List of Policies and Procedures for JCC Review 10-21-25					
Blue (Hospital-wide); Grey (Departmental)					
Status	**Dept.**	**Policy #**	**Title**	**Owner/ Reviser**	**Notes**
Revised	NSPP	A 2.0	Nursing Services: Organization, Authority/Responsibility and Operations	**C. Figlietti**	• Changed "CNO" to "DON's (1) South Tower and (2) North Tower" • Removing Appendix on Nursing Organizational Chart -> Referring to HWPP #01-01 Appendix A: Hospital Organizational Chart • Updated Nursing Services Administration personnel list to current job titles • Removed "Temporary Agency Nurses are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift…" – they are not told to do this. Agencies provide this information • Removed Respiratory Care Practitioners in section re: demonstration of competence. Nursing does not dictate what RT's do • Removed sections that are addressed by HR (e.g., prospective hires showing proof of current CPR, documentation of physical disability) • Referred to HWPP 80-05 Staff Education Programs • Removing Attachment and updating reference list Additional Changes made per HC request in August: • Added: DONs to report to CEO/NHA • Added "Chief Nursing Officer" to Nursing Services Administration • Add" CEO/NHA and CNO" to members of NEC • Add: "Co-Chairs" to DONs role of NEC and removed Nurse Manager as a Co-Chair
Revised	DPH	18-04	Order Entry	**Z. Amenhotep**	1. Added "and licensed Clinical Laboratory Personnel"
Revised	DPH	18-05	Blood and Blood Component Administration	**Z. Amenhotep**	1. Defined additional licensed individuals by professional title, beyond RNs, who are qualified to serve as transfusionists including MD, DO, DPM, NP, PA, CNM, CRNA. 2. Defined examples of providers who can serve as a 2nd individual or "Checker" for pretransfusion cross checks including, MD, DO, DPM, NP, PA, CNM, CRNA (and, for ED, appropriately trained PharmDs). 3. Defined the role of Departments where transfusions occur in conducting Transfusionist and Checker training and competency and maintaining records those records. Note: Autotransfusionists/Perioperative Blood Management Technologists may collect and process blood but do not transfuse blood at DPH/ZSFG. ZSFG also does not use perfusionists for blood transfusion. 4. Defined standard terms for… • Blood Product Label (front side of bag) vs. • Blood Order Label (affixed to the back side of the bag) • Transfusion Report Form (attached by rubber band to all bags; used only during EHR downtime, emergency or massive transfusions to document Transfusionist/Checker(s) attestations. 5. Redefined workflow for ROUTINE transfusions • Transfusionist who is logged in to the EHR and the "Checker" will electronically co-sign to attest pretransfusion checks (by policy, still exploring whether attestation language can be added to Epic). 6. Added Direction to Order Transfusion Reaction workups [in Epic] (can be verbal or telephone order). 7. Compatibility Table and Exceptions: • Expanded compatibility table to include references to whole blood, which is not currently offered at ZSFG but may become available in the future. • Included reference to emergency use of low titer group O whole blood (LTOWB), which is not currently offered at ZSFG but may become available in the future. • Added a reference to the use of Group A plasma for massive transfusion in patients whose ABO blood type is unknown or unconfirmed, or who are known to be group B or AB when type specific and/or type compatible plasma inventory is severely limited. • During emergency or massive transfusion, Rh-positive red cells may be issued to Rh-negative males of any age, and/or Rh-negative females who are beyond 55 years of age. 8. Revised Form Examples (e.g., Transfusion Report Form and Transfusion Reaction Report Form) 9. Updated Key Points and Transfusion Observation Checklist 10. Expanded list of cross references to include all hospital-wide (ZSFG and LHH) and department specific polices related to transfusion.
New	LHHPP	25-16	Safe Use of Medicinal Cannabis Products	**A. Lam**	New policy
New	LHHPP	25-16 Attachment A	Laguna Honda Medicinal Cannabis Policy Acknowledgement	**A. Lam**	New Policy
Revised	LHHPP	24-06	Resident and Visitor Complaints/Grievances	**A. Fishman**	1. Updated weekly review to weekly reviewed by NHA and as needed 2. Added awareness to opportunity 3. Removed "Discussion of the data shall be documented in the minutes" 4. Removed "and during community meetings" from Resident Council
Revised	LHHPP	24-06 Attachment A	Resident Grievance Information Flyer	**A. Fishman**	Added Fax (415) 759-2374
Revised	LHHPP	24-06 Attachment B	24-06 Attachment B Resident Grievance Form	**A. Fishman**	Updated form with resident signature electronic option

Revised	LHHPP	24-06 Attachment D	Resident Grievance Response Form	**A. Fishman**	Simply form to current process
Revised	LHHPP	24-28	Behavioral Health	**Y. Qian**	1. Shortened sections 1 and 3; moved procedural details to separate standard work 2. Added reference: Standard Work: Managing Resident Challenging Behaviors 3. Update the title for policy MSPP D16 4. Minor edits
Revised	LHHPP	65-02	Monitoring of Third Party Agreements	**N. Zahir**	1. Added "All contracts performance measures will be monitored and evaluated annually by the LHH Performance Improvement and Patient Safety (PIPS) Committee." 2. Deleted "LHH Administration Office is responsible for centralizing all agreements and Monitoring Reports. The CEO/NHA or designee will delegate this task to support staff." 3. Added "S. F. Adm. C. Chapter 21: Acquisition of Commodities and Services and Chapter 21A: Health Related Commodities and Services." 4. Deleted "Third Part Agreement: Monitoring Report (refer to Appendix A)" 5. Added "evaluation that shall include a review of established performance measures. The evaluation of contracted services shall be conducted in relation to LHH's expectations. The evaluation will be reported to PIPS committee at least once a year." 6. Deleted "The Monitoring Report is due to LHH Administration by July 30th every year. The review period is the previous fiscal year" 7. Deleted the instructions for completing the Third Party Agreement: Monitoring Report 8. Added "The review and evaluation of contracted services performance measures by the PIPS Committee shall be submitted annually to the Joint Conference Committee (a committee of the Governing Body), for review and approval."
Deletion	LHHPP	65-02 Attachment A	Monitoring of Third Party Agreements	**N. Zahir**	No longer needed since all mentions of "Third Part Agreement: Monitoring Report" have been removed from the policy.
Revised	MSPP	MSPP-003-03	Billing for Physician Services	**D. Minassian**	Minor editorial, no content changes.
Revised	MSPP	MSPP-D15	Prescribing Controlled Substances for Chronic Pain Management	**D. Minassian**	Removing reference to deleted (outdated attachment) and instead referencing standard clinical practice of informed consent and documentation.
Deletion	MSPP	MSPP-D15_Attachment A 1	Prescribing Controlled Substances for Chronic Pain Management	**D. Minassian**	Removed because no longer pertinent and felt to be redundant, outdated.
Revised	OPC	A2	Outpatient Clinic Appointment System	**H. Chen**	Changes: added revision date, added standard procedures for late arrivals (section 3 a-d), added primary care to description of attending physician, added statement about drop-in patients.
Revised	OPC	C7	Shelf-life of Sterile Packages	**H. Chen**	Page 1: added stipulation about manufacturer's instructions for use, and the use of published expiration dates, referenced the expiration date of sterile peel pouch/sleeves, removed "time or event dated) Page 3: referenced LHH G10 re: temperature-controlled environments and appropriate storage, added "or designee", added "upcoming expiration", added "all hospital sterilized equipment will be reprocessed annually Added review/revision dates
Deletion	OPC	C4	High-Level Chemical Disinfection	**H. Chen**	No longer being done in the clinic
Deletion	OPC	C5	Flexible Nasopharyngeal Laryngoscope	**H. Chen**	No longer being done in the clinic
Revised	Volunteer Services	A01.0	Volunteer Recruitment Process Life Cycle	**S. Smith**	Updated policy to reflect current information and operating procedures.
Revised	Volunteer Services	A02.0	Volunteer Fingerprinting	**S. Smith**	Updated policy to reflect current information.
Revised	Volunteer Services	A03.0	Volunteer Orientation	**S. Smith**	Updated policy to reflect current information and operating procedures. Rephrased wording of sections for clarity.
Revised	Volunteer Services	A04.0	Volunteer Infection Prevention	**S. Smith**	Updated policy to reflect current information and operating procedures. Rephrased wording of sections for clarity.
Revised	Volunteer Services	A06.0	Record Keeping	**S. Smith**	Updated policy to reflect current information and operating procedures.
Revised	Volunteer Services	A08.0	Clothing Room	**S. Smith**	No revisions effective July 2025. It looks like this version had revisions to reflect current information and operating procedures that were updated by previous Volunteer Services staff.
Revised	Volunteer Services	A09.0	Resident Library	**S. Smith**	Updated policy to reflect current information and operating procedures.
Revised	Volunteer Services	A10.0	Holiday Gifts	**S. Smith**	Updated policy to reflect current information and operating procedures.
Revised	Volunteer Services	A11.0	Volunteer ID Badge	**S. Smith**	Procedure Updated policy to reflect current information and operating procedures.

JCC Follow-up

NURSING SERVICES: ORGANIZATION, AUTHORITY/RESPONSIBILITY AND OPERATIONS

POLICY:

The operational units of Nursing Services include skilled nursing, medical acute, and rehabilitation acute care. Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing Services shall be organized, staffed, equipped, and supplied to meet the needs of the residents/patients of LHH.

PURPOSE:

To describe and communicate LHH Nursing Services structure, authority, responsibility, and operations.

~~RELEVANT DATA:~~

1. The ~~Chief Nursing Officer (CNO)~~Directors of Nursing (DON's) {(1) South Tower and (1) North Tower}, or designee:

   a. Report to the Chief Executive Officer/Nursing Home Administrator;

   ~~a.~~b. Holds an active Registered Nurse license and is employed by SFDPH as ~~the~~ a ~~CNO~~ DON on a full-time basis, defined as 40 or more hours per week;

   ~~b.~~c. Actively participates in the organization's leadership functions with the Governing Body, Medical Staff, Hospital Management, and Clinical Leaders in the Hospital's decision-making structures and processes;

   ~~c.~~d. Ensures the continuous and timely availability of nursing services to residents/patients;

   ~~d.~~e. Ensures that Nursing Practice Guidelines and Nursing Policies and Procedures are consistent with current evidence-based practice and nationally recognized professional standards;

   ~~e.~~f. Implements the findings of current research from nursing and other literature into policies and procedures that govern the provision of nursing care;

   ~~f.~~g. Ensures that Nursing Services staff carry out applicable processes in resident/patient care and organization wide functions;

   ~~g.~~h. Assigns responsibility for individuals or groups of nursing staff members to act on improving the performance of Nursing Services through the implementation of an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to residents/patients;

   ~~h.~~i. Participates with leadership from the Governing Body, Medical Staff, Hospital Management, and other Clinical Leaders in planning, promoting, and conducting organization wide performance improvement activities;

   ~~i.~~j. Collaborates with other hospital leaders in designing and providing resident/patient care programs, services, policies, and procedures that describe how residents'/patients' nursing care needs are assessed, evaluated, and met;

   ~~j.~~k. Develops and implements the organization plan for providing nursing care to those residents/patients requiring nursing care;

~~k.~~l. Participates with hospital leaders in providing for a sufficient number of appropriately qualified nursing staff to care for residents/patients'; and

~~l.~~m. Manages the Nursing Services' portion of the hospital budget.

~~m.~~n. May serve as a C~~c~~harge N~~n~~urse only when the facility has average daily occupancy of 60 or fewer residents/patients.

ORGANIZATION

LHH Nursing Services are provided within a decentralized organizational structure~~. (See Appendix A "Nursing Organizational Chart"). {Refer to Hospital-wide Policy and Procedure (HWPP) #01-01 Appendix A: Hospital Organizational Chart}~~

The Nursing Services Administration includes the following personnel:

- Laguna Honda Hospital (LHH) ~~Chief Nursing Officer~~Chief Executive Officer (CEO)/Nursing Home Administrator (NHA)
- Directors of Nursing Services (DONs)
- Chief Nursing Officer (CNO)
- ~~Nursing~~ Nurse Directors
- Nursing Operations ~~Supervisors~~Nurse Managers
- ~~Shift Supervisors~~
- Nurse Managers
- Nursing Leadership which supports nursing management and/or resident/patient care functions (e.g., ~~Advanced Practice Nurses,~~ Clinical Nurse Specialists, Minimum Data Set/Resident Assessment Instrument (MDS/RAI) Program Coordinators, MDS Coordinators, ~~Informatics Nurses~~Clinical Liaison, EPIC Super-Users, ~~Nurse Recruiter,~~ Nursing Recruitment and Hiring Manager, Nursing Orientation Coordinator, and ~~Nurse~~ Educators)

All areas providing Nursing Care/Service are represented at the Nursing Executive Committee (NEC) that is chaired by the ~~CNO~~ DONs/designee.

AUTHORITY/RESPONSIBILITY

All areas providing Nursing Services are accountable to the ~~Chief Nursing Officer~~Directors of Nursing Services ~~-~~ for Nursing Practice Guidelines, Nursing Policies & Procedures, and Quality Assurance and ~~-~~ ~~Nursing~~ Performance Improvement Programs.

~~1.~~ Authority for Nursing Services is specified in the job descriptions of the nursing leadership staff.

1.

~~2.~~

2. The DONs assume the duties of the NHA in their absence.

~~3.~~ The CNO is usually present in the hospital during business hours Monday through Friday. When the CNO is not present, she/he will designate a Nursing Administrator Director to assume overall

responsibility for the operation of Nursing Services. The Nursing Operations Supervisor assumes all responsibility on evening and night shifts, weekends, and holidays.

3.

4.

5. The Nursing Directors are usually present in the hospital during business hours Monday through Friday. Each is responsible for making arrangements for administrative coverage for their divisional/unit operations in the event of their absence.

6.

7.4. Individuals in nursing administrative/nursing leadership positions are knowledgeable about hospital/nursing services goals and objectives, hospital/nursing organizational structure, hospital/nursing policies and procedures, nursing staff job descriptions, staffing methodologies, scope of services provided by each nursing unit, and mechanisms for monitoring/evaluating the quality and appropriateness of resident/patient care.

OPERATIONS

A. INTEGRATION

1. The Nursing Directors of Nursing Services, Nursing Operations Supervisors, Clinical Nurse Specialists, Advanced Practice Nurses, MDS/RAI Program Coordinators, Chair of the Nurse Managers Council, and Director of Quality Management are members of the Nursing Executive Committee.
2. Nursing Services administrative staff (listed as above) participate with other hospital leaders in the decision-making of structures and processes.
3. Nursing Services are represented and participate oin hospital, medical staff, and nursing committees.
4. The NEC may appoint Task Forces and Ad Hoc Committees when needed to accomplish specific projects or goals.

B. MANAGEMENT FUNCTIONS

1. Structure:

The Nursing Services organizational structure, delineating lines of authority and accountability, is displayed graphically in the Nursing LHH Leadership Organizational Chart (See Appendix A). Other documents describing authority, accountability, and communication within the department are located in job descriptions and in policy/procedure statements.

2. Personnel Policies and Procedures:

Nursing Services works within the framework of personnel policies/procedures set forth by the Human Resource Services Department that have been developed and reviewed with input and involvement of the Hospital Executive Committee.

The CNO DONs and members of the NEC are responsible for the identification of qualifications required for each classification of nursing positions. The CNODONs, in collaboration with the Director of Nursing Operations, Nurse RecruiterNursing Recruitment and Hiring Manager, and a representative from Human Resources, has the authority to make decisions with regard to employment, deployment, and assignment of nursing staff.
Employment activities and placement of nursing personnel are coordinated with the Human

Resource Services Department through the Nursing Recruitment and Hiring Manager~~Nurse Recruiter~~ or designee.

The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.

3. Nursing Policies & Procedures, Criteria/Indicators:

Nursing Services Policies and Procedures are reviewed and approved by the NEC. Performance criteria are derived from job descriptions and policies/procedures. Individual nursing performance criteria are evaluated through criteria-based performance appraisals annually. Quality improvement indicators are used to measure, assess, evaluate, and improve the quality of Nursing Services. Quality improvement activities are reported to the Nursing ~~Quality~~Quality Assurance and Performance ~~–~~Improvement ~~Coordinating~~ Committee. (Refer to HWPP 01-01 Approval and Format of Hospital-wide and Departmental Policies and Procedures)~~.~~

4. Nursing Executive Committee (NEC):

a. The Nursing Executive Committee is the decision-making body relating to Nursing Services at LHH. The goals of the NEC are:

i. to set policy for Nursing Services;

ii. to define the mission, philosophy, and goals for nursing at LHH;

iii. to approve Hospital Policies and Procedures that affect nursing services and care delivery;

iv. to promote communication throughout all levels of Nursing Management across the organization;

v. to oversee nursing practice throughout the organization;

vi. to discuss innovations in nursing care delivery and management systems;

vii. to discuss and promote interdepartmental and institutional relation.

b. Members of the Nursing Executive Committee are:

i. ~~Chief Nursing Officer~~Directors of Nursing (Co-Chairs)

~~i.~~ii. Chief Executive Officer/Nursing Home Administrator

iii. Chief Nursing Officer

~~ii.~~iv. ~~Nursing~~ Nurse Directors

~~iii.~~v. Chair of Nurse Manager Council

~~iv.~~vi. Operations Supervisors

~~v.~~vii. Clinical Nurse Specialists

~~vi.~~viii. ~~Bed Control~~Patient Flow Coordinator

c. The ~~Chief Nursing Officer~~Directors of Nursing ~~and a Nurse Manager~~ co-chair the Nursing Executive Committee. The NEC meets once a month. An agenda is prepared and a permanent record of proceedings is maintained.

5. Licensing and Certification:

Nursing Services participates in the Licensing and Certification Survey with the Department of Health Services (DHS). Nursing administrative staff has knowledge of the Title 22 Regulations and other regulatory standards.

6. Licensure:

a. Nursing Services complies with Title 22 and other regulatory requirements regarding staff licensure and certification requirements.

b. Nursing Services hires Registered Nurses, Licensed Vocational Nurses~~/Licensed Psychiatric Technicians~~, and Certified Nurse Assistants who are licensed or certified to practice in the State of California. ~~The process for verifying and monitoring current licensure or certification status is written and available for review.~~ Human Resource Services (HRS) Department has the responsibility of verifying and ongoing maintenance and monitoring of all personnel licenses. HRS collaborates with the Nursing Department through the Director of Nursing Operations or designee to ensure that the system of ongoing license monitoring is achieved.

c. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

~~d. Temporary Agency Nurses (e.g. Nurse Registries) are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift. The responsibility for verifying licensure and ongoing maintenance rests with the employing agency per the Temporary Services Contract language.~~

7. Competency Assessment Program:

a. The competency of all Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, and other nursing personnel is evaluated at the time of hire, at the end of the probationary period, and annually thereafter. Evaluations for nursing personnel involved in direct patient care activities are criteria-based and related to performance criteria specified in the individual's job description.

b. Employees from temporary help agencies (e.g. Nurse Registries) are evaluated by the unit Nurse Manager or designee, with input from nursing staff, following their initial shift and annually thereafter if the assignment is for an extended period of time.

8. Job Descriptions:

a. The job description for each nursing classification delineates functions, responsibilities, and qualifications of the position. Job descriptions are reviewed and revised when necessary to reflect changing job requirements. They are maintained in the nursing office and by Human Resource Services Department.

b. Job descriptions are available to nursing personnel at the time they are hired and when requested.

c. Appropriate staff will demonstrate competence in cardiopulmonary resuscitation (CPR)

basic life support (BLS) issued by the American Heart Association (AHA) in compliance with the California Code of Regulations: Title 22, and according to established standards of the AHA.

i. Competence must be demonstrated by direct care providers such as LHH Registered Nurses (includes staff nurses, nurse managers, nursing directors, clinical nurse specialists, educators, supervisors, and nursing directors), Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs)~~, and Respiratory Care Practitioners~~.

~~ii. Cardiopulmonary Resuscitation training is provided at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) monthly, while taking into consideration the availability of on-campus BLS instructors. American Health Association Standards are used to evaluate levels of competency.~~

~~iii. Prospective employees are expected to show proof of current CPR certification from the AHA prior to being considered for employment in any class requiring CPR/BLS as a minimum qualification. Current BLS cards will be submitted as part of the hiring packet/process. Copies of AHA eCards are also acceptable, as long as they are able to be verified using the AHA eCard verification system.~~

~~iv. Staff with no evidence of valid CPR certification and no valid documentation of physical disability are unable to work until proof of current certification is presented to their manager/supervisor.~~

9. Staffing:

a. Nursing Services plans for and implements staffing requirements according to staffing guidelines, policies, legislative requirements, and budgetary considerations.

b. Each nursing area specifically plans for staffing assignments based on staff competencies, resident/~~client~~ patient care needs, the care delivery system, and volume indicators.

c. Skilled nursing areas are budgeted according to Hours Per Patient Day (HPPD).

10. Nursing Process, Plan of Care, and Documentation:

Nursing contributes to the inpatient interdisciplinary plan of care and documents resident/patient assessment, planning, intervention, and evaluation as defined in policies/procedures.

11. Education/Training Programs (Refer to HWPP 80-05 Staff Education Programs):

a. Education/training programs for nursing services staff are ongoing and designed to augment knowledge of pertinent developments in resident/patient care and to maintain current competence.

b. The scope and complexity of the program is based on the educational needs of nursing staff. Educational needs are identified through monitoring and evaluation activities, annual competency evaluation, and needs assessment surveys.

c. Nursing collaborates with the Department of Education and Training in development and coordination of nursing hospital orientation activities and required training.

~~12.~~ **Quality ~~Assessment~~ Assurance and Performance Improvement:** ~~this is NEC Quality and~~

~~**Safety (there is only one NEC and it is the quality and admin meeting so we should put the NEC quality charter language in this section**~~

~~13.~~12. ~~Nursing Services has a planned and systematic process for monitoring and evaluating the quality and appropriateness of resident care and for resolving identified problems~~Nurse Executive Committee's (NEC) Quality and Safety Committee provides guidance and oversight to ensure the existence of, and adherence and improvement of nursing standards; promote a culture of continuous improvement: and identify, monitor and address emerging quality issues.~~ Nursing services follows the process outlined in LHHPP 60-01 Quality Assurance Performance Improvement (QAPI).~~

~~14.~~13. **Interdepartmental Relationship:**

Nursing Services work collaboratively with other hospital departments and disciplines to promote quality resident/patient care. Policies and procedures are developed collaboratively with other disciplines for the provision of an interdisciplinary approach to resident/patient care.

ATTACHMENTS:

NONE

REFERENCE:

Hospital-wide Policies and Procedures

File #01-01 Approval and Format of Hospital-wide and Departmental Policies and Procedures
File #80-05 Staff Education Programs

California Code of Regulations: Title 22

https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

Date Adopted: 2007/10

Revised: 2022/07/12, 2022/12/13; 2023/06/13; 2025/05/23

Reviewed: 2023/06/13

Approved: 2023/06/13

Revised DPH Wide Policies and Procedures

City and County of San Francisco
~~London N. Breed~~
Daniel Lurie, Mayor

San Francisco Department of Public Health
~~Dr. Grant~~
~~Colfax~~Daniel Tsai
Director of Health

San Francisco Department of Public Health

Policy & Procedure Detail*

Policy & Procedure Title: 18.04 ORDER ENTRY	
Category: General Administration	
Effective Date: ~~8/3/2019~~10/24/2025	**Last Reissue/Revision Date:** 2/28/2023; 12/2023; TBD
DPH Unit of Origin: ZSFG	
Approval by DPH Network Policy and Procedure Subcommittee: 3/14/2023; 12/2023 (email vote); TBD	
Approval by ZSFG Nursing Executive Committee: 4/19/2023; 1/17/2024; TBD	
Approval by ZSFG Medical Executive Committee: 4/20/2023; 1/18/2024; TBD	
Approval by ZSFG Performance Improvement and Patient Safety Committee (PIPS): 4/26/2023; 1/24/2024; TBD	
Distribution: DPH-wide ☒	**If not DPH-wide, other distribution:**

All sections in table required. Updated 5/2023

1. Purpose of Policy

To ensure patient safety and quality of care by reducing the potential for error or misinterpretation when orders are communicated.

2. Statement of Policy

This policy describes how ordering is managed at the San Francisco Department of Public Health (DPH).

3. Definitions

- **STAT**: orders are carried out within one (1) hour of order start time.
- **Routine orders**: orders that do not specify "stat" should be acknowledged within two (2) hours of order entry for acute care and within four (4) hours of order entry for long term care.
- **Ordering provider**: The ordering provider is the practitioner who chooses to place the order. The ordering provider will vary depending on the order mode. For example, a nurse can be the ordering provider for a "per protocol" order but the provider (MD, NP, PA) is the ordering provider for a verbal or telephoned order.
- **Authorizing provider**: The authorizing provider is the practitioner whose name is selected as "authorizing". This field is generally the same as the ordering provider, except in situations where one practitioner is supervising the activities of another provider due to facility policy or billing requirements.
- **Authenticating provider**: The authenticating provider is the practitioner whose electronic signature has been attached to the order.

4. Procedures

A. Provider Orders

a. All orders should be placed electronically with a provider signature or co-signature except during downtime

   i. See section 4.B.e. for downtime ordering information.

   ii. Medication orders written on paper shall be immediately faxed to the pharmacy

b. Each order must be reviewed prior to acknowledging, verifying, and/or initiating.

   i. Provider orders are acknowledged by staff legally authorized to accept orders per their scope of practice.

   ii. At Zuckerberg San Francisco General Hospital, where a Pharmacists is in house 24 hours, all medication orders must be verified by pharmacy before administering to the patient UNLESS a licensed independent practitioner controls the ordering, preparation, and administration of the medication OR in urgent situations, when the resulting delay may harm the patient.

      1. If a medication order is deemed inappropriate by the pharmacist but was already administered prior to pharmacist verification, follow the process outlined in Appendix A

   iii. If a medication order is verified in error, the pharmacist shall contact the provider and "discontinue" the medication order, then sign the order as "telephone with read-back" order mode.

   iv. Orders that require clarification should be acknowledge but not carried out. Concerns should be communicated with the ordering provider and documented as appropriate.

   v. Orders that have do not use abbreviations will not be transcribed or carried out unless it may delay the care or comfort the patient

   vi. See institutional policies for further details on ordering

      1. ZSFG Admin policy 16.31 for further details on Medication Ordering

      2. Laguna Honda Hospital (LHH) hospital wide policies 25-02 and 25-03, and Nursing Policy C 9.0.

B. Orders entered, modified, or deleted by Non Providers

a. Any order placed by a non provider that requires a provider co-sign must be co-signed before it is active.

b. Pended Orders

   i. Pended orders are electronic recommendations. Pended orders are not active until signed by the provider.

ii. Providers review, edit, and sign the pended orders that they want active, and delete others.

c. Orders entered by non-providers

i. Verbal and Telephone Orders

1. Verbal orders refer to those situations in which the ordering provider is physically present and provides a verbal communication for patient care.

2. Telephone orders refers to those situations in which the ordering provider is not physically present when providing patient care orders. With telephoned orders, the practitioner may be in another location within the facility or outside the facility.

3. Verbal and telephone orders are only accepted by staff legally authorized to take verbal and telephone orders within their scope of practice and are limited to those orders that are within their scope of practice (e.g. Registered Nurses, Licensed Vocational Nurses, Registered Pharmacists, Respiratory Therapists, Physical Therapists, Occupational Therapists, Speech Pathologists, and licensed Clinical Laboratory Personnel).

4. Verbal and telephone orders are entered immediately and read back to the ordering provider upon transcription.

5. Pharmacists can take telephone orders in Outpatient Pharmacy only, and in circumstances as outlined in the Procedures section 4.A.b.ii above.

6. In acute care areas, verbal and telephone orders are only accepted in emergent situations for pain management or situations in which a delay may adversely affect the patient.

7. In acute care, the provider who initially dictates a verbal or telephone order must countersign these orders within 48 hours (except for emergency blood product orders). The provider who dictates a verbal or telephone order authorizing the release of emergency blood products, must countersign these orders within 72 hours. In Long Term Care (including the Behavioral Health Center), the ordering provider must countersign these orders within five (5) days.

d. Per protocol: no cosign required and Per protocol: cosign required

i. "Protocol" within Epic refers to any of the following:

1. Per protocol no cosign required (see Appendix A)

a. Standardized procedures developed collaboratively by interdisciplinary teams, including providers and nurses, and approved through the Credentials and Medical Executive Committee.

b. Pharmacy protocols are standardized procedures developed collaboratively by interdisciplinary teams including providers and pharmacists and approved by the Pharmacy & Therapeutics Committee.

c. Orders for services that do not legally require a provider order, including non provider driven consults (for example: Social Work, Wound, and Spiritual Care Consults) and some precautions (such as High Risk Falls precautions) do not require a provider cosign in Epic.

2. Per protocol cosign required include (see Appendix A):

a. Protocol not utilizing standardized procedure development.

e. Ordered during downtime

i. Review downtime policy for specific downtime requirements.

f. Transcribed from paper: See downtime policy for transcription procedure.

C. **Transitions of Care**

a. Review of all orders is required by the provider, Pharmacists (for medication orders), and nurse at: change in level of care and change in service.

b. Release of Orders:

i. In the ED

- RNs will release orders per the Appendix C CARE OF THE INPATIENT BOARDER IN NON-INPATIENT CARE AREAS.

ii. In PACU

- RNs will select individual orders to make active per the boarder policy
- Once an RN and an Anesthesiologist have signed off on a patient, then the PACU RN will make all of the patient's signed and held orders active

iii. In ICU and Med Surg

- ICU orders will be released by the ICU nurse

iv. PES patients

- Signed and held orders will be released when the patient arrives on the Inpatient Psych unit.

D. **References/Attachments**

Appendix A: List of non provider orders (not including precautions)
Appendix B: Care of the Inpatient Boarder in Non-Inpatient Care Areas

See Medical Staff Bylaws / Rules and Regulations of the Medical Staff of SFGH

ZSFG Hospital Administrative Policy 13.11 Medical Record Documentation

ZSFG Hospital Administrative Policy 16.31/ Pharmaceutical Services: Patient-Specific Medication Ordering Policy & Procedure

ZSFG Hospital Administrative Policy 16.34 Change in Level of Care for the Inpatient

SUPERSEDES:

ZSFG Nursing policy 11.6 Acknowledgement, Verification, and Transcription of Orders (2019)

ZSFG Nursing policy: Transcription of Physician Orders (12/10)

Date Adopted: 7/84
Reviewed: 12/87, 12/89, 11/90, 11/91, 11/03, 1/06, 3/06, 10/07, 01/10, 12/10, 06/13, 01/15, 3/18, 2/23
Revised: 4/86, 12/88, 2/92, 11/93, 7/96, 3/99, 3/00, 6/04, 1/06, 10/07, 01/10, 12/10, 06/13, 01/15, 5/18, 2/23, 12/23, TBD

Appendix A: List of orders that can be placed by non provider, and the order mode that should be used for this process. This list is meant for staff guidance and is not a complete list of orders that non providers can place.

Order	Order Mode	Who can write, modify, and/or delete this order?	Details
Admitted patients boarding in the ED	Per Protocol with cosign required	Nurses and Providers	Admission Nursing orders that have been completed in ED need to be reordered for inpatient nurses to follow. If the Inpatient Provider is available to do this at the time of arrival on the inpatient unit, the provider can reorder them instead.
Chaplaincy consult	Per Protocol no cosign required	Anyone with order access	
Close Observation (including Coach)	Per Protocol with cosign required	Nurses and Providers	By acknowledging / co-signing the Close Observation order the RN/Provider agree they have communicated with the ordering RN/Provider regarding the need for Close Observation.
Diet orders	Pended Order	SLPs and RDs	
Durable Medical Equipment (DME)	Per Protocol Cosign Required		For CMS related DME items
Ethics consult orders	Per Protocol no Cosign required	Anyone who has access to write orders may write this order	Response time for and ethics consult is 1 business day. Please provide a number where you can be reached within this timeframe.
Flu	Per Protocol no cosign required	Inpatient Nurses at ZSFG	See Standardized Procedure approved by Credentials and Medical Executive committees.
Lab orders: Modifying an existing lab draw order frequency to "Add-On."	Per Protocol no cosign required	Nurses or others who do lab draws	
Medication Recommendations from the Addiction Care Team Licensed Vocational Nurses: • Nicotine Replacement • Medications for Alcohol Use Disorder (e.g. Naltrexone)	Pended Order	Licensed Vocational Nurses on the Addiction Care Team with documented competency for this procedure.	• Nicotine Patch • Nicotine Lozenge • Nicotine Gum • Naltrexone PO • Extended-release Naltrexone • Gabapentin PO (for alcohol use disorder)
MERT Standardized procedure	Per protocol no cosign required	MERT RNs	See Standardized Procedure approved by Credentials and Medical Executive committees.
Medication order deemed inappropriate by the pharmacist, but already administered to patient prior to	telephone with read-back	Pharmacists	Including, but not limited to: • Patient allergies • Inappropriate dose • Inappropriate indication

Order	Order Mode	Who can write, modify, and/or delete this order?	Details
pharmacist verification			The pharmacist may "reject" the medication order in the verification queue after communicating with the provider, and nurse if appropriate. The pharmacist will note the reason for rejection, then sign the order as "telephone with read-back" order mode and link the provider who prescribed the original order. If appropriate, the pharmacist shall report the error in the Unusual Occurrence (UO) System.
Nutrition consult	Protocol no cosign required	Rehab, Nursing, Pharmacy, Providers, Nutrition	
Nutrition Therapy and Monitoring Orders	Pended Orders	Dietitians	In orders to meet nutrition therapy goals, the following orders may be pended: • Oral Nutrition Supplements • Tube Feeding and TF Panel Components • TPN and TPN Panel Components • Vitamin and Mineral Supplements • Nutrition Related Labs • Weight Monitoring • Calorie Count • Others nutrition related orders as indicated
Pharmacy and Therapeutics Committee approved pharmacy protocols	Per protocol no cosign required	Pharmacists	• Adult Intravenous Vancomycin Per-Pharmacy Dosing Protocol • ZSFG Therapeutic Drug Substitutions (Inpatient) • ZSFG Inpatient Pharmacist Medication Order Clarification Protocol • LHH Therapeutic Interchange and Generic Substitution • LHH Warfarin Protocol
Point of Care glucose test	Per protocol cosign required	RNs	
Vascular access related orders (including PICC Panels)	Per protocol cosign required	VAS/PICC RNs	
Precaution: Aspiration	Per protocol cosign required	RNs at ZSFG Med Surg and ICU	Order can be placed by nursing for any patients with a failed bedside RN swallow screen
Precaution: At Risk	Per protocol with cosign required	RNs at ZSFG ED, Med Surg, and ICU	ZSFG only All patients in Psych/PES are "at risk."

Order	Order Mode	Who can write, modify, and/or delete this order?	Details
			Peds/NICU uses code pink, not code green
Precaution: Delirium	Per protocol no cosign required	RNs at ZSFG Med Surg	Delirium precautions are activated for patients who have or are at risk for delirium/or other cognitive impairment.
Precaution: High Falls Risk	Per protocol no cosign required	RNs at ZSFG	Determined by nursing using falls risk tool combined with clinical judgement
Precaution: Neutropenic	Per protocol no cosign required	RNs at ZSFG inpatient, not including IP Psych	Ordered for an absolute neutrophil count (ANC) 500/mm^3 or less. When ANC is expected to fall rapidly, Provider may consider the pt to be neutropenic when ANC <1000 per microliter.
Precaution: Seizure Precaution is NOT used in MHRC	Per protocol no cosign required	RN at ZSFG, not including MHRC	
Rehab plan of care	Cosign required	PT, OT, SPT	
Restraints	In emergent scenarios only: Verbal with readback	RNs	PES and In-patient Psych will not be allowed to enter verbal orders for restraints even in emergency scenarios
"Schedule to PODS" order	Per protocol no cosign required	RNs and Pulmonary Function Techs	PODS = Pulmonary Outpatient Diagnostic Service
Supply ordering	Per protocol no cosign required	Anyone with ordering access	
SW Consult	Protocol no cosign required	Anyone with order access	
Transfusion reaction workup	Verbal Order (verbal with readback)	RNs	This order is triggered by a BPA when a nurse charts a transfusion reaction occurred. This order is considered emergent and placed as a verbal order by the nurse because of the tight timeframe for obtaining the blood sample for transfusion reaction.

Appendix B: CARE OF THE INPATIENT BOARDER IN NON-INPATIENT CARE AREAS

PURPOSE:

There are cases in which a patient who is awaiting an inpatient bed assignment will be boarded in a non-inpatient care area such as the Emergency Department (ED) This policy guides the care of these boarded patients.

STATEMENT OF POLICY:

The ED is subject to holding a number of inpatient boarders awaiting a medical/surgical level bed assignment. While these patients are waiting for a bed assignment in the current physical area in which they are receiving care, there can be inpatient medical/surgical provider orders that must be completed by the Registered Nurse (RN).

DEFINITIONS:

The following definitions serve as a guide for determining terms related to the patients and care areas described within this policy.

1. INPATIENT BOARDER: When a patient who is being admitted to inpatient status, has a bed request placed, has an accepting inpatient team/service, and has inpatient orders completed.
2. BOARDER CARE AREA: Any area where the patient is waiting for a bed assignment after having a bed request placed, an inpatient team has accepted the admission, and inpatient orders have been placed.
3. SELECTIVE ORDER RELEASE: This is a time period defined by each boarder care area in which a bed request has been placed, an inpatient team has accepted the admission, and inpatient orders have been placed. This time period is the time in which the boarder patient has selective orders that will be carried out by the RN in the boarder care area.
4. SELECTIVE ORDER RELEASE LIST: This is defined as the list of order that must be carried out in the selective order release timeframe. This list will be described in each unit-specific policy and procedure.

CROSS REFERENCES

EMERGENCY DEPARTMENT POLICY AND PROCEDURE: Selective Order Release for Boarding Patients in the Emergency Department

TITLE: SELECTIVE ORDER RELEASE FOR BOARDING PATIENTS IN THE EMERGENCY DEPARTMENT

PURPOSE:

There are cases in which a patient who is awaiting an inpatient bed assignment will be boarded in a non-inpatient care area such as the Emergency Department (ED) These are instances when patients who are in need of a medical/surgical level of care are boarded while they wait for a medical/surgical bed to become available. This policy guides the care of these boarded patients in the ED.

STATEMENT OF POLICY:

The ED is subject to holding a number of inpatient boarders awaiting a medical/surgical level bed assignment. While these patients are waiting for a bed assignment in the current physical area in which they are receiving care, there can be inpatient medical/surgical provider orders that must be completed by the Registered Nurse (RN). This is the ED specific policy and procedure to describe the care that is delivered to these boarded patients.

DEFINITIONS:

The following definitions serve as a guide for determining terms related to the patients and care areas described within this policy.

1. INPATIENT BOARDER: When a patient who is being admitted to inpatient status, has a bed request placed, has an accepting inpatient team/service, and has inpatient orders completed. The inpatient boarder in the ED can be waiting for a medical/surgical level bed, a telemetry bed, and/or an ICU bed.

2. BOARDER CARE AREA: Any area where the patient is waiting for a bed assignment after having a bed request placed, an inpatient team has accepted the admission, and inpatient orders have been placed.

3. SELECTIVE ORDER RELEASE: This time period is the time in which the boarder patient has selective orders that will be carried out by the RN in the ED.

4. SELECTIVE ORDER RELSEASE TIMER: A 10-hour timer that is initiated when the ED provider places the order to admit (bed request equivalent). This timer is to allow the ED nurse to practice a selective release of the inpatient orders for the boarder patient. Once the boarder patient has reached the 10-hour boarded time, all inpatient orders must be released, and the system will have a pop-up window that reminds the RN to release. This timer is only applicable to medical/surgical and telemetry patients that are being boarded in the ED. All ICU boarders will have the inpatient orders carried out in entirety at the time they are placed within the EHR.

5. SELECTIVE ORDER RELEASE LIST: This is defined as the list of order that must be carried out in the selective order release timeframe. The following list of orders are those that must always be released in the 10-hour selective order release time frame.

- Any STAT items, or items the admission team deems needing to be done in a timely manner within the selective release time frame (these will require communication with the primary nurse in the ED)
- Vital Signs
- Any system assessments that are required on a specified frequency that fall within selective release time frame
- Maintenance IV fluids

- Medications initiated in the ED that are on a specific regimen (antibiotics, IV drips, etc) that fall within the selective release time frame.
- Diagnostics (radiologic/labs) that fall within the selective release time frame
- Blood administration orders
- Diet orders
- Precaution orders (any isolation, fall risk, elopement risk, etc)

San Francisco Department of Public Health
~~Dr. Grant Colfax~~Daniel Tsai
Director of Health

City and County of San Francisco

~~London N. Breed~~Daniel Lurie,
Mayor

San Francisco Department of Public Health

Policy & Procedure Detail

Policy & Procedure Title: Blood and Blood ~~Product~~ Component Administration	
Category: General Administration	
Effective Date: ~~06~~10/~~01~~25/~~2023~~2025	**Last Reissue/Revision Date:** ~~12/31/2019~~06/01/2023
DPH Unit of Origin: ZSFG Clinical Laboratory and Nursing	
ZSFG Policy and Procedure Number: Admin 18.05	
Approval by ZSFG Transfusion Committee: ~~04/24/2023~~07/28/2025	
Approval by ZSFG DPH Policy and Procedure Subcommittee: ~~**5/9/2023**~~**TBD**	
Approval by Nursing Executive Committee: ~~5/17/2023~~TBD	
Approval by Medical Executive Committee: TBD~~5/18/2023~~	
Approval by Performance Improvement and Patient Safety: TBD~~5/24/2023~~	
Policy Contact - Employee Name and Title; and/or DPH Division: Zane Amenhotep, MD; Interim Medical Director, ZSFG Blood Bank and Transfusion Service	
Approval signature:	
Contact Phone Number(s): (628) 206-8584	
Distribution: DPH-wide ☒	**If not DPH-wide, other distribution:**

I. Purpose of Policy

To describe the policies and procedures for ordering, receiving, and administering blood products (i.e., transfusing blood and blood components) that are issued from the Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) Blood Bank/Transfusion Service, including performing pre-transfusion checks, setting-up and starting transfusions, monitoring patients during the procedure, documenting transfusions, initiating assessment, treatment and laboratory investigation in case of suspected transfusion reactions, and returning blood products to the Blood Bank.

This policy is applicable to general adult and pediatric transfusions. Transfusions in neonates and infants and those in special situations are addressed in separate policies.

II. Policy

The licensed and trained Registered Nurse (RN) is responsible for the safe administration of ~~blood products~~ blood and blood components upon a provider order~~s~~. In some clinical settings (e.g., anesthesiology) a qualified licensed provider (e.g., MD, DO, DPM, NP, PA, CNM, CRNA) may transfuse blood and blood components.

A. GENERAL

1. This policy addresses b~~B~~lood and blood product administration ~~or~~ including the transfusion ~~is the infusion~~ of whole blood or blood components, i.e., red blood cells (RBCs), platelets, plasma, or cryoprecipitate. See Appendix B for blood product details. Separate policies address autotransfusion; see Operating Room Policy 21a.

   Notes:

   a. The Blood Bank ~~also~~ issues **Rho(D) Immune Globulin** (also known as **RhIG** or by various trade names, e.g., RhoGAM®, HyperRHO®, etc.) for ***intramuscular*** *injection*. Ordering, delivery, pick-up, patient-product identification check, completion of the T~~t~~ransfusion R~~r~~eport F~~f~~orm is the same as for blood components; **Rh~~o(D)~~ IG** does not routinely require vital sign monitoring or informed consent ~~fto~~ transfusion. It does contain human-derived plasma, which some patients may choose to decline~~or vital sign recording~~.

   b. The Blood Bank **does not** ~~Products that are **not**~~ dispense~~d~~ Rho(D) Immune Globulin for *intravenous* administration, or ~~by Blood Bank (and therefore **not** addressed by the blood administration policies and procedures described here) include~~ other plasma derivatives, such as, albumin, fibrin (tissue) glue, ~~Rho(D)IG for *intravenous* administration~~ fibrinogen concentrate (e.g., RiaSTAP®, Fibryga®), Prothrombin Complex Concentrate (KCENTRA®) and other coagulation factor products. ~~As~~ such, these products are not addressed by blood administration policies. Call the Pharmacy with any questions about ordering, dispensing, and/or administration of these products.

2. **Informed consent to transfusion** is required prior to administering blood and blood components, except in emergencies. The patient's clinical provider is responsible for obtaining informed consent to transfusion or documenting (e.g., on the transfusion consent form) that there is a clinical emergency that prevented obtaining informed consent; see ZSFG Administrative Policy 2.03 *Informed Consent to Blood Transfusion and Declination (Refusal) of Blood Transfusion.*

~~2.~~3. Information about blood products that were issued by the Blood Bank is accessible in the patient's medical record or by contacting the Blood Bank directly (e.g., type and number of units ordered).

~~3.~~4. Autologous and designated blood units are labeled with an extra tag identifying their nature:

   a. Green tag = Autologous

   b. Orange tag = Designated

   c. These tags must not be removed from the blood units.

~~4.~~5. The following is the preferred order of administration of blood products if such choice is available:

a. 1st = Autologous Units

b. 2nd = Designated Units

c. 3rd = Random Units

~~5.~~6. All blood and blood components must be administered through a blood administration set with an in-line blood filter designed to retain particles that are potentially harmful to the recipient. The set must be changed at a minimum after 4 hours of use to prevent bacterial growth. It is also recommended to change the set after every 2 units or if the ABO group differs between units to minimize clogging caused by contact of red blood cells and plasma of different ABO type on the filter.

~~6.~~7. Each transfusion must be started within 30 minutes and completed within 4 hours of blood component release from an approved storage location (e.g., Blood Bank, OR Blood Refrigerator, Blood Bank Cooler). This is to minimize the risk of bacterial contamination and growth, and loss of unstable components, for example certain plasma coagulation factors. Storage of blood and blood components intended for transfusion is only permitted in Blood Bank-approved blood storage locations.

~~7.~~8. Infusion pumps may be used for transfusions provided the ~~particular pump~~pump model has been approved or cleared by the FDA for blood administration ~~by the manufacturer~~ and is ~~is~~ operated according to the manufacturer's specifications. Transfusionists who us~~e~~ing infusion pumps should be trained and competent on their use. See Appendix C for more detail ~~on infusion device~~s.

~~8.~~9. Blood warmers that have been approved or cleared by the FDA for this purpose may be used when specified by provider's order or by specific nursing unit policy~~, if available~~. Transfusionists who us~~e~~ing blood warmers should ~~should~~ be trained and competent in their use. Observe the following when using blood warmers:

a. Follow the manufacturer's instructions for the ~~particular~~ model of blood warmer that is available for use in the clinical area.

b. Check equipment function and temperature before each use.

c. Blood warmers that fail operational inspection or that heat to above 42~~.0~~°C must not be used. If the temperature rises above 42~~.0~~°C during transfusion or the alarm function indicates overheating, take the warmer out of service immediately.

d. Notify Biomedical Engineering as soon as possible to service any units that do not function properly.

e. Platelets and cryoprecipitate should not be given through a blood warmer, as warming may render these blood components less effective.

f. See Appendix C for more detail on blood warmers.

~~9.~~10. Rapid infuser~~sion~~ that have been approved or cleared by the FDA for this purpose may be used by ~~under pressure is performed by~~ a qualified, trained and competent provider or RN in specialty areas in case of severe blood loss where transfusion under pressure is necessary (see precautions on using Rapid Infusion Devices in Appendix C)~~.~~.

~~10.~~11. There is no written provider order when blood is transfused by anesthesia in the operating room; the transfusion is documented in the O.R. or ~~record of~~ anesthesia record.

~~11.~~12. ~~Universal~~ Standard Precautions (~~i.~~e.g., personal hygiene and wearing ~~gloves~~personal protective equipment) are employed for all aspects of blood and blood product administration.

B. PRE-TRANSFUSION TESTING ORDERS AND BLOOD TYPE CONFIRMATION

1. "**Type and Screen**": This test identifies the patient's blood type (ABO and Rh) and screens for common and unexpected antibodies prior to red cell transfusion~~s~~s. Except in emergencies, the Blood Bank requires a current Type & Screen blood sample (~~current = sample~~ drawn within the previous 3 days) ~~is required for~~ to prepar~~eation~~ and ~~release~~ issue ~~of~~ red cell products ~~by Blood Bank~~.

2. "**ABO/Rh Recheck**"~~Confirmation~~: Patients ~~without~~ with no a pr~~evious~~evious Blood Bank history at ZSFG ~~will~~ require a ~~second~~ 2nd specimen (~~collection~~ preferably collected by a different phlebotomist) for ABO/Rh T~~t~~ype c~~C~~onfirmation prior to issuing crossmatched, ~~group~~ type specific (~~specific~~ or type compatible) red cells ~~and/or~~ or other blood components. It is critical that ~~Each~~ ABO Recheck specimens ~~should~~ must be a SEPARATE phlebotomy, collected at a different time (routinely at least five minutes apart) ~~e (preferably at least five minutes apart~~from the Type & Screen~~) except for i~~ specimen to avoid/detect patient ID and labeling errors. In the Emergency Department ~~where~~ a shorter ~~collection~~ interval may be necessary~~.~~.

C. ORDERING BLOOD COMPONENTS

1. Order blood products electronically whenever possible. ~~See *the Order Entry policy (Epic Admin 18.04)* for ordering details.~~ During downtime, use a paper Blood Bank requisition~~s~~ ~~for~~ to submit ***Prepare*** orders for routine and emergency blood requests. All verbal orders for blood products must be cosigned by the ordering provider. See *Admin Policy 18.04: Order Entry* for details.

   a. "**Prepare**" orders are directed to the Blood Bank and indicate to prepare and *allocate* blood products (make them available for issue) to a specific patient ~~for release~~.

      Prepare orders for ***RBC*** components include an order for a ***crossmatch***, except when the order is to "**Prepare <u>Emergency</u> RBCs,**" which, by definition, are **UNCROSSMATCHED**.

~~An authorized ordering provider must also sign an authorization for emergency release.~~

b. "**Transfuse**" orders are directed to transfusionists~~-~~ and indicate to ***administer*** prepared blood products. *Prepare* and ~~–~~*Transfuse* orders for a given blood product can occur ~~be issued~~ concurrently ~~with respective *Prepare* orders.~~,

c. ~~and must be ***released*** in Epic to generate prompts for documentation of the transfusion.~~**Issuing**: Blood Bank routinely *issues* blood products as individual units when transfusions are expected to begin within the next 30 minutes. For higher volumes of blood components (e.g., emergency or massive transfusion) the Blood Bank will issue blood in coolers to approved locations; see unit policies.

Note: The ordering provider must sign an authorization for emergency release blood products, as is included in electronic orders for *Massive Transfusion Protocol Activation*, emergency *Prepare orders*, and the Blood Bank downtime requisition. The Blood Bank will require a provider to sign a separate waiver if compatible blood is unavailable and it is necessary to issue incompatible blood.

d. Electronic Orders must be ***released*** in the EHR to generate prompts for documentation of the transfusion.

Note: Individual *Prepare* and *Transfuse* orders are not required for blood components that are administered under an activated massive transfusion protocol.

D. PLATELETS

1. Platelets are issued as an apheresis product (approximate rangely ~~250~~150-~~400~~ 440 mL/unit, median 215 mL). Apheresis platelets are infused through a standard blood administration set with in-line filter issued by the Blood Bank. This set must be used for platelet infusion.

2. Platelets should be administered as rapidly as can be tolerated by the patient in order to achieve hemostatic platelet levels in circulation.

3. Platelets must never be refrigerated or stored in a cooler with ice packs and should not be administered through a blood warmer.

E. CRYOPRECIPITATE

1. Cryoprecipitate is usually issued in pre-pooled bags ~~pools~~ equivalent to ~~of~~ 5 individual units. The typical adult dose is 10 units (2 pre-pooled bags) Cryoprecipitate is infused through a standard blood administration set with in-line filter issued by the Blood Bank. This set must be used for cryoprecipitate infusion.

2. Cryoprecipitate should be administered as rapidly as tolerated.

3. Cryoprecipitate must never be refrigerated or stored in a cooler with ice packs and should not be administered through a blood warmer.

F. COAGULATION FACTOR CONCENTRATES [Factor VIII, ~~/~~ VWF-FVIII COMPLEX (Humate-P®)~~,/~~ Factor IX, Factor VIIa (NovoSeven® RT~~Novo7®~~), 4-Factor Prothrombin Complex Concentrate (~~s, Kcentra~~KCENTRA®), fibrinogen (RiaSTAP®, Fibryga®)].

1. Coagulation factor concentrates~~s~~ are issued by the Pharmacy

III. Procedure:

A. EQUIPMENT

EQUIPMENT	OBTAINED FROM:
Blood Administration set with filter	Unit stock
Bag of Normal Saline or Plasmalyte 148	Unit stock
Angiocath or other vascular access	Unit stock
For Platelets and cryoprecipitate	
Blood component recipient set (standard blood administration set with in-line filter) for apheresis platelets and cryoprecipitate	Supplied by Blood Bank with blood product

B. SET-UP OF BLOOD COMPONENTS

1. Inform the Blood Bank the patient is ready for blood by phone. The Blood Bank staff does not receive blood ~~blood~~ issue requests through the electronic health record (~~Epic~~EHR). Blood Bank staff will contact the Messenger Center or courier for transport of blood products to the floor.

   a. When a blood product is delivered to the nursing unit, an RN~~/LVN, MD, DO, NP, PA, CNM, provider,~~ or appropriate designee must write the time when the blood product was received on the Blood Bank Delivery Receipt for Blood and Blood Products~~,~~ and sign the form. This ~~will~~ documents that the messenger or courier has made timely delivery of ~~the~~ each blood or blood component unit that is ~~/ blood product~~ intended for the recipient.

   b. If the blood product is picked-up at the Blood Bank window by staff from the ordering location, the RN, provider or appropriate designee ~~RN/LVN, MD, DO, NP, PA, CNM, or designee~~ must bring evidence of patient ID and sign the delivery slip before leaving. Evidence of patient ID is one of the following: blood requisition, registration card, stamped or printed label with the patient's full name and medical record number. This is to ensure that blood products are released for the intended patient. Blood products will not be released without evidence of patient identification.

2. The administering RN~~/LVN~~ or provider ~~MD or DO or PA or NP or CNM~~ will ensure that the patient has:

   a. An identification band securely attached to their body in all cases prior to transfusion, including outpatients and emergency situations.

   b. An intact IV with a needle or catheter large enough to allow appropriate flow rates without damaging the vein.

      i. An ~~18 gauge~~18-gauge catheter or larger, central line, or intraosseous line is optimal. Smaller catheter sizes (e.g., gauge 20 or~~,~~ 22) and scalp vein needles (for pediatrics) may be used, as long as blood flow is adequate to complete the infusion within 4 hours from issuance ~~release~~ or removal from ~~of blood from~~ storage (see section ~~Relevant Information~~ II.A.6, above). Risk for hemolysis increases as catheter size decreases.

         NOTE: Rapid infusers/pressure cuffs should **not** be used when smaller than ~~18 gauge~~18-gauge needles are used, since hemolysis may result from forcing blood cells through ~~a~~ narrow needle or catheter lumens.

      ii. The starter solution should be **Normal Saline** or **Plasmalyte 148**, if none is ordered.

         NOTE: DO NOT use Lactated Ringers, 5% Dextrose, 1/2 or 1/4 Normal Saline, as they ~~are~~ are **contraindicated** ~~because~~ and~~they~~ ~~may~~ can cause hemolysis and clotting.

      iii. **Warning: DO NOT~~Do not~~** add any medications to blood or blood components. Only Normal Saline or Plasmalyte 148 may be run in the same tubing with blood components.

3. Administration of the blood product must start within 30 minutes of being a) ~~release~~ issued from the Blood Bank (for products not in a Blood Bank-issued cooler), *or* b) being removed from a Blood Bank-approved blood storage location (e.g., ~~Operating Room~~ Blood R~~r~~efrigerator~~,~~ or ~~certified~~ Blood Bank-issued Blood C~~c~~ooler) ~~within the time specified on the cooler to ensure proper storage conditions have been maintained~~.

   Red blood cells and/or plasma inside Blood Bank-issued Blood Coolers are stable until the time specified on the cooler and must be kept in the closed cooler until the patient is ready for transfusion, to ensure proper storage conditions are maintained.

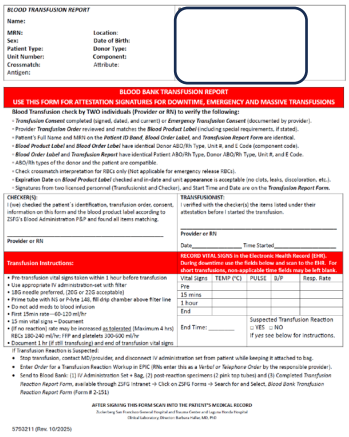
   ~~If~~ When it ~~is~~ becomes clear that the start of the infusion will be delayed past th~~e~~ ~~is~~ 30-minute ~~30 minute~~window and/or when products that the Blood Bank issues in a Blood Cooler are close to expiration ~~period~~, call the Blood Bank immediately to report unused units and promptly return them.

C. REQUIRED PRETRANSFUSION CHECKS (MANDATORY BEFORE ~~ANY~~ EACH TRANSFUSION)

1. Immediately prior to transfusion, two licensed individuals, routinely the ***Transfusionist*** and a 2nd individual (RN or Provider*) who serves as a **"Checker"** will positively identify the intended recipient (patient) and verify in the recipient's presence that all information linking the following items matches, item-by-item.

   a. **Transfusion Consent** – Except for emergencies
   b. **Transfusion order** – Blood Component and any Special Requirements
   c. **Patient ID Band** (as attached to the patient)
   d. **Blood Product Label** (Front Side) – Contains Donor and Product Information
   e. **Blood Order Label** (Back Side) – Patient & Donor Testing and Compatibility
   f. **Transfusion Report Form** (attached by rubber band) – Used only during EHR downtime and for emergency or massive transfusion to document attestations.

Blood Product Label **Blood Order Label** **Transfusion Report Form**



It is critical that this pre-transfusion safety check is consistently performed in a formal manner and completed without interruptions or distractions.

*Examples of providers who may serve as a "Checker" include MD, DO, DPM, NP, PA, CNM, CRNA, and CRNA. Appropriately trained PharmDs may also serve as a "Checker" in the Emergency Department.

Note: Each department is responsible for ensuring and maintaining records of initial training and ongoing competency assessments for transfusionists and individuals who serve as a "Checker" for blood product administration. Competency assessment may be incorporated into the privileging process for members of the medical staff.

Exception for Emergency or Massive transfusion: When the transfusionist is unable to perform and document two-person-checks without risk to patient safety (e.g., if all hands are occupied), the real-time two-person-check may be performed by two other licensed individuals (RN or Provider*) in the presence of the transfusionist. **The transfusionist must still verify and attest that the complete check was properly performed after-the-fact (once it is safe to document that attestation).**

~~Two-person-checks prior to transfusion:~~
~~Immediately prior to transfusion, the transfusionist and a second licensed individual (RN/LVN, NP, PA, CNM, MD, DO) will positively identify the recipient and verify in the recipient's presence that all information linking the order, the blood product, and the intended recipient matches, item by item. It is~~

~~critical that this pre-transfusion check is performed in a formal manner and completed without interruptions or distractions.~~

~~1.~~

~~2. **Exception: In massive transfusions, the two-person check may be performed by two licensed individuals (RN/LVN, NP, PA, CNM, MD, DO) without the transfusionist. In this case the transfusionist must still verify that the complete check was properly performed and that all items matched before starting the transfusion.**~~

~~3.~~

~~4. **Check that the *physician's orders* match the blood unit(s). This step may be omitted in emergency situations, for patients on massive transfusion protocol, and for transfusions administered by the ordering provider, i.e., transfusions administered by licensed Anesthesia providers.**~~

~~5.~~

6. **Check** for a current ***Blood Transfusion Consent*** (ZSFG Form 5799916, F999C) or *combined procedure/transfusion consent form*, signed and dated by the patient and the provider, or whether the provider has indicated an emergency transfusion.~~Verify that the patient and provider have signed, dated, and timed a ZSFG Blood Transfusion Consent (Form 5799916, F999C) and that the consent remains in effect prior to starting the transfusion.~~

2.

~~7.~~

8. ~~Note: The patient's clinical provider is responsible for obtaining informed consent prior to transfusion; see ZSFG Administrative Policy 2.03 *Informed Consent Prior To Blood Transfusion and Counseling of Patients About Autologous and Designated Blood Donation Options and Declination (Refusal) of Blood Transfusion*.~~

~~9.~~

10. ~~Note: Signed transfusion consent forms remain in effect for the remainder of the hospitalization during which they are signed or for 12 months of an outpatient treatment period beginning from the date and time that they are signed, provided that specific transfusion risks do not change, and the patient does not later withdraw the consent in writing.~~

~~11.~~

12. ~~Note: In an emergency, if the patient is unable to complete an informed consent, the ordering provider must sign the statement on the consent form pertaining to emergency transfusions.~~

Check the ***Transfusion Order*** (e.g., RBCs, FFP, platelets, cryoprecipitate), including any special requirements (e.g., CMV neg, irradiated), against the blood product issued for transfusion (see ***Blood Product Label***, ***Blood Order Label*** *and* ***Transfusion Report Form***).

3.

Note: For emergency transfusion (in the emergency department) and active massive transfusion protocols (MTP) the timing of transfusion of individual units will be directed in real-time by the ordering provider; see *Admin Policy 2.06 Massive Transfusion*.

4. **Check** that the following agree item-by-item by having one person read ~~the information~~ out loud the information from one source while the second person verifies what is read against the information on the second source.

~~one source (***patient ID band*** and container label) while the second person verifies what is read against the information on the Blood Bank Transfusion Report (Form F932A) attached to the blood container:~~

i. **Check** the ~~***Full name and hospital number on***~~ ***Patient ID band*** (and ***Transfusion Report Form*** *if downtime or emergency release)* ~~vs.~~against the ***Blood Order Label*** ~~Blood Bank Transfusion Report.~~ for matching ***full name, medical record number***, and ***date of birth (DOB).***

In a conscious, verbal patient, also verify ~~this~~ ID information with the patient: "What is your full name? What is your date of birth?"

ii. **Check** the ~~**ABO/Rh type** on the~~ ***Blood Product Label*** (and ***Transfusion Report Form*** *if downtime or emergency release)* vs. the ~~container label~~ ***Blood Order Label*** ~~vs.~~ to verify…

- Identical **Patient (Recipient) ABO/Rh Type** ~~ABO/Rh type of the intended~~
- Identical **Donor ABO/Rh Type**
- ***Patient*** **ABO/Rh type** and ***Donor*** **ABO/Rh** type are **compatible** – They ~~recipient on the Blood Bank Transfusion Report~~need not be identical but ***must be compatible*** ~~. *These blood types need not be identical but must be compatible*~~ *(see Appendix D for compatibility table and exceptions).*
- Identical Donor **Unit number and Product Code (ECode)**

~~13. However, the donor blood type on the container label must match the donor blood type on the Transfusion Report.~~

~~14.~~ Verify that the unit ***Expiration date*** on the ***Blood Product Label*** is not exceeded.

5.

~~15. **Unit number** on the container label vs. Blood Bank Transfusion Report~~

~~16.~~

~~17. **Expiration date** on container label (must not be exceeded)~~

~~18.~~

6. **Special requirements**: ~~If applicable, v~~Verify that the unit meets all special orders, such as, autologous, designated, CMV negative, irradiated, sickle cell screen negative ~~or RBC antigen matched)~~, etc. See the order and the ***Blood Product Labels***. - *This is not applicable for emergency or massive transfusion.*

7. Verify the ***crossmatch interpretation*** for red cells only (if performed) on ***Blood Order Label*** and ***Transfusion Report Form***. - *Not applicable for emergency or massive transfusion.*

   Note: Patients who are issued units that are marked “incompatible” (based on a signed provider waiver) require closer monitoring for possible hemolysis.

~~19.~~

~~20. Verify the **interpretation of crossmatch tests**, if performed, that are printed on the report attached to the blood container.~~

8. **Check** the ***appearance of the blood bag*** to verify that it is normal. For example, there should be no bag leaks, blood product discoloration, clots, or abnormal cell clumping.

9. **DO NOT TRANSFUSE** if there is **any** discrepancy with the written blood order or patient/blood identification, if **any** checks do not match, or if the appearance of the bag raises suspicion that the unit may not be suited for transfusion (e.g., bag leaks, discoloration, presence of clots, etc., or cell settling that persists after gentle inversion); if that occurs, **return the blood bag to Blood Bank immediately**.

10. **Pre-transfusion vital signs** (temperature, pulse, blood pressure, respiratory rate, and oxygen saturation) should be taken prior to starting transfusion and close to, i.e., not more than 1 hour before transfusion. This helps to serve as reliable reference points in case of suspected transfusion reactions (see Appendix A).

~~**a. Scan the blood product into Epic to assist with accurate documentation. The following information must be scanned: patient wrist band, unit number (DIN), product code, unit type, and expiration date. Scanning does not replace any of the checking detailed above.**~~

~~**Note: Emergency release units must be manually entered into Epic for documentation as they are not registered in Epic at the time they are released.**~~

~~**b. Do not transfuse if any discrepancy with the written blood order or patient/blood identification is noted, or if the integrity of the blood bag or the appearance of the blood product raises suspicion that the unit may not be suited for transfusion (for example bag leaks, discoloration of blood, presence of clots or cell clumps). Return the blood bag to Blood Bank immediately.**~~

~~**g.**~~

~~**h. Pre-transfusion vital signs (temperature, pulse, blood pressure, respiratory rate) must be taken close to, i.e., not more than 1 hour before transfusion. This is to ensure they serve as reliable reference points in case of suspected transfusion reactions (see Appendix A). Pre-transfusion vital signs are documented in Epic or during downtime using unit-specific downtime procedures.**~~

~~21.~~11. **Documen~~ting~~~~tation OF~~ Pre-T~~t~~ransfusion Cross Checks**

a. The ***Transfusionist*** and the ***Checker*** must each certify the integrity and successful completion of all required pre-transfusion checks.

b. For ROUTINE transfusions, the **Transfusionist** who is logged in to the EHR attests, and the **"Checker"** will electronically co-sign to attest, that they have *checked the patient's identification, consent (if applicable), the transfusion order, and the information on the* ***Blood Order Label,*** *and the* ***Blood Product Label*** *according to DPH Admin Policy 18.05 and found all items matching. If an additional Checker is used, they should verify and sign the accompanying* ***Transfusion Report Form*** *and scan the signed form to the EHR.*

c. For DOWNTIME, EMERGENCY and MASSIVE transfusions, the ***Transfusionist*** and the ***Checker*(s)** will each manually sign the ***Transfusion Report Form***, to attest that they have *checked the patient's identification, consent (if applicable), the transfusion order, and the information on the* ***Blood Order Label,*** *the* ***Blood Product Label*** *and the* ***Transfusion Report Form*** *according to DPH Admin Policy 18.05 and found all items matching.* Both signatures must be present (i.e., 2 signatures are required).

Note: During emergency or massive transfusion, if the two-person-check is performed by two licensed individuals, without the *Transfusionist*, both of the ***Checkers*** must sign the ***Transfusion Report Form*** in the space for "Checker" and the ***Transfusionist*** must sign in the space for *Transfusionist* once the emergency abates (i.e., 3 signatures are required).

Scan the signed ***Transfusion Report Form*** (all signatures) to the patient EHR.

d. **DO NOT** remove the ***Blood Order Label*** or the ***Blood Product Label*** from the blood product bag.

D. DOCUMENTING BLOOD TRANSFUSIONS:

1. For ROUTINE (NON-EMERGENCY) TRANSFUSION

a. Concurrent with pre-transfusion checks, scan the following barcodes into the EHR to assist with accurate documentation.

i. Patient ID band (e.g., wristband) attached to the patient.
ii. Unit number (DIN)
iii. Product Code (ECode)
iv. Barcode Expiration date

Note: Scanning does not replace any of the checking detailed above.

b. Record the vital signs (pre-transfusion, during transfusion, and post transfusion) in the EHR blood administration module or unit specific EHR flow sheets (e.g., Emergency Department, Operating Room/Anesthesia).

c. Record the Transfusion **Start Date and Time** and **Stop Date and Time** and the **volume administered** for of each transfusion.

2. For DOWNTIME AND EMERGENCY AND MASSIVE TRANSFUSION

a. Manually enter the **unit number** and **product code (ECode)** in the EHR for documentation as they are not registered in the EHR when they are issued.

b. Record vital signs (pre-transfusion, during transfusion, and post-transfusion) on the ***Transfusion Report Form*** or in the EHR blood administration module or unit specific EHR flow sheets (e.g., Emergency Department, Operating Room/Anesthesia) or using downtime procedures.

c. Record the Transfusion **Start Date and Time** and **Stop Date and Time** and the **volume administered** for of each transfusion.

For massive transfusions (MT), if it is impractical to capture the exact start and stop times of each unit, documenting the units administered using the location specific EHR flowsheet may aid lookbacks in the event of a transfusion reaction investigation.

~~Routinely, a checker and a transfusionist must each certify integrity and successful completion of pre-transfusion checks by signing their legal names in the provided fields on the front of the Blood Bank Transfusion Report. Both signatures must be present, i.e., 2 signatures are required, and the date and start time of transfusions must be filled in. The checker will also be required to sign in Epic.~~

~~During a massive transfusion, if the two-person check is performed by two licensed individuals (RN/LVN or MD), without the transfusionist, both checkers must sign the Blood Bank Transfusion Report in the space for the checker, and a member of the transfusion team (RN/LVN or MD) must sign the Transfusion Report in the space for transfusionist once the emergency abates, i.e., 3 signatures are required.~~

~~Tear off the top of the Blood Bank Transfusion Report (chart copy), making sure that the last copy (unit tag) remains firmly attached to the component container. Securely affix the chart copy to a yellow laboratory report sheet, and do not overlap these sheets. Record vital signs and other required information regarding the transfusion in Epic. The **start time** of the transfusion is when blood in the tubing set enters the patient's body. During downtime, record this information on the back of the Blood Bank Transfusion Report.~~

~~The completed paperwork should be included in the patient's medical record.~~

~~D.~~E. BLOOD ADMINISTRATION (ALL COMPONENTS) procedure: see Elsevier/Mosby's Skills (link below) and include the following in your process:

Administer all blood components through an in-line blood administration filter following specific blood administration set directions.

Note: Blood Bank will issue Apheresis platelets and Cryo with specific blood administration sets that should be used for the transfusion of those components.

1. Prime the tubing with Normal Saline or Plasmalyte 148 only; squeeze the drip chamber several times until the fluid level is above the filter.

~~1.~~2. Gently invert the blood bag a few times to undo settling of blood components and to help facilitate flow.

~~2.~~ Wearing clean gloves, spike the port with the blood tubing.

3.

~~Administer all blood components through an in-line blood administration filter following specific blood administration set directions.~~

~~**Note:** Blood Bank will issue Apheresis platelets and Cryo with specific blood administration sets that need to be used for the transfusion of those components.~~

4. Ensure the fluid and/or ~~Squeeze the drip chamber several times until~~ blood level remains ~~is~~ above the filter; if not squeeze the drip chamber several times until it is.

   Note: ~~.~~ The filter must be covered by fluid or blood because the red blood cells can be fragmented if blood is allowed to drip directly on the filter.

~~3.~~5. Adjust the flow rate to approximately 1-2 mL/min (60-120 mL/hr) for the first 15 minutes, - unless the patient's condition requires a different infusion rate, - and observe the patient closely for transfusion reactions.

~~4.~~6. Record blood pressure, pulse, respiration, and temperature:

   a. 15 minutes after the start of the transfusion*

   b. One hour after the start of the transfusion*

   c. At transfusion completion

   ***Note: The start of transfusion is when the blood in the line reaches the patient's body.**

~~5.~~7. If there is good tolerance of the transfusion after 15 minutes, increase the infusion rate so that the transfusion is completed within 1-2 hours or, if applicable, to the rate ordered by the provider.

   The recommended infusion time for red cells is 1½ to 2 hours per unit, but if rapid infusion is necessary, blood may be given as fast as ~~is~~ tolerated by the patient's circulatory system.

   Plasma and ~~Apheresis~~ platelets ~~should~~ are generally ~~be~~ infused as rapidly as tolerated, usually 5-10 mL/min (300-600 mL/hr), exercising care to avoid fluid overload.

   All blood or plasma units must be transfused within 4 hours.

   Rapid infusion using specifically designed devices is performed by a provider or RN in specialty areas in case of severe blood loss.

~~6.~~8. If symptoms of a transfusion reaction occur, see Appendix A (Management of Transfusion Reactions).

   a. Report the transfusion reaction to the blood bank using the ***Blood Bank Transfusion Reaction Report Form*** **(Form # 2-151)** (see example in Appendix E), which can be searched and printed from the DPH Clinical Forms SharePoint~~ZSFG Intranet home page > ZSFG Forms.~~

https://sfgov1.sharepoint.com/sites/DPH-ClinicalForms/SitePages/DPH-Clinical-Forms.aspx → ZSFG Clinical Forms.

b. Order a "Transfusion Reaction Workup" in ~~Epic~~ the EHR to generate a specimen label, and an order for the Blood Bank workup~~.~~.

c. Additional units may be infused through the same needle or catheter, but the administration set may have to be changed (see section Relevant Information II.A.~~5~~6. above).

~~E.~~F. PEDIATRIC BLOOD TRANSFUSION (EXCEPT INFANT CARE CENTER)

1. The procedure for pediatric blood transfusions follows the adult procedure except:

   a. The provider order must specify the volume of product to be infused (in mL)

   b. Two RNs will independently double check the programming of the infusion pump to ensure the correct rate and volume of infusion

~~F.~~G. POST BLOOD ADMINISTRATION (ALL TRANSFUSIONS)

1. When the blood component is completely infused, discard the blood bag and IV tubing according to ~~Universal~~ Standard Precautions.

2. Record the transfusion **Stop Date** and **Stop Time** and the **amount transfused (volume)**; also see Documentation.

~~2.~~3. Post infusion monitoring: In addition to post transfusion vitals, …

   a. Inpatients are monitored according to their regular vital sign schedule.

   b. Outpatients are requested to stay at the infusion center for at least 30 minutes after transfusion.

   c. At Laguna Honda, patients stay on the acute unit for 1 hour post transfusion. When they return to the skilled nursing facility (SNF) ~~SNF~~ unit, increased monitoring will be performed per facility policy.

~~3.~~4. Acute transfusion reactions may manifest ~~themselves~~ during transfusion or up to 6-24 hours after transfusion. Follow instructions in Appendix A if signs or symptoms suggest a transfusion reaction in a recently transfused patient. Outpatients must be given **Post-Transfusion instructions before leaving the infusion center.**

~~G.~~H. SPECIAL TRANSFUSION SITUATIONS

Transfusion Situation	**Hospital Area**
Manual Partial Exchange Transfusion	Outpatient Infusion Center, ICUs, Infant Care Center

Blood and Blood Component Administration for Infants: Birth to 12 Months of Age	Infant Care Center
Blood Administration and Management in the OR	Operating Room
Perioperative Blood Recovery and Reinfusion	Operating Room
Autotransfusion	Emergency Department
Emergency Department Procurement of Group O Blood	Emergency Department
Blood Storage in Cooler in Labor and Delivery	Birth Center
Massive Transfusion (Admin Policy 2.6)	Emergency Department, Operating Room, Intensive Care Units, Interventional Radiology

IV. ~~References/Attachments – See attached at the end of this document~~Appendices

Appendix A – Management of Transfusion Reactions
Appendix B – Blood Components
Appendix C – Blood Warmers and Infusion Devices
Appendix D – ABO/Rh Compatibility Table
Appendix E – Sample: Blood Bank Transfusion Reaction Report Form
Appendix F – Key Points Pre- and Post-Blood Product Administration
Appendix G – Transfusion Observation Audit Check List
Appendix H – Sample Blood Product Label, Blood Order Label & Transfusion Report Form

~~IV.~~ REFERENCES
V.

~~Appendix A - Management of Transfusion Reactions~~
~~Appendix B - Blood Components~~
~~Appendix C - Blood Warmers and Infusion Devices~~
~~Appendix D – ABO/Rh Compatibility Table~~
~~Appendix E - Sample: Blood Bank Transfusion Reaction Report Form~~
~~Appendix F - Key Points Pre- and Post-Blood Product Administration~~
~~Appendix G – Transfusion Observation Audit Check List~~

~~**REFERENCES**~~

Click here for Mosby's Skills information on blood product administration.

~~V.~~

VI. CROSS REFERENCES ~~to ZSFG Policies~~

ZSFG Administrative Policy 2.03: Informed Consent ~~Prior~~ To Blood Transfusion ~~, Counseling of Patients About Autologous and Designated Blood Donation Options,~~ and Declination ~~(Refusal)~~ of Blood Transfusion

ZSFG Administrative Policy 2.06: Massive Blood Transfusion

ZSFG Administrative Policy 3.09: Consent to Medical and Surgical Procedures

ZSFG Administrative Policy 8.08: Notification of Transfusion Recipients Who May Have Been Exposed to Bloodborne Pathogens by Transfusion

ZSFG ~~Infant Care Center Policy: Blood and Blood Component Administration for Infants (0-12 mos.)~~Acute Hemodialysis Policy 3.02: Blood Transfusion During Dialysis

ZSFG Birth Center Policy 3.1: Blood Product Storage in Coolers in the Birth Center

ZSFG Birth Center Policy 28.1: Rh(D) Immune Globulin (Rhogam) Administration

~~Birth Center Policy: Protocol forPartial Exchange Transfusion~~

~~Birth Center Policy 3.0: Blood Product Storage in Coolers in the Birth Center~~

ZSFG Emergency Department Policy: Emergency Department Procurement of Group O Blood

ZSFG Infant Care Center Policies:
- Neonatal and Infant Blood Administration
- Partial Exchange Transfusion
- Double Volume Exchange Transfusion

ZSFG Nursing Policy 3.4: Manual Partial Exchange Transfusion (Adult)

ZSFG Nursing Policy 16.7: Placement and Maintenance of Peripheral Intravenous Catheters

ZSFG Nursing Policy 16.9: Management and Care of Central Venous Access Devices (CVADs)

~~Nursing Policy 3.4: Manual Partial Exchange Transfusion (Adult)~~

~~Nursing Policy 16.7: Placement and Maintenance of Peripheral Intravenous Catheters~~

ZSFG ~~Emergency Department Policy: Emergency Department Procurement of Group O Blood~~

~~Operating Room~~O.R. Policy 20.0: Blood and Blood Product Management in the Operating Room

ZSFG O.R. Policy 21(a): Perioperative Blood Recovery and Reinfusion

ZSFG O.R. Policy 21(b): Operating Room Blood Refrigerator Policy

ZSFG Outpatient Dialysis Policy 2.03: Infusing Blood During Dialysis

ZSFG Outpatient Dialysis Policy 4.03: Blood Transfusion Reactions

Laguna Honda Hospital Blood Administration Policies

~~Birth Center Policy: Protocol forPartial Exchange Transfusion~~

~~Birth Center Policy 3.0: Blood Product Storage in Coolers in the Birth Center~~

SUPERSEDES:
Nursing Policy 3.1

Date adopted: 8/3/2019
Date revised: ~~04~~07/~~24~~28/202~~3~~

Appendix A: Management of Transfusion Reactions
Patient Exhibits Signs & Symptoms of A Transfusion Reaction

1. **Stop the transfusion immediately and disconnect the i.v. tubing, leaving i.v. access intact**
2. **Keep i.v. site open with 0.9% saline TKO in different i.v. tubing**
3. **Contact Physician/authorized provider for medical assessment and to determine if transfusion should continue**
4. **Enter Order for a Blood Bank Transfusion Reaction Work-up (RNs use Verbal Order with Provider Cosign required)**
4.5. **Check vital signs at least every 15 minutes until stable (initiate continuous monitoring if reaction is severe)**
5.6. **Check all labels, tags and patient's identification band to determine if there is a clerical discrepancy**
6. **Verify:**
7. A. The patient's name and MRN on the ID band and blood tag match
   _____B. The patient's ABO/Rh type is identical/compatible with the unit ABO/Rh type
   _____C. The unit is not expired.

The physician/authorized provider will determine if transfusion should continue

Serious Signs and Symptoms?

- ANY new/acutely worsening symptoms within first 15 min. of transfusion
- Fever (≥ 38°C and ≥ 1°C rise from baseline); also see *Minor Signs/Symptoms*
- Rigors/chills; back/flank/chest pain; pain/oozing at the iv site; hematuria
- Dyspnea/respiratory distress, hypoxemia (SpO2<90%), pink frothy sputum
- Hypotension/shock; tea colored urine (hemoglobinuria); oliguria/anuria
- Unexplained tachycardia, hypertension, elevated CVP, arrhythmias
- Severe allergic: hives/rash covering > ¼ of body; generalized flushing
- Generalized bleed; Nausea/Vomit; unexplained anxiety, 'sense of doom'
- Any feeling different than usual

DO NOT restart the transfusion!

- Manage patient reaction as per order by the authorized provider
- Notify Blood Bank and send the following immediately
- Two Pink Top Tubes (minimum 6 mL each)
- Completed Transfusion Reaction Form
- Blood container with attached administration set (w/o needle)
- Consider: Chest x-ray, ECG, ABG, Blood cultures, Urine specimen, Other Tests, as requested by authorized provider or Blood Bank, e.g., BNP for respiratory symptoms, hemolysis labs (i.e., haptoglobin, LD, total and direct bilirubin, fibrinogen, UA), etc.

Think: Acute Hemolytic, Severe Allergic, Anaphylactic/Anaphylactoid, TRALI, _____TACO, Bacterial Contamination

Clerical Discrepancy?

Minor Signs/Symptoms Only?

- Hives/rash ONLY, covering max. ¼ of the body
- Temperature rise 1°C to < 2°C from baseline to ≥ 38°C, onset > 15* minutes into transfusion, AND NO OTHER SIGNS OR SYMPTOMS
  *Caution: Fever may be the only early sign of a severe reaction
- Mild dyspnea, responding to slowing down of transfusion rate

Per order by authorized provider ONLY:

- Treat with Diphenhydramine 25-50 mg iv or po for hives; acetaminophen 650 mg po for fever
- Resume transfusion cautiously if clinical condition warrants and there is time to complete transfusion w/in 4 hours from start
- Document assessment, interventions, and patient's response in patient's chart
- Remain with the patient for the first 5 min. after resuming transfusion, then observe every 5 min. for next 10 min.
- **If any further signs & symptoms of reaction, IMMEDIATELY stop the transfusion. Follow serious signs & symptoms pathway**
- For all cases send to Blood Bank upon completion of transfusion:
- Two Pink Top Tubes (minimum 6 mL each)
- Completed Transfusion Reaction Form
- Blood container with administration set (w/o needle)

Think: Minor Febrile Non-Hemolytic, Minor Allergic or Mild TACO

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APPENDIX B: BLOOD COMPONENTS

COMPONENT	COMPOSITION	INFUSION RATES/TIMES	APPROXIMATE VOLUME	INDICATIONS
Cryoprecipitate (Available in pools of 5 in pre-pooled bag) Smaller single units are issued when appropriate for pediatrics ~~(Usually only available as pools of 5)~~	Fibrinogen, Factors VIII and XIII, von Willebrand's factor	As rapidly as tolerated by the patient (Usually 5-10 mL/min).	1 = 10-20 mL 5 = 50-100 mL	Deficiency of fibrinogen, FXIII. Emergency replacement of Factor VIII (Hemophilia A) or treatment von Willebrand's disease when purified factor products (from Pharmacy) are unavailable. **Use administration set with filter issued by Blood Bank. DO NOT REFRIGERATE. DO NOT ADMINISTER THROUGH A BLOOD WARMER.**
Fresh Frozen Plasma or Thawed Plasma or Liquid Plasma~~Fresh Frozen or Thawed Plasma~~	Plasma; all coagulation factors (FV and FVIII slightly lower in thawed plasma); complement, no platelets	As rapidly as tolerated by the patient (Usually 5-10mL/min).	220 mL	Treatment of coagulation factor (II, V, VII, X, XI) and certain plasma proteins (for example C-1-esterase) deficiencies. Thawed plasma and/or liquid plasma are routinely used in massive transfusion.~~Treatment of coagulation factor (II, V, VII, X, XI) and certain plasma proteins (for example C-1-esterase) deficiencies.~~
Frozen-Thawed deglycerolized RBC	RBC; minimal WBC and Platelets; no plasma	Usually 2 hours.	250 mL	Increase red cell mass in symptomatic anemia-frozen-thawed units are usually autologous or rare blood type.
Platelets (single donor platelet apheresis product)	Platelets; some WBC; plasma (=> 3.0x 10^{11} platelets/bag); rare RBC	As rapidly as tolerated by the patient (Usually 5-10mL/min).	250 – 400 mL	Bleeding due to thrombocytopenia or thrombocytopathy. Sometimes HLA- or cross-matched for patients with anti-platelet antibodies. **Use administration set with filter provided by Blood Bank. DO NOT REFRIGERATE. DO NOT ADMINISTRATE THROUGH A BLOOD WARMER.**
Red Blood Cells (RBC)	RBC; Reduced Plasma, WBC	Usually 2 hours.	350 mL	Increased red cell mass in symptomatic anemia (WBC and platelets not functional). All units are leukoreduced and are considered "CMV safe."
RBC Quad Pack (each piece)	RBC; Reduced Plasma, WBC	Usually 2 hours.	75 mL	Total amount given from each pack depends on ~~MD~~ the provider order. All quad packs are CMV seronegative and irradiated.

*** Infusion must be started within 30 minutes ~~and completed within 4 hours from~~of ~~release~~ issuance of the blood product ~~component~~ from the Blood Bank ~~(~~or~~-~~ removal from a Blood Bank approved storage location~~s~~ (e.g., O.R. Blood Refrigerator or Blood Bank-Issued Cooler~~indicated in this policy~~), and completed within 4 hours of the transfusion start time.~~.~~**

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APPENDIX C: BLOOD WARMERS AND INFUSION DEVICES

Blood Warmers

Purpose
Blood warmers are used to decrease the incidence of arrhythmias and cardiac arrest associated with massive transfusion of cold blood and to prevent hemolysis in patients with severe cold agglutinin syndrome in whom cold-activated autoantibodies bind to and lyse the patient's red blood cells.

Indications
1. Adults or children receiving multiple, rapid transfusions.
2. Rapid infusion through central venous catheters.
3. Transfusion of rare patients with clinically significant cold agglutinin syndrome (keeping the patient warm may be sufficient; the utility of blood warming in these patients is controversial).

Blood warmers are not indicated for routine transfusion of blood.

Type

Heat-exchange warmers in use at ~~SFGH~~ ZSFG (Hotline, Level One) have been specifically designed to warm blood and blood components. Follow the manufacturer's instructions for use.

Safety Features:

When warming of blood is indicated, it should be accomplished without risking hemolysis. The warming system must be equipped with a visible thermometer and an audible alarm. Blood must not be warmed above 42° C. Manufacturer's instructions should always be followed when warming blood.

All blood warmers in use at ~~SFGH~~ ZSFG display the operating temperature and are equipped with safeguards to prevent overheating.

Restrictions
- Never run blood under hot water, use an unmonitored hot water bath, or use a microwave oven to warm blood, as these methods may cause hemolysis due to uneven heating.
- Platelets and cryoprecipitate should not be given through a blood warmer as warming may render these blood components less effective.

Other Considerations
Blood which has been warmed must not be re-refrigerated for later use or reissued. Warming tends to accelerate red cell metabolism producing hemolysis and may permit bacterial growth. Red blood cell units that have been warmed must be returned to the Blood Bank clearly marked "**WARMED**".

Localization and Maintenance of Blood Warmers at SFGH
Blood warmers are kept in Anesthesia/Perioperative, Emergency Department (ED), and ICU locations. Biomedical Engineering services all blood warmers at least annually and checks for proper functioning of warming and alarm systems, oversees maintenance work performed by users, and keeps an inventory list of blood warmers, their status (active or removed from service) and maintenance records.

APPENDIX C: BLOOD WARMERS AND INFUSION DEVICES cont.

Infusion Devices

Types and Function

- Electromechanical “blood pumps” are designed to deliver parenteral fluids including blood and components at specified flow rates. Other IV infusion pumps may be used following manufacturer’s instructions if the manufacturer has documented safety of use with red blood cells and/or other components, as applicable.

- Syringe pumps deliver a precise volume of parenteral fluids at a controlled rate by electromechanically pushing the plunger of a filled syringe which is inserted into the device. This type of infusion device is routinely used in the nursery for small volume transfusions.

- Rapid infusion devices use external pressure devices to administer a unit of blood within a few minutes. These should only be used with a large gauge needle, i.e., 18 gauge or larger. External pressure devices should apply pressure evenly over the entire bag, have a gauge to monitor the pressure and never exceed 300 mm Hg of pressure. Ideally, they should also have an alarm.

  Note:

  Blood pressure cuffs should not be used as infusion devices. Cuffs do not exert uniform pressure against all parts of the bag and irregularly applied pressure may cause the blood bag to leak.

Localization and Maintenance of Rapid Infusion Devices at SFGH

Rapid infusion devices are kept in Anesthesia/Perioperative, Emergency Department (ED) and ICU locations. Biomedical Engineering services all rapid infusion devices at least annually, checks for proper functioning, oversees maintenance work performed by users and keeps an inventory list of rapid infusion devices, their status (active or removed from service) and maintenance records.

Updated ~~3/2/16~~07/28/25

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

APPENDIX D: ABO/RH COMPATABILITY OF RECIPIENT AND BLOOD DONOR

~~ABO Group of~~ Recipient ABO Blood Group	Compatible Donor ABO Group		
	Red Blood Cells	~~Red Blood Cells~~Whole Blood	Plasma
A	A, O	A~~, O~~	A, AB
B	B, O	B~~, O~~	B, AB
AB	A, B, AB, O	A~~, B, A~~B~~, O~~	AB
O	O	O	O, A, B, AB

Note: Low-titer Group O whole blood (LTOWB) may be used across different blood groups in emergency situations, particularly for massive hemorrhages from trauma. As of the time of this policy update the Blood Bank does not offer whole blood, but that product may become available for use in massive transfusion settings in the future.

Exception: Group A plasma may be issued and administered to patients with unconfirmed ABO type in the setting of a massive transfusion. This is primarily used as a bridging product until the patient's ABO blood type is confirmed and type specific/type compatible plasma is available. In an emergency, such as, massive transfusion, when the available type specific and/or type compatible plasma inventory is severely limited, the Blood Bank may issue Group A plasma to patients who are confirmed to be blood group B or AB. This situation is considered included under the emergency blood release authorization.

ABO-compatible, Rh-negative red cells ~~and plasma~~ can be given to any ~~Rh-positive~~ recipient.

ABO-compatible, Rh-positive red cells are routinely issued only to Rh-positive recipients. During emergency or massive transfusion, Rh-positive red cells may be issued to Rh-negative males of any age, and/or Rh-negative females who are beyond 55 years of age.

APPENDIX E: SAMPLE TRANSFUSION REACTION REPORT FORM

Print Date: Feb/24/2023

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

NAME
DOB
MRN
PCP
Patient ID/ Addressograph

Blood Bank Transfusion Reaction Report

Provider Name: _____ Patient Location: _____
Print Name CHN ID Pager/Extension

SIGNATURE OF STAFF WHO COLLECTED POST-TRANSF. SPEC. (REQUIRED)

Date: _____ Time: _____ RN: _____
Print Name Signature INV ID

Report all suspected reactions promptly to blood bank. Follow these instructions:

- Stop the transfusion and immediately notify the responsible MD to assess the patient.
- Fill out this form completely.
- Send completed form to Blood Bank ***with post-transfusion specimens (2 pink top tubes, 10ml each) and blood bag(s) with clamped-off administration set still attached.***

Patient Diagnosis: _____

Check Signs And Symptoms Noted:		Pre-Transfusion	Post-Transfusion
General:	☐ Fever ☐ Chills ☐ Pain at I.V. Site ☐ Nausea ☐ Back Pain	Temp. _____	Temp. _____
Respiratory:	☐ Dyspnea/SOB ☐ Wheezing	B/P _____	B/P _____
Cardiovascular:	☐ Hypotension ☐ Shock ☐ Chest Pain	Pulse _____	Pulse _____
Genitourinary:	☐ Hemoglobinuria ☐ Oliguria ☐ Anuria	Resp. Rate _____	Resp. Rate _____
Skin:	☐ Urticaria ☐ Flushing ☐ Rash	O2 Sat. _____	O2 Sat. _____
Hematological:	☐ Generalized Bleeding	O2 Admin _____	O2 Admin _____
☐ *Other:* _____			

Donor Unit Number(s) and Blood Component(s), (RBC, FFP, PLT, CRYO) Associated With Reaction

Unit No. _____	Comp. _____	Unit No. _____	Comp. _____
Unit No. _____	Comp. _____	Unit No. _____	Comp. _____
Unit No. _____	Comp. _____	Unit No. _____	Comp. _____

Date of Transfusion: _____

Transfusion Start Time: _____ **/ Stop Time:** _____

Amount Given: _____

When Was The Reaction Noted? – Time: _____

☐ **During Transfusion** ☐ **After Transfusion Completed**

If After, How Long After? _____

I.V. Solution Used in the Tubing With Bood?

☐ No ☐ Yes What? _____

Medication Added to Donor Unit or Tubing?

☐ No ☐ Yes What? _____

Blood Warmer Used? ☐ No ☐ Yes

Additional Comments (Use reverse side if needed):

***The Final Report will be under the Patient's Name in the Lifetime Clinical Record (LCR);*
***See Patient Menu Section - Results - Lab - Blood Bank - Transfusion Reaction Work-up.*

NOT A PART OF MEDICAL RECORD

SFGH CLINICAL LABORATORY, 1001 Potrero Ave., Bldg. 5, Rm. 2M, San Francisco, CA 94110
BARBARA HALLER, MD, PHD, DIRECTOR

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SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

Blood Bank Transfusion Reaction Report Form

NAME
DOB
MRN
PCP
Patient ID/ Addressograph

Provider Name: _____ Patient Location: _____
Print Name DPH Provider ID # Pager/Extension

SIGNATURE OF STAFF WHO COLLECTED POST-TRANSFUSION SPECIMEN (REQUIRED)

Date: _____ Time: _____ RN: _____
Print Name Signature ID#/ DSW#

Report all suspected reactions promptly to blood bank. Follow these instructions:

- Stop the transfusion **and** immediately notify the responsible provider to assess the patient.
- Fill out this form completely.
- Send completed form to Blood Bank ***with post-transfusion specimens (2 pink top tubes, 6 mL each) and blood bag(s) with clamped-off administration set still attached. (Do not send any needles to the Blood Bank)***

Patient Diagnosis: _____

Check Signs and Symptoms Noted:

General: ☐Fever ☐Chills/Rigors ☐Pain at I.V. Site ☐Nausea ☐Back Pain

Respiratory: ☐Dyspnea/SOB ☐Wheezing ☐Hoarseness/Stridor ☐ Hypoxemia

Cardiovascular: ☐Hypotension ☐Shock ☐Chest Pain

Genitourinary: ☐Hemoglobinuria ☐Oliguria ☐Anuria

Skin: ☐Urticaria(Hives) ☐Pruritus(Itch) ☐Flushing ☐Rash ☐Angioedema

Hematological: ☐Generalized Bleeding

☐ ***Other:*** _____

Vitals	Pre-Transfusion	Post-Transfusion	During* Reaction
Date			
Time			
Temp. (C°/F°)			
BP (mmHg)			
Pulse (bpm)			
Resp. Rate (/min)			
O2 Sat. (%)			
O2 Admin			

* If reaction and transfusion completion occurred at different times.

Donor Unit Number(s) and Blood Component(s), (RBC, FFP, PLT, CRYO) Associated with Reaction (Use reverse side if needed)

Unit No._____ Comp._____ Unit No._____ Comp._____
Unit No._____ Comp._____ Unit No._____ Comp._____
Unit No._____ Comp._____ Unit No._____ Comp._____

Transfusion: Start Date: _____ **Stop Date:** _____
Start Time: _____ **Stop Time:** _____
Amount Given: _____

Reaction: When Was the Reaction Observed?

Reaction Date: _____ **Reaction Time:** _____

☐During or ☐After Transfusion. If after, how long after? _____

I.V. Solution Used in the Tubing with Blood?

☐ No ☐ Yes What? _____

Medication Added to Donor Unit or Tubing?

☐ No ☐ Yes What? _____

Blood Warmer Used? ☐ No ☐ Yes

Additional Comments (Use reverse side if needed):

***A final interpretation summary, titled, Transfusion Reaction Workup, will appear in the medical record under lab results.*
***A full consult note will appear under the notes section of the medical record.*

NOT A PART OF MEDICAL RECORD

2-151 (rev. 08/25) CLINICAL LABORATORY, BARBARA HALLER, MD, PHD, DIRECTOR Page **1** of **1**

~~ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER~~

APPENDIX F: KEY POINTS PRE- AND POST-BLOOD PRODUCT ADMINISTRATION

I. Receiving Blood Products

- Delivery Receipt timed, signed & dated

II. Picking up Blood Products

- Bring evidence of patient identification (e.g.,~~,~~ blood requisition, registration card, stamped or printed label with the patient's full name and medical record number)~~a stamp label~~

III. Chart Check

- ~~MD~~ Provider Order reviewed
- Informed consent form completed, signed & dated (and not expired)

IV. Patient ID/ Unit Check - two licensed* individuals perform check

* (~~MD, DO, NP, PA, CNM, RN, LVN~~RN or Provider or Emergency Department PharmD)

A. Conscious Patient (skip to B if patient unable to respond)

- Patient was asked: "What is your name?" "What is your date of birth?"
- Stated name and birthdate agree with name on ID band

B. All patients

- Name & hospital number on *ID band*, *Blood Order Label* (and ~~and~~ *Transfusion Report Form*, *if downtime or emergency or massive transfusion)* ~~(unit tag)~~ agree
- ABO/Rh types of the donor and the patient (recipient) are compatible
- ABO/Rh types of the donor on *Blood Order Label* (and *Transfusion Report Form, if downtime or emergency or massive transfusion)* ~~*Transfusion Report Form* (unit tag)~~ and *Blood Product~~unit~~ ~~L~~label* are identical
- Unit number on *Blood Order Label* (and *Transfusion Report Form, if downtime or emergency or massive transfusion)* and *Blood Product Label* ~~Transfusion Report Form (unit tag) and unit label~~ agree~~s~~
- Special requests are met (if applicable)

C. Downtime, Emergency, and Massive Transfusions

- Transfusion S~~s~~tart Date and T~~t~~ime noted on Transfusion Report Form (or Flow Sheets) ~~(tag); form signed & dated~~
- ~~Signed and dated~~ Transfusion Report Form Signed by Transfusionist and Checker(s)~~(top copy only) placed in patient's chart~~

If any discrepancies are noted or unit seems unfit for transfusion, DO NOT TRANSFUSE, and immediately contact Blood Bank.

BLOOD TRANSFUSION MUST BEGIN WITHIN 30 MINUTES OF UNIT'S RELEASE ISSUE FROM THE THE BLOOD BANK OR REMOVAL FROM AN APPROVED BLOOD STORAGE LOCATION.

V. **Documentation (Blood Stamp, Electronic Chart, Anesthesia Record)**

- Transfusion Report Form Signed by Transfusionist and Checker(s), scanned to patient chart (Only required for Downtime, Emergency, and Massive Transfusions)
- Blood product, chronological order, unit number and needle size recorded
- Vital signs recorded before, during (15 minutes, 1 hour, etc.) and at the end of transfusion during and at the end of transfusion
- Transfusion Start Date and Start Time Recorded
- Transfusion Stop Date and Stop Time Completion time of transfusion Recorded
- Patient tolerance of transfusion recorded

~~ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER~~

APPENDIX G: TRANSFUSION OBSERVATION AUDIT CHECK LIST

Confidential Quality Assurance Document
Protected by Section 1157, California Evidence Code

Check List

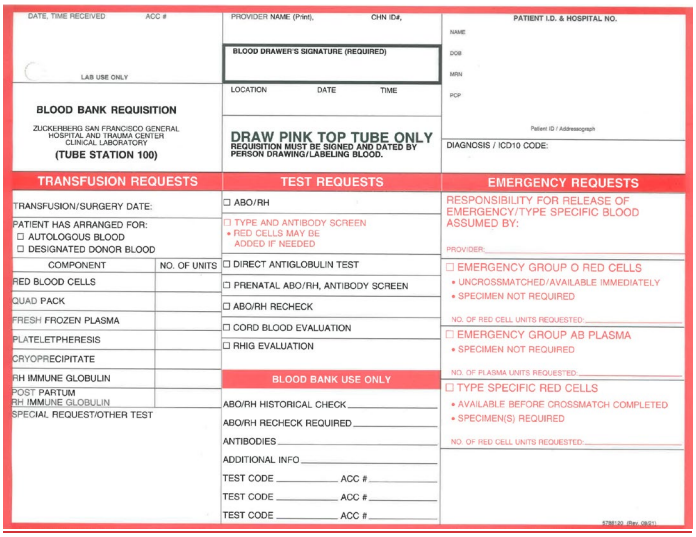
Observe each item upon initiation of transfusion:	**Yes**	**No**	**N/A**	**Comment**
01. Transfusion consent has been checked (ask transfusionist).				
02. MD order has been checked (ask transfusionist).				
03. Delivery form is checked / completed correctly *				
04. Recipient wears wristband.				
05. Conscious patient is requested to state full name and birthdate.				
06. Two persons perform patient/ unit identification.				
07. One person reads aloud the wristband identification.				
08. 2nd person~~Second person~~ verifies ~~that the wristband~~ ID Band matches ~~matches the~~ information on ~~the~~ Blood Order Label (and ~~transfusion~~ Transfusion R~~r~~eport F~~f~~orm for downtime or emergency) ~~(unit tag)~~.				
09. One person reads information on Blood Order Label~~transfusion report from~~ attached to unit, e.g., patient/donor ~~(unit #,~~ blood types, unit #/product code, expiration date~~)~~.				
10. 2nd person ~~Second person~~ verifies that ~~the~~ information on the Blood Order Label~~transfusion report form~~ agrees with that on the Blood Product Label (and Transfusion Report Form for downtime, emergency or massive transfusion)~~unit label~~, e.g., patient/donor blood types, unit #/product code, expiration date ~~(unit #, blood type, expiration date~~, special requests~~)~~.				
11. Both signatures are documented in the EHR (either in EHR blood administration module or on scanned ~~Both persons sign and date~~ Transfusion Report F~~f~~orm). ~~*~~				
12. Discrepancies, if any, are identified and resolved.				
~~13. The last copy of the Transfusion Report Form (unit tag) remains attached to the unit.~~				
1~~3~~4. Appropriate blood filter is used (standard set for RBC and FFP, y-set for platelet concentrates and cryoprecipitate).				
1~~4~~5. Normal saline or plasmalyte 148 is used to start the transfusion.				
1~~5~~6. Start Date and T~~t~~ime of the transfusion is recorded.				
1~~6~~7. Transfusion is started within 30 minutes of blood issuance from Blood Bank or retrieval of blood from OR refrigerator.				
1~~7~~8. Baseline vital signs are recorded.				
1~~8~~9. Patient is more closely observed by the transfusionist for adverse reaction for at least the first 15 minutes of transfusion.~~n.~~				
After transfusion completed (6 hours later or next day):				
~~20~~19. Transfusion R~~r~~eport F~~f~~orm is present in the chart (if downtime emergency or massive transfusion).				
2~~0~~1. Transfusion consent is in chart.				
2~~2~~2. Transfusion consent is filled out correctly. *				
2~~3~~3. Vital signs are recorded at 15 minutes.				
at 1 hour.				

at completion of transfusion.				
24. Completion time of transfusion is recorded.				
25. Stop Date and Time of transfusion is recorded, and Transfusion is completed within 4 hours from issue of blood.				
26. Volume administered is recorded.				
276. Patient Tolerance is recorded.				

***~~-~~Indicate in Comment column if specific deficiencies are noted (e.g., missing date/ time/ signatures on consent form)~~, for example "*Date missing*" or "MD name missing"~~**

APPENDIX H: EXAMPLE OF BLOOD BANK FORMS AND LABELS

Figure A: Blood Bank Downtime Requisition



DATE, TIME RECEIVED ACC #

LAB USE ONLY

BLOOD BANK REQUISITION

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER CLINICAL LABORATORY

(TUBE STATION 100)

PROVIDER NAME (Print), CHN ID#,

BLOOD DRAWER'S SIGNATURE (REQUIRED)

LOCATION DATE TIME

DRAW PINK TOP TUBE ONLY

REQUISITION MUST BE SIGNED AND DATED BY PERSON DRAWING/LABELING BLOOD.

PATIENT I.D. & HOSPITAL NO.

NAME

DOB

MRN

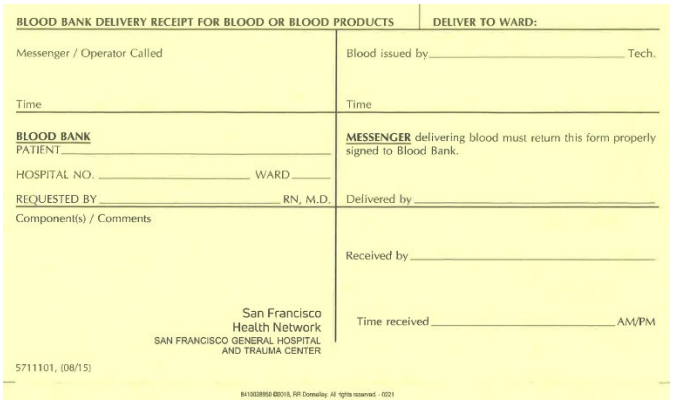
PCP

Patient ID / Addressograph

DIAGNOSIS / ICD10 CODE:

TRANSFUSION REQUESTS		TEST REQUESTS	EMERGENCY REQUESTS
TRANSFUSION/SURGERY DATE:		☐ ABO/RH	RESPONSIBILITY FOR RELEASE OF EMERGENCY/TYPE SPECIFIC BLOOD ASSUMED BY:
PATIENT HAS ARRANGED FOR: ☐ AUTOLOGOUS BLOOD ☐ DESIGNATED DONOR BLOOD		☐ TYPE AND ANTIBODY SCREEN • RED CELLS MAY BE ADDED IF NEEDED	PROVIDER:
COMPONENT	NO. OF UNITS	☐ DIRECT ANTIGLOBULIN TEST	☐ EMERGENCY GROUP O RED CELLS • UNCROSSMATCHED/AVAILABLE IMMEDIATELY • SPECIMEN NOT REQUIRED
RED BLOOD CELLS		☐ PRENATAL ABO/RH, ANTIBODY SCREEN	NO. OF RED CELL UNITS REQUESTED:
QUAD PACK		☐ ABO/RH RECHECK	☐ EMERGENCY GROUP AB PLASMA • SPECIMEN NOT REQUIRED
FRESH FROZEN PLASMA		☐ CORD BLOOD EVALUATION	NO. OF PLASMA UNITS REQUESTED:
PLATELETPHERESIS		☐ RHIG EVALUATION	☐ TYPE SPECIFIC RED CELLS • AVAILABLE BEFORE CROSSMATCH COMPLETED • SPECIMEN(S) REQUIRED
CRYOPRECIPITATE		**BLOOD BANK USE ONLY**	NO. OF RED CELL UNITS REQUESTED:
RH IMMUNE GLOBULIN		ABO/RH HISTORICAL CHECK	
POST PARTUM RH IMMUNE GLOBULIN		ABO/RH RECHECK REQUIRED	
SPECIAL REQUEST/OTHER TEST		ANTIBODIES	
		ADDITIONAL INFO	
		TEST CODE ACC #	
		TEST CODE ACC #	
		TEST CODE ACC #	

Figure B: Blood Bank Delivery Receipt



BLOOD BANK DELIVERY RECEIPT FOR BLOOD OR BLOOD PRODUCTS | **DELIVER TO WARD:**

Messenger / Operator Called

Time

Blood issued by _____ Tech.

Time

BLOOD BANK

PATIENT

HOSPITAL NO. _____ WARD

REQUESTED BY _____ RN, M.D.

Component(s) / Comments

MESSENGER delivering blood must return this form properly signed to Blood Bank.

Delivered by

Received by

San Francisco Health Network

SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

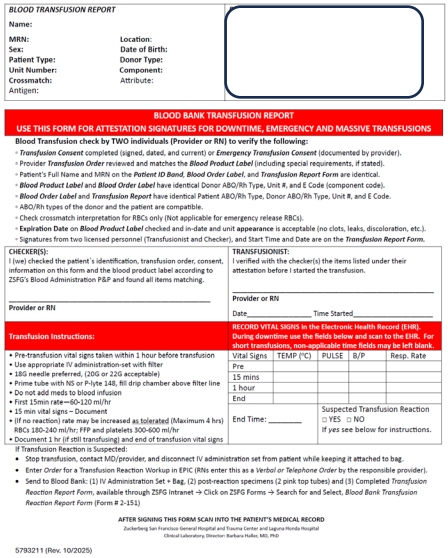
Time received _____ AM/PM

5711101, (08/15)

Figure C: Blood Product Label (Front of Container/Bag)

Figure D: Blood Order Label (Rear of Container/Bag)

Figure D: Transfusion Report Form (Attached to bag by Rubber Band)



BLOOD TRANSFUSION REPORT

Name:

MRN: Location:
Sex: Date of Birth:
Patient Type: Donor Type:
Unit Number: Component:
Crossmatch: Attribute:
Antigen:

BLOOD BANK TRANSFUSION REPORT
USE THIS FORM FOR ATTESTATION SIGNATURES FOR DOWNTIME, EMERGENCY AND MASSIVE TRANSFUSIONS

Blood Transfusion check by TWO individuals (Provider or RN) to verify the following:

- ***Transfusion Consent*** completed (signed, dated, and current) or ***Emergency Transfusion Consent*** (documented by provider).
- Provider ***Transfusion Order*** reviewed and matches the ***Blood Product Label*** (including special requirements, if stated).
- Patient's Full Name and MRN on the ***Patient ID Band***, ***Blood Order Label***, and ***Transfusion Report Form*** are identical.
- ***Blood Product Label*** and ***Blood Order Label*** have identical Donor ABO/Rh Type, Unit #, and E Code (component code).
- ***Blood Order Label*** and ***Transfusion Report*** have identical Patient ABO/Rh Type, Donor ABO/Rh Type, Unit #, and E Code.
- ABO/Rh types of the donor and the patient are compatible.
- Check crossmatch interpretation for RBCs only (Not applicable for emergency release RBCs).
- **Expiration Date** on ***Blood Product Label*** checked and in-date and unit **appearance** is acceptable (no clots, leaks, discoloration, etc.).
- Signatures from two licensed personnel (Transfusionist and Checker), and Start Time and Date are on the ***Transfusion Report Form.***

CHECKER(S):
I (we) checked the patient's identification, transfusion order, consent, information on this form and the blood product label according to ZSFG's Blood Administration P&P and found all items matching.

Provider or RN

TRANSFUSIONIST:
I verified with the checker(s) the items listed under their attestation before I started the transfusion.

Provider or RN

Date_____ Time Started_____

Transfusion Instructions:

- Pre-transfusion vital signs taken within 1 hour before transfusion
- Use appropriate IV administration-set with filter
- 18G needle preferred, (20G or 22G acceptable)
- Prime tube with NS or P-lyte 148, fill drip chamber above filter line
- Do not add meds to blood infusion
- First 15min rate—60-120 ml/hr
- 15 min vital signs – Document
- (If no reaction) rate may be increased as tolerated (Maximum 4 hrs) RBCs 180-240 ml/hr; FFP and platelets 300-600 ml/hr
- Document 1 hr (if still transfusing) and end of transfusion vital signs

RECORD VITAL SIGNS in the Electronic Health Record (EHR). During downtime use the fields below and scan to the EHR. For short transfusions, non-applicable time fields may be left blank.

Vital Signs	TEMP (°C)	PULSE	B/P	Resp. Rate
Pre				
15 mins				
1 hour				
End				

End Time: _____

Suspected Transfusion Reaction
□ YES □ NO
If yes see below for instructions.

If Transfusion Reaction is Suspected:

- Stop transfusion, contact MD/provider, and disconnect IV administration set from patient while keeping it attached to bag.
- Enter *Order* for a Transfusion Reaction Workup in EPIC (RNs enter this as a *Verbal or Telephone Order* by the responsible provider).
- Send to Blood Bank: (1) IV Administration Set + Bag, (2) post-reaction specimens (2 pink top tubes) and (3) Completed *Transfusion Reaction Report Form*, available through ZSFG Intranet → Click on ZSFG Forms → Search for and Select, *Blood Bank Transfusion Reaction Report Form* (Form # 2-151)

AFTER SIGNING THIS FORM SCAN INTO THE PATIENT'S MEDICAL RECORD

Zuckerberg San Francisco General Hospital and Trauma Center and Laguna Honda Hospital
Clinical Laboratory, Director: Barbara Haller, MD, PhD

5793211 (Rev. 10/2025)

New Hospital-wide Policies and Procedures

SAFE USE OF MEDICINAL CANNABIS PRODUCTS FOR TERMINALLY ILL OR CHRONICALLY ILL RESIDENTS OVER 65

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to adhere to California state law requiring healthcare facilities to allow the use of medicinal cannabis on premises for patients who 1) are terminally ill, and/or 2) are over the age of 65 and living with a chronic disease declared by a physician assessment as a serious medical condition, and a physician's assessment states that the use of medicinal cannabis is appropriate.

In compliance with California state law, patients should not be denied admission to LHH, in whole or in part, because of their use of medicinal cannabis.

Except for the provisions of this policy, cannabis is prohibited and subject to Policy No. 75-07: Illicit Or Diverted Drugs And/or Paraphernalia Possession/Use By Residents Or Visitors and other applicable policies.

PURPOSE:

California state law (Cal. Health & Safety Code §§ 1649-1649.6 requires skilled nursing facilities (SNFs) and general acute care hospitals to allow patients to use medicinal cannabis who are either terminally ill or—for SNFs but not general acute care hospitals—are over the age of 65 with a chronic disease meeting specific criteria. CDPH has issued All Facilities Letters on this law, including AFL 22-04, AFL 23-07, and AFL 24-06.

DEFINITION:

1. **Cannabis** means substances derived from the *Cannabis sativa* plant. The medicinal properties of cannabis derive partially from two of the primary components: THC (delta—9-tetrahydrocannabinol) and CBD (cannabidiol). THC and CBD can be found in varying proportions in cannabis products. THC is the primary psychoactive component of cannabis or marijuana. The California Department of Cannabis Control (DCC) ensures the safety of commercially available cannabis products.

2. **Medical cannabis or Medicinal cannabis** means cannabis or a cannabis product used in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the California Health and Safety Code.

3. **Medical Marijuana Identification Card (MMIC)** means a valid identification card authorized by section 11362.715 of the California Health and Safety Code.

4. **Primary caregiver** means, as defined in California Health and Safety Code section 11362.7(d), the individual at least 18 years of age, designated by a qualified patient, who has consistently assumed responsibility for the housing, health, or safety of that patient.

5. **Pure cannabidiol (CBD; Epidiolex®)** means the Schedule V substance that is FDA-approved for treatment of Lennoxy-Gastaut syndrome (LGS), Dravet syndrome, or tuberous sclerosis complex (TSC) in patients 1 year of age or older.

6. **Qualifying patient** means an LHH SNF patient who meets one or both of the following criteria: (1) is terminally ill, or (2) over the age of 65 with a chronic disease declared by a physician assessment as a serious medical condition and that the use of medicinal cannabis is appropriate.

7. **Qualifying patient** also means general acute care hospital patients who are terminally ill but does not include patients over the age of 65 with a chronic disease that is a serious medical condition.

8. **Serious medical condition** means each of the following conditions, as defined by California Health and Safety Code Section 11362.7(h): Acquired immune deficiency syndrome (AIDS); anorexia; arthritis; cachexia; cancer; chronic pain; glaucoma; migraine; persistent muscle spasms; including, but not limited to, spasms associated with multiple sclerosis; seizures, including, but not limited to, seizures associated with epilepsy; severe nausea; and any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activities as defined in the federal Americans with Disabilities Act of 1990, or, if not alleviated, may cause serious harm to the patient's safety or physical or mental health.

9. **Terminally ill** means a medical condition resulting in a prognosis of one year or less to live, if a disease follows its natural course.

PROCEDURE:

10. Use of medicinal cannabis may not be used as a reason to deny admission.

11. Qualifying for use.

a. The person must be a qualifying patient as defined above.

b. Qualifying patients must provide the health care facility a copy of their medical marijuana identification card (MMIC) or written documentation from a provider outside of Laguna Honda which includes an assessment and recommendation in order to qualify to use medicinal cannabis under this policy.

i. Copy will be provided to HIM for entry into the electronic medical record.

c. For a patient at LHH that has decision-making capacity and has expressed an interest in medicinal cannabis and does not already have a valid MMIC, the person should be referred to a medical provider who does not work at or is affiliated with LHH for evaluation of whether the patient qualifies for medicinal cannabis.

d. The patient or responsible party shall understand that California law allows access to medicinal cannabis products, but not through smoked or inhalational use (including vaping) at healthcare facilities.

e. The patient shall provide a copy of their physician's assessment (may use the medicinal cannabis authorization form CDPH 9044), or a photocopy of a valid, unexpired MMIC to be added to their medical record.

i. MMIC will be verified on CDPH's registry: https://mmic.cdph.ca.gov/MMIC_Search.aspx

f. The patient shall be informed that failure to safely store cannabis products, sharing of cannabis products, smoking or vaping cannabis products, or development of a use disorder are reasons that access to cannabis may be discontinued (signature of an informed consent document is advised).

12. LHH Physician Documentation

a. If the LHH primary care physician deems medical cannabis to be contra-indicated, this will be discussed with the patient and primary caregiver, and the following steps will not ensue. The rationale will be documented in the medical record.

b. For patients that qualify, the LHH primary care physician shall enter "Cannabis use" onto the problem list (ICD-10 F12) and indicate if the person has terminal illness or age over 65 with identified chronic disease in order for to be a qualifying patient.

c. The patient should have listed on their problem list the terminal illness and/or chronic disease for which they qualify.

13. Procuring Medicinal Cannabis

a. The patient/resident must obtain the non-smoked cannabis product themselves, either through an authorized out on pass trip, or from a primary caregiver.

b. If a designated primary caregiver will be the courier of the cannabis products, the following protocol must be followed:

i. One-time primary caregiver pre-registration with LHH shall be completed:

- Qualifying patient/resident must first request registration for the primary caregiver through the resident care team (RCT)
- The RCT will escalate to the CEO/NHA, ANHA, CMO, and CQO.
- LHH Administration will maintain a list of primary caregivers and send updates to the Nursing Operations office and the San Francisco Sheriff's Office (SFSO) whenever updated.

ii. Qualifying patient/resident and/or primary caregiver will inform the unit nurse supervisor of a planned cannabis delivery at least 24 hours in advance.

~~iii.~~ Unit nurse supervisor will inform Nursing Operations, who will inform SFSO in advance of the delivery, per LHHPP75-10 (Security Services Standard Operating Procedures).

iv. Upon primary caregiver arrival, SFSO will:

- verify the identity of the primary caregiver against the list of primary caregivers,
- notify nursing,
- direct the primary caregiver to place medicinal cannabis in a tamper-evident bag, and
- inform the nurse that the primary caregiver is en-route to the floor.

14. Storage and Handling

a. Medicinal cannabis will be stored on the patient/resident unit using two levels of security to prevent theft or diversion of medicinal cannabis:

i. a lockbox or locked bag that a patient/resident or primary caregiver can access that is secured in a locked storage area that charge nurses can access.

- The patient/resident will hold the key to this lockbox.

- The charge nurse will have the key to the storage area and provide the patient/resident or primary caregiver access to their own lockbox upon request.

ii. Cannabis must be stored in the lockbox provided by the facility and the lockbox must be stored in the locked storage area at all times between use.

iii. When the patient/resident or primary caregiver adds inventory to the lock box, the nurse will log the product and expiration date on the Medical Cannabis Resident Inventory form, which will be stored inside the lock box with the medicinal cannabis.

b. Only the patient/resident, or their primary caregiver, should remove the cannabis product for use.

i. The patient/resident may request access to their cannabis, and the charge nurse will unlock the locked storage area so that the patient may access their own lockbox

ii. If the patient/resident is physically unable to retrieve the lockbox, the charge nurse may bring the lockbox to the patient.

iii. The patient/resident or primary caregiver must retrieve the desired amount of medicinal cannabis and lock the lockbox before returning the lockbox to the secured storage area

c. Healthcare staff must not handle the cannabis except as outlined by LHH medication disposal policy. This means staff are prohibited from administering the cannabis to the patient and may not retrieve it from lockbox, even by patient request.

d. If the patient/resident or primary caregiver is unable to safely secure the cannabis products and prevent loss or diversion, the team should convene an RCC to discuss and document the situation and apply the medication disposal policy.

15. Administration

a. The patient/resident will self-administer the cannabis product at a 3 they feel is necessary to control their symptoms.

16. Clinical Monitoring

a. If the patient/resident has a change in clinical status, including any of the symptoms listed below (c), the LHH physician should be notified. In contrast, there are normal physiologic effects from cannabis use that may be observed include: increases in heart rate, decrease in blood pressure, dry eyes/mouth, decreased urination, increased appetite, and decreased attention.

b. If the LHH physician or RCT is concerned that the patient is developing unhealthy use of cannabis and may have a cannabis use disorder, consultation from addiction medicine or psychiatry should be sought (MSPP D-16).

c. Excessive use of cannabis does not stop respiration or cause an overdose syndrome with apnea (no breathing) and cyanosis (turning blue). Excess cannabis may lead to the following symptoms, and if present, should be reason to inform the primary care provider:

   i. Changes in resident behavior

   ii. Increased, unexplained drowsiness

   iii. Lack of coordination

   iv. Slurred speech

   v. Mood changes

   vi. Loss of consciousness

   vii. Hyperemesis

   ~~viii.~~Paranoia or hallucinations

17. Patient Education, Policy Violations and Diversion

a. Patients and primary caregivers desiring to participate in this policy must be educated on reporting if they are being asked, pressured, or forced to share or violate this policy.

b. Patients found to be sharing their medicinal cannabis product(s) violation of this policy will automatically forfeit the right to medicinal cannabis within LHH.

c. Sharing with a patient that does not have capacity to consent to use of the cannabis product must be reported as a patient abuse case following abuse reporting policies and follow Diversion policies (25-12 and 75-05).

d. If the patient is found to be sharing their cannabis product(s) with a patient that does have capacity to consent to use, then the primary care provider should be contacted to evaluate the patient with whom the cannabis was shared, and staff should follow the policy and procedure for Diversion (25-12 and 75-05).

e. If a primary caregiver is found to be sharing medicinal cannabis with someone other than a person who is using medicinal cannabis in accordance with this policy, then this person will be subject to all applicable laws and policies including but not limited to Diversion policy 75-05.

18. Staff Training

a. LHH shall train staff on the use and disposal of medicinal cannabis.

19. Disposal

a. Upon discharge, policy violation, other reasons for stopping use, medicinal cannabis will be disposed of by patients or primary caregivers. However, if they do not remove the medicinal cannabis, the product must be disposed of according to the LHH policies and procedures.

20. Suspension of Policy

a. If a federal regulatory agency, the United States Department of Justice (US DOJ), or the federal Centers for Medicare and Medicaid Services (CMS) takes one of the following actions, or makes an inquiry about LHH's activities under this Policy, staff may suspend compliance with this Policy until the regulatory agency, the US DOJ, or CMS notifies the health care facility that it may resume permitting the use of medicinal cannabis within the facility:

   i. A federal regulatory agency or the US DOJ initiates enforcement action, including a notice to suspend funding, against LHH related to the facility's compliance with a state-regulated medical marijuana program.

   ii. A federal regulatory agency, the US DOJ, or CMS issues a rule, guidance, or otherwise provides notification to LHH that expressly prohibits the use of

medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

b. LHH hospital administration and/or quality management will issue guidance to all staff, including when the Policy has been suspended, in the event that either of these situations exists.

ATTACHMENT:
Attachment A: Laguna Honda Medicinal Cannabis Policy Acknowledgement

REFERENCE:

AFL 22-04: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-04.aspx

AFL 24-06: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-24-06.aspx

Proposal for Rescheduling of Cannabis. https://www.dea.gov/sites/default/files/2024-05/Scheduling%20NPRM%20508.pdf Additional information here: https://www.justice.gov/opa/pr/justice-department-submits-proposed-regulation-reschedule-marijuana

LHHPP 75-95 Illicit or Prohibited Drugs and Paraphernalia Possession/Use By Residents or Visitors

Laguna Honda House Rules and Responsibilities

LHHPP 22-12 Clinical Search Protocol

LHHPP 75-10 Security Service Standard Operating Procedures

Standard Work: Contraband Items Handling, Storage & Disposal

MSPP D-16 Clinical Services For Residents With Substance Use Disorders

DEA Rescheduling of pure cannabidiol: https://www.dea.gov/press-releases/2018/09/27/fda-approved-drug-epidiolex-placed-schedule-v-controlled-substance-act

Most recent review: (Month/Day/Year)

Revised: (Month/Day/Year)Original adoption: 10/21/05(Month/Day/Year)

Attachment A

Laguna Honda Medicinal Cannabis Policy Acknowledgement

I agree to follow the Laguna Honda Hospital's policy and processes for medical cannabis. ~~F~~I understand that failure to safely store cannabis products, ~~prohibit~~ sharing of cannabis products, or development of a use disorder are reasons that access to cannabis may be discontinued.

Patient/Resident Name:_____

Date:_____

Primary Caregiver Name:_____

Date:_____

Revised Hospital-wide Policies and Procedures

RESIDENT/PATIENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents/patients/visitors' complaints/grievances and addresses residents/patients/visitors' concerns.

2. LHH encourages residents to raise concerns for resolution with their Resident Care Team (RCT), at Community meetings, or at Residents' Council without discrimination or fear of reprisal.

3. LHH encourages patients on the acute medical unit to raise concerns for resolution with the care providers on the acute unit without discrimination or fear of reprisal.

4. LHH shall make prompt efforts to resolve grievances residents/patients/visitors may have by actively working toward a resolution.

5. Individual resident/patient concerns that are addressed by the RCT or acute medical care team shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

6. When methods for resolving concerns have not been successful and residents/patients/visitors choose not to use any of the above methods, LHH has a Complaint/Grievance form that can be submitted to the Administration Department (Administration) to address unresolved complaints/grievances in equitable and inclusive manner via unit-based grievance boxes and suggestion boxes throughout the facility.

7. The neighborhood bulletin board shall display necessary information, consistent with federal requirements on the residents/patients/visitors right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances, including how to contact the Ombudsman.

8. The Assistant Nursing Home Administrator for Care Experience (ANHA-~~-~~CEX) shall act as the Grievance Official and is responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating with state and federal agencies as necessary.

PURPOSE:

1. To ensure that complaints are addressed, and appropriate follow-up actions are taken to resolve the issue to the fullest extent possible.

2. To optimize the experience and satisfaction of the residents/patients/visitors with the care and services in a timely manner.

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints/grievances may include those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.

    a. If admitted to the acute medical unit at Laguna Honda, the admitting nurse will remind the patient of their right to file a grievance.

2. The Resident/Patient/Visitor Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident's Rights annual in-services.

3. Resident/Patient/Visitor Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

4. Grievance forms and submission boxes shall be located near the elevators of each neighborhood so that residents, families, and visitors may submit grievances without the assistance of LHH staff.

5. The RCT in the Skilled Nursing Facility, and/or the care team on the medical acute unit, shall encourage a resident/patient to complete the Resident/Patient/Visitor Complaint/Grievance form when methods for resolving concerns are not successful despite attempted interventions and the resident's concerns continue to be unresolved.

6. Should the grievance be concerning property loss, the resident/patient may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee

reimbursement for the lost or stolen property. The Medical Social Worker or any member of the RCT may assist the resident/patient in completing claims form.

a. LHH is liable for damage or loss of the personal property of a resident/patient, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions, or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

7. If the resident/patient/visitor is unable to or does not wish to complete the grievance form, staff may document the resident/patient's complaint/grievance on behalf of the resident/patient/visitor. The Resident/Patient Complaint/Grievance form may be submitted via the Grievances boxes near the elevators on the neighborhoods, to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to Administration.

8. Residents/Patients/Visitors who wish to file their grievances anonymously may submit their Complaint/Grievance form into drop boxes labelled "Suggestion box" located at near the elevators on the neighborhoods, at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

9. Contents from Suggestion Boxes shall be picked up Monday through Friday, excluding holidays by the Resident/Patient Safety Advocate or designee. Complaint/Grievance forms and Suggestion forms sent via email to the main Laguna Honda email address, laguna.honda@sfdph.org, and then shall be routed to the AHNA-CEX or their designee and members of the Executive Leadership team.

10. The Resident/Patient Safety Advocate, with guidance from the ANHA-CEX as needed, shall triage the complaint/grievance. The grievance shall be logged into the grievance log and assigned to the appropriate departments for timely follow up.

11. The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident/patient in within the same day of receipt of the grievance. The resident/patient's right to confidentiality and privacy will be respected at all times.

12. If the complaint/grievance is anonymous, follow up with the complainant is not possible. However, the appropriate department head is still responsible for acknowledging receipt of the complaint/grievance, investigate the complaint/grievance, and address the general concerns of the complaint if the matter can be confirmed to the Grievance Official.

13. The Grievance Official shall respond to the complaint/grievance with a final resolution in 10 business days. In the event that the grievance cannot be resolved within 10

business days, the Grievance Official will inform the resident/patient of the plan to resolve the grievance and the estimated time frame to resolution. The Grievance Official will continue to monitor the progress until the grievance has been resolved, and communicate with the resident/patient regarding the progress to resolving the grievance.

14. Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident's rights is confirmed.

15. Documentation consistent with federal requirements related to resident grievances shall be maintained for a period of 3 years from the issuance of the grievance decision.

16. Complaints/grievances shall be evaluated and analyzed by the Grievance Official with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems. Data will be reported out in the following committees and meetings:

    a. Weekly ~~by NHA and as needed at the Executive Committee meeting~~to the Nursing Home Administrator and Chief Executive Officer and LHH executive team to ensure leadership have the awareness and opportunity to address complaints during leadership rounding. ~~Discussion of the data shall be documented in the minutes.~~

    b. Monthly at Resident Council ~~and during Community Meetings~~. Discussion of the data shall be documented in the respective groups' meeting minutes.

    c. Quarterly at the Quality Assurance Performance Improvement/Performance Improvement and Patient Safety (PIPS) meeting.

ATTACHMENT:
Attachment A: Grievance Information Flyer
Attachment B: Grievance Form
Attachment C: Grievance Acknowledgment
Attachment D: Grievance Response Form

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 22-03 Residents' Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 75-07 Theft and Lost Property
Appendix PP/Guidance to Surveyors for Long Term Care Facilities F585/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 22/08/17, 22/08/30, 22/12/13, 23/05/09, 23/07/18, 23/11/14, 25/04/14, 25/10/21 (Year/Month/Day)

Original adoption: 92/03/01

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Resident Grievance Information

Laguna Honda Hospital wants to provide you with quality health care in a respectful, compassionate manner. If we did not meet your expectations, we want to hear about it.

Any resident may file or communicate a complaint/grievance regarding their treatment. If you are unable to file or communicate a complaint/grievance, a family member, spouse, caregiver, or significant other may file a concern on your behalf.

Complaint/Grievance forms may be obtained from each unit, in the Social Services Office, in the Nursing Office, and/or in the Administration Office. Please submit the form either in person to staff, mail in, or email. You may also anonymously drop it in one of the Suggestion Boxes located at the Pavilion lobby entrance, Outpatient Clinic lobby, or Administration lobby.

Once the complaint/grievance form has been submitted, our office will send an acknowledgment form that we have received your concern. We will reach out to the department where the concern occurred, and a representative will contact you to learn more about your experience. We will let you know the results within 10 business days.

Resources for accessing additional information regarding resident care at the facility include the local long-term care ombudsman at 415-751-9788, felton.org/social-services/seniors/sf-ltc-ombudsman-program/, and ombudsman@felton.org, CDPH's Licensing and Certification Program's website (cdph.ca.gov/Programs/CHCQ/LCP/Pages/LandCProgramHome.aspx), the California Health Facility Information Database (Cal Health Find) page (cdph.ca.gov/programs/chcq/lcp/calhealthfind/Pages/Home.aspx), and the Cal Long Term Care Compare website (CalLongTermCareCompare.org).

Reporting resident care complaints can be done using the local long term care ombudsman information above and through the CDPH complaint process (cdph.ca.gov/Programs/CHCQ/LCP/Pages/LandCProgramHome.aspx).

Forms can be sent to:

Chief Executive Officer
375 Laguna Honda Blvd
San Francisco, CA
94116

If you have any questions, feel free to contact our office:

Call between
8am-5pm M-F
(628) 754-2363

Email
laguna.honda@sfdph.org

Thank you! Your Feedback Helps Us Improve!

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Resident Grievance Form

PART I: RESIDENT INFO

TODAY'S DATE _____

First Name _____ Last Name _____

Date of Birth _____ Medical Record # _____

Address _____
STREET CITY STATE ZIP

Email _____

Telephone _____ Ok to Leave message? ☐ YES ☐ NO

Where do you usually receive care? _____

Name of your usual/primary doctor/ nurse practitioner _____

How will we reach you? ☐ WRITE TO ME ☐ CALL ME ☐ I WILL CALL YOU ☐ EMAIL ME

Resident Signature _____

If submitting on behalf of resident:

Your Name _____

Relationship to resident

☐ SPOUSE ☐ FAMILY MEMBER ☐ CARE GIVER ☐ SIGNIFICANT OTHER ☑ OTHER

Your Contact info _____
STREET CITY STATE ZIP PHONE

Email _____

Signature _____

Forms can be mailed to:
Chief Executive Officer
375 Laguna Honda Blvd
San Francisco, CA 94116

If you have any questions, feel free to contact our office:

Call between
8am-5pm M-F
(628) 754-2363

Email
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Thank you! Your Feedback Helps Us Improve!

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Laguna Honda Hospital
and Rehabilitation Center
375 Laguna Honda Blvd
San Francisco, CA 94116
(628) 754-2363 [T]
(628) 754-2374 [F]
laguna.honda@sfdph.org

Resident Grievance Form

PART II: STATEMENT

Where did incident happen?

_____

_____

Date incident happened _____

Time incident happened _____

Concern Category (check all that apply)

- ☐ Medical Treatment
- ☐ Pain Med Management
- ☐ Communication
- ☐ Property Loss/Theft
- ☐ Privacy Violation/HIPAA
- ☐ Rude/Unprofessional Behavior
- ☐ Long Wait to Access Services
- ☐ Environmental/Cleanliness
- ☐ Other

Summary of Experience

PLEASE INCLUDE NAMES AND/OR POSITION OF STAFF INVOLVED, IF KNOWN

PLEASE ADD MORE PAGES AS NEEDED

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Resident Grievance Response Form

PART I: ACKNOWLEDGMENT

TODAY'S DATE _____

To: _____

From: Grievance Official

Re: Resident Grievance Response

You submitted a Resident Grievance Form on: _____

The Resident Grievance Form was received on: _____

Concern Category (check all that apply)

- ☐ Medical Treatment
- ☐ Pain Med Management
- ☐ Communication
- ☐ Property Loss/Theft
- ☐ Privacy Violation/HIPAA
- ☐ Rude/Unprofessional Behavior
- ☐ Long Wait to Access Services
- ☐ Environmental/Cleanliness
- ☐ Other

PART II: SUMMARY OF EXPERIENCE

Date incident happened _____ Time incident happened _____

Summary of Experience:

Thank you! Your Feedback Helps Us Improve!

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Laguna Honda Hospital
and Rehabilitation Center
375 Laguna Honda Blvd
San Francisco, CA 94116
(628)754-2363 [T]
laguna.honda@sfdph.org

Resident Grievance Response Form

PART III: NEXT STEPS

Your concern has been referred to the following department(s) for investigation:

_____

Pertinent Finding(s)/Resolution(s)

Was grievance/complaint resolved? ☐ Yes, describe resolution. ☐ No, explain why not.

Corrective Action(s) Taken:

Notification

Methods used to notify the resident and/or representative of the resolution:

☐ Written notification ☐ Telephone ☐ One-on-one discussion

Resident Signature (received by): _____ Date notified: _____

Witness Signature (if resident unable to sign):_____ Date: _____

Contact Information

Please feel free to contact me if you have any questions regarding the above response. Name of Grievance Official: _____

Contact Number: _____

Administrator Signature _____ Date: _____

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 physical, mental and psychosocial functioning.

PURPOSE:

1. 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).

8. 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~~ uncommon for schizophernia to first emerge~~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 determining~~assessing~~ a resident's mental and psychosocial status and providing person-centered care. ~~This process includes, but is not limited to:~~

      ~~b. PASARR screening.~~

      ~~c. 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.~~

~~d. Ongoing monitoring of mood and behavior, including identifying individual resident responses to stressors~~

~~e. Care plan development and implementation.~~

~~f. 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 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 D16 Clinical Services for Residents and Patients with Substance Use Disorders STARS).~~

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 and/or addiction medicine services can be made (see MSPP D08-02 LHH Psychiatry Scope and Organization; MSPP D08-03 Access to LHH Psychiatry Services, MSPP D16 Clinical Services for Residents and Patients with Substance Use Disorders).

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 D~~08-~~1607~~)~~

- 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 (~~SUDs~~)~~ 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 details see MSPP D1608-07 Clinical Services for Residents and Patients with Substance Use Disorders, ~~Treatment and Recovery Services,~~ Section 47~~)~~).

- ~~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.

4. 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.

~~5. 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.~~

~~6. 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.~~

~~7. The interdisciplinary team, including the resident, and as appropriate the resident's family, should develop a behavioral plan with identified behaviors through the RAI process.~~

~~8. 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.~~

~~9. 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.~~

~~10. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care.~~

~~11.~~5. The care plan and behavioral plan should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.

h. 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.

~~a. 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.~~

~~i. 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.~~

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

- ~~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).~~
- ~~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.~~
- ~~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.~~

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

i. For psychiatric emergencies, refer to 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.

j. 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. 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:

None.

REFERENCES:

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.

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.

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.

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.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013

HWPP 20-04 Discharge Planning

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.

HWPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) and Resident Care Conference (RCC)

MSPP D08-02 LHH Psychiatry Scope of Services and Organization

MSPP D08-03 Access to LHH Psychiatry Services

MSPP D01-05 Psychotropic Medication Management

MSPP D08-09 Mental Health Services

MSPP D16-Clinical Services for Residents and Patients with Substance Use Disorders

MSPP D08-01 Psychiatric Emergencies

Activity Therapy A02-0 Scope of Services

Standard Work: Managing Resident Challenging Behaviors

Most recent review: 2023/01/20 (Year/Month/Day)
Revised: 2023/01/20, 2023/03/14, 24/05/14
Original adoption: 2022/12/03

MONITORING OF THIRD PARTY AGREEMENTS

POLICY:

1. Third party agreements are defined as agreements that Laguna Honda Hospital and Rehabilitation Center (LHH) works with the Department of Public Health (DPH) Central Contract office to execute. This includes, but is not limited to contracts, Memorandums of Understanding, and intern and school agreements.

2. The Contract Manager (LHH Managers who oversee third party agreements) is responsible for establishing written agreements that define clear expectations and standards of quality. Written agreements must be developed in accordance with City and DPH contract policies and be approved by DPH contract office and City Attorney. The LHH Chief Executive Officer/Nursing Home Administrator (CEO/NHA) signs the agreement prior to the start date of goods and services.

3. All third party agreements shall have a formal evaluation annually to assure accountability and compliance with contractual standards, identify problem areas and provide information for future planning. Any contractual service which has not been monitored will not be considered for contract renewal unless good cause can be shown.

~~3.~~4. All contracts performance measures will be monitored and evaluated annually by the LHH Performance Improvement and Patient Safety (PIPS) Committee.

~~4. LHH Administration Office is responsible for centralizing all agreements and Monitoring Reports. The CEO/NHA or designee will delegate this task to support staff.~~

5. All Request for Proposals must comply with S. F. Adm. C. Chapter 21: Acquisition of Commodities and Services and Chapter 21A: Health Related Commodities and Services.

PURPOSE:

To ensure that third party agreements between DPH/LHH and the party providing the good or service meet clear objectives, standards of quality, City regulations, are provided safely and effectively and formally monitored annually.

PROCEDURE:

1. Respective LHH Contract Managers are responsible for:

    a. Establishing agreements with third party vendors through DPH Central Contracts and City Attorney's Office. The LHH CEO/NHA signs the agreement.

b. Submitting on a timely basis a copy of signed written agreements to LHH Administration, including extensions, modifications and/or new agreements.

c. Reading and clearly understanding the expectations and quality of services rendered by the ~~third party~~third-party vendor.

d. Verifying and approving invoices (if any) submitted for payment from the third party.

e. Completing ~~the~~ an annual ~~*Third Party Agreement: Monitoring Report* (refer to Appendix A)~~evaluation that shall include a review of established performance measures. The evaluation of contracted services shall be conducted in relation to LHH's expectations. The evaluation will be reported to PIPS committee~~QAPI~~ at least once a year. ~~The Monitoring Report is due to LHH Administration by July 30th every year. The review period is the previous fiscal year.~~ If multiple departments work with the third party under the same contract, it is the responsibility of the designated Contract Manager to gather performance input from all individuals involved.

f. Provide ongoing review of the ~~third party~~third-party work as needed. Throughout the year if performance concerns arise, the Contract Manager must document these issues and speak with the appropriate person at the time. If needed, the Monitoring Report may be used at this point to document concerns and to develop Performance Improvement Plans (PIP).

g. In the event of an adverse outcome, inappropriate conduct, or failure to meet the standard of care, the Contract Manager shall immediately notify the contractor and develop a plan for correction and performance improvement.

~~2. Instructions for completing the *Third Party Agreement: Monitoring Report*~~

~~a. Part A: The Contract Manager rates the third party's performance on a scale from 1 (unacceptable) to 4 (exceeds standards) for four overall measures.~~

~~b. If the average performance rating is less than a three (< 3) then the Contract Manager and the third party shall develop a Performance Improvement Plan.~~

~~i. The plan describes what will be done to improve performance and compliance. It also includes a timeline and no later than quarterly progress reports.~~

~~ii. For the PIP, the Contract Manager documents regular progress assessments and provides status updates to their Direct Supervisor. If program performance does not improve, this will be handled on a case by case basis~~

~~c. Part B: The Contract Manager communicates the findings from the monitoring report in Part A with the appropriate representative from the third party. The third party documents the response to the performance rating by either responding in an email to questions specified or acknowledging and signing a paper version.~~

~~d. Part C: The direct supervisor of the LHH Contract Manager reviews Part A, including the PIP, and Part B. The direct supervisor responds to the questions in Part C. When sufficient work has been completed, the direct supervisor and Contract Manager will provide their final signatures to complete the monitoring process.~~

~~3.~~2. LHH Administration Office support staff is responsible for:

a. Maintaining paper and electronic copies of all third party agreements for LHH, as submitted by the Contract Manager.

b. Tracking agreements in an electronic spreadsheet, including the annual overall performance rating.

c. Providing reports to Contract Managers, direct supervisors and Executive Committee as requested.

~~4.~~3. Direct Supervisor is responsible for:

a. Communicating as needed with the Contract Manager about the performance of third party agreements.

b. Providing supervisory support as needed during the Monitoring Report process. Completing Part C of the Monitoring Report after ensuring the Part A and B are completed.

c. Working with the Contract Manager to address performance measures rated less than a three (< 3). Providing oversight during the PIP development, implementation and review process.

~~5.~~4. The Performance Improvement and Patient Safety (PIPS) Committee is responsible for:

a. Each patient care contract shall have the performance measures ~~shall be~~ reviewed by the LHH PIPS Committee annually. The purpose of this review is to provide administrative, clinical and medical staff leaders with an opportunity to evaluate the performance of the sources of clinical services provided through contractual agreements. This evaluation shall include a review of the annually established performance measures. The evaluation of the contracted services shall be conducted in relation to LHH's expectations.

b. The PIPS Committee shall ensure that steps are taken to improve contracted services that do not meet expectations. Examples of improvement efforts that may be considered include the following:

i. Increased monitoring of the contracted services,

ii. Providing consultation or training to the contractor,

iii. Renegotiating the contract terms,

iv. Applying defined penalties, and

v. Terminating the contract.

c. The review and evaluation of contracted services performance measures by the PIPS Committee shall be submitted annually to the Joint Conference Committee (a committee of the Governing Body), for review and approval.

ATTACHMENT:
None.~~Appendix A: Monitoring Report Summary~~

REFERENCE:
Health Commission Contract Policies

Revised: ~~24/~~04/09/24, ~~25/~~05/12/25, 10/21/25 (~~Year/~~Month/Day/Year)

Original adoption: ~~14/~~11/25/14 (~~Year/~~Month/Day/Year)

Deletion Hospital-wide Policies and Procedures

Appendix A

PART A

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

THIRD PARTY AGREEMENTS: MONITORING REPORT

Third Party Provider:		
Scope of Services:		
Laguna Honda Contract Manager:	Department:	Today's Date:
This is: ☐ New contract ☐ Ongoing contract	Fiscal Year in Review:	

Rating Scale: Use the following 1 through 4 metrics when rating the Third Party's program performance and compliancy.
*A Performance Improvement Plan is required for *any* measure that is less than a three (< 3).

1. *	2. *	3.	4.
Unacceptable	Improvement Needed/ Below Standards	Acceptable/ Meets Standards	Commendable/ Exceeds Standards

A) Were the requested goods and/or services completed in a *satisfactory* manner?	☐1.* ☐2.* ☐3. ☐4.
B) Were the requested goods and/or services completed in a *timely* manner?	☐1.* ☐2.* ☐3. ☐4.
C) Did the requested goods and/or services follow the necessary *policies, procedures and regulations*?	☐1.* ☐2.* ☐3. ☐4.
D) Did the completed good and/or services match the invoice(s)? (Write NA if not applicable.)	☐1.* ☐2.* ☐3. ☐4.
E) Other measures specific to contract:	☐1.* ☐2.* ☐3. ☐4.

Overall Performance Rating: Average the ratings for the measures (round to the nearest 10th of a point): _____

Findings and Commendations:

*** Performance Improvement Plan (Required for Any Rating < 3):** Working with the Third Party Provider, describe what will be done to improve performance and compliancy. Include a timeline and regular progress checks.

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee. Return to Laguna Honda Administration by January 30 every calendar year. Rev: 7/8/14

PART B

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

Note: Additional comments or a detailed report may be attached as needed.

THIRD PARTY AGREEMENTS: MONITORING REPORT
THIRD PARTY PROVIDER RESPONSE

1) **Option 1 — Email Response:** The Third Party Representative Replies via email that they have reviewed the Monitoring Report and must answer the following questions:

   a) I have received the Monitoring Report and acknowledge the findings. *(Yes; No)*
   b) I have assisted in developing the Performance Improvement Plan. *(Yes; No; Not Applicable)*
   c) I have received Monitoring Report and disagree with the findings. My response is included. *(Yes; No; Not Applicable)*

   Third Party Provider also includes standard email signature to identify the company name and job tittle. Attach email response to this form.

2) **Option 2 — Hard Copy Signature:** The Third Party complete the form below and sends the signed copy back to the Laguna Honda Contract Manager.

   Checks all that applies below:

I have received the Monitoring Report and acknowledge the findings.	☐ Yes ☐ No ☐ Not Applicable
I have assisted in developing the Performance Improvement Plan.	☐ Yes ☐ No ☐ Not Applicable
I have received Monitoring Report and disagree with the findings. My response is attached.	☐ Yes ☐ No ☐ Not Applicable

_____ _____
Signature of Authorizing Contract or Provider Representative Date

_____
Name and title

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee.
Return to Laguna Honda Administration by January 30 every fiscal year. Rev: 4/9/24

PART C

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

THIRD PARTY AGREEMENTS: MONITORING REPORT
DIRECT SUPERVISOR REVIEW AND SIGNATURES

Laguna Honda Direct Supervisor reviews the following items:

1) completed Part A of the Monitoring Report;
2) the Performance Improvement Plans (if any); and,
3) Part B with the Third Party response.

Director Supervisor checks all that apply below:

Third Party Provider performance is adequate and no action is needed.	☐
Performance Improvement Plan is comprehensive and I will continue to received regular updates on the progress	☐
The Third Party Provider performance is unacceptable. Terms of current contract needs to be reviewed. Renewal of contract needs to be reconsidered.	☐

Other Comments:

Final Signatures

Signature of Laguna Honda Contract Manager	Signature of Director Supervisor
Date	Date
Name and Title	Name and Title
Date	Date
Department	Department
Date	Date

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee.
Return to Laguna Honda Administration by January 30 every fiscal year. Rev: 4/9/24

Deletion Medical Services Policies and Procedures

BILLING FOR PHYSICIAN SERVICES

Policy:
~~It is the hospital's policy for the employee~~ Pphysicians ~~to~~ shall ~~complete an encounter form~~ document and bill for each patient or resident ~~seen after an~~ evaluation and management service or treatment appropriately according to Medicare guidelines.

Purpose:
To establish guidelines for physicians and ensure the application of the proper CPT codes assigned for the purpose of billing payer.

~~**Definition:**~~
~~Evaluation and management service will use the acronym of E/M.~~

~~The term Initial Hospital Care is when the E/M service is on the same date as the Hospital Admission.~~

PRESCRIBING CONTROLLED SUBSTANCES FOR CHRONIC PAIN MANAGEMENT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH), in alignment with SFHN primary care clinics, that all physicians follow an approach for the use of controlled substance in chronic pain management that:

1. conforms to standards of practice set by the Medical Boards of California;

2. promotes the safe, adequate, appropriate and effective management of chronic pain that optimizes residents' functional status, addresses the risks, benefits and side effects of therapy and attempts to minimize resident misuse of prescribed medications;

3. facilitates sharing of information and coordination of care of residents with chronic pain within the SFHN and with other safety net sites (e.g., the San Francisco Community Clinic Consortium (SFCCC)) using a shared electronic health record (EHR)

PURPOSE:

The purpose of this policy is to define minimum standards for the use and monitoring of controlled substances in chronic pain management (excluding cancer and end-of-life pain) in LHH. This document outlines the procedure by which primary care physicians assess chronic pain, develop and monitor individualized treatment plans and document pain management in the medical records of residents whose plans include the long-term use of controlled substances for pain.

PROCEDURE:

1. **Pain Assessment**
   a. Physicians will perform and document an initial pain assessment that follows Medical Board of California guidelines.

2. **Treatment Plan Objective**
   a. Physicians will design and document an individualized treatment plan in consultation with the resident. Opioids are to be initiated as a therapeutic trial for a defined period of time if other treatment options have been tried and failed or if the resident was previously prescribed opiates and is transferring from another physician. The plan will outline:

      i. any planned diagnostic evaluations and/or specialty consultation, if indicated (including referral to LHH Psychiatry for mental health and/or substance use screening);

      ii. any and all prescribed therapeutic modalities (e.g., medications, physical therapy, acupuncture);

iii. treatment goals by which the plan will be evaluated, such as level of pain relief, improved physical and psychosocial functioning and/or improved quality of life;

iv. a plan to discontinue opioids if this becomes indicated.

3. Safety Measures

~~a. Consent and Agreement~~

~~Physicians will complete and include in the medical record an annually renewed "LHH Resident Consent and Resident-Provider Agreement for Controlled Medications for Chronic Pain Management (excluding cancer and palliative care)" form, that is signed by the physician and the resident (Attachment A). This Consent and Agreement form outlines components of the treatment plan and situations in which the plan may be reviewed, altered or discontinued, as well as risks, benefits and side effects of prescribed treatment(s) and how these issues will be monitored.~~

a. Informed consent will be obtained by prescribing provider and treatment risks and benefits will be documented in the chart as per practice standards.

b. Overdose Risk/Response

Physicians will educate the resident (and family/caregivers if possible) about respiratory depression and overdose and will offer a prescription for naloxone if appropriate, in accordance with CA Assembly Bill 2760 (Wood, Chapter 324).

c. Urine toxicology

At a minimum, residents will be asked to provide urine for toxicology testing at least once per year. Physicians may decide to increase the frequency of this monitoring on a case-by-case basis.

d. Prescription drug monitoring program (CURES)

For residents for whom they are prescribing controlled substances for pain, physicians must review a Controlled Substance Utilization Review and Evaluation System (CURES) report in compliance with California Health and Safety Code 11165.4 when applicable. Physicians are strongly encouraged to review a CURES report on a regular basis for high-risk residents or when clinically indicated.

4. Periodic Review

Physicians will perform and document a periodic reassessment of chronic pain that focuses on the resident's progress toward treatment goals on an annual basis (or more frequently as deemed necessary by the physician) to determine the absence of substantial risks or adverse events such as overdose or diversion and the appropriateness, continuation or modification of the treatment plan.

5. Documentation in the Electronic Medical Record (EHR)

Physicians will use the EHR to document up-to-date pain treatment and update the problem list with the appropriate diagnoses of chronic pain that is being treated

6. Quality Assurance

Quality assurance for prescribing practices for chronic pain shall be provided per plans and initiative by the Pharmacy and Therapeutics Committee of LHH, under the oversight of Medical Executive Committee.

~~**ATTACHMENT:**~~

~~Appendix A: LHH Resident Consent and Resident-Provider Agreement for Controlled Medications for Chronic Pain Management (excluding cancer and palliative care)~~

REFERENCES:

1. HWPP 25-06 Pain Assessment and Management
2. Medical Board of California Guidelines for Prescribing Controlled Substances for Pain (https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf)
3. State of California DOJ/CURES monitoring program (https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/cures-mandatory-use.pdf?)
4. CA Assembly Bill 2760: Prescription drugs: prescribers: naloxone (https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2760)
5. State of California Health and Safety Code 11165.4 CURES monitoring (http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11165.4.&lawCode=HSC)

Most recent review: ~~21~~25/08/05 (Year/Month/Day)
Revised: ~~21~~25/08/~~05~~21
Original adoption: 21/08/05

Deletion Medical Services Policies and Procedures

LHH Resident Consent and Resident-Provider Agreement for Controlled Medications for Chronic Pain Management (excluding cancer and palliative care)

I, _____ and _____
(Resident//SDM) (Doctor)
have decided to use controlled medications to treat _____
(Symptom, Medical Condition)

Purpose

The purpose of this agreement is to make clear what I can expect when I am prescribed controlled medications (like opioids such as buprenorphine, fentanyl, methadone, morphine, oxycodone, and benzodiazepines such as clonazepam, lorazepam) as part of the treatment of my pain. It describes what I can expect from my doctor and what my doctor expects of me.

My Doctor's Responsibilities

It is my doctor's responsibility to assess my pain and to create and monitor a treatment plan that is safe and appropriate for my condition. My doctor is also responsible for making sure that my treatment follows the law about controlled medications. This includes making sure that I do not misuse the medications prescribed for me and/or that others do not get a hold of or use my medications.

My Responsibilities

I,_____ understand and agree to the following responsibilities:
(Resident)

1. My treatment plan may include other things besides medications like: diagnostic tests, group visits or specialty visits. I agree to follow the treatment plan that my doctor and I have agreed to.

2. Only I will take these medications. I will not share, give away, lend, sell or trade these medications. I will not let others use my medications.

3. I will only take these medications as directed.

4. I agree to not ask for my medications to be left at the bedside by LHH nursing staff.

5. I will not keep any unused medications for myself or for sharing with others.

6. I will not seek controlled medications from other places without talking to my doctor. This includes urgent care and the emergency department. I will tell my doctor right away if I get a prescription for other controlled medications.

7. I agree that my pharmacy records may be reviewed.

8. I will behave respectfully towards all staff. I will not engage in threats or abuse when expressing concerns related to controlled medications.

9. I have been advised not to use illegal drugs or alcohol or unprescribed controlled medications as there may be dangerous interactions that may require my medications to be adjusted. I understand that I may be asked to do drug testing at any time:
   a. If my drug test shows illegal drugs or unprescribed medications, or I decline drug testing, my

LHH Resident Consent and Resident-Provider Agreement for Controlled Medications for Chronic Pain Management (excluding cancer and palliative care)

medications may be reduced or stopped to ensure that I am not harmed.

b. I may be asked to engage in a screening assessment for substance use disorder, and if appropriate, I may be encouraged to participate in substance treatment.
c. If I decline drug testing, I may be offered pain treatment without controlled medications.
d. If my drug test does not show that I am using my prescribed medications, my doctor may stop these medications.

10. I understand there is an increased risk of death with the combination of controlled medications and other unprescribed medications or substances.

11. I understand that any medical treatment starts on a trial basis. My prescription may be reduced or stopped if the risks of the medications outweigh the benefits. This would happen if there are no signs that the medications are helping me, or if there are signs of harm or misuse.

12. I understand that mental health and substance use treatment services are available to assist me at LHH.

13. I understand that I should talk to my doctor if I am pregnant or want to get pregnant.

14. I understand that if I break this agreement, my doctor may be required to change my treatment plan.

15. I understand that this agreement will be reviewed at least once a year. It may also be reviewed if I break the agreement or have a change in my clinical condition or change of doctors.

16. I understand that controlled medications can cause serious risks to my health, such as: death, falls, respiratory depression, confusion, constipation, worsened pain, tolerance, and risk of developing a use disorder/addiction.

17. I have discussed with my doctor any other relevant risks related to the controlled medications.

18. Other terms: ____

☐ **I understand this form. I have been able to ask questions about this agreement and have them answered. I have been offered a copy of this form.**

I am signing this form because I want to. I accept all of its terms.

Resident Signature: ____________________ Doctor Signature: ______________________

Date: _____/_____/______

- -

☐ **I don't agree with this form. I opt to receive pain treatment without controlled medications at this time. I am signing this form because I want to.**

Resident Signature: ____________________ Doctor Signature: ______________________

Date: _____/_____/______

Revised Outpatient Clinic Policies and Procedures

OUTPATIENT CLINIC APPOINTMENT SYSTEM

POLICY:

It is the policy of the Laguna Honda Hospital (LHH) Outpatient Clinic (OPC) to provide access to health care in a timely and cost-effective manner. All OPC services require a scheduled appointment. Drop-ins are accepted according to the patient's clinical needs as directed by patient's Attending or Consulting Physicians.

PURPOSE:

The purpose of this policy is to:

1. Define standard procedure for the scheduling of patient appointments based on urgency and health care concerns
2. ~~1.~~ Define standard procedure for late arrivals.

PROCEDURE:

1. Request for Clinic Services:
   a. The Attending (primary care) Physician or other authorized physician completes an E-Referral request for consultation. (refer to E-Referral Consultation for Outpatient Clinics Policy MSPP-A00)

2. Scheduling:
   a. Clinic Staff or the Consultant reviews the E-Referral request for consultation.
   b. Clinic Staff schedules an appointment through the EHR system for the patient based on the availability of the Consultant Staff and LHH contractual arrangement. Medical Services updates and posts the Consultant schedules on the LHH intranet.
   c. If a Clinic is cancelled or rescheduled, the Clinic Staff reschedules the patient for the next available Clinic.
   d. If a patient misses an appointment, the Clinic Staff reschedules the patient for the next available Clinic
   e. Follow up appointments are scheduled per the request of the Consultant or Attending physician.
   f. Drop-in patients may be accommodated after discussion with the Consultant physician.
3. Late arrivals:
   a. Patients who arrive 15 minutes or more after their scheduled appointment will be deemed a late arrival
   b. Late arrivals may be accommodated later in the same clinic session if there is availability, at the discretion of the Consulting Physician
   c. If the later appointment is more than 1 hour away, the clinic reserves the right to return the patient to their home unit to wait and may request assistance with transportation from the home unit
   ~~e.~~ d. If the patient cannot be accommodated on the same day, they will be rescheduled for the next available Clinic.

REFERENCES:
Medical Services Department Policy MSPP-A00 "E-Referral Consultation for Outpatient Clinics" -

Shelf Life of Sterile Packages~~: DRAFT~~

POLICY:
All sterile supplies including those supplies that are purchased sterile are included in the sterile shelf life program.

The loss of sterility of any sterilized item is "event" related and not "time" related unless there is a specific manufacturer's "Instructions for Use" (IFU) that documents an expiration date. Sterilized supplies are considered sterile and may be used up to any published expiration date if ~~as long as~~ the integrity of the package is not compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

Commercially sterilized packages that contain materials that will become outdated or will decompose over time are time dated by the manufacturer of the product.

Sterile Packages are stored in accordance with LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)."

PURPOSE:

Sterility must be maintained until the product is used.

PROCEDURE:

1. Commercially sterilized packages

   The shelf life of commercially sterilized packages is indicated by the manufacturer's expiration date (time dated) unless the integrity of the package is compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

2. Hospital sterilized packages

   a. The shelf life of hospital sterilized packages is ~~event dated.~~based on the expiration date(s) of the peel pouches/sleeves used to sterilize equipment, currently one year from the date of sterilization.

   b. All items processed for sterilization are properly wrapped and processed in such a manner so as to provide an effective barrier to microbial contamination.

   c. All hospital sterilized supplies are wrapped in either two layers of disposable, synthetic ~~non-woven~~non-woven material or in peel pouches. *Indicator tape* will be applied to all wrapped packages as a visual indicator that item was processed.

   d. The outside wrapper or peel pouch/sleeve of hospital sterilized packages is externally labeled with
      - Date of sterilization,
      - Load control identifier (may be the date of sterilization if only one load/day is processed),
      - Initials of the technician processing the package

~~3.~~ Inspection of sterile supplies prior to use:

3. All sterile packages ~~(time or event dated)~~ should be inspected by the user before use.~~.~~

Any package that is stained (water marked), wet or damp, torn or punctured should be considered contaminated and either discarded or reprocessed.

4. Storage of sterile supplies

Sterile packages are stocked and rotated on the principle of "first in, first out." The oldest dated sterile supply is used first.

Packages that exceed 12 months of inactivity are evaluated for necessity with the Clinic Director or Clinic Nursing Director.

Sterile packages should be stored:
- In a clean environment,
- On racks that are 8 to 10 inches from the floor and at least 18 inches from the ceiling and at least 2 inches from the wall,
- In a position to avoid curving, bending or compression, and
- In closed shelving to maintain dust-free conditions.
- In positive pressure, humidity and ~~temperature-controlled~~temperature-controlled environments as per LHH G10.

Sterile supplies should not be stored under sinks~~, under exposed water.~~ or where they may be exposed to water.

Sterile supplies with turn~~-~~around times of greater than three months should have a protective plastic wrap or double ~~peal~~ peel pouch protection. Supplies that have a short ~~turn-around~~turnaround time do not require a dust cover

5. Periodic inspection of sterile supplies

The Clinic Nurse or designee will inspect sterile supply storage at 3-month intervals for:
- Evidence of tampering,
- Wrapping material decomposition,
- Punctures,
- Moisture, or
- Other signs of compromised packaging.
- Upcoming expiration

All hospital sterilized equipment will be reprocessed at least annually.

Reference
LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)"

Most recent reviews: 09/08,-
13/08/14,14/01/28
Revised: ~~14/01/28~~April 22, 2025

Deletion Outpatient Clinic Policies and Procedures

HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:

High-level chemical disinfection is performed by trained and qualified Clinic Staff according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

PURPOSE:

High-level chemical disinfection is a process used for the disinfection of semi-critical resident care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores

PROCEDURE:

1. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments" and to LHH Outpatient Clinic Policy C3 "Cleaning of Medical Instruments Prior to Disinfection and Sterilization".

2. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.

3. Hospital approved high-level disinfectants must be used.

   Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

4. Refer to Appendix A for Specific instructions on the use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for high-level disinfection.

5. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and *Legionella*.

Reference:
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
CDC Guideline for Disinfection and Sterilzation in Healthcare Facilities, 2008

Revised: 12/05/15

Appenidix A: Use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for High-Level Chemical Disinfection

For Complete information on use refer to Cidexplus®OPA Product information

1. Material Compatibility

For compatibility of device materials with Cidexplus® OPA refer to device manufacturer's recommendations and Cidexplus® OPA Product information.

2. Cleaning Agent Compatibility

Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus® OPA Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus® OPA Solution.

3. Safety

Caution: Contains *Ortho*-Phthalaldehyde

- Harmful by inhalation and if swallowed
- Irritating to respiratory system and skin
- Risk of serious damage to eyes
- May cause sensitization by inhalation and skin contact

Precautions

- Wear suitable protective clothing, gloves and eye/face protection
- Use only in well-ventilated areas
- Avoid contamination of food
- Avoid release to the environment

First-Aid Measures

- Refer to Cidexplus® OPA Product Information

4. Directions for Use

Activation

a. Does not require activation before use.

b. Test the activated solution with compatible test strips prior to each use. The minimum effective concentration (MEC) of *ortho*-Phthalaldehyde is 0.3%.

5. Cleaning

Feces, mucous, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus® OPA Solution.

Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus® OPA Solution.

Clean and rinse lumens of hollow instruments before filling with Cidexplus® OPA Solution.

6. Usage

a. **Test the solution with Solution Test Strips prior to each use.**
b. Immerse cleaned and rough dried medical devices completely in the Cidexplus® OPA Solution, filling all lumens.
c. Leave medical devices completely **immersed for at least 12 minutes at room temperature** for High-Level Disinfection.
d. Rinse with sterile water
e. Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal

Revised: 12/05/15

FLEXIBLE NASOPHARYNGEAL LARYNGOSCOPE

POLICY:
Flexible nasopharyngeal laryngoscopes are cleaned and disinfected consistent with LHH Infection Control Policies G4 "Cleaning of Reusable Medical Instruments", G7 "High-Level Chemical Disinfection" and F9 "Chemical Sterilization Standards".

PURPOSE:
To destroy microorganisms both cleaning and high-level disinfection are necessary to prevent disease transmission.

PROCEDURE:

1. Classification and processing requirements

A flexible nasopharyngeal laryngoscope is classified as a semi-critical medical device because during use the device makes contact with mucous membranes but does not usually penetrate normally sterile areas of the body. Refer to Infection Control Policy G2, "Classification of Reusable Medical Devices and Processing Requirements."

High-Level Disinfection is acceptable for processing semi-critical medical devices.

2. High-level disinfection on the day of use

a. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

b. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."

c. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

d. Prepare the proper container for the high-level disinfectant and pour the solution into it.

e. Immerse the scope for the scope and disinfectant manufacturers' recommended time and temperature conditions for high-level disinfection.

f. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

NOTE: These conditions should be strictly followed since over immersion may damage the scope.

g. Using sterile gloves:

- Remove the scope from chemical solution.
- Rinse the scope thoroughly using sterile water.
- Dry the scope thoroughly using sterile gauze.

3. Cleaning after procedure and use of the laryngoscope

Immediately after removing the laryngoscope from the patient:

A. Gently wipe all debris off insertion tube with gauze soaked in freshly prepared enzymatic detergent solution.

B. Ensure all debris has been removed from the insertion tube, deflection section, and illumination/observation windows.

C. Transfer the laryngoscope from the procedure room to the reprocessing room in a leak proof enclosed container. .

D. In the reprocessing room thoroughly but gently wash the entire outer surface of the scope with a mild pH enzymatic detergent following the manufacturer's instructions.

E. Thoroughly rinse the scope with potable water and gently dry or allow to air dry.

4. High-level disinfection after initial cleaning procedure

A. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

B. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."

C. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

D. Prepare the proper container for the high-level disinfectant and pour the solution into it.

E. Immerse the scope for the scope and disinfectant manufacturers' recommended time and temperature conditions for high-level disinfection.

F. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

NOTE: These conditions should be strictly followed since over immersion may damage the scope.

G. Using sterile gloves:

- Remove the scope from chemical solution.
- Rinse the scope thoroughly using sterile water.
- Dry the scope thoroughly using sterile gauze.

5. Storage

Store the laryngoscope in a clean, dry, dust-free locked storage cart. The storage area will be cleaned with a hospital approved disinfectant each time the laryngoscope is used. The laryngoscope will be placed in a cleaned tray lined with a new chuck and locked until the next time it is used.

6. DISPOSAL OF *Ortho*-PHTHALALDEHYDE SOLUTION

Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and placed in a sealed container provided by the Industrial Hygienist and will be picked up by Facility Services for disposal.

References:
LHH Infection Control Policy G2, "Classification of Reusable Medical Devices and Processing"
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments"
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
LHH Infection Control Policy F9, "Chemical Sterilization Standards"

Revised: 12/05/15

Revised Volunteer Services Policies and Procedures

VOLUNTEER RECRUITMENT PROCESS LIFE CYCLE

POLICY:

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center is responsible for the full business life cycle of volunteers, including recruitment, placement, retention, and dismissal.

PURPOSE:

1. To outline formal steps involved in developing and maintaining a general pool of volunteers available to the hospital.

2. To meet the specific human resource needs of hospital departments requesting the assistance of Volunteer Services Department.

3. To ensure that hospital residents receive volunteers of the highest quality to provide companionship and support.

PROCEDURE:

Volunteer Recruitment

1. ~~Friends of Laguna Honda Website~~Laguna Honda Volunteer Services Website
   a. ~~Friends of Laguna Honda (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.~~Prospective volunteers may sign up on the Interest List on the Laguna Honda Volunteer Services website.
2. Outreach
   a. The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.
   b. When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.
3. Media
   a. The Volunteer Services Department ~~and Friends of Laguna Honda~~ may utilize written and electronic media (i.e. public service announcements) for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.

Volunteer Placement

1. Orientation

a. Each prospective volunteer is required to participate in the volunteer orientation prior to placement.
b. At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.
c. Each volunteer is required to complete a volunteer application prior to the interview.

2. The Interview
    a. Content of the interview include:
        i. Review information on the application
        ii. Visual inspection of a picture ID
        iii. Reasons and motivations for doing volunteer work
        iv. Discussion of areas of interest and hospital placement need
        v. Review abuse reporting policy and sign form
        vi. Review volunteer agreement and sign form
        vii. Arrangements for TB test, ID badge, and parking permit
        viii. Criminal background check and fingerprinting
    b. During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.
    c. The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department where he/she will volunteer.
    d. The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.
    e. A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.
3. Placement
    a. The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident involved.
    b. Volunteers are assigned a supervising staff member from the department in which they are placed for accountability. All volunteers are required to have a schedule, notify their supervisor if they are sick or plan to be on vacation and must comply with all hospital rules and regulations (e.g. annual tuberculosis test and flu vaccination).
    c. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators will assume responsibility for the supervision of the volunteer.
    d. The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) or the supervising staff member in the specific department he/she is interested in. The POC/supervising staff member and the volunteer will then further discuss logistics (commitment, time, schedule, etc.) to finalize placement.
    e. The number of volunteer hours per week or month is negotiated between

the volunteer and the supervising staff member taking into consideration the needs of the activity, neighborhood, resident, and the availability of the volunteer.

f. The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes.
g. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).

4. The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.

Encouragement and Retention

1. The Volunteer Services Department~~, in conjunction with Friends of Laguna Honda, through~~ plan several events during the annual National Volunteer Week in April to express appreciation toward all volunteers.

a. These actions may include an appreciation luncheon/dinner or other similar event.
b. Banners or posters will be displayed throughout the hospital recognizing National Volunteer Week.

2. The appreciation Luncheon/dinner will recognize volunteers for the number of annual cumulative hours served, and the number of years given in service.

a. Certificates will be awarded with the total number of annual volunteer hours (i.e. March 2018 – March 2019 total annual volunteer hours). These certificates are signed by the Chief Executive Officer of Laguna Honda Hospital & Rehabilitation Center.

b. Service pins are awarded to Volunteers with the following years of service
   i. Five years
   ii. Ten years
   iii. Fifteen years
   iv. Twenty years
   v. And so on in increments of 5 years

3. Volunteer supervisors are given the opportunity to nominate a volunteer(s) from his/her department to be recognized at the event called “Special Awards”. These nominations are based on the volunteer’s commitment to ongoing volunteer service and who have made a significant impact on the hospital.
4. Volunteers who are on duty during the day are entitled to a 50% discount at the Hospital’s cafeteria for one meal during their shift. Volunteers must show their volunteer identification badge to the cashier to receive the discount.

5. Thank You cards may be sent to individual volunteers to recognize those who help above and beyond the call of duty (i.e. special events, special projects, Holiday Programs and those who come in on days they are not scheduled).
6. Volunteer Coordinators will make an effort to respond to volunteer questions, concerns or needs in a timely manner.

Volunteer Dismissal

Volunteers who do not adhere to the policies and procedures of the program or who fail to satisfactorily perform their volunteer assignment are subject to dismissal. At the discretion of the Volunteer Coordinator or Volunteer Supervisor, any volunteer not meeting the requirements of what was agreed upon in their application can be dismissed at any given time.

Corrective Action

Corrective/disciplinary action may be taken if the volunteer's work is unsatisfactory. The procedure for disciplinary action is usually a three step process but the Volunteer Coordinator or Volunteer Supervisor has the authority to dismiss a volunteer at his/her discretion at any given time.

1. First a formal written notice is sent to the volunteer from the Volunteer Supervisor.

2. Second formal notice is sent and a meeting is scheduled with the volunteer and their supervisor from the area they volunteer (and may include the Volunteer Coordinator if needed).

3. Notice is sent to the volunteer being dismissed of their duties from their Supervisor. A copy will be given to the Volunteer Services Department to be placed in the volunteer's record. The volunteer will be responsible to turn in their ID Badge and a parking permit (if they have one).

Conduct or behavior which may lead to disciplinary action includes, but is not limited to:

- Poor Timekeeping and/or unreliability
- Failing to follow rules, policies or procedures as described in the Orientation Packet
- Rudeness or hostility towards residents, staff or other volunteers
- Intoxication on alcohol or other illegal substances
- Theft of property
- Accepting compensation for assisting residents
- Failure to perform volunteer duties as agreed

- Bringing illegal substances onto the hospital campus
- Breach of confidentiality
- Falsification of any materials

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 2019/20/08, 2015/20/03, 2015/08/19, 2017/02/05
Original Adoption: 1998/06/01

VOLUNTEER FINGERPRINTING

POLICY:

The Volunteer Services Department requires that all prospective volunteers complete a criminal conviction background check through the City and County of San Francisco, Department of Human Resources (DHR) prior to starting their volunteer service.

PURPOSE:

1. To meet the specific human resource needs of the department and the organization.

2. To ensure that Laguna Honda Hospital (LHH) residents and staff receive the highest protection and safety.

PROCEDURE:

1. The Volunteer Coordinator will schedule an appointment (time and date) for the prospective volunteer for fingerprinting at the Department of Human Resources (DHR) through DHR's online Fingerprinting Appointment Scheduling Link.

2. The Volunteer Coordinator will then inform the volunteer of the appointment and the address via email and/or verbally during the interview.

3. The City and County of San Francisco, Department of Human Resources, Fingerprinting office is located at:

   ~~One South Van Ness on the corner of Market and South Van Ness~~
   ~~4th Floor (back of Bank of America),~~
   ~~City & County Human Resources Department~~
   City Career Center at City Hall
   1 Dr. Carlton B. Goodlett Pl., Room 110
   San Francisco, CA 94102

   If the prospective volunteer misses a scheduled fingerprinting appointment they will receive one additional opportunity to reschedule his/her appointment. If a second fingerprinting appointment is missed, the prospective volunteer will be disqualified.

   To reschedule a fingerprinting appointment, the prospective volunteer must notify the Volunteer Coordinator a minimum of 24 hours in advance to cancel the appointment. We can accommodate rescheduling fingerprinting appointment only if we are notified a minimum of 24 hours in advance. The Volunteer Coordinator will reschedule the prospective volunteer's appointment using the online appointment scheduler.

4. The resulting report from DHR of a prospective volunteer's conviction history (if any)

will be used to determine if disqualification is appropriate.

5. The DHR will consider many factors before disqualifying a volunteer based on the conviction or arrest such as:

   - Nature and gravity of the offense
   - Volunteer-relatedness of the offense
   - Time elapsed since the conviction or release from sentencing
   - Convictions for murder, attempted murder, mayhem, arson- related offenses, and sex offenses requiring registry are considered disqualifying convictions regardless of the time elapsed since the conviction or release from sentencing

   DHR will notify the Volunteer Services Department whenever a prospective volunteer is disqualified. DHR will also notify the prospective volunteer of their disqualification directly.

ATTACHMENT:
None

REFERENCE:
CCSF – DHR

Revised: 2019/08/20, 14/10/07, 2016/08/11
Original Adoption: 2015/10/07

VOLUNTEER ORIENTATION ~~REGISTRATION~~

POLICY:

The Volunteer Services Department will register all prospective volunteers for an orientation via: ~~via one of the three methods below:~~
~~- Friends Of Laguna Honda website, http://friendsoflagunahonda.org/volunteer/~~
~~- Main email, volunteers@sfdph.org~~
- Main telephone, 415-759-3333

PURPOSE:

To provide an overview of Laguna Honda Hospital's operations and expectations to volunteers~~To provide potential volunteers an opportunity to sign up for an orientation through various channels~~.

PROCEDURE:

~~1.~~ Volunteer orientations are conducted via telephone by the Volunteer Coordinator, during which the orientation packet and onboarding materials will be reviewed with the volunteer. ~~Volunteer Orientations are scheduled on the first Saturday of each month from January through October.~~

~~2. Volunteer Coordinators (VC) will be responsible to screen and review all incoming calls from the Volunteer general phone line (415.759.3333) to register possible volunteers on a daily basis. The VC will also check the general Volunteer email (volunteers@sfdph.org) daily to respond to inquiries and to help register prospective volunteers.~~

~~3.~~

~~4. Prospective volunteers that have signed up for a volunteer orientation online will receive a confirmation email (regarding time, date, location, etc.) 24 to 48 hours prior to the selected orientation date. If the prospective volunteer calls to confirm via the main volunteer phone line they will receive verbal information and confirmation.~~

~~5. The maximum capacity for each orientation is 25 attendees. When the number of attendees exceeds 25, the VC will contact the prospective volunteers to register for a different orientation date.~~

ATTACHMENT:
None

REFERENCE:
None

VOLUNTEER INFECTION PREVENTION

POLICY:

The Volunteer Services Department will comply with infection control policies established by the Infection Control Committee and Medical Staff at Laguna Honda Hospital (LHH).

PURPOSE:

To protect the health of residents, employees and their families, volunteers, and visitors by preventing the transmission of tuberculosis (TB), influenza and other infectious diseases.

PROCEDURE:

1. All volunteers receive infection control training as part of the CMS slide deck provided during onboarding. Volunteers are required to review the material and complete a corresponding assessment to demonstrate understanding.

~~All volunteers receive instruction about infection control at the volunteer orientation.~~

   a. Topics covered include:

      i. Hand washing
      ii. Standard precautions related to bodily fluids
      iii. Staying away from LHH when a volunteer is ill

2. All new volunteers are required to have two TB/ PPD skin test or one Quantiferon/TB Gold blood test prior to beginning their volunteer service at the Hospital.

   a. Volunteers may get the TB test at the LHH Medical Clinic or with their own provider.

   b. If a volunteer has documentation of a prior PPD negative test that was completed within a year, validated by the Medical Clinic, then only one test result is required.

3. If a volunteer has a positive reaction to the TB test, they must submit a chest x-ray result. They must also complete the TB Symptoms Screening Questionnaire.

4. All active volunteers will be required to receive an annual TB test/screening. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptoms review for those with prior positive skin tests.

5. The Medical Clinic will maintain all volunteer TB documentation and create a spreadsheet to share with the Volunteer Services Department.

6. Annual TB testing will take place from April 1st through June 30th of each year.

7. Volunteers who fail to get an annual TB test will be contacted by Volunteer Services and their volunteer service will be temporarily suspended until he/she submits an updated TB test result. Once the volunteer has received TB clearance from the medical clinic, the Volunteer Coordinator (VC) will reactive his/her badge and the volunteer can resume his/her volunteer duties.

8. All volunteers are required to receive an annual influenza vaccination.

    a. Volunteers are required to get an influenza vaccination by the beginning of flu season as identified by the hospital's Infection Control Committee.

        i. Volunteers can receive the flu vaccinations at the Medical Clinic if supplies of the vaccine are available.

        ii. Volunteers can also get the flu vaccination form their provider and submit proof of vaccination to the Medical Clinic.

    b. Volunteers who have received the flu vaccination at the Medical Clinic will be provided with a sticker to be placed on the ID badge which will allow access to resident areas during flu season.

    c. Volunteers who decline the flu vaccination will have to:

        i. fill out a declination form
        ii. wear a mask in applicable areas when volunteering
        iii. If the volunteer fails to complete the two items above, his/her volunteer privileges will be terminated

ATTACHMENT:
None

REFERENCE:

LHHPP 72-01 Infection Control Manual

LHHPP 72-04 Employee Annual Health Examination
Volunteer Services policy A 1.0 Volunteer Orientation

Revised: 2019/08/20, 2014/06/09, 2015/08/19, 2016/07/12
Original Adoption: 2012/08/14

RECORD KEEPING

POLICY:

Laguna Honda Hospital Volunteer Services maintains records of participating volunteers.

PURPOSE:

To adequately record volunteer activity for recognition, operations improvement and volunteer references.

PROCEDURE:

1. The Volunteer Services Department utilizes the Volgistics database system in managing volunteer records.

    a. All onboarding and annually required materials are saved in each volunteer's personnel folder. ~~The Volunteer Services Department also maintains a scanned e-copy of the hand-written application with information from each active volunteer.~~ The following information is maintained in a secured location on the computer.
        i. ~~Application form~~
        ii. Adult Abuse Reporting Requirement form
        iii. Volunteer Agreement/Checklist
        iv. Volunteer Confidentiality form

2. Upon acceptance and placement within the volunteer program, the Volunteer Coordinator (VC) is responsible to ensure that the volunteer's information is entered into Volgistics including, but not limited to, assignment, schedule, and emergency contact information.

3. The VC is responsible to scan an e-copy of all hard copy forms and save electronic documents in a secured computer location available to all staff within the Volunteer Services Department. All hard copy forms will be securely shredded.

4. All volunteers are required to log onto Volgistics at the beginning of their shift and log out at the end of their shift using the kiosk located in the lobby of the Pavilion building, outside of the Medical Clinic on the first floor and in the lobby of the Administrative building.

5. If the computer is not operational, volunteers are required to either 1) report their time in/out to his/her supervisor and ask that the supervisor reports back to one of the VC, or 2) report their time in/out directly to one of the VC, so that the VC can manually input the hours into the Volgistics database.

6. The Volunteer Services Department is able to generate reports from Volgistics to

be used for recognition activities and productivity reports.

7. Volunteers are required to notify the Volunteer Services Department when they plan to discontinue their volunteer service.

    a. Records for volunteers who have completed their service or who have separated are archived within Volgistics.

    b. E-copy files are removed from storage and deleted appropriately.

8. At the end of each quarter of the fiscal year, a VC runs an inactivity report to identify volunteers who have not reported to their assignment within the past four months.

    a. The VC makes a determination as to whether the record should be archived or to maintain the volunteer's active status.

9. Volunteers who resume their service after a period of inactivity have their files restored within Volgistics by the VC.

    a. The information is reviewed and updated as appropriate.

10. Volunteers who resume their service after a period of inactivity must complete all applicable hard copy forms, which will be scanned into an e-copy and stored in a secure location.

    a. After an inactive period of 1 year, volunteers will need to re-do orientation, background check, and other on-boarding processes.

ATTACHMENT:
None

REFERENCE:
None

Revised: 2019/08/20, 2014/06/09, 2015/08/19, 2018/05/05
Original Adoption: 1998/06/01

~~File: A8.0B 3.0 Clothing Room Revised August 3117, 20152~~

CLOTHING ROOM

POLICY:

Laguna Honda Hospital (LHH) will provide a process for distribution of clothing and to residents.

PURPOSE:

To provide clothing for the needs of the residents of LHH.

PROCEDURE:

1. The Clothing Room is under the management of the Volunteer Services Department and is staffed by LHH volunteers.

2. All clothing brought to the Clothing Room is either donated or recycled from resident units. Clothing is sorted, cleaned if necessary, and organized for selection by LHH volunteers or staff.

3. Any clothing determined to be inappropriate is donated to other community organizations.

4. Residents must be accompanied by a staff member or unit volunteer, or provide a signed clothing room form from unit staff to receive clothing, which must indicate the items needed.

5. Hospital staff, Clothing Room Volunteers or Unit Volunteers must accompany the resident in selecting clothing at the Clothing Room.

6. The resident is not to be left alone in the Clothing Room.

7. Residents should be actively involved in selecting clothing, if this is not feasible, nursing
staff or volunteers may assist the resident in selecting clothing.

8. The Clothing Room Form must be completed by hospital staff or volunteers and submitted to the Clothing Room.

9. If a Clothing Room Volunteer is unavailable, hospital staff ~~(~~Social Worker, Nursing staff,
Activity Therapist or Neighborhood Volunteer may obtain the key from the Nursing Station. All ~~Nerighborhoods~~Neighborhoods have access to the clothing room 24/7. An ID badge which gives access to the 4th floor entrance as well as a key to the clothing

room was made available -to all neighborhoods as well as the Social Work Department and the Administrative Office.) ~~or Unit Volunteer may obtain the key from the Social Work Department or Volunteer Services by signing the sign out sheet. Hospital staff and volunteers must return the keys to the Department key was obtained from, and sign them back in.~~

Hospital staff and volunteers must ensure that the Clothing Room is left in an orderly fashion.

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10. Clothing room forms will be compiled, and quarterly reports of clothing usage will be made to the volunteer coordinator.

11. ~~Clothing Room H~~hours ~~are Mondays and Fridays from 10AM to 2PM.~~ The extension to reach the Clothing Room at Laguna Honda Hospital is x44036.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 12/08/17 Revised: 12/08/17, 15/07/01, 18/05/05

RESIDENT LIBRARY

POLICY:

Laguna Honda Volunteer Services manages the operations of the Resident Library. This may include the acquisition and organization of donated and purchased reading materials, coordinating the maintenance of the library computers and internet access, and volunteer staffing of the library. Depending on library security needs modified workers may be enlisted to help staff the library.

PURPOSE:

To enhance the quality of life for the Residents of Laguna Honda Hospital (LHH).

PROCEDURE:

1. The library is open Monday to ~~Sunday~~ Friday 10am-4pm, closed for lunch from 12pm-1pm ~~8:00 AM to 4:30 PM~~. The door is set to a timer for opening and closing during the designated hours of operation.

2. The Volunteer Services Department acquires books for the library through a book share program with the San Francisco Public Library. Books are also acquired through donations from the public.

~~3. The Volunteers Services Department maintains subscriptions of newspapers and magazines financed through Friends of Laguna Honda, a private non-profit volunteer organization.~~

~~4.~~3. Computing:

   a. Computers with internet access are available to the residents during regular library hours. The library computers are for use by residents only, or staff assisting residents who are present.

   b. The library iPad is for resident use only.

   c. The use of the library computers including the iPad is limited to one hour at a time if other residents are waiting.

   d. Internet access is restricted from accessing pornography in the library. Residents & visitors have the right not to be exposed to sexually explicit materials or behaviors, under the LHH Resident's Sexual Rights and Responsibilities Policy.

   e. Library computers are maintained by Volunteer Services with technical assistance from IT staff.

~~5.~~4. The Resident Library is staffed by volunteer coordinators and volunteers. The responsibilities of the volunteers staffing the library may include the following:

a. Assist residents with locating reading materials
b. Enforce library policies
c. Assist residents with the use of the computers (internet, email, etc.)
d. Enforce the rule that the computers are for resident use only
e. Shelve books appropriately
f. Organize magazines and newspapers in a manner that enhances access and utilization by residents
g. Organize/clean resident computers, Ipad, tables and chairs to provide the greatest access possible for residents

~~6.~~5. The Resident Library may not be used as a staff break room, or for any staff-related functions, unless approved by Volunteer Services.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 2019/08/21, 15/07/23
Revised: 14/08/20, 18/05/05
Original Adoption: 98/06/01

HOLIDAY GIFT PROGRAM

POLICY:

~~Friends of Laguna Honda~~The Resident Gift Fund supports an annual gift program to be distributed to residents during the holiday season between November and December.

PURPOSE:

To ensure that each resident receives a holiday gift that is appropriate for enhancing their quality of life.

PROCEDURE:

1. The Volunteer Services Department is responsible for maintaining an accurate inventory of gifts.

2. A catalog of items is created by the Volunteer Department to determine what residents can select from (e.g. clothing, backpacks, etc.)

    a. Activity Therapists are given a catalog so that they can discuss with the resident what he/she would like to receive.

    b. Each resident can choose gifts totaling up to a pre-determined amount.

3. The Volunteer Services Department will begin to process the orders in the month of October.

4. The shipment of merchandise will begin arriving from October through November. The Volunteer~~s~~ Services Department is responsible for recruiting volunteers to assist with the inventory and packaging of gifts.

5. Once the orders are filled, the Volunteer Services Department will contact the assigned neighborhood Activity Therapist to arrange a gift delivery schedule and ensure gifts are delivered as appropriate.

6. If items ordered are not available, the Volunteer Services Department will inform the Activity Therapist of substitutes. If these substitutions are not appropriate, Activity Therapist will contact the Volunteer Coordinators who will offer other items available in the inventory.

7. The gifts are to be distributed to residents by nursing staff and/or Activity Therapists generally during the holiday parties. Activity Therapists are responsible for ensuring that each resident receives their gifts.

8. After the holiday gifts are processed and distributed, the Volunteer Services Department is responsible for taking inventory for the next year.

ATTACHMENT:

None

REFERENCE:

None

Most recent review: 14/08/20 Revised: 19/08/21, 15/03/20, 15/08/19
Original adoption: 08/08/25

VOLUNTEER ID BADGE PROCEDURE

POLICY:

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center (LHH) is responsible for issuing identification badges to fully process volunteers who can make a 6 months or longer commitment to volunteer at LHH.

PURPOSE:

To ensure that each volunteer is given an identification badge to wear at all times when volunteering at LHH.

PROCEDURE:

1. The Volunteer Services Department will issue an identification badge in the Facilities Department.

2. The following procedure are the steps taken when creating and issuing an ID badge to volunteers:
    a. Set up the volunteers profile in the Volgistics Database
    b. Create and issue volunteer ID badge at the Facilities Department
    c. Walk volunteer through sign in/out process at a volunteer kiosk
    d. Confirm badge access is activated by checking that badge can access one of the locked doors

Volunteer badges are valid for ~~6~~ 12 months at a time. In the event a badge has expired and he/she is still an active volunteer, the Volunteer Coordinator will reactivate the badge for another ~~6~~ 12 months.

3. Volunteers are responsible for returning their badges to the Volunteer Coordinator or their respective department supervisor once they decide to end his/her volunteer service.

4. Deactivated badges are appropriately disposed of.

ATTACHMENT:
None

REFERENCE:
None

Original adoption: 05/02/17
Revised Date: 2019/08/21