's experiences and preferences.

e. Maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.

f. Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated.

g. Address any other individualized needs the resident may have related to the mental disorder or the SUD. This includes incorporating behavioral plan~~-~~ recommendations (if any) from LHH Psychiatry providers working with the resident.

h. Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.

3. Interventions, Monitoring and Documentation

a. LHH ~~Resident Care Teams (~~RCT~~)~~ shall implement person-centered care approaches designed to meet the individual goals and needs of each resident. These may include achieving expected improvements or maintaining the expected stable rate of decline based on the progression of the resident's diagnosed condition.

b. Individualized, person-centered approaches to care should be implemented based upon the comprehensive assessment, in accordance with the resident's customary daily routine, life-long patterns, interests, preferences, and choices. These shall be implemented to address expressions or indications of distress. Feedback from the the resident, resident's family, and/or representative(s) shall be included when possible.

c. The RCT shall be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress. Identifying the frequency, intensity, duration, and impact of a resident's expressions or indications of distress, as well as the location, surroundings or situation in which they occur, may help the RCT identify individualized interventions or approaches to care to support the resident's needs.

d. Individualized, non-pharmacological interventions shall be developed and implemented to help meet behavioral health needs of all ages. These may include, but are not limited to:
   i. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);
   ii. Encouraging exercise;
   iii. Providing pain relief;
   iv. Individualizing sleep and dining routines;
   v. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;
   vi. Adjusting the environment to be more individually preferred or homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);
   vii. Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment when possible);
   viii. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns;
   ix. Assisting the resident outdoors in the sunshine and fresh air (e.g~~.~~.., in a non-smoking area for a non-smoking resident);

x. Providing access to pets or animals for the resident who enjoys pets (e.g~~.~~., a cat for a resident who used to have a cat of their own);
xi. Assisting the resident to participate in activities that support their spiritual needs;
xii. Assisting with the opportunity for meditation and associated physical activity (e.g~~.~~., chair yoga);
xiii. Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;
xiv. Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing;
xv. Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible (see MSPP D08-07 LHH Substance Treatment and Recovery Services).
xvi. Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy (see MSPP D08-03 Access to LHH Psychiatry services); and
xvii. Providing support with skills related to verbal de-escalation, coping skills, and stress management.

e. RCT shall monitor the effectiveness of the interventions, changing those approaches, if needed, in accordance with current standards of practice. Additionally, staff shall accurately document these actions in the resident's medical record and provide ongoing assessment as to whether they are improving or stabilizing the resident's status or causing adverse consequences.

f. If indicated, referrals for LHH Psychiatry services can be made (see MSPP D08-02 LHH Psychiatry Scope of Services and Organization; MSPP D08-03 Access to LHH Psychiatry Services).
   i. Services by LHH Psychiatry providers (and related policies) include:
      - psychotropic medication management (MSPP D01-05)
      - mental health services (MSPP D08-09)
      - substance treatment and recovery services (STARS, including Non-specialty outreach and engagement of resident with SUDs and specialty substance treatment, MSPP D08-07)
      - neuropsychological and psychological testing services (MSPP D08-08)
      - behavioral management services (including behavioral consultation, behavioral planning, and Health and Behavior Services, MSPP D08-10)

   ii. Recommendations from and interventions by LHH Psychiatry providers shall be incorporated into the resident's care plan through collaboration between the RCT and LHH Psychiatry providers.

   iii. For residents with substance use disorders (SUD) receiving specialty SUD treatment services, the resident must give written consent using a facility-

approved authorization form for such treatment information to be shared with the RCT (for detailssee MSPP D08-07 Subtance Treatment and Recovery Servicies, Section 7).

- If the resident gives such consent, LHH Psychiatry providers will document summary information about the resident's specialty SUD treatment in LHH EHR.
- If the resident does not give such consent, LHH Psychiatry providers may only document in Epic behavioral health treatment information that is NOT about specialty SUD treatment, such as:
  - Mental Health Assessment and treatment;
  - Neuropsychological services;
  - non-specialty level SUD services;
  - Psychotropic medication treatment; and
  - Behavioral consultation and planning recommendations.

iv. LHH RCT members may ask the resident about how they are doing with the referral to SUD treatment, and document in Epic what the resident chooses to disclose, if any.

v. Regardless of whether the resident consents to disclosing any specialty SUD treatment records, LHH RCT shall care plan for the resident's SUD condition(s) based on available clinical information and observations.

g. The Therapeutic Care Team (TCT) under the Behavioral Response Team Department helps create and maintain a safe, equitable, and therapeutic care environment for LHH residents and assist staff to recognize early signs and symptoms of escalation and other at-risk behaviors. TCT provides culturally appropriate, non-violent crisis intervention training, and individualized de-escalation techniques while collaborating with multidisciplinary staff to ensure consistent response from resident care team. TCT collaborates with RCT and LHH Psychiatry team to problem solve around incorporating behavioral management recommendations from Psychiatry providers into care plans as well as intervention implementation.

h. Residents who exhibit behaviors which could endanger themselves, other residents, or staff may benefit from a behavioral plan to ensure they are receiving appropriate services and interventions to meet their needs.

i. Upon admission of a new resident, the Unit Nurse Manager or designee will determine if the resident's behaviors may benefit from a behavioral plan.

ii. Within twenty-four hours of admission, the Unit Nurse Manager or designee should develop an interim behavioral plan, until the comprehensive assessment and care plan are developed. Any behavioral interventions should also be included in the baseline care plan.

iii. The interdisciplinary team, including the resident, and as appropriate the resident's family, should develop a behavioral plan with identified behaviors through the RAI ~~(Resident Assessment Instrument)~~ process.

iv. Information regarding the resident's usual routine may be gathered from the pre-screening application tool, from the resident and family members, and/or the comprehensive assessment.

v. Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions.

vi. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care.

vii. The care plan and behavioral plan should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.

i. A behavioral plan may include a behavioral contract. If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other requirements of participation.

i. Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge.

ii. A behavioral contract can include a schedule of daily life events, which addresses the individuality of the resident. The contract should reflect the resident's personal preferences and usual routine, to the extent possible. The contract should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet the resident's highest practicable well-being.

iii. If a contract is used, it may also address:

1) The resident's right to have a leave of absence and the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).
2) Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable.
3) Steps the facility may take if substance use is suspected, which may include:
   - Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents.
   - Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff.
   - Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition.
   - Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others.

4) Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons.

j. For psychiatric emergencies, refer to ~~22-09~~MSPP D08-01 Psychiatric Emergencies. For other behavioral management related practices, refer to relevant hospital policies, such as: HWPP 24-25 Harm Reduction, HWPP 24-26 Dementia Care, HWPP 24-12 Laguna Premier Club: A Neurobehavioral Day Program, HWPP 22-09 Resident Activities, HWPP 22-10 Management of Resident Aggression, HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use By Residents or Visitors.

k. In cases where a resident's condition or behavior becomes such that the resident's needs cannot be met in LHH, or the health or safety of individuals is endangered due to the clinical or behavioral status of the resident, the RCT may seek alternative placement for the resident. See HWPP 20-04 Discharge Planning, Section 7 under Procedure: Involuntary Discharges.

~~k.~~l. All assessment, care plans, interventions, revisions and referrals shall be documented in the electronic health record (EHR).

4. Staff Training

All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following:

a. Person-centered care and services that reflect the resident's goals for care.
b. Interpersonal communication that promotes mental and psychosocial well-being.
c. Meaningful activities which promote engagement and positive meaningful relationships.
d. An environment and atmosphere that is conducive to mental and psychosocial well-being.
e. Individualized, non-pharmacological approaches to care.
f. Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, substance use disorder, or other behavioral health conditions.
g. Care specific to the individual needs of residents that are diagnosed with dementia.
h. Care specific to residents with ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care.

ATTACHMENT:

REFERENCES:

1. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F740 – Behavioral Health Services. 42 C.F.R. §483.40.
2. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F741 – Sufficient/Competent Staff - Behavioral Health Needs. 42 C.F.R. §483.40.
3. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F742 – Treatment for Mental/Psychosocial Concerns. 42 C.F.R. §483.40.
4. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F949 – Behavioral Health Training. 42 C.F.R. §483.95.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013
6. HWPP 24-25 Harm Reduction
7. HWPP 24-26 Dementia Care
8. HWPP 24-12 Laguna Premier Club: A Neurobehavioral Day Program
9. HWPP 22-09 Resident Activities
10. HWPP 22-10 Management of Resident Aggression
11. HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use By Residents or Visitors.
12. HWPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) and Resident Care Conference (RCC)
13. MSPP D08-02 LHH Psychiatry Scope of Services and Organization
14. MSPP D08-03 Access to LHH Psychiatry Services
15. MSPP D01-05 Psychotropic Medication Management
16. MSPP D08-09 Mental Health Services
17. MSPP D08-07 Subtance Treatment and Recovery Servicies
18. ~~22-09~~MSPP D08-01 Psychiatric Emergencies
19. Therapeutic Activity Programming policies
20. HWPP 20-04 Discharge Planning

Most recent review: ~~2022/12~~2023/01/20 (Year/Month/Day)
Revised: 2023/01/20
Original adoption: 2022/12/~~13~~03

CREMATION ASSISTANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) provides funding assistance to the families of LHH residents who do not have the means to pay for cremation arrangements.

2. The amount expended for cremation assistance to families shall not exceed the budgeted amount within the Laguna Honda Gift Fund (Gift Fund) for a given fiscal year.

PURPOSE:

To establish guidelines for the request and expenditure of funding from the Gift Fund for assistance to families of LHH residents for cremation.

CHARACTERISTIC:

1. The Gift Fund shall be the funding source for cremation assistance. A budget for cremation assistance shall be established on an annual basis as part of the Gift Fund budget and approved by the Health Commission.

2. The Gift Fund is a limited resource and all efforts are made to find alternatives, or to use the funds to supplement other sources.

PROCEDURE:

1. The Resident Care Team (RCT) shall identify candidates for burial assistance.

    a. The resident is nearing end-of-life and is expected to pass away as a resident at LHH.

    b. The resident has no or inadequate funds in ~~his or her~~their trust account to pay for cremation.

    c. The family of the resident has no or inadequate funds to pay for the resident's cremation.

    d. Without financial assistance, a referral would need to be made to the Public Administrator for disposition of the body.

2. The Social Worker shall contact the Gift Fund Program Manager or designee to confirm that there are sufficient funds remaining in the burial assistance budget for the fiscal year.

3. The Social Worker shall evaluate the need for cremation assistance.

    a. The Social Worker shall contact the Accounting Department to ascertain the resident's balances in the Trust Account.

    b. The Social Worker shall consult with the resident's family if available to determine if they are able to pay the cost of cremation.

    c. The Social Worker shall document the information in the resident's medical record.

4. If need is established, the Social Worker shall contact a city-approved mortuary for a written quote for cremation.

5. The Social Worker shall facilitate the completion of a Cremation Assistance Request Form and submit to the Director of Social Services.

6. Upon approval from the Director of Social Services, the Social Worker shall consult with the resident and/or the family to establish funeral plans.

7. Copies of all documents related to the Creation Assistance Request shall be forwarded to the Program Monitor overseeing the Rols 1000325 Gift Fund project code.

8. Upon the passing of the resident, the Director of Social Services or designee shall facilitate payment to the mortuary via the PeopleSoft eProcurement process using the following chartfields.

    a. Fund: 22150

    b. Department: 207690

    c. Project Code: 10000325

    d. Authority: 10001

9. The Program Monitor shall approve the requisition within PeopleSoft.

10. Copies of all documents related to the Creation Assistance Request and service procurement shall be forwarded to the Gift Fund program Coordinator to be filed.

ATTACHMENT:
Attachment A: Cremation Assistance Request Form
Attachment B: List of City-Approved Mortuaries

REFERENCE:
Admissions and Eligibility Department Policy 07-02 Procedure for Disposition of Expired
LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates
LHHPP 45-01 Gift Fund Management
NPP D8.0 Post-Mortem Care
MSPP C01-01 Patient Expiration
Social Services Departmental Policy 7.19 Burial and End of Life Care Arrangements Resident and Distribution of Funds

Original Adoption: 19/03/12 (Year/Month/Day)

HOSPITAL EQUIPMENT AND SUPPLIES BUDGET AND PROCUREMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH~~aguna Honda~~) shall have available equipment and supplies needed to render appropriate care to residents.

PURPOSE:

To ensure that physician-ordered care can be ~~provided at all times~~always provided through the use of equipment and supplies.

PROCEDURE:

1. **The Finance Manager or a Designee**

    a. Shall establish budgeting, appropriation management, purchasing and expenditure accounting policies and procedures.

2. **The Associate Administrator for Operations**

    a. Shall establish Materials Management and Central Supply inventory control policies and procedures.

3. **Division Heads**

    a. Shall be responsible during budget preparation to make adequate annual appropriation requests for suitable equipment and supplies for their divisions.

    b. Shall be responsible to expend appropriated funds to ensure that priority is given to equipment and supplies necessary to maintain essential services.

4. **Department Heads**

    a. Shall be responsible during budget preparation process to make adequate annual appropriation requests for suitable equipment and supplies for their departments and otherwise make every effort to enumerate all equipment and supplies deemed necessary to maintain a legally compliant and high standard of resident care;

    b. Shall be responsible to expend appropriate funds in a timely fashion to ensure that priority is given to equipment and supplies necessary to provide ordered or indicated services; and

    c. Shall be responsible to implement, within their departments, equipment life-cycle projections, inventory controls, and par estimates sufficient to assure that

equipment and supply orders are placed in a timely fashion which take into account known order requirements, bid specifications, constraints, and order lag time of the City Purchaser.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 02/01/02, 92/05/20, 07/12/18, 11/05/13, 15/03/10, 16/01/12 (Year/Month/Day)
Original adoption: 88/01/22

INVENTORY AND DISPOSAL OF HOSPITAL PROPERTY

POLICY:

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

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

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

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

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

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

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

PURPOSE:

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

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

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

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

DEFINITION:

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

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

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

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

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

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

PROCEDURE:

1. Equipment is received by CPD.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT:
None.

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

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

MOLLY'S FUND - ASSISTIVE TECHNOLOGY PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) utilizes Molly's Fund to provide assistive technology services and devices to residents to maximize their level of functioning, decrease environmental barriers, improve quality of life, and to increase participation in daily activities, leisure pursuits, and socialization.

PURPOSE:

To provide appropriate and effective distribution of assistive technology services and equipment resulting from donations made to the LHH Gift Fund specifically related to Molly's Fund.

CHARACTERISTICS:

1. The funding source for assistive technology devices and services is Molly's Fund, a sub fund within the LHH Gift Fund. A project code has been established within the Gift Fund to accept contributions from donors who wish to support assistive technology programs at the hospital.

2. The distribution of assistive technology equipment and services is the responsibility to the Assistive Technology Committee, which includes members of Activity Therapy, Rehabilitation Services, Nursing, Accounting, and Administration.

3. Assistive Technology services are made available to residents and is in accordance to a standard procedure when all other funding options have been explored.

4. Devices acquired through Molly's Fund and provided to residents~~,~~ shall be the property of LHH and shall only become the property of the resident upon a planned discharge. A device may be repossessed by LHH and reallocated to another resident if a resident expires, or if the device is misused or not utilized for its intended purpose.

5. The definition of Assistive Technology includes:

   "Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional capabilities of a person with a disability." (IDEA2004, Disability Rights California), (The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015)

PROCEDURE:

1. The Resident Care Team shall discuss assistive technology needs of the resident and designate a staff member to assist with completion of the Assistive Technology Fund application.

2. The completed form is submitted to the Assistive Technology Committee for consideration.

3. The Assistive Technology Committee is convened by the Accounting Partner and meets at least four times annually and/or when a Molly's Fund application/request has been received.

4. If the application is approved, the committee shall request an Occupational Therapy (OT) or Speech/Language Pathology (SLP) referral from the assigned physician as needed. OT/SLP shall conduct an assessment of the resident and develop a treatment plan including identification of an assistive technology device.

5. Every effort will be made to acquire a device, for trial purposes, from a community-based lending library to determine if it is appropriate for the resident.

6. When an assistive technology device or service has been determined to be appropriate for the resident, attempts will be made to acquire funding from all sources including insurance and resident/family.

7. If funding from Molly's Fund is determined to be the best option, OT/SLP will send Assistive Technology recommendations to the committee, to include goals and required devices or services. Information on attempts to secure funding from traditional sources shall also be provided to the committee.

8. The committee will approve or deny funding of devices or services.

9. If approved, the~~The~~ OT/SLP will review the Assistive Technology Contract with the resident and/or resident representative and get the necessary signatures. The signed contract will be kept on file in the Rehabilitation Services Department.

10. OT/SLP shall facilitate the purchasing process though Information Technology (IT) p~~P~~rocurement processes.

    a. Chartfield Codes includes:

        i. Fund: 22150

        ii. Department (Gift Fund): 207690

        iii. Project Code: 10000328

11. OT/SLP shall train the resident and neighborhood staff on the use of the assistive device.

12. The Rehabilitation Representative to the neighborhood will monitor the appropriate use technology equipment provided to the resident.

    a. If the determination is made that the resident is not meeting the terms of the Assistive Technology Contract, the Rehabilitation Representative will consult with the RCT to determine if additional support is needed.

    b. If the RCT determines that the appropriate course of action is to reallocate the equipment, the OT/SLP responsible for completion of the contract will be responsible to retrieve the equipment from the resident.

ATTACHMENT:
Attachment 1: Assistive Technology Application Form
Attachment 2: Assistive Technology Contract
Attachment 3: The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015

REFERENCE:
LHHPP 45-01 Gift Fund Management
IT Procurement Guidelines
IDEA2004, Disability Rights California

Original Adoption: 18/07/10 (Year/Month/Day)

ENTERAL NUTRITION CHARGE PROCEDURE

POLICY:

An Enteral Nutrition Charge Form shall be completed monthly for all Laguna Honda Hospital and Rehabilitation Center (LHH) residents receiving enteral nutrition therapy.

PURPOSE:

1. To ensure that that an accurate bill is sent to the corresponding health insurance plan(s) that provides coverage for enteral nutrition therapy.

2. To capture the costs and charges for enteral nutrition therapy that is not covered by health insurance plans as part of the SNF's routine costs of providing care to the residents.

PROCEDURE:

1. Generating Monthly Charge Forms

a. At the beginning of each month, the Dietetic Technician (DTR) shall print an Enteral Nutrition Charge Form (see Appendix A) with the current enteral feeding formula label and formula container labels for all residents receiving enteral nutrition therapy. The DTR shall deliver these Charge Forms, plus 3 blank Enteral Nutrition Charge Forms and container labels to the respective neighborhood nursing station.

b. When a resident is newly started on enteral feeding therapy, the enteral nutrition diet order shall be prescribed by the physician through the electronic health record (EHR). The designated Licensed Nurse shall contact Nutrition Services diet office and inform the Diet Clerk of the new enteral nutrition diet order. The licensed nurse shall utilize one of the blank Enteral Nutrition Charge forms to record charges for the enteral nutrition formula and supplies used during the month.

c. Upon notification of a resident who is newly started on enteral feeding, the Diet Clerk shall enter the new feeding order into the CBORD diet office computer system.

2. Change of Formula/Calories from Physician Order

a. When a resident has a change of enteral nutrition diet order, it shall be prescribed by the physician through the electronic health record (EHR). The designated Licensed Nurse shall contact Nutrition Services diet office and inform the Diet Clerk of the change for the enteral nutrition diet order.

b. The DTR shall print a new label with the new Formula/Calories and formula

container labels for the following month at the end of each month and send it to the Neighborhood Nursing Unit.

3. Completing Charge Forms

a. At the beginning of each month, the designated Licensed Nurse shall stamp the resident's addressograph plate information onto each of the respective Enteral Nutrition Charge Forms received. If the enteral feeding formula label is not correct, the Licensed Nurse shall write the current order on the bottom section of the Form along with the date of the order ~~change, and~~change and notify Nutrition Services diet office of the correct enteral nutrition order prescribed through the EHR. These Enteral Nutrition Charge Forms shall be placed in the Unit Treatment Sheet binder.

b. Each day, the designated Licensed Nurse records the use of enteral nutrition supplies on the Enteral Nutrition Charge Forms. Whenever there is a change in enteral feeding orders, the Licensed Nurse indicates the order change on the Form and notifies Nutrition Services (refer to Appendix B: Instructions for Completing Enteral Nutrition Charge Forms).

c. If the resident is relocated, the Enteral Nutrition Charge Form accompanies the medical record to the relocated unit for continued use.

d. Only one Enteral Nutrition Charge Form is needed each month unless the resident is discharged from LHH or the acute units, or expires during the month. If the resident is thus discharged from the hospital, the date of discharge is written on the Charge Form and signed by the Nurse Manager or designated Charge Nurse, then forwarded to the Billing Department.

e. At the end of each month, the Nurse Manager or designated Charge Nurse must sign the Enteral Nutrition Charge Forms to verify the completeness of the Form and the charge forms are sent via fax to the billing department.

4. Gathering and Reconciling Enteral Nutrition Charge Forms

a. On the 1st business day of each month, the completed Enteral Nutrition Charge Form shall be sent via fax to the billing department from all nursing units.

b. If there are any missing Charge Forms, or other concerns related to the Charge Forms, the appropriate Nurse Manager will be contacted by Billing Department staff to resolve or clarify any issues and questions.

5. Physician Order Change of Formula/Calories

a. Billing Office shall review the Enteral Charge Forms.

6. Billing for Enteral Nutrition Therapy

a. The designated Billing Clerk is responsible for coordinating the completion of the Certificate of Medical Necessity, which is a required document for all initial and revised claim submissions for enteral nutrition therapy. Subsequent certifications or recertification are required according to instructions covered in the CMS Program Manuals – Medicare Carrier (Chapter 20), Section 100.2.1- 100.2.2. Evidence of Medical Necessity for Potential and Enteral Nutrition. Additional instructions at CMS Manuals- LCD: Centers for Medicare & Medicaid services. LCD for Enteral Nutrition L11568.

b. The completion of the Certificate of Medical Necessity is a collaborative effort comprised of designated staff from the Billing, Nutrition Services, Medical, and Health Information Services Departments.

c. Additional medical record documentation may be required to substantiate the billing claims requested for enteral nutrition therapy. Health Information Services Department staff shall provide copies of requested medical record documentation to the Billing Department.

ATTACHMENT:
Appendix A: Enteral Nutrition Charge Form
Appendix B: Instructions for Completing the Enteral Nutrition Charge Form
Certificate of Medical Necessity Form CMS-10126

REFERENCE:
CMS Program Manual - Medicare Carrier (Chapter 20) Internet Directory, On-line Website: http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf. Additional Program Manual -LCD; Centers for Medicare and Medicaid Services. (LCD for Enteral Nutrition L11568). Internet Directory, On-line Website www.cms.hhs.gov/mcd/

Revised: 08/03/25, 19/07/09 (Year/Month/Day)
Original Adoption: Developed 05/12/09 by the Enteral Nutrition Task Group

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPI)

POLICY:
Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to quality and patient safety and recognizes that patients, staff, and visitors have the right to a safe environment. It is the policy of LHH to ~~establish and maintain an ongoing, systematic, and proactive organization-wide process to measure, assess, and improve patient care and safety based on the organization's True North and regulatory requirements.~~develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Identifying, analyzing, and resolving systems and human behavior risks sets a foundation grounded in patient safety. The QAPI Program provides the framework to achieve and maintain a safe environment by promoting a culture that encourages error identification, reporting and prevention through education, system redesign and human behavior management.

The Medical Staff, through the Medical Executive Committee, is responsible for the establishment, maintenance and support of an on-going, organization-QAPI Program in accordance with Federal and State requirements, professional regulations, and the LHH Medical Staff Bylaws.

Hospital leadership works collaboratively with the medical staff and the governing body to set expectations for performance improvement and manages processes to ensure that the QAPI Program is meeting the hospital's goals as well as meeting all regulatory requirements.

PURPOSE:

The intent of the QAPI Program is to promote a culture of safety and provide a systematic, coordinated and continuous approach to optimizing clinical outcomes and patient safety. ~~This is achieved by:~~

This is achieved by:~~A.~~

1. Collaboration of the Governing Body, Joint Conference Committee, and Hospital Leadership to establish annual performance goals directly linked to the ~~Laguna Honda Hospital and Rehabilitative Center (~~LHH~~)~~ True North Metrics.

2. Creating a culture of safety to anticipate, identify and acknowledge risks and errors and promote error reporting as part of the provision of care and safety of the patient.

3. Assessing the perceptions of patient safety by administering a Culture of Safety Survey at least every 24 months.

4. Establishing a "just-culture" framework that addresses both systems issues and

human behaviors that can undermine performance and patient safety.

5. Aggregating data to identify trends and high-risk activities while defining measures to address identified safety issues.

6. Review and follow-up on Patient/Resident Safety Events – includes adverse events or potential adverse events that are determined to be preventable; and healthcare-associated infections~~, as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee, that are determined to be preventable~~.

   ~~G. Educating staff to their role in identifying and resolving errors and involving staff in proactive risk assessments and behavioral improvements.~~

7. Ensuring that proactive risk assessments ~~(e.g., Failure, Mode, Effect and Analysis)~~ and process improvements are communicated to managers and those directly involved when appropriate.

   ~~I. Gathering standardized clinically relevant information about patient safety events and close calls that may adversely impact patients;~~

8. Developing solutions to systemic patterns and practices that place patients at risk and to stimulate, initiate and support interventions designed to reduce risk of errors and to protect patients from harm;

9. Promoting a uniform monitoring and evaluation process for performance improvement and patient safety activities;

10. Promoting the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve processes and patient outcomes;

11. Promoting a culture geared toward proactive risk assessment by increasing the reporting of medical errors and adverse events and expanding opportunities to reduce errors and adverse outcomes; and

    ~~N. Prioritizing initiatives to enhance patient outcomes/safety based on analysis and assessment of the data, and in accordance with the organization's True North, care and services provided, and the population served;~~

    ~~O. Facilitating an interdisciplinary, collaborative approach to improving the quality of care, patient safety, and utilization of resources through the designation of continuous performance improvement and patient safety initiatives;~~

12. Guiding LHH in meeting legal, professional, accreditation, and regulatory requirements~~; and~~.

~~Q. Providing education~~

DEFINITION:

"Adverse Event" is an untoward, undesirable and ~~communication~~usually unanticipated event that causes death or serious injury, or the risk thereof.

"High Risk Areas" refers to care or service areas associated with significant risk to the health or safety of residents. Errors in these care areas have the potential to cause adverse events resulting in pain, suffering, and/or death. Examples include tracheostomy care; pressure injury prevention; administration of high-risk medications such as anticoagulants, insulin and opioids.

"High Volume Areas" refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem (e.g., transcription of orders; medication administration; laboratory testing).

"Performance Improvement (PI)" is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.

"Problem-Prone Areas" refers to care or service areas that have historically had repeated problems (e.g., call bell response times; staff turnover; lost laundry).

"Quality Assurance (QA)" is the specification of standards for quality of service and outcomes, and systems throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance ~~improvement principles and tools.~~ is at risk or has failed to meet standards.

"Quality Assurance and Performance Improvement (QAPI)" is the coordinated application of two mutually reinforcing aspects of a quality management system: (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes, while involving residents and families in practical and creative problem solving.

~~**LEADERSHIP PRINCIPLES** – How we as leaders Align, Enable and Improve to achieve True North.~~

~~A. Align~~

~~1. We create value for the patient~~

~~2. We think systematically~~

~~3. We have a constancy of purpose~~

~~B. Enable~~

~~1. We lead with humility~~

~~2. We respect every individual~~

~~3. Transparency through visual management~~

~~C. Improve~~

~~1. Seek perfection~~

~~2. Ensure quality at the source~~

~~3. Embrace scientific thinking~~

~~4. Focus on process~~

PROCEDURE:

1. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) COMMITTEE

a. **The Performance Improvement and Patient Safety Committee is an interdisciplinary executive and medical staff committee promoting:**

i. Communication – Cross-functional learning from departmental reflection on problem solving drivers.

ii. Alignment – Identify common goals, challenges, opportunities, partners.

iii. Accountability – Ensure all levels of organization are driving true north.

~~iii.~~iv. The PIPS Committee is responsible for implementing the objectives of the organization wide QAPI program. The PIPS Committee takes an interdisciplinary and proactive approach in the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety as a core value in providing quality patient care. The PIPS Committee uses data to drive improvement efforts, guide day to day operations and prioritize performance improvement projects that includes input and experience from healthcare workers, residents, families and other stakeholders.

~~iv.~~v. The PIPS Committee is a Joint Hospital Leadership and Medical Staff Committee. The Committee shall consist of the following members: Chief of Medicine or designee, Chief of Physical Medicine and Rehabilitation Services or designee, Chief of Outpatient Clinics or designee, Chief of Psychiatry or designee, Chair of the Medical Quality Improvement Committee or designee, ~~Chair of the EASI Committee or designee,~~ Chief Dietician or designee, Chief Health Informatics or designee, Director of Social Services or designee, Director of Pharmacy or designee, Director of Activity Therapy or designee, Infection Prevention and Control Officer or designee, Director of Rehabilitative

Services or designee~~, Patient/Resident Safety Officer, Hospital Administrator for Strategic Performance Management or designee,~~ Privacy/Compliance Officer or designee, ~~Manager~~Director of ~~Administration or designee~~Regulatory Affairs, Director of Risk Management, Director of Performance Improvement, Quality Improvement Coordinators and a Deputy City Attorney. Executive Leadership Team members, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Nursing Officer (CNO) and Chief of Staff are committee members. The Chief Medical Officer (CMO) serves as Chair of the PIPS Committee, and the Chief Quality Officer serves as ~~Vice~~ Co-Chair.

b. **Functions of PIPS Committee Include:**

i. On ~~a biannual~~an annual basis, reviews the effectiveness of the LHH QAPI Program in meeting the organization-wide purpose, goals and objectives and revises the program as necessary;

ii. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from: Serious Adverse Events in the SNF (SAE) and Sentinel Events in Acute (SE); patient/resident safety events; patient case reviews; risk management reports; infection prevention and control reports, hospital claims; patient and staff surveys; patient/visitor concerns; clinical service and ancillary/diagnostic department performance improvement reports; ongoing medical record review, and other sources as appropriate;

iii. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and PI committees as appropriate;

iv. Makes recommendations based on an evaluation of the care provided (e.g. efficacy, appropriateness) and how well it is done (e.g., availability, timeliness, effectiveness, continuity with other services/practitioners, safety, efficiency, and respect and caring).

v. Reports and forwards recommendations monthly to the Medical Executive Committee, Joint Conference Committee and the Health Commission (Governing Body) through the Chief Medical Officer and Chief Quality Officer.

vi. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources.

vii. Reviews and approves the clinical and departmental performance improvement measures and patient safety initiatives of LHH.

viii. Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreements.

ix. Reviews and approves the QAPI plan;

x. Develops recommendations for performance improvement activities according to potential impact upon patient outcomes and safety and in accordance with the hospital's mission, vision, care and services provided, and the population served;

~~xi. Ensures integration of approved performance and safety improvement recommendations into LHH management accountabilities;~~

~~Participates in the strategic planning process for patient safety and recommends that performance improvement findings are incorporated into goals and objectives of that process;~~

~~xii.~~xi. Ensures that safety issues have priority status and are taken into account when designing and redesigning processes; and

~~xiii.~~xii. Ensures appropriate review, analysis and follow-up of performance improvement opportunities, including analyses of staffing adequacy related to undesirable patterns, trends, or variations pertaining to safety or quality~~; and~~.

~~xiv. Provides oversight for patient safety event reviews, ensuring compliance with facility policies and procedures related to investigation, analysis, corrective actions and monitoring; and~~

~~xv. Measuring performance against established standards and evaluating results; and~~

~~xvi. Oversees the work of the Office of Patient Experience (OPEX).~~

~~c. **PIPS Subcommittees Include:**~~

~~i. Code Blue Subcommittee: Oversees the organization and operations of the Code Blue Team. All findings from review of code activities related to performance improvement and patient safety activities are reported to this committee for evaluation and recommendations. The chair of the committee reports to PIPS on a twice-yearly basis.~~

~~ii. Event Analysis and Systems Improvement Committee: Analyzes events that occur within the Hospital affecting patient care and patient safety. The committee is responsible for the oversight of the review process that includes, but is not limited to, identification of clinical risk, system vulnerabilities, and opportunities for quality improvement. Additionally,~~

~~the committee is responsible for ensuring the implementation of action plans aimed to mitigate future recurrence of similar events. The chair of the committee reports to PIPS on a twice-yearly basis.~~

~~2. PATIENT/RESIDENT QUALITY AND SAFETY PLAN~~

~~The Patient/Resident Quality and Safety Plan is a subset of the overall QAPI program for the Acute and SNF units and is approved and reviewed annually through PIPS. The Patient/Resident Safety Officer works collaboratively with other LHH-wide patient/resident quality and safety champions to concentrate on the following areas in alignment with the LHH QAPI Plan:~~

~~See attached LHH QAPI Plans (Appendix A)~~

~~3.~~2. THE GOVERNING BODY

The San Francisco Health Commission is ultimately responsible for maintaining the quality of patient care and safety. Through the LHH Joint Conference Committee of the Health Commission~~, governance is achieved as follows~~:

a. Approves the LHH ~~Hospital Patient/Resident Quality and Safety Program and~~ QAPI Plans for SNF and Acute units;

b. Through the Director of Public Health and the LHH Chief Executive Officer, supports performance improvement and patient safety initiatives and mechanisms by employing specific staff to provide technical and consultative support to the various departments and programs;

c. Ensures quality planning is incorporated into the strategic planning process~~, and~~;

d. Through the Joint Conference Committee and the PIPS Committee, regularly reviews reports on performance improvement and patient safety activities and acts upon them when appropriate~~.~~; and

e. Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreement.

4. INDIVIDUAL ROLES AND RESPONSIBILITIES

~~a.~~ Director of Public Health

a. ~~1.~~ **:** Provides support and facilitates communication throughout the Department of Public Health in regard to activities and mechanisms for monitoring and evaluating the quality of patient care/safety, identifying and resolving problems, and identifying opportunities for improvement. Serves as the Chief Executive Officer of the Health Commission.

b. LHH Chief Executive Officer

i. ~~1.~~ Assumes overall administrative accountability and responsibility for the LHH ~~Patient/Resident Quality and Safety~~QAPI Program; and

~~2.~~

ii. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems.

c. Chief Medical Officer

i. Works with the Chief Quality Officer to develop and implement the ~~Patient/Resident Quality and Safety~~QAPI Program;

~~2.~~

ii. Participates in and leads performance improvement and patient safety initiatives;

~~3.~~

iii. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues;

iv. Ensures medical staff and infection prevention and control review of all patient deaths and identification of deaths that may be preventable or related to hospital-acquired infections.

~~5.~~

v. Serves as Co-Chair of the PIPS Committee;

~~6.~~

vi. Ensures that the LHH Medical Staff Bylaws reflect the function and role of the PIPS Committee;

~~7.~~

vii. Oversees and participates in the education of Medical Staff, nursing staff, and others regarding performance improvement and patient safety

~~8.~~

viii. Presents performance improvement reports to the Medical Executive Committee and to the Joint Conference Committee.

d. Chief Quality Officer

i. Develops, implements, and monitors the ~~Patient/Resident Quality and Patient Safety~~QAPI Program under the direction of the LHH CEO; ~~and~~

ii. In collaboration with the CMO, coordinates projects of the PIPS Committee; ~~and~~

iii. Administers the Unusual Occurrence System; ~~and~~

iv. Analyzes data for trends and makes recommendations to reduce or prevent

incidents that may adversely affect patient care or the safety of patients/residents, visitors, employees and visitors; ~~and~~

v. Offers technical assistance with regards to ~~Quality and Patient Safety~~QAPI activities to the Medical Staff, ~~Hospital~~LHH staff, Committees, performance improvement and patient safety teams**,** and LHH leadership; ~~and~~

vi. Reviews departmental and committee performance improvement reports to identify interdepartmental and/or interdisciplinary quality or patient safety issues; ~~and~~

vii. Participates in resolving patient care/safety issues as identified from unusual occurrence data and regulatory agency reports; ~~and~~

viii. Develops pertinent reports for the CEO, Medical Staff, committees and external agencies; ~~and~~

ix. Provides education to the Medical Staff, LHH leadership, and others regarding performance improvement and patient safety; ~~and~~

x. Consults with Department of Education and Training on LHH performance improvement and patient safety education curriculum; and

xi. Serves as ~~Vice~~ Co-Chair of the PIPS Committee.

~~e.~~ The Chief Nursing Officer

~~f.~~e.: Ensures that Nursing quality improvement activities are clearly delineated and implemented in alignment with the QAPI Plan and True North.

~~g.~~f. The Chief of Service, LHH Leadership, and Department Managers

It is recognized that all leaders have a major role in promoting Quality and Patient Safety at LHH. Chiefs of Service, LHH Leadership, and Department Managers are responsible for the continuous, effective operation and improvement of their respective departments. The Chiefs of Service, LHH Leadership, and Department Managers:

i. Define the scope of services provided and identify key functions and indicators to monitor practice. Communicate monitoring, evaluation, and improvement results to other disciplines and departments as appropriate. Incorporate strategic planning goals into PI activities, as appropriate;

ii. Develop and implement performance improvement activities in accordance with the ~~Hospital Quality and Patient Safety~~QAPI Program;

iii. Develop, implement and monitor performance measures within each department and report status of measure to PIPS;

~~ii.~~iv. Assign representatives to participate in the PIPS Committee and to present performance improvement and patient safety activities as scheduled; and

~~iii.~~v. Participate in Morbidity and Mortality and Peer Review to ensure safe physician practice.

~~h.~~g. Medical Director for Risk Management

i. Provides medical oversight of the management of SAE, SE, the Unusual Occurrence system and the process for around-the-clock reporting of patient safety events; and

1. ~~Serves as Chair of the Event Analysis and Systems Improvement Committee.~~

h. Director of Regulatory Affairs and Director of Risk Management

i. Provides administrative oversight of the management of SAE, SE, the Unusual Occurrence system, and the process for around-the-clock reporting of patient safety events; and

~~2.Serves as Vice Chair of the Event Analysis and Systems Improvement Committee.~~

i. Patient/Resident Safety Officer

i. The Patient/Resident Safety Officer collaborates with the Chief Quality Officer, ~~Manager of Quality,~~ Director of Regulatory Affairs ~~and~~,Director Risk Management, Chief Medical Officer ~~and Manager~~, Nurse Director of Education and Training in developing and planning the ~~hospital's~~ Patient/Resident ~~Quality and~~ Safety Plan;

ii. Presents Patient/Resident ~~Quality and~~ Safety Plan to PIPS for approval and coordinates its implementation;

ii. Works collaboratively with the Chiefs of Service, Associate Administrators, Infection Prevention and Control, and Department Managers in the evaluation of processes and activities implemented or noted in the Patient/Resident Safety Plan; and

iii. Facilitates communication of proactive risk assessments and the results of ~~patient~~Patient/Resident ~~Quality and~~ Safety ~~projects~~Plan to managers and staff.

~~**Manager**~~

j. Nurse Director of Education and Training

i. Determines education and training needs by assessing a variety of data sources which include the Performance Improvement and Patient Safety Committee;

ii. In collaboration with Performance Improvement and Patient Safety Committee, develops and implements an annual mandatory training program that addresses identified needs; and

iii. Provides assistance and consultation to managers and supervisors hospital-wide to determine educational needs and to enhance the competency and performance level of all employees.

~~j.~~k. Infection Prevention and Control Nurse

i. Performs the annual Infection Control Risk Assessment for the Facility in collaboration with Infection Control Committee Chairs and members.

ii. Develops and organizes the Infection Prevention and Control Annual Plan using results of the risk assessment. The Annual Plan will identify educational activities, plan for investigating unusual infectious events, and develop other routine program activities.

iii. Assumes responsibility for surveillance and investigation of infectious exposure incidents or outbreaks and prepares and utilizes statistical analysis as appropriate to judge significance of data.

~~k.~~l. LHH Staff and Providers

The responsibility for providing quality services is shared by all staff. The staff:

i. assist in identifying opportunities for improvement of the quality of patient care/safety;

ii. participate in performance improvement and patient safety activities;

iii. incorporate performance improvement and patient safety findings into patient care, treatment and services; and

iv. report medical/health care errors and near misses through the unusual occurrences reporting system.

~~l.~~ Clinical and Support Departments

m. : The clinical and support departments are responsible for developing and maintaining performance improvement and patient safety activities based on the LHH's prioritized initiatives.

~~n.~~ **Patient/Client/Resident**

~~o.~~n. : LHH recognizes that the Patient/Resident is an integral part of the healthcare team. Upon admission and throughout their hospitalization, the Patient/Resident is informed of his/her rights, responsibilities and role in patient safety. This includes providing accurate information about their current health, allergies, current medications and their past medical history.

5. COMMUNICATION PATHWAYS AND REPORTING

a. Communication pathways are established to provide feedback to all committees, task forces, departments, and services responsible for performance improvement and patient safety activities.

b. Hospital, Departmental, and Medical Staff Committees have functions related to the improvement of patient/resident outcomes and safety, development of standards of care and/or improvement of organizational systems and functions, and report to the Performance Improvement and Patient Safety Committee at least annually.

c. The Chief Medical Officer and/or the Chief Quality Officer report performance improvement activities and issues to the LHH Medical Executive Committee and the LHH Joint Conference Committee.

6. IDENTIFICATION OF POTENTIAL PATIENT SAFETY ISSUES

LHH annually reviews the scope and breadth of its services. During this review, attention is paid to systems and processes that may have a significant negative impact on the health and well-being of patients if an error or “near miss” occurs. Sources used to identify potential patient safety issues are:

a. Performance improvement data, including performance measures.

b. Unusual occurrence, sentinel event, staff patient safety suggestion tool, patient complaint and medical device failure reports.

c. Regulatory and/or accrediting agencies survey reports and changes in their regulations and/or standards.

d. Input is solicited from patients and families for improving patient safety by:

i. Conversations with patients and families during routine care and patient safety rounds,

ii. Comments from Patient Satisfaction surveys, and/or

iii. The grievance process.

7. USE OF DATA

a. Performance monitoring and improvement activities are data driven. Data collection is prioritized by the LHH PIPS Committee based on the organization's mission, care, treatment and services provided, and the population served. Data collection for performance improvement activities focuses on processes that have a major impact upon patient outcomes (e.g., high risk, high volume, problem prone). The data is drawn from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the QAA committee.

   i. The QAA committee analyzes the data in order to identify or better understand a problem.

b. Once a potential problem is identified, the committee utilizes a systematic approach (e.g., Five Whys, flowcharting, fishbone diagram, etc.) to help identify the root cause of the problem.

c. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes.

d.

~~a.~~e. ~~Performance monitoring and improvement activities are data driven. Data collection is prioritized by the LHH PIPS Committee based on the organization's mission, care, treatment and services provided, and the population served. Data collection for performance improvement activities focuses on patient flow and processes that have a major impact upon patient outcomes (e.g., high risk, high volume, problem prone). All data and information containing protected health information (PHI) is secured to protect patients' privacy in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.~~

~~b.~~f. The PIPS Program encompasses data and information collected from the following established processes:

   i. The facility assessment

   ii. Grievance logs

   iii. Minimum Data Set

   iv. Quality measures

   v. Survey outcomes

~~i.~~vi. Medication errors, including near misses

~~ii.~~vii. Adverse Drug Events

~~iii.~~viii. Environment of Care data;

~~iv.~~ix. Patient, family and staff satisfaction surveys;~~-~~

~~v.~~x. Unusual Occurrence reports (~~UORs~~UOs), including but not limited to:

- Medication errors
- ~~b)~~ Death and complications
- ~~c)~~ Violence
- ~~d)~~ Patient/Resident abuse
- ~~e.)~~ Patient/Resident Falls
- ~~f)~~ Absent Without Leave (AWOL)
- ~~g)~~ Performance measures data~~;~~
- ~~h)~~ Restraint and seclusion use~~;~~
- ~~i)~~ Core Measures required by CMS and selected by the Hospital's leadership~~;~~
- ~~j)~~ Outcomes related to resuscitation~~;~~
- ~~k)~~ Mortality and autopsy results~~;~~
- ~~l)~~ Infection Prevention and Control Surveillance~~;~~
- ~~m)~~ Claims~~;~~
- ~~n)~~ Clinical Service and ancillary/diagnostic department performance improvement reports~~;~~
- ~~o)~~ SAE and SE Review findings~~;~~
- ~~p)~~ Patient/Resident grievances~~;~~
- ~~q)~~ Ongoing medical record review~~; and~~
- ~~r)~~ Other sources as appropriate~~.~~

~~c.~~g. The PIPS Committee identifies and ensures appropriate follow-up of organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data.

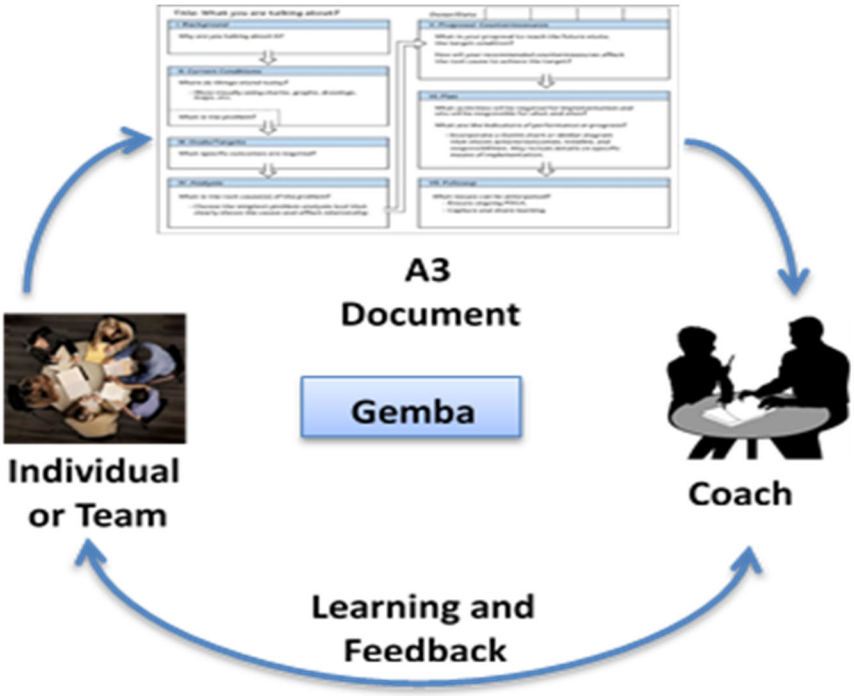
~~d.~~h. The PIPS Committee selects at least one process annually for proactive risk assessment.

8. PERFORMANCE IMPROVEMENT METHODOLOGY

~~A. LHH uses *Lean* as the framework for our LHH performance improvement work.~~

Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. A combination of process and outcome measures are used to measure success following the implementation of change. Performance improvement ~~and patient safety efforts~~efforts are conducted and documented by using a Lean improvement strategy A3 Thinking. A3s are a standard language and template for problem solving and improvement plans. A3

thinking includes defining a problem, understanding root causes, considering countermeasures and studying and adjusting for results (PDSA: Plan-Do-Study-Act).



Using A3 thinking, LHH selects measurable gaps and targets to improve that will impact system-wide goals (True North metrics). We learn by sharing our problem solving and inviting questions. We improve continuously by focusing on performance gaps aligned with True North. In addition to A3 thinking, LHH also utilizes the following tools to improve performance:

a. **Value Stream Map** – A full visual representation of a specified process from start to finish, typically from the patient's perspective. This process map is developed through direct observation of patients and staff.

b. **Kaizen** – a word used to describe the process of taking something apart and making it better, also referred to as a process of continuous improvement.

c. **Daily Management System** – A system comprised of a set of tools designed to empower frontline staff to become problem solvers and use data to drive improvements**.**

d. **Leader Standard Work** – A standardized approach that allows a leader to create a stable organized plan for their day, week and month. Leader standard work also creates focus on the important work of improving and sustaining.

~~B. The Failure Mode, Effects and Criticality Analysis (FMEA) methodology is utilized to perform proactive risk assessment.~~

~~9. **RISK ASSESSMENT AND PERFORMANCE MEASUREMENT TO ENSURE**~~

~~**PATIENT SAFETY**~~

~~A. Annually, a system or process identified as having the potential to impact patient safety will be selected for a 'proactive risk assessment' using the FMEA process. Internal/external data sources and The Joint Commission publications are used to determine which system or process is to be assessed.~~

~~B. The process is assessed to determine steps where there is or may be undesirable variations (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.~~

~~C. For each failure mode, possible effects on patients, as well as the seriousness of the effect, are identified.~~

~~D. The process is redesigned to minimize the risk of failure modes.~~

~~E. The redesigned process is tested and implemented.~~

~~F. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time are identified. In addition, the following are measured:~~

~~1. The perceptions of risk to patients and suggestions for improving care.~~

~~2. The level of staff reluctance to report errors in care.~~

~~G. The PIPS Program is reassessed by the Medical Executive Committee on an annual basis. Elements to be evaluated include but are not limited to:~~

~~1. Achievement of goals and objectives;~~

~~2. Evidence of process improvement; and~~

~~3. Evidence of improvement in patient care.~~

~~10.~~9. FEEDBACK

a. Feedback from staff, residents, resident representatives, and other sources will be used to identify problems that are high-risk, high-volume, and/or problem prone, as well as opportunities for improvement.

b. Feedback is actively sought from staff members. Sources of staff feedback may include, but are not limited to:

   i. Staff satisfaction surveys

ii. Staff meetings

iii. One on one discussion with management

iv. Suggestion or comment boxes

c. Feedback is actively sought from both residents and their family members/representatives. Sources of resident and family feedback may include, but are not limited to:

a. Resident and family satisfaction surveys

b. Resident Council meetings

c. Care plan meetings

d. Grievance Log

e. Suggestion or comment boxes

~~11.~~10. **CONFIDENTIALITY**

a. All monitoring results, abstracted data, related records, correspondence, and all reports developed for quality improvement purposes are confidential to the fullest extent permitted by law.

b. Discussions, deliberations, records and proceedings of all medical staff committees having responsibilities for evaluation and improvement of quality of care rendered in this Hospital are confidential to the fullest extent permitted by law.

ATTACHMENT:
Appendix A: LHH QAPI Plan

REFERENCE:
LHHPP 01-03 Hospital Organizational Chart
LHHPP 60-13 Patient Safety Committees and Plans
~~Performance Improvement Organizational Chart~~
~~Performance Improvement Reporting Calendar~~
~~Performance Improvement Team/Committee Description~~
~~Performance Improvement Team/Committee Meeting Calendar~~

Revised: 1998/04/01, 2008/01/08, 2016/07/12, 2018/11/13, 2020/09/08, 2022/03/08,

2022/12/14 (Year/Month/Day)
Original adoption: 1995/05/01

PROCEDURES FOR GRANT APPLICATION, ACCEPTANCE AND EXPENDITURE

POLICY:

Laguna Honda staff will coordinate grant applications, proposals, acceptances, and expenditures with the Accounting Department and the DPH Grants Office, which provide advisory information and technical assistance throughout the grant process.

PURPOSE:

To ensure~~assure~~ that all grant-related documents meet the specific requirements of the DPH Grants Office as well as the specific requirements of the Board of Supervisors, Controller's Office, and City Attorney.

PROCEDURE:

1. Prior to any significant interaction with a grantor agency, Laguna Honda staff will consult the Department of Public Health (DPH) Grants Handbook. Staff may contact the DPH Grants Office for questions and consultation.

2. All grant applications shall be approved by the Director of Public Health.

3. Grants applications equal or greater than five million dollars ($5,000,000) require Board of Supervisor approval.

4. All grants, no matter the amount, must go through an Accept and Expend process directed by the DPH Grants Office.

    a. Grants equal to or greater than one hundred thousand dollars ($100,000) require approval from the Board of Supervisors.

    b. Grants less than one hundred thousand dollars ($100,000) require approval from the Controller's Office.

    c. Once the grant is awarded, the Accept and Expend process takes two to four months. It is not possible to automatically begin using funds from the award.

5. Staff assemble documents making up the Accept and Expend Package and submit to the DPH Grants Office.

    a. Grants Resolution Information Form including disability checklist
    b. Grant Line-Item Budget and Grant Budget Justification
    c. Grant Application
    d. Grant Award Letter from funding agency
    e. Ethics form 126 (if applicable)

f. Contracts, leases/agreements (if applicable)

6. For grants requiring Board of Supervisor approval, staff, in consultation with the Deputy City Attorney, will draft an "Accept and Expend" resolution for submission to the Board of Supervisors through the DPH Grants Office.

7. After approval, the grant process owner consults with the Accounting Department to set up the grant in the City's Financial System following the Controller's Accounting Policies and Procedures, and identify program managers and roles for requisition and purchase order approval.

8. Grant related activities resulting in expenditures proceed ~~in~~ according to~~per~~ grant guidelines.

9. Program managers have the responsibility of making sure the expenditures are compliant with grantor's requirements.

10. Program managers are responsible to obtain written consent from the grantor on any expenditure substitutions.

    a. For changes in the total award, the program manager will be referred to the DPH Grants Office.

11. For reimbursement based grants, the program managers are responsible to submit information for billing to the Accounting Department.

12. Operation and program manager complete monitoring and reporting requirements as specified by the grantor agency.

    a. Copies of all reports shall be forwarded to the Accounting Department.

13. Program managers are responsible to provide and support any audit needs related to the grant.

14. The Accounting Department reconciles grant budget and actuals, including revenue and expenditures, and reports to the Controller's Office on a quarterly basis.

ATTACHMENT:
None.

REFERENCE:
San Francisco Department of Public Health Grants Handbook
https://www.sfdph.org/dph/files/PoliciesProcedures/GAD4_GrantsPolicy.pdf
City and County of San Francisco – Office of the Controller Accounting Policies and Procedures

San Francisco Administrative Code 10.170-1

Revised: 02/10/31, 12/09/25, 18/09/11 (Year/Month/Day)
Original adoption: 98/04/01

MRSA TESTING

POLICY:

Patients who are admitted to the acute care units shall be tested for MRSA within 24 hours of admission.

PURPOSE:

To reduce the transmission of MRSA to others, to prevent complication of MRSA infections, and to comply with California Health and Safety Code Sections 1255.8 (b) (1), (3), (4); (c); and (d)
925-390-2622
DEFINITION:

MRSA: Methicillin-resistant *Staphyloccoccus aureus* is a bacterium commonly found on the skin that has become resistant to many antibiotics, is difficult to treat when infections occur and can be transmitted to others. MRSA infections can lead to sepsis which can result from blood stream infections, pneumonia, wound/surgical site infection, and death.

MRSA is often transmitted by direct contact and can survive for hours on some surfaces including towels, razors, and other items. Intact skin, proper hand hygiene, proper use of personal protective equipment (PPE) including gloves and thorough disinfection of equipment used by infected patients can reduce the spread of MRSA to others.

PROCEDURE:

1. The attending physician shall write an order for MRSA testing upon the patient's admission to an acute care unit.

2. When a patient tests positive for MRSA, the attending physician is to inform the patient or patient's representative of the positive results in a timely manner.

3. A patient who tests positive for MRSA shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of MRSA to others (refer to Appendix A).

4. A patient, who has been previously tested on admission and shows evidence of increased risk of invasive MRSA, shall again be tested for MRSA immediately prior to discharge from the facility, unless s/he has tested positive for MRSA infection or colonization upon entering the facility.

ATTACHMENT:

Appendix A: Aftercare Discharge Instructions and Precautions to Prevent the Spread of MRSA to Others (Source: Website address: ~~http://www.sfcdcp.org/mrsa.html~~http://www.sfcdcp.org/mrsa.html) NOT specific to MRSA

REFERENCE:
California Health and Safety Code Section 1255.8

Revised: 20/10/13 22/10/13 (Year/Month/Day)
Original adoption: 11/03/24

Aftercare Discharge Instructions And Precautions to Prevent The Spread of MRSA to Others

(Source: ~~http://www.sfcdcp.org/mrsa.html~~http://www.sfcdcp.org/mrsa.html)
no link to MRSA

While at Laguna Honda, you were tested for MRSA. MRSA is methicillin-resistant *Staphylococcus aureus*, a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections. As with all regular staph infections, recognizing the signs and receiving treatment for MRSA skin infections in the early stages reduces the chances of the infection becoming severe.

A positive test result simply means you have been exposed to MRSA and colonized. Unless you are also sick, a colonized test result may not get treated.

Your test results were positive. This means you have MRSA present on your body. You may carry on with your daily routine as usual. It is recommended that you take prevention measures to make sure you and your loved ones stay healthy. These include:

- Know the signs of MRSA skin infections and get treated early
- Keep cuts and scrapes clean and covered
- Encourage good hygiene such as cleaning hands regularly
- Discourage sharing of personal items such as towels and razors
- Wash your hands thoroughly and frequently
- Do not share bath towels, linens, razors or anything else that touches the skin
- Avoid skin to skin contact of open wounds or sores. This can happen when playing sports or while having sex or other activities that involve skin to skin contact.
- Clean and disinfect any items that are shared before and after every use
- Use lotion to keep skin moist. Damaged skin can provide an opening for infection

Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or other drainage
- Accompanied by a fever

Laguna Honda wishes you a speedy recovery from your illness. If you have any questions, please call 415-759-3000.

DISINFECTION FOR ISOLATION ROOM ~~DISINFECTION~~

POLICY:

1. Disinfection of an isolation room shall be coordinated between staff from Laguna Honda Hospital (LHH) Nursing and Environmental Services (EVS) departments.
~~1.~~2. Only Environmental Protection Agency (EPA) disinfectants and cleaners on the EPA list for specific microbes will be utilized

~~2.~~3. Standard Precautions and any transmission-based precautions that were in effect shall be maintained during terminal cleaning of an isolation room including hand hygiene and use of personal protective equipment (PPE).

~~3.~~4. Cleaning must be accomplished before disinfection can be accomplished.

~~4.~~5. Clean from “clean to dirty” as possible.

PURPOSE:

To promote infection prevention and control standards and prevent cross-contamination of organisms.

PROCEDURE:

1. Terminal cleaning of the isolation room is to be carried out when a resident is relocated, discharged, or expired. The Nurse Manager or Charge Nurse shall assign a CNA/PCA or HHA to initiate the terminal cleaning process.

2. Terminal cleaning is a shared process between Nursing and EVS staff. Coordination of services is needed by the Nurse Manager or designee for timely and appropriate cleaning and disinfection. If concerns, contact the Infection Control Nurse (ICN) for guidance.

3. Nursing and EVS will utilize Standard Precautions and any transmission-based precautions that were in effect at the time the room was vacated.

    a. This includes the appropriate PPE required for the type of isolation case (i.e. Contact, Contact Enhanced, Droplet, and/or Airborne Precautions)

    b. Keep room door closed to reduce air contamination with dust, chemicals, and pathogens while cleaning and disinfecting.

    c. Change gloves during the cleaning procedure when they become visibly soiled or when moving from dirty to clean tasks, such as from cleaning the bed to gathering clean linens.

    d. Hand hygiene is removed before donning and after removing gloves.

4. Nursing staff will remove the bed linens from the bed and place in the dirty linen hamper. Nursing staff will also clean and remove items from the previous occupant. Nursing will notify EVS once this is completed.

5. EVS cleans and disinfects room with appropriate disinfectant(s) according to EVS Policy XII Critical Areas Cleaning Procedure. This includes the remaining furniture, floor, walls (including the TV on the wall), and bathroom, including high touch areas such as light switches, nurse call button, and door handles/knobs.

6. EVS shall notify the Nurse Manager or Charge Nurse when terminal cleaning is completed.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
Nursing Policy and Procedure D9 3.0 Bed Stripping and Bedside Cleaning
Environmental Services Policy XII Critical Areas Cleaning Procedure
CDC. Centers for Disease Control and Prevention. (2020, April). Environmental Cleaning Procedures. Best practices for environmental cleaning in healthcare facilities. Retrieved from website September 1, 2020. https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html

Revised: 14/05/27, 20/10/13 (Year/Month/Date)
Original Adoption: 05/11/01

CLASSIFICATION OF REUSABLE MEDICAL DEVICES AND PROCESSING REQUIREMENTS

POLICY:

1. Laguna Honda Hospital (LHH) utilizes the Spaulding Classification System of medical devices for cleaning, disinfection, and/or sterilization according to standards of practice as a best practice.

PURPOSE:

To provide guidance for the cleaning and reprocessing of reusable resident medical devices in an effort to prevent transmission of microorganism to other residents.

PROCEDURE:

1. Classification categories for the cleaning and reprocessing of reusable resident medical devices are based on:

   a. Type of resident contact (e.g. invasive vs. non-invasive)

   b. Likelihood of contamination with pathogenic organisms

   c. Expected level of contamination (e.g. bioburden)

   All reusable medical devices will be classified and processed according to the following standards of practice.

2. Prior to final processing, all medical devices are to be thoroughly cleaned to remove organic material and decrease the bioburden.

3. Reusable medical devices are classified and processed as follows:

   a. **Critical Devices:**

      i. Refer to LHHPP Outpatient Clinic policies in references.

   b. **Semi-Critical Devices:**

      i. Are devices that touch mucous membranes or non-intact skin and should be free of all microorganisms with the exception that some bacterial spores are acceptable.

      ii. Examples of semi-critical devices include: flexible endoscopes, thermometer, laryngoscope blades, endotracheal tubes, respiratory therapy and anesthesia equipment, diaphragm fitting rings, and other similar devices. Devices must be processed between resident contacts. If item is being used

for use on one resident, devices should be processed on intervals recommended by the manufacturer or according to current standards and when visibly soiled.

iii. Semi-critical devices require high-level disinfection using chemical disinfectants according to manufacturer's recommendation. Specific items may require specific procedures including sterile water rinses and air drying

c. **Non-Critical Devices:**

i. Refer to LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
Outpatient Clinic Policy C3 Cleaning of Medical Instruments Prior to Disinfection or Sterilization
Outpatient Clinic Policy C4 High-Level Chemical Disinfection
Outpatient Clinic Policy C5 Flexible Nasopharyngeal Laryngoscope
Outpatient Clinic Policy C6 Steal Sterilization
Nursing Policy D9 7.0 Wheelchair and Geriatric Chair Cleaning
CDC. (2016). Infection control; disinfection and sterilization. A Rational Approach to Disinfection and Sterilization. Retrieved from website September 2, 2020. https://www.cdc.gov/infectioncontrol/guidelines/disinfection/rational-approach.html

Revised: 16/03/08, 22/11/18~~20/10/13~~ (Year/Month/Day)
Original adoption: 05/11/01

CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE EQUIPMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) staff is responsible for routine cleaning and disinfection of non-critical resident care equipment according to established facility procedures and manufacturer guidelines.

PURPOSE:

To minimize the risk of transmission of pathogens during use of non-critical resident care equipment.

DEFINITION:

Non-critical is the classification level given to resident care equipment that does not come into contact with any sterile body cavity or mucous membrane. Non-critical resident care equipment requires low level disinfection procedures between resident use. Such items may include but are not limited to blood pressure cuffs or pulse oximeters in which the intact skin serves as an effective barrier to pathogens.

The **standard hospital-wide approved disinfectant** are hydrogen peroxide-based disinfectant wipes. These shall be used for cleaning and disinfecting non-critical resident care equipment unless otherwise noted in attachment LHH Non-Critical Resident Care Equipment Disinfectant Exceptions.

The sodium hypochlorite-based (bleach) disinfectant wipe must be used for disinfection of equipment used by residents infected with pathogens that cannot be killed with hydrogen peroxide, such as *Clostridioides difficile (C. diff.)*.

Dedicated equipment: Any medical equipment that will be used by a single resident and is not shared with other residents for the duration of the prescribed treatment.

Multi-resident use equipment: Shared equipment used for multiple residents for care when intact skin will provide a sufficient barrier. Shared equipment is cleaned and/or disinfected after each resident use.

Minimum contact time: Time required to effectively render the pathogen inactive and not capable of being transmitted to others. Contact time is determined and listed on the product label.

PROCEDURE:

1. Multi-resident use equipment is cleaned and/or disinfected after each resident use.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Disinfectant Guide

CELEBRATING 150 YEARS OF DEDICATED AND COMPASSIONATE SERVICE TO SAN FRANCISCO
150
LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

How to use:

1. Unplug any electrical item from power source before cleaning to prevent electrical shock
2. Perform hand hygiene, don clean gloves
3. Wipe down surfaces ensuring that high touch surfaces are thoroughly cleaned
4. Ensure surface is visibly wet with product and allow to dry (Do not wipe dry)
5. To achieve required contact time, more than one wipe may need to be used
6. Obtain a new wipe between surfaces and if the wipe no longer has sufficient product
7. Upon task completion, discard wipe, remove gloves and perform hand hygiene
8. Do not refill containers, they should be thrown away when empty

Product

Use	Standard Product	Contact Time	Alternative Product	Contact Time
	Purell Dispenser		Purell Hand Sanitizer or 3G Hand Sanitizer Packet	
☑Hands Only		Until Hands Dry		Until Hands Dry
Use	**Standard Product**	**Contact Time**	**Alternative Product**	**Contact Time**
	PDI Sani-Cloth Prime Germicidal Disposable (Purple Top)		PDI Sani-Cloth Germicidal Bleach (Orange Top)	
☑Glucometers, Cisco phones, WOWs and Medical Equipment		☑For all residents (Except C. Diff. Residents) 1 Minute		☑For C. Diff. Residents 4 Minutes

Adopted: (06262020)
Version: 1.3 Rev 08082022

CONTACT EVS at DPH-LHHEVSLeadership@sfdph.org with questions

a. Perform hand hygiene and don clean gloves.
b. Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet.
c. Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection.
d. Remove gloves, perform hand hygiene.

2. Dedicated equipment is cleaned daily and as needed by Nursing staff to reduce the spread of pathogens while in use. Single use or dedicated equipment used for one resident is obtained from Central Processing Department (CPD) when first ordered for the resident.

a. Perform hand hygiene and don clean gloves.
b. Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet.
c. Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection.
d. Remove gloves, perform hand hygiene.
e. At the conclusion of the prescribed treatment, any disposable tubing, attachment, and devices are discarded, and the equipment is disinfected by Nursing staff prior to being picked up by CPD. CPD will then perform the necessary cleaning, disinfection, and preventive maintenance before placing the equipment into their inventory or returned to the vendor.

3. In the event the standard hospital-wide approved disinfectants are not immediately available, equivalent products may be considered when in compliance with Biomed, the Safety Officer, and Infection Control Nurse to ensure the product meets manufacturer's guidelines and does not damage equipment.

a. Changes in disinfectant product(s) shall be communicated to staff using the new product(s) through methods such as electronic learning modules, memorandums, and in-services.

ATTACHMENTS:
1. LHH Non-Critical Resident Care Equipment Disinfectant Exceptions
2. Standard Work Single-Resident Blood Pressure Cuffs

REFERENCE:
LHHPP 72-01 Infection Control Manual, E4 Central Supply / Materials Management
APIC Guideline for Selection and Use of Disinfectants, 1996
APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996.

The Association for the Advancement of Medical Instrumentation.

Revised: 2011/2005, 2012/05/22, 2016/01/12, 2020/06/23 (Year/Month/Day)
Original adoption: Est. 2005/11/01

Deletion Hospital-wide Policies and Procedures

INTRAVASCULAR DEVICE GUIDELINES

POLICY:

1. Intravascular device policies shall be consistent with guidelines from Centers for Disease Control and Prevention (CDC) to reduce transmission of pathogens via the bloodstream.

2. Intravascular devices shall be used for the minimum amount of time necessary.

PURPOSE:

To provide general guidelines on intravascular devices that are consistent with current national standards for prevention of catheter-associated bloodstream infection.

DEFINITIONS:

- **Intravascular Devices**: A device that is placed within the blood system via an artery or vein usually for the purpose of administering medications and fluids, frequently monitoring blood lab values, or both. This term is broad in scope and may include any type of device including but not limited to peripheral IVs (venous), PICC lines, arterial lines such as central lines, or other vascular access devices.

- **Central Line-Associated Bloodstream Infection (CLABSI)**: Pronounced CLAB-SEE, this is a term used by National Healthcare Safety Network (NHSN) that refers to a primary blood stream infection in a resident/patient with a central line within the 48-hour period before development of the infection and is not a blood stream infection related to an infection at another site. A CLABSI is a serious infection that occurs when germs enter the bloodstream through a catheter (tube) that healthcare providers place in a large vein in the neck, chest, or groin to give medication or fluids or to collect blood for medical tests.

PROCEDURE:

1. Ongoing prevention and management of CLABSIs is achieved through multidisciplinary activities including education, hand hygiene program and observations, antimicrobial stewardship activities, and ongoing surveillance.

2. Performance improvement efforts shall be ongoing and based upon surveillance findings combined with improvement initiatives and evidence-based recommended practices.

3. The Infection Control Nurse (ICN) reports monthly acute unit surveillance data for CLABSIs to NHSN.

4. Insertion of central venous catheters (CVC's) (any line ending in a great vessel) includes full barrier precautions and judicious use of devices.

5. Insertion and care of intravascular devices is described in Nursing policies and procedures and states the appropriate discipline to perform tasks associated with peripherally inserted central catheters (PICCs), central venous catheters, tunneled devices and peripheral midline catheters.

6. Clinicians shall follow general guidelines for preventing catheter-related bloodstream infections that include education and training, demonstrated competency, hand hygiene and aseptic technique, appropriate skin preparation, catheter site dressing regimens, resident cleansing, use of catheter securement devices, antimicrobial/ antiseptics and impregnated catheters/cuffs, and anticoagulants and removal/ replacement procedures.

7. Clinicians shall participate in education and training provided initially and annually through required training and orientation with additional training as scheduled.

8. Nursing competency with intravascular devices is assessed prior to insertion and care.

9. Hand hygiene activities and aseptic technique specific to intravascular device management include the following CDC recommendations:

    a. Perform hand hygiene procedures, either by washing hands with soap and water or with alcohol-based hand rub (ABHR).

    b. Hand hygiene should be performed before and after palpating catheter insertion sites as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter.

    c. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained.

    d. Maintain aseptic technique for the insertion and care of intravascular catheters.

    e. Wear clean gloves, rather than sterile gloves, for the insertion of peripheral intravascular catheters, if the access site is not touched after the application of skin antiseptics.

10. Clinicians shall follow skin preparations as outlined in Nursing policies and procedures, which may include the following CDC recommendations:

    a. 70% alcohol, tincture of iodine, or alcoholic chlorhexidine gluconate solution before peripheral venous catheter insertion.

b. >0.5% chlorhexidine with alcohol and catheter site dressing for central lines dressing changes.

c. Antiseptics should be allowed to air dry (do not blow on or fan the site) according to the manufacturer's recommendation prior to placing the catheter.

d. Catheter securement devices are recommended to reduce the risk of infection, catheter migration and dislodgement.

11. Prophylactic antimicrobial lock solution is generally not recommended unless there is a history of multiple CLABSIs for residents with long-term catheter.

12. Routine use of anticoagulants to reduce the risk of CLABSI is not recommended.

13. Blood cultures shall be ordered by the physicians when an infection is suspected. Negative cultures suggest that the intravascular device is an unlikely source of infection.

14. Document and promptly report signs of infection. Document other interventions according to Nursing policy and procedures.

ATTACHMENT:
None.

REFERENCE:
LHH Nursing Policy J6.0 Intravenous Therapy
LHH Nursing Policy J7.0 Central Venous Access Device (CVAD) Management
LHH Nursing Policy J7.1 Peripherally Inserted Central Catheters (PICC)
CDC Intravascular Catheter-related Infection available at:
https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html
CDC NHSN Surveillance for Bloodstream Infections available at:
https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html

Revised: 16/07/12, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

MEDICATION HANDLING/DISPENSING GUIDELINES

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) are responsible for the safe and effective requisition, storage, administration, and recording of drugs in the resident care areas in accordance with applicable state and federal regulations, and hospital policy.

2. Nursing follows the expiration date information provided in LHHPP Pharmacy 02.01.06 Expiration Dating of Pharmaceuticals.

3. Nursing ensures drugs are stored at the appropriate temperatures.

PURPOSE:

Pharmacy and Infection Prevention and Control reviews policies and guidelines for the proper storage, handling, and dispensing of medications in regards to infection control and prevention practices to provide for safe and consistent practices to reduce transmission of microorganisms.

PROCEDURE:

1. Medications are administered via the following routes: oral, intravenous (IV), intramuscular (IM), subcutaneous, intradermal, ophthalmic, otic, nasal, vaginal, rectal, topical, and/or aerosolized via nebulizer or metered dose inhaler.

2. Nurses and dispensing clinicians will adhere to Standard Precautions practices including safe injection precautions, hand hygiene, proper use of personal protective equipment (PPE), and any transmission-based precautions that are in effect at the time of the medication administration.

3. Registered Nurses may administer prepared intravenous solutions using a patent IV access line following strict asepsis.

    a. Observe proper hand hygiene prior to any preparation activities.

    b. Inspect all IV bags/bottles/vials under good lighting for crack and leaks and ensure there is clarity in the solution. Do not use any suspected tampered or contaminated solutions.

    c. Do not enter a medication vial, bag, IV line, or bottle with a used syringe or needle.

    d. Use aseptic technique when preparing and administering injections.

e. Do not administer medications from the same syringe to more than one resident, even if the needle is changed or you are injecting through an intervening length of IV tubing.

4. Registered Nurses will not inject any medication or solution directly into a vein without a patent venous access port placed under aseptic technique.

5. Registered Nurses may not add or superimpose medications to intravenous solution bags; additives should be completed by a pharmacist under strict aseptic conditions.

Maintenance of Sterility and Retention/Expiration of Medications

6. **Injectable medications and diluents**: Medications for injection or infusion should be drawn up in a designated clean medication prep area. Clean and disinfect prep areas for medication administration frequently. Do not prepare medications for injections ahead of time of use which can compromise the sterility and stability of the medication.

   a. Single dose:

      i. Should be discarded after a single use

      ii. Do not use medications packaged as single-dose or single-use for more than one resident

   b. Multi-dose:

      i. Multi-dose vials of injectable shall be visually inspected prior to use and discarded if any of the following occur:

         - There is a change in appearance of the solution
         - There is damage or loss of integrity of the closure
         - The drug has been improperly stored
         - The vial is known or to suspected to be contaminated
         - The septum (rubber top) should not be entered with a used needle
         - Do not leave a needle sticking in the rubber septum which provides an open and direct route for microorganisms to enter the vial and contaminate

   c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.

d. Tuberculin testing solution (e.g. Aplisol® or Tubersol®) vials shall be dated upon initial entry, refrigerated, and discarded after 28 days.

e. Insulin vials are dated upon initial entry and refrigerated after use. Insulin vials are for individual resident use. Open and in use vials shall be discarded after 28 days. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

7. Oral liquid medications:

   a. May be used until the manufacturer's expiration date on the product.

   b. If contaminated or contents spill onto the outside of the container obscuring the label, the product must be returned to Pharmacy for relabeling or discarded.

   c. Suspension medications, prepared by adding a diluent to a powder, must be discarded after the recommended expiration date for reconstituted suspension described on the product.

8. External or topical medication:

   a. May be used until the manufacturer's expiration date on the product.

   b. If contents spill onto the outside of the container obscuring the label, the product must be returned to Pharmacy for relabeling or discarded.

   c. Not to be shared between residents.

   d. Wear gloves when administering topical creams or lotions.

9. Sterile irrigation solutions:

   a. The expiration date shall be assigned by the pharmacist as per standard references or standard pharmacist practice.

ATTACHMENT:
None.

REFERENCE:
LHHPP 31-01 Wireless Refrigerator and Freezer Temperature Monitoring System
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
Nursing J-01.0 Medication Administration
Pharmacy 02.01.06 Expiration Dating of Pharmaceuticals

Revised: 16/01/12, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

RESPIRATORY CARE GUIDELINES

POLICY:

1. Management of residents and equipment to prevent healthcare associated pneumonia and other respiratory tract infections shall be done according to the following procedure and other related policies.

2. Staff shall follow standard and transmission based precautions, including hand hygiene and appropriate use of gloves and other personal protective equipment (PPE).

3. Respiratory infection surveillance and antimicrobial stewardship is ongoing.

4. *Legionella* is a water-borne bacterial infection that is transmitted via inhalation of aerosolized water containing the bacteria. Less commonly, *Legionella* can be transmitted via aspiration of drinking water. *Legionella* is not usually transmitted from person-to-person.

    a. Construction, the formation of biofilm and fluctuating water temperatures can influence outbreaks of legionella. Construction can release the bacterial from water pipes when pipes are interrupted. Biofilm is a protective slime layer that lines water pipes that makes the bacteria very resistant to disinfectants.

    b. *Legionella* is transferred most frequently through aerosolized water containing the bacteria through showers, cooling towers, contaminated aerosolized devices including CPAPs, eye-wash stations, aerators on faucets, ice machines, hot tubs, decorative water fountains, and water main breaks

    c. Residents/patients at risk for a *Legionella* diagnosis includes but is not limited to those over the age of 50, smokers, have chronic lung disease such as COPD or emphysema, underlying morbidities or have had recent exposure to hot tubs.

    d. A *Legionella* Hazard Analysis Critical Control Plan (HACCP) is available to guide water plan-related maintenance and monitoring. This plan is kept in Facility Services. LHH will have a water management program to reduce the risk of *Legionella* growth and spread that is reviewed annually. This plan will include a risk assessment of the facility that is completed by Facility Services and reviewed with the Performance Improvement Patient Safety (PIPS) committee at least annually.

5. *Aspergillosis* is a fungal/mold disease caused by the common mold *Aspergillus* that can be found in soil, decomposing plant material, household dust, building materials food and water. The spores are inhaled and cause lung, skin, and other respiratory infections in those who have severely weakened immune systems. *Aspergillosis* is not spread transmitted from person-to person and does not require isolation.

PURPOSE:

To minimize the potential for acquiring healthcare-associated pneumonia and other respiratory infections in a manner that is consistent with Centers for Disease Control and Prevention (CDC) guidelines.

PROCEDURE:

1. Staff shall follow related Laguna Honda Hospital (LHH) policies that address potential risk factors for healthcare associated respiratory infections. Risk factors generally include:

    a. Factors that enhance colonization of the oropharynx and/or stomach by microorganisms that may include administration of antimicrobial agents, admission to the ICU, or presence of underlying chronic lung disease

    b. Conditions favoring aspiration into the respiratory tract or reflux from the gastrointestinal tract that may include initial or repeat endotracheal intubation, insertion of a nasogastric tube, placement in a supine position, coma, surgical procedures involving the head, neck, thorax, or upper abdomen, and immobilization due to trauma or illness

    c. Host factors that may include extremes of age associated with fragility, malnutrition, and severe underlying conditions including immunosuppression

    d. Potential exposure to contaminated respiratory devices

    e. Contact with contaminated or colonized hands of staff

    f. Risk factors also include prolonged use of mechanical ventilatory support

2. LHH policies that address the above risk factors include, but are not limited to, policies addressing:

    a. Oral care

    b. Prevention of complications of immobility, including turning, repositioning, ambulation and procedures to maximize independence in activities of daily living

    c. Use and cleaning of respiratory equipment and devices

    d. Pneumococcal and influenza vaccines and respiratory hygiene

e. Facility monitoring and maintenance to prevent and detect contaminated air and water supply equipment (e.g. with potential pathogens such as legionella and aspergillus)

3. General guidelines for maintaining respiratory equipment and devices include:

   a. Respiratory single use equipment and devices are preferred

   b. Cleaning and disinfection per manufacturer's recommendations occurs between residents or in the absence of manufacturers recommendation, use of an Environmental Protection Agency (EPA) approved disinfectant

   c. Do not reprocess equipment or devices that are manufactured for a single use only

   d. Reprocessing may occur for some respiratory equipment during times of emergency needs such as pandemics. Reprocess according to the most current CDC guidance at the time of use

   e. Replace nebulizer tubing and mask according every 24 hours or in the event of contamination

   f. Use sterile water for rinsing reusable semi-critical equipment and devices used on the respiratory tract after they have been disinfected chemically

   g. High touch surfaces including respiratory equipment in the resident/patient room should be surface cleaned and disinfected daily

   h. Thoroughly clean all equipment and devices before sterilization or disinfection

   i. Sterilize or use high level disinfection for semi-critical equipment or devices

   j. Tracheostomy care and suctioning shall be performed aseptically according to Nursing policy and procedures

4. Facility Services staff and vendors shall maintain and monitor water and air delivery systems to prevent contamination by potential pathogens, such as *Legionella* and *Aspergillus*.

5. Primary prevention of Legionnaire's disease (legionellosis), when no cases of healthcare-associated legionellosis have been documented, includes maintaining a high index of suspicion for legionellosis and appropriately using diagnostic tests for legionellosis in residents with healthcare-associated pneumonia who are at high risk of developing the disease.

   a. If one or more healthcare-associated legionellosis occurs, then culturing the facility water may be indicated after consulting with the local health department. Culturing

requires trained outside experts for culturing and analysis and should not be performed by unskilled, untrained personnel.

b. Legionellosis is a serious pneumonia caused by the bacteria *Legionella* and is a reportable infection to the local health department.

6. Primary prevention of Aspergillosis includes:

   a. Provide a private room for residents on neutropenic precautions, providing a well-fitting mask when resident must leave the room, minimizing time outside of the room, and coordinating with Environmental Services (EVS) for cleaning when the resident is out of the rom as much as possible to decrease aerosolization of spores.

   b. During construction in areas with high risk residents provide barriers, and re-route traffic flow and clean newly constructed area prior to residents entering.

   c. In case of an *Aspergillosis* case among residents or staff, report to the Infection Control Nurse (ICN). The ICN will coordinate with Facility Services to eliminate the source of infection.

7. Clinicians shall continue to collaborate with the ICN for consultation, required reporting, and to obtain case-specific recommendations from the local health department as needed and as required.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A7 Reportable Communicable Diseases
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 72-01 F1 Renovation/Construction Infection Control Guidelines
LHHPP 72-01 F11 Classification of Reusable Medical Devices and Processing Requirements
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan
LHHPP 73-09 Respiratory Protection Program (RPP)
NPP I2.0 Tracheobronchial Suctioning
NPP I3.0 Tracheostomy Care
CDC 2008 Guideline for Disinfection and Sterilization in Healthcare Facilities
CDC 2003 MMWR Recommendations and Reports, Guidelines for Environmental Infection Control in Health-Care Facilities

Revised: 16/07/12, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

URINARY CATHETERIZATION GUIDELINES

POLICY:

1. Urinary catheterization includes indwelling catheters and non-indwelling (i.e. intermittent catheters). Both are sterile insertion procedures that require strict adherence to sterile protocols to reduce infection transmission.

2. Clinical and medical staff will evaluate the need for urinary catheterization on a case-by-case basis and utilizing alternative methods where possible.

3. Urinary catheterization protocols must include measures to reduce the use and duration of catheter days for this vulnerable population to reduce catheter-associated urinary tract infections (CAUTI) which can lead to increased illness, increased hospitalization, increase use of antibiotics, sepsis, and death.

PURPOSE:

The infection prevention and control program (IPC) at Laguna Honda Hospital (LHH) has adopted guidelines for the management of urinary catheterization that are consistent with Centers for Disease Control and Prevention (CDC) guidelines and minimize the potential for CAUTI and improve resident outcomes.

Urinary tract infections (UTIs) are the most common type of healthcare-associated infection (HAI) in long-term care facilities. UTIs are not identified by urine odor or color but identified positively by a urine culture. UTIs may present with or without symptoms. Care and treatment of symptomatic UTIs, asymptomatic UTIs, and bacteriuria are different, require careful assessment, and have different reporting requirements.

Urinary drainage bags serve as reservoirs for multi-drug resistant organisms (MDROs) that can be transmitted to other staff and residents. Indwelling urinary catheters are uncomfortable and often unnecessary. Urinary catheters support biofilm growth with colonization rendering them virtually impossible to eradicate without removing the device.

DEFINITIONS:

- **Symptomatic urinary tract infection (SUTI):** Pronounced soot-ee, SUTIs are identified with a positive urine culture and with symptoms that may include fever, suprapubic pain, dysuria (painful urination), and malaise.
- **Asymptomatic bacteremic urinary tract infection (ABUTI):** Pronounced ah-boot-ee, ABUTI urine cultures shows a measurable number of bacteria with no symptoms noted.
- **Bacteriuria:** Presence of bacteria in the urine, not to be confused with a UTI. After 1 month of indwelling catheter use, the risk of bacteria in urine is almost 100%.

PROCEDURE:

1. The physician will assess new admissions with indwelling urinary catheters upon admission and evaluate the need for continuing the catheter or determine if alternate methods are available.

    a. Straight (intermittent) catheterization may be used to obtain sterile specimens, urine specimens when the resident is unable to void voluntarily, or for intermittent catheterization for urinary retention or neurogenic bladder.

2. The physician should consider alternatives to indwelling catheters, such as suprapubic catheters (SPCs), straight/intermittent catheterization, or male external (condom) catheters.

3. Hand hygiene and proper personal protective equipment (PPE) are used for any catheter insertion or removal, contact with the catheter, or contact with the urinary drainage bag following LHHPP Nursing F5.0 Nursing Management of Urinary Catheters.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
NPP F5.0 Nursing Management of Urinary Catheters
Association for Professionals in Infection Control & Epidemiology (APIC). (2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: APIC Association for Professionals in Infection Control & Epidemiology.
CDC. (2015, November). Background | CAUTI Guidelines | Guidelines Library | Infection Control | CDC. Retrieved August 18, 2020, from https://www.cdc.gov/infectioncontrol/guidelines/cauti/background.html

Revised: 16/07/12, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

WEST NILE VIRUS

POLICY:

The guidelines provide information in the prevention, evaluation and management of West Nile Virus (WNV) infection in accordance with the most current CDC recommendations. WNV is a mosquito-borne illness that is not passed from person-to-person and does not pose a threat to others. Isolation is not required and Standard Precautions with appropriate personal protective equipment (PPE) is all that is required for WNV infection precautions. WNV is a reportable disease once diagnosed.

West Nile Virus does not cause symptoms or prolonged illness in most individuals. 1 in 5 people infected with WNV will have a fever and 1 in 150 will suffer severe illness, up to and may include death according to the CDC. Residents who may have been exposed to mosquitoes and develops symptoms should be considered for testing for WNV.

PURPOSE:

The Infection Control program at Laguna Honda Hospital and Rehabilitation Center (LHH) has adopted guidelines in accordance with the CDC recommendations to reduce the risk of West Nile Virus infection for residents in LHH. Reducing the mosquito population or exposure to mosquito bites will reduce the likelihood of exposure to West Nile Virus. There is no known person-to-person transfer of the infection of West Nile Virus. WNV is transmitted by infected mosquito bites.

PROCEDURE:

The guidelines provide information in the prevention, evaluation and management of West Nile Virus (WNV) infection.

1. Mode of transmission

West Nile Virus is transmitted to humans by infected mosquitoes. Not all mosquitos are infected with WNV and further assessment should be performed when mosquitoes, mosquito bites and symptoms are found together. Care should be taken to reduce exposure to mosquitos during the summer months when mosquitos are more prevalent.

West Nile virus is NOT transmitted from person-to-person contact and is not a respiratory disease. WNV does not require isolation or quarantine. Standard Precautions for PPE are adequate for care of those infected with WNV. Follow needle stick safety precautions as a part of Standard Precautions when caring for those with WNV.

<u>West Nile virus, when confirmed, is reportable to local and/or state health departments within one working day of identification.</u>

2. Symptoms of West Nile Virus

West Nile disease may present differently to those infected. WNV may be present in persons without any symptoms. 8 out of 10 people infected do not show any symptoms of West Nile Virus disease and have no lasting effects of the infection.

West Nile fever may present as a mild form of the disease. West Nile Fever occurs in 1 in 5 of those people affected with WNV. West Nile Fever consists of mild symptoms, including fever, headache, and body aches, occasionally with a skin rash on the trunk of the body and swollen lymph glands. Other symptoms may include malaise, fever, anorexia, fatigue, nausea, vomiting, eye pain, and mental status changes. Symptoms of mild disease will generally last a few days.

West Nile may present as a severe case of infection in some individuals. West Nile Virus may present as encephalitis or meningitis symptoms which may include headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, and paralysis.

Severe neurological manifestations include ataxia (defective muscular coordination), cranial nerve abnormalities, myelitis (inflammation of bone marrow), optic neuritis, polyradiculitis (inflammation of spinal nerve roots) and seizures and 1 in 10 with severe neurological manifestations may result in death. Symptoms of severe disease may last several weeks but neurological effects may be permanent.

The time between the mosquito bite and the onset of illness (incubation period) ranges from 5 to 15 days.

3. Diagnosis and Treatment of West Nile Virus

The initial diagnosis of WNV infection is based primarily on clinical suspicion and evidence of increased WNV disease activity in animals such as horses and birds in the community.

WNV should be strongly considered in adults ≥50 years who develop unexplained encephalitis or meningitis **in summer or early fall.** Suspicion of viral encephalitis or meningitis should be reported without delay to the local health department to reduce the likelihood of an outbreak. Serum or cerebrospinal fluid samples (CSF) may be requested for testing to detect WNV-specific IgM antibodies.

a. Diagnosis:

i. WNV-specific IgM antibodies are detectable 3-8 days after onset of illness and may persist for 30-90 days or longer.

ii. Cerebrospinal fluid may also detect the presence of IgM antibodies for a recent infection.

iii. Viral cultures to detect viral RNA including RT-PCR may also be performed on serum, CSF or other body tissue.

b. Treatment:

i. There is currently no vaccine to prevent WNV and no specific medication to treat WNV. Treatment is aimed at clinical management of symptoms.

ii. Supportive treatment includes intravenous fluids, pain relief and fever reducing medications. Additional medication may be used to treat specific symptoms.

iii. Close monitoring for intracranial pressure (ICP) and seizures for those that develop neurological symptoms.

iv. Persons requiring hospital admission may require intensive care and mechanical ventilation support.

4. Prevention and Monitoring of West Nile Virus

A mosquito prevention and control program has been instituted in Laguna Honda Hospital to reduce the prevalence of mosquitos in the surrounding area to reduce the risk of all mosquito-borne diseases including WNV. (Cross-reference: Laguna Honda Hospital Mosquito Prevention and Control Plan)

Some birds are known to be affected by WNV as well and their presence may aid in alerting authorities to a potential outbreak. Dead birds, particularly a crow, jay, magpie or raven may provide evidence of the WNV in the area. Do not attempt to remove these animals. Contact Pest Control for removal and possible laboratory testing.

5. Protecting residents from West Nile Virus

During summer months when mosquitoes are abundant, residents should remain indoors in the early morning and twilight, when mosquitoes are most active for feeding/biting. Residents should wear long pants and long sleeves and socks when outside during these hours.

Repellents should be used cautiously in the elderly. Contact the provider for guidance if concerns. The most common repellent used is DEET. DEET is absorbed through the skin and should not be used on non-intact skin, wounds are near IV opening. Discontinue use and wash area with soap and water if rash or other symptoms of allergic reaction develops after application.

If WNV is diagnosed in close proximity to a recent blood transfusion or organ transplant, notification to the health department is necessary to screen for possible blood bank/organ tissue transmission.

6. The following is a summary of the CDC recommendations for repellant use

a. Persons using repellents should read and follow the manufacturers insert directions before using any chemical product on skin and persons with open skin lesions or irritated skin.

b. Do not apply to eyes or mouth and apply sparingly around ears. When using sprays, do not spray directly on face – spray on hands first and then apply to face.

c. Repellents containing DEET should be applied sparingly to exposed skin.

d. Do not spray repellents around food.

e. Avoid inhaling (breathing) repellent spray.

f. Repellents should not be applied to the hands of residents who commonly put their hands or fingers in their mouth.

g. A higher percentage of DEET does not mean that protection is stronger; it means that protection will last longer. Choose a product that provides for the amount of time the person will be outdoors. Reapply the product if the time outdoors is extended or if mosquitoes begin to bite.

h. Wear long pants, long sleeve shirts and socks when outside at dawn and dusk. Spray clothing to prevent mosquitoes from biting through thin clothing. Repellents should not be used under clothing.

i. After returning indoors, wash treated skin with soap and water or bathe. This is particularly important when repellents are used repeatedly in a day or on consecutive days. Also, wash treated clothing before wearing it again. (This precaution may vary with different repellents – check the product label).

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A7 Reportable Communicable Diseases
Reportable Diseases and Condition City and County of San Francisco Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20 and §2800-2812. Title 17, CCR §2500 (h)(i)

Revised: 20/08/10, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

New Nursing Policies and Procedures

DOCUMENTATION OF CARE – ACUTE UNIT

POLICY:

1. The Laguna Honda Hospital (LHH) Acute Unit are defined as the Acute Medical and Acute Rehab units. The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF).
2. The responsible Physician, Nurse Manager (NM), Charge Nurse, and the Nursing Director (ND) will be notified of any new admissions.
3. The Registered Nurse (RN) implements and documents the nursing process in the delivery of care to the patient in the electronic health record (EHR): assessments, nursing diagnoses, outcomes and planning, implementation and evaluation.
4. Each nursing role (e.g., RN, Licensed Vocational Nurse [LVN], Patient Care Assistant [PCA], or Home Health Aide [HHA]) will perform and document care delivered that is within the scope of their practice.
5. If no PCA is available, the RN will perform PCA tasks and documentation.
6. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
7. Float LVN or RN assigned to the Acute Unit will receive a unit-specific orientation to the environment of care and unit routine from a trained acute staff or Nursing Supervisor prior to providing care. They may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g., medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Refer to policy X X.X Nursing Staff Education – Acute Unit.

PURPOSE:

To outline nursing documentation standards and requirements related to patient in the Acute Units.

PROCEDURE:

A. Principles of Nursing Documentation

1. Documentation of Nursing Care:
    a. is recorded in the medical record and is reflective of the care provided.
    b. will be factual, accurate, complete, sequential, and legible.
    c. is subject to legal review and must be without ambiguity in interpretation (e.g., only use standardized/approved abbreviations)
    d. will contain a date, time, and the author's signature and credentials (legibly written or electronic) for each entry.
    e. is recorded and signed immediately after the care event or the observation has taken place. When this cannot occur, the author changes the time in the EHR to reflect the time that the action and observation occurred.
    f. will not be recorded in advance of care being provided.
    g. is entered with any changes in condition and is documented with enough detail to ensure continuity of care and level of care.

2. Documentation identifies late entries (when documentation is completed outside the shift performed) with the date and time of the observation and clearly indicates the added documentation is a late entry. The delay reason must also be included. This information is attached to the component of documentation that is being added as a late entry.
3. Incorrect documentation cannot be deleted or erased as the medical record is a legal documentation. Errors in the EHR require a "correction" comment to be entered with pertinent details for the reason for the correction if applicable.
4. Paper Documentation:
    a. will be completed using a blue or black ink pen.
    b. will be crossed out with a single line and reason written next to it for any errors. This correction must be signed or initialed, dated, and timed. White-out is prohibited.
5. Documenting Nursing Care and Assessments
    a. The LHH Acute Unit uses a combination of documentation methods:
        i. Charting by exception for assessment only (e.g., Within Defined Limits [WDL])
        ii. Documenting changes
        iii. Set, periodic documentation
        iv. Documentation specific to the acute admission or come-and-go procedure
    b. WDLs can be utilized to document assessments when the definition is available in the EHR for the documenting clinician and the clinician has assessed all elements within the definition.
    c. Fields that do not pertain to the patient's care or condition may be left blank.

B. Nursing Documentation

1. Shift documentation: Document as warranted by patient condition with a minimum of once per shift or as ordered. Documentation includes assessment data, newly identified or changes to nursing diagnosis (care plan problems), interventions implemented, and evaluation of patient's response to interventions.
    a. Head-to-toe assessment is completed at least once per shift, at the beginning of the shift or when first admitted.
    b. Vital Signs are documented at a minimum every shift on Acute Rehab at the beginning of the shift and every 4 hours on Acute Medical.
    c. Pain should also be assessed prior to administering routine pain medication, before and after as needed pain medication, and when clinically indicated. Refer to 25-06 Pain Assessment and Management.
    d. Intake and output will be documented each shift for all patients.
    e. Weights are documented at a minimum weekly on Acute Rehab and daily on Acute Medical.
    f. Complete additional assessments as clinically indicated every shift and as needed (e.g., lines, drains, airways, and wounds [LDA], restraint, coach).
    g. Initiate, revise, continue or resolve care plans and write a care plan note reflecting the patient's progress toward goals at a minimum every shift.
    h. Document a progress note every shift to provide a narrative of any supplemental information including, but not limited to:
        i. shift events
        ii. physician notification
        iii. interventions and evaluation of patient's response to interventions

iv. injuries, falls, or accidents
v. critical labs and abnormal test results (e.g., x-ray)
vi. medication errors
vii. any pertinent, relevant information necessary for continuity of care

i. Patient acuity will be documented before the end of every shift and reported to the nursing office.

2. Additional pertinent information about the patient will also be collected and documented as deemed appropriate by the RN, such as critical lab values and physician communication.
3. Allergies: observe for allergic reactions and adverse drug reactions during the patient's stay. For any new reactions, notify the physician. The physician adds new allergies and/or adverse drug reactions to the EHR allergy section.
4. Weekly assessments are determined by the patient's clinical condition and can include wound and behavior. Refer to K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury, K 2.0 Wound Assessment and Management, and G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning.
5. Psychotropic drugs require a consent and may use consents from a previous encounter (i.e., SNF admission). Monitor behavior every shift. Refer to policy 25-10 Use of Psychotropic Medications and J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications.
6. Document the use of interpreters. Refer to policy 29-05 Interpreter Services and Language Assistance.

C. **PCA or HHA shift documentation**:

1. Vital signs, pain, height and weight, consistent with unit frequency and as needed as directed by the RN.
2. Intake and output, except for nephrostomy output and enteral input/output, which is documented by the RN.
3. Activities of daily living
4. Daily Cares
5. Additional documentation as needed per patient condition or assignment (e.g., coach, restraint, etc.)
6. Notes: document any supplement data not noted in other areas as needed (e.g., nurse notifications, changes in condition, etc.)
7. When no PCA or HHA is available, the RN will perform the tasks and documentation.

D. RN and LVN:

1. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
2. If an LVN or RN has not been oriented and is assigned to the Acute Unit, they may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g, medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Trained acute staff may provide a brief unit orientation to ensure safe practice.

E. Plan of Care

1. **Assessment**: the RN will use a systematic approach to collecting and analyzing data about the patient. RN assessment and data gathered include sources such as physician notes, orders, nursing notes, allied health notes and information obtained from the patient/family.

2. **Diagnosis**: the RN's clinical judgment about the patient's response to actual or potential health conditions or needs, including for discharge.
3. **Outcomes/Planning**: based on the assessment and diagnosis, the RN sets measurable and achievable short- and long-range goals for the patient.
    a. The plan of care will include evidence-based care plans that are the most relevant to the patient/family and their clinical condition.
    b. The anticipated end date for those evidence-based care plans will be appropriate for the patient/family and their clinical scenario.
    c. Care plans are multidisciplinary (i.e., Social Services input in the Discharge planning care plan)
4. **Implementation**: nursing care is implemented according to the care plan.
5. **Evaluation**: the patient's status and effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.
    a. Care plans will be resolved when they are no longer applicable to the patient.
    b. The progress to the patient's plan of care should be documented every shift in a care plan note and as needed per the patient's condition and status.

F. Patient/Family Education

Nurses will document patient/family education in the medical record. Documentation will include patient/family response and retention of information provided.

G. Leave of Absence

1. When a patient leaves the hospital for a temporary period of time on a physician's written order, the patient's status is assessed and documented.
2. On return, a focused assessment of status, including the patient's reported adherence to medication or other therapeutic plan will be documented.

H. Admissions

1. Notifications:
    a. Notify the physician and patient care team at the time the patient arrives.
    b. Notify Nursing Operations for off hours admissions.
    c. Notify Admissions & Eligibility when the patient information is incorrect.
    d. Notify Food Services to order the first meal tray after the physician provides the diet order.
    e. For any patients admitted from SNF, request SNF Unit send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) with the patient to the Acute Unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.
2. Procedures:
    a. Apply new identification band to wrist.
        i. If resident is allergic or refuses, note on the electronic health record and use alternative method of identification.
        ii. Cut/remove any identification bands that came from LHH SNF or another facility.
        iii. Refer to NPP J 1.0 Medication Administration.
    b. Review allergies.

c. Itemize clothing, property and valuables on the Inventory Property Sheet and obtain patient signature. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
d. Obtain MRSA surveillance specimen within 24 hours of admission per order. Check for results within 72 hours. Document any positive MRSA results, and notifications and education provided to the patient, surrogate decision maker (SDM) or receiving unit or facility. Refer to 72-01 Infection Control Manual C21 MRSA Testing.
e. Admissions to the Acute Unit are new encounters with new a Contact Serial Number (CSN) and orders.

3. Assessment:
   a. Obtain vital signs and pain score. Screen Acute Rehab patients for orthostatic hypotension.
   b. Obtain height and weight. Refer to NPP G 4.0 Measuring Resident's Height and NPP G 7.0 Obtaining, Recording and Evaluating Resident's Weight.
   c. Complete a head-to-toe and admission assessments (e.g., allergies, fall risk).
   d. Complete additional assessments at admission (e.g., fall, smoking, elopement, pain) as well as other assessments or repeat assessments when clinically indicated (e.g., lift sling, restraint).
   e. Examine skin for any lines, drains, airways and wounds (LDA) and document in the EHR. Complete an Unusual Occurrence for any pressure injuries, suspicious bruises or markings. Report any suspect lice or scabies infestation to Nurse Manager, Infection Control Nurse and Physician. For any wounds, complete a wound assessment and schedule weekly wound monitoring in the EHR. Refer to 24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries and K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury.
   f. Initiate care plan within 4 hours of admission.
   g. Inventory belongings.
   h. If the admitting nurse is unable to complete the entire admission assessment, the following shift's nurse is to continue and the complete the remainder of the assessment as endorsed.

I. Come-and-Go Procedures

1. Come-and-Go procedures, such as blood transfusions and medication infusions, are not admissions and do not require admission documentation.
2. Documentation will occur on the Skilled Nursing Facility (SNF) medical record.
3. Documentation will follow the procedure as outlined in Procedure section B Nursing Documentation, as ordered and as specified in other policies, such as the NPP J 8.0 Blood Product Administration.

J. Discharges

1. Any transfer to an outside acute hospital for emergency services is a discharge.
2. The physician or nurse will inform the patient, family or surrogate decision maker of any acute medical problem and the reason for transfer to the outside acute facility. Notification and time must be documented in the EHR.
3. The physician must complete a discharge order and medication reconciliation, unless the patient is deceased.
4. The nurse will document the resident's condition at the time of discharge, including skin.

5. The nurse will provide transfer documents from the EHR to send with the patient that contain the interfacility transfer records, resident's profile and diagnosis, hospital course, medications, treatments, dietary requirement, allergies, treatment plan, and advance directive documents.
6. Education at discharge
7. The nurse will arrange transportation/ambulance based on medical urgency. For life-threatening situations requiring immediate response of a paramedic team, the nurse may activate a 911 call per physician order.
8. Reconcile and itemize clothing, property and valuables on the Inventory Property Sheet. Indicate discharge disposition of property. Label and secure the remaining property. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
9. Discharge the patient from the unit in the EHR.
10. For Psychiatric Emergency Services discharges, refer to the Psychiatric Emergency Policy.
11. For expirations:
    a. Complete the expiration documentation.
    b. Verify the physician has notified Donor Network West (DNW) organ donation network (1-800-55-DONOR or 1-800-553-6667) within 1 hour of death. The caller will document the date, time and referral number. Refer to C01-03 Organ/Tissue Transplant Donation Program.
12. Notifications:
    a. Nursing operations, food services and social services when a patient is discharged to an outside acute hospital.
    b. For any patients being discharged back to SNF, send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) to the SNF unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.

K. Significant Changes

1. For any significant changes, notify the physician and Nurse Manager or Nurse Supervisor of significant change. The physician or nurse will notify patient, family or surrogate decision maker of the significant change. Document any notification and attempts to notify, with the date, time and individual's name.

L. Acute Rehabilitation (IRF)

1. Interdisciplinary Team Meetings shall occur and be documented weekly, beginning with the date of admission, to discuss the plan of care, provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care.
2. Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) must be completed for all acute rehabilitation patients.
    a. Complete the assessments required for the IRF-PAI by the 3rd calendar day of the rehabilitation stay for the admissions and on the date of discharge for the discharges.
    b. Complete the admission IRF-PAI by day 4. Complete discharge IRF-PAI by day 4 after discharge.
3. Refer to 27-06 Guidelines for Inpatient Rehabilitation Facility Documentation

CROSS REFERENCES

20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
20-04 Discharge Planning
21-05 Medical Record Documentation
22-05 Handling Resident's Property and Prevention of Theft and Loss
22-XX Physical Restraints - Acute Units
24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries
25-06 Pain Assessment and Management.
25-10 Use of Psychotropic Medications
27-06 Guidelines for Inpatient Rehabilitation Facility Documentation
29-05 Interpreter Services and Language Assistance
72-01 Infection Control Manual C21 MRSA Testing
C 1.0 Admission and Readmission Procedure
C 1.3 Discharge to Acute
C 3.0 Documentation of Resident Status/Care by the License Nurse
C 3.2 Documentation of Resident Care by Nurse Assistants
C 4.0 Notification and Documentation of a Change in Resident Status
G 1.0 Vital Signs
G 3.0 Intake and Output
G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning
G 4.0 Measuring Resident's Height
G 7.0 Obtaining, Recording and Evaluating Resident's Weight
J 1.0 Medication Administration
J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications
K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury,
K 2.0 Wound Assessment and Management
Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing
Medicine C01-03 Organ/Tissue Transplant Donation Program

REFERENCES

California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on August 31, 2022

§70749 – Patient Health Record Content
§70753 – Transfer Summary
§70217 – Nursing Service Staff

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing Section 2725

Standards of Competent Performance, California Code of Regulations, Title 16, Section 1443.5

California Code of Regulations, Title 22, Section 70215

Department of Health and Human Services 42 CFR Part 482-Conditions of Participation for Hospitals,
California Assembly Bill 631, Section 7184
Public Law 99509, Section 9318

Revised Nursing Policies and Procedures

OXYGEN ADMINISTRATION

POLICY:

1. A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.

2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.

3. Residents requiring continuous oxygen shall be placed in a room that has wall oxygen.

4. Oxygen tank shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.

5. Disposable oxygen tubing administration devices shall be labelled with the date and initials every 7 days and PRN. Routine weekly changes shall be documented by the AM shift nursing staff.

PURPOSE:

To safely administer oxygen therapy.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply.

2. Obtain from Central Supply, as needed:

   - "NO SMOKING" sign(s)
   - Small “E” tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)
   - Appropriate regulator
   - Compressed Air Connector if no humidification required
   - Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.

B. <u>Safety measures</u> for oxygen are to be followed.

1. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.

2. “OXYGEN IN USE” signs are to be <u>clearly visible</u>:

   a. around the neck of the wall mounted oxygen flow regulators
   b. on oxygen or compressed air tanks in carriers or on wheelchairs
   c. outside the door of resident’s room when oxygen or compressed air is in use in the room

3. "OXYGEN STORAGE. NO SMOKING. NO OPEN FLAME" signs visible where oxygen is stored

4. **No alcohol or tincture, oil, glycerin, Vaseline or petroleum** product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure oxygen is turned off and tubing is stored in bags by the resident's bedside

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:
    a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
    b. Always look at the cylinder gauge to determine contents before administering any.
    c. Oxygen cylinders in storage shall be equipped with valve protection devices, and stored in oxygen cabinet.
    d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
    e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.

C. Setting up and monitoring oxygen cylinders:

1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.
4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be posted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and compressed air connector will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder. Cylinders stored in the open are protected from weather.
9. Empty cylinders are segregated from full cylinders.
10. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

D. Breaking down oxygen cylinders.

1. Remove regulators from cylinders.

2. Place valve covers on cylinders.
3. Nursing will disinfect the oxygen cylinder (avoiding valve stem) ~~with a 70% isopropyl alcohol agent~~with the facility-approved disinfectant.
4. Nursing will put "empty tag" on the oxygen cylinder and place the disinfected cylinder in the oxygen storage cabinet in the clean utility room in the designated location for empty cylinders.
5. Central Supply will pick up used/empty cylinders.

E. Procedure

1. Refer to Elsevier Clinical Skills titled "Oxygen Therapy: Nasal Cannula or Oxygen Mask."

REFERENCES:

Elsevier Clinical Skills: Oxygen Therapy: Nasal Cannula or Oxygen Mask, Adapted from Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Published: September 2021

https://point-of-care.elsevierperformancemanager.com/skills/380/quick-sheet?skillId=GN_22_1&virtualname=sanfrangeneralhospital-casanfrancisco

CROSS REFERENCES:

Respiratory Services Policies & Procedures:
- A 2. Safety Regulations for Oxygen Therapy
- A 6. Oxygen Administration: Nasal Cannula
- A 7. Oxygen Administration: Simple- Oxygen Mask
- A 8. Oxygen Administration: Non-Rebreather Mask
- A 9. Oxygen Administration: Venturi Mask

Revised: 2006/03, 2006/04, 2009/08, 2017/01/10; 2019/03/12; 2022/01/11; 2022/07/12; 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

Revised Medical Services Policies and Procedures

LAGUNA HONDA PSYCHIATRY ~~SUBSTANCE TREATMENT~~SUBSTANCE TREATMENT AND RECOVERY ~~SERVICES~~SERVICES (STARS)

~~POLICY:~~
POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) provides Substance Treatment and Recovery Services (STARS) for its residents with substance use service needs. These services include both non-specialty resident outreach and engagement services, as well as specialty substance use treatment services, in alignment with San Francisco Health Network Behavioral Health Services (SFHN-BHS) and Medicare/MediCal standards.

PURPOSE:

1. To establish Policies and Procedures through which LHH Psychiatry clinicians deliver services for LHH residents with substance use disorders (SUDs).

2. To ensure that specialty substance treatment services are evidence-based, including the use of co-occurring service models, modeled after a Drug Medi-Cal (DMC) Organizational Delivery System (ODS) Outpatient Program, and meet SFHN-BHS requirements. (The specialty substance treatment portion of STARS shall be referred to as “DMC program” below.)

3. To ensure that the results of services to residents with SUDs are meaningful and helpful to the residents and are communicated where appropriate to the attending physician or the referral party.

OVERVIEW:

LHH STARS program is part of LHH Psychiatry, which is a Clinical Service under LHH Medical Staff Services. The STARS program provides outpatient level non-specialty outreach efforts to engage LHH residents with SUDs in services, as well as specialty substance use treatment services (DMC program). The DMC program portion of STARS is modeled after the regulatory guidelines of Drug-Medi-Cal (DMC), SFHN-BHS of San Francisco Department of Public Health, and The Department of Health Care Services of California (DHCS).

~~PHILOSOPHY:~~

PHILOSOPHY:

All STARS services are provided in alignment with the SFHN-BHS philosophy of care; elements include but are not limited to:

- Person centered
- Non-judgmental
- Evidence based
- ~~Strength~~Strengths based

- Individually tailored
- Trauma informed
- Culturally sensitive
- Harm Reduction
- Promoting autonomy, optimism and hope
- Integrating care for bio-psycho-social-spiritual aspects of the whole person.

PROCEDURE:

I. Non-specialty outreach and engagement of resident with SUDs

All LHH Psychiatry staff shall incorporate low barrier and welcoming approaches with the above philosophical principles in clinical encounters with residents with SUDs. This means any door is the right door, i.e. regardless of the types of clinical services staff are providing (i.e. psychotropic medication management, mental health services, neuropsychological and psychological services, behavioral consultation and planning, health and behavioral interventions), screening and checking in about substance use concerns (if any) are an integral part of the service. Depending on the resident's stages of change, clinicians may discuss with residents about their substance use concerns under the context of these existing Psychiatry services, providing brief interventions if indicated and appropriate, as well as referring the resident to specialty DMC program if indicated.

Documentation for such non-specialty services for residents with SUDs shall be entered into the electronic health record (EHR) section designated for LHH Psychiatry, under non-substance treatment related service areas (i.e., specialty mental health, non-specialty mental health, or primary care behavioral health service areas), in the LHH EHR. Such documentation can be accessed by LHH Resident Care Team members.

II. Specialty Substance Treatment Program (DMC Program)

DMC program treatment services (including but not limited to: screening, assessment, treatment planning, individual and group counseling services) and other substance recovery related services (e.g. motivational interviewing, harm reduction counseling) are provided by a team of LHH Psychiatry staff who are registered, licensed, or certified to provide substance use and/or mental health services in California. These services are provided under the direction of Chief of Psychiatry, Behavioral Health Program Director, and designated STARS psychiatrist, and coordinated on a day-to-day basis by the ~~STARS Clinical Coordinator.~~Behavioral Health Program Director or designee. The practice procedures outlined below are the general service delivery process. Staff will follow the steps as they are implemented during the program development process.

1. Referral

a. Any LHH residents with known, suspected, unresolved or history of substance use, or residents who exhibit substance use behavior, with or without history of treatment, that may meet DSM-5 criteria for a SUD diagnosis (excluding nicotine~~-~~only use) shall be referred by the LHH Primary Physician for SUD screening and/or treatment services via the E-Consult process for LHH Psychiatry.

~~b.~~ Any LHH resident and/or family can request a substance use treatment screening/assessment for the resident. The resident and/or family shall notify the resident's primary physician who shall make the referral to LHH Psychiatry. They

b. may also notify their currently assigned LHH Psychiatry provider, who can provide the service or make an internal referral, as appropriate.

c. Residents may decline services by LHH Psychiatry clinicians for SUD related services, including screening, assessment or treatment. Resident participation in the ~~DMC~~ specialty SUD treatment program (DMC program) is voluntary.

d. Designated LHH Psychiatry triage staff will review the referral within one business day of the E-consult entry. ~~Any referrals where substance use is a clinical concern will be assigned to a DMC program clinician for screening.~~

e. The assigned clinician will review the resident's medical record and complete a screening within five (5) business days after being assigned, sooner if clinically indicated, unless the residents' special medical or other conditions warrants otherwise (the reasons for delayed screening and assessments need to be documented in the ~~e-consult response and the~~LHH electronic health record (EHR~~).~~) section designated for LHH Psychiatry.

2. Information Gathering

~~a.~~ a. The assigned clinician will collect information from the resident, medical records, staff, the LHH primary physician, and other entities authorized by the resident.

~~b.~~ b. The clinician will screen the following areas:

i. The resident's history of using one or more substances (excluding nicotine-only use) including prescription medications or medicinal cannabis, whether such use meeting criteria for a DSM-5 substance use disorder diagnosis. This may include mild use disorders, SUD in remission, and if the resident is at risk for relapse without outpatient treatment.

ii. Motivation for Treatment (stages of change model).

iii. Physical and cognitive capacity to participate and benefit from receiving substance treatment.

~~c.~~ c. Until the resident is diagnosed with a substance use disorder and agrees to specialty treatment, all initial documentation will be entered into the EHR section designated for LHH Psychiatry, non- substance treatment related service areas (i.e~~.~~., specialty mental health, non-specialty mental health, or primary care behavioral health service areas~~).~~), in the LHH EHR.

d. For residents who are assessed to be appropriate for and who are able/willing and ready to participate in the specialty DMC program, the resident will be internally referred (within LHH Psychiatry) to and enrolled in the DMC program. The enrolling/treating SUD treatment provider may or may not be the same clinician who completes the initial SUD screening.

~~d.~~ d. For residents who are assessed to be appropriate for but who decline to participate in the specialty DMC program during the initial encounter:

i. The clinician shall explain to the resident, that they can request to be re-~~-~~assessed and ~~admitted to~~enrolled in the specialty DMC program at any time during their LHH stay.

ii. The clinician will leave their contact information and STARS related information materials with the resident~~.~~, if acceptable to the resident.

iii. The LHH Psychiatry clinician will make at least one more attempt based on their clinical judgment to engage the resident in specialty DMC program through outreach efforts and other ~~non-treatment~~ recovery services~~.~~ (that are not treatment per se).

iv. The LHH Psychiatry clinician ~~must~~shall notify the referring primary physician and STARS Clinical Coordinator regarding the residents' decision to not participate in the specialty DMC program. The clinician ~~must~~shall document the communication~~.~~ in the EHR.

3. Admission to specialty DMC program

a. Inclusion Criteria:

i. The resident meets criteria for a DSM-5 Substance Use Disorder diagnosis (including in sustained remission), excluding nicotine-only use.

ii. The resident is interested in, or is ambivalent but still willing to participate in, the specialty DMC program.

iii. The resident has the basic cognitive and physical capacity to participate in and benefit from treatment.

b. Once admitted to the specialty DMC program, the resident must be opened in the designated behavioral health EHR for LHH specialty DMC program.

c. For residents who are admitted to the specialty DMC program, the clinician will:

i. Complete an Intake assessment (this may be extended over multiple sessions if preferred by the resident).

ii. Complete necessary treatment consent ~~and if indicated, Authorization~~.

~~ii.~~iii. Ask the resident to ~~Disclose Private Health~~sign the consent for Release of Information (ROI) (Form Name: Permission To Share Your Substance Use Disorder (SUD) Treatment Records) for the SUD treatment provider to share specialty SUD treatment information with the RCT (see Section 7 below~~)~~).

~~iii.~~iv. Have the designated STARS psychiatrist review the physical exam (must be within the past 12 months),

~~iv.~~v. Have a licensed clinician review and approve (as indicated) the clinical elements per the current DMC guidelines, such as: DSM-5 diagnosis(es) and medical necessity of admission, the screening and Intake Assessment by the primary clinician (if non-licensed~~) and/or per DMC guidelines.~~).

4. Specialty DMC program Treatment Plan of Care

a. Upon completion of the Intake Assessment, the primary DMC program clinician shall develop a Treatment Plan of Care with the resident, as per DMC requirements. Necessary signatures shall be obtained as per DMC requirements.

b. The resident's assessment and treatment plan are shared among the DMC clinicians for review and comment.

c. Treatment plan reviews and renewals will be documented according to DMC requirements.

d. The treatment plan is developed using person-centered principles.

5. Substance Use Treatment

a. Substance use treatment modalities at LHH may include:
   i. admission and intake assessment/reassessment
   ii. person-centered treatment planning and treatment plan reviews
   iii. individual and/or group (and when appropriate, couples or family) therapy and psychoeducation
   iv. crisis intervention
   v. collateral sessions (meetings with family or others in the resident's natural support network)
   vi. medication support and management
   vii. coordination with hospital-based case management (RCT and medical social worker), including assistance with discharge planning and developing community-based substance use recovery plans. (See LHH HWPP 20.-04 Discharge Planning)

b. All services are to be provided with a wellness recovery approach.

6. Documentation

a. Documentation of LHH ~~STARS~~specialty substance treatment services will be completed in the designated behavioral health EHR. Paper records including the resident's signature will be kept in a separate DMC program medical record. Upon the resident's discharge from LHH, such records will be forwarded to SFHN-BHS Medical Record.

b. ~~All~~All specialty substance treatment documentation will follow the most current instructions for documentation, including but not limited to timing and content, based on the current Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual. Provision of the instructions is the ~~joint~~ responsibility of the LHH Psychiatry Behavioral Health Program Director (or designee~~) and the STARS Clinical Coordinator.~~).

7. Privacy and Authorization to Disclose Substance Treatment Information

a. LHH Psychiatry clinicians will follow federal and state laws that govern the disclosure and re-disclosure of specialty substance use treatment information.

b. LHH provides team-based services and the Resident Care Team concept is central to LHH's holistic approach to care. Communication between the Resident Care Team (RCT) and LHH Psychiatry staff is critical to this process.

c. In order to facilitate care coordination, whenever appropriate, any LHH providers (DMC program ~~clinician~~clinicians, Psychiatry ~~provider~~providers or RCT members) ~~may ask~~shall encourage the resident to ~~sign the DPH "Authorization to Disclose Health Information Form" indicating authorization for~~ give consent for ROI, i.e., permission for the resident's specialty substance use treatment information to be disclosed to the RCT ~~members~~. The ~~form shall indicate specifically if~~specialty SUD treatment provider will go over the DPH form "Permission To Share Your Substance Use Disorder (SUD) Treatment Records" with the resident ~~is authorizing verbal~~. Once a resident signs the form indicating authorization for disclosure ~~of treatment information, release of written substance treatment documentation, or both. The~~, the original signed form will be filed in the resident's DMC program chart, with a copy uploaded to the resident's record in the LHH EHR.

d. Providers are encouraged to explain to the resident the importance, benefits, and risks (if any) of care coordination, while understanding that authorizing disclosure of substance treatment information is voluntary, and that the residents have the right to revoke the authorization, verbally or in writing, at any time. Providers are encouraged to inform residents of the legal exceptions to confidentiality.

e. In cases where the resident gives consent for ROI:
   i. LHH Psychiatry SUD treatment provider will document summary information of the resident's SUD treatment in LHH EHR.
   ii. LHH RCT incorporates the SUD treatment information into the resident's care plans.
   iii. LHH Psychiatry SUD treatment provider will still document detailed SUD treatment information in the behavioral health EHR.
   iv. If the resident changes their mind and revokes their consents for ROI at some point, no further entries will be made in LHH EHR by LHH Psychiatry specialty SUD treatment providers.

~~e.~~f. Recipients of such disclosed substance treatment information are responsible for complying with legal requirement to refrain from re-disclosing substance treatment information except with the resident's written authorization or as specifically required by law.

g. In cases where a resident desires and participates in specialty SUD treatment but does not consent for ROI:
   i. LHH Psychiatry SUD treatment provider will NOT document SUD treatment information in LHH EHR.
   ii. SUD treatment information will be documented in the behavioral health EHR only and LHH Psychiatry SUD treatment provider will note in the behavioral health EHR that the resident does not consent (or has revoked prior consent) to disclosure of records.

iii. LHH Psychiatry SUD treatment providers may still document in LHH EHR behavioral health treatment information that is NOT about specialty SUD treatment, such as:
- Mental Health assessment and treatment;
- Neuropsychological services;
- Non-specialty level SUD services;
- Psychotropic medication treatment; and
- Behavioral consultation and planning recommendations.

iv. LHH RCT members may ask the resident about how the resident is doing with the referral to SUD treatment, and document in Epic what the resident chooses to disclose in response, if any.

v. LHH RCT will care plan for the resident's SUD condition(s) based on available clinical information and observations.

vi. If the resident changes their mind and consents for ROI at some point, LHH Psychiatry SUD treatment providers shall follow steps c-e above.

vii. LHH Psychiatry SUD providers will periodically (at least annually) ask residents whether they would like to consent for ROI, for the benefit of care coordination.

~~f.~~h. As the DMC program is part of the comprehensive behavioral health program of LHH Psychiatry, and LHH Psychiatry providers provide clinical cross-coverage for each other, a resident's DMC clinician may share the resident's substance treatment information with other LHH Psychiatry providers. Minimum necessary requirements of HIPPA will be followed.

8. Quality Assurance

LHH ~~STARS program~~Psychiatry shall collaborate with LHH Quality Management on gathering, tracking and analyzing data related to STARS services for quality assurance and improvement purposes. Areas of improvement and countermeasures shall be identified and implemented following the LEAN quality improvement framework.

III. Other Substance Use Recovery Related Groups and Activities

1. In addition to treatment services, LHH STARS program ~~will~~may also include outreach, engagement and educational services for the general resident population and for those who are not ready to commit to active treatment. These services are focused on reduction of active use and harm. They may be provided if feasible based on resources and Infection Control protocols.

2. ~~STARS outreach program~~Outreach may include peer support services such as AA (Alcoholics Anonymous), NA (Narcotics Anonymous), and others.

a. Appropriate approval and clearance by the LHH Chief Medical Officer must be obtained before such groups may start.

b. Coordination of these groups and activities will be through the LHH ~~STARS Clinical Coordinator~~Psychiatry Behavioral Health Program Director or designee.

c. Information about participation in peer support services for admitted residents will be collected from the resident during individual and/or group sessions. This information will be documented by STARS clinicians in individual and/or group counseling progress notes.

IV. Active Use, Contraband and Searches for Illicit Drugs and Paraphernalia

1. LHH Psychiatry clinicians are NOT to participate in any clinical searches for the purpose of maintaining milieu safety. This is to ensure that the therapeutic alliance formed between the LHH Psychiatry clinician and the resident, which is the foundation for effective therapeutic interventions, can be preserved, so that the resident would not suffer from breaking the trust in their treatment provider~~.~~ (which may lead to negative treatment outcomes).

2. For residents with behavioral issues related to active use and negatively impacting care, LHH Psychiatry clinicians will collaborate with the RCT on behavioral management services. See LHH MSPP D08-10 Behavioral Management Services by LHH Psychiatry.

3. For other aspects involving resident active substance use and contraband presence, see LHH Policy 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By Residents or Visitors.

V. Education about Substance Use Treatment

1. All LHH Psychiatry clinicians have a role in helping hospital staff, family members and/or the general resident population at LHH to learn about substance use disorders, wellness and recovery principles, and harm reduction principles.

2. The purpose is to reduce stigma, promote greater understanding of these disorders and potential consequences, and to increase the skills of staff and family especially in participating in treatment planning and helping to promote residents' recovery.

3. Such educational activities may include but are not limited to: input in staff training, family psychoeducation, consultation to the RCTs for specific residents, Learning Circles, and other means for increasing and improving communication, learning and understanding about SUDs.

ATTACHMENT:
None

REFERENCE:

1. 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By Residents or Visitors
2. Community Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual, 2015
3. MSPP D08-03 Access to LHH Psychiatry Services
4. MSPP D08-10 Behavioral Management Services by LHH Psychiatry.
5. HWPP 20-04 Discharge Planning

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