List of Policies and Procedures for JCC Review 11-9-26

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Status	Dept.	Policy #	Title	Owner/ Reviser	Summary of Changes
Revised	Department of Public Health - San Francisco Health Network	18.04	Order Entry	**C. Struble** **C. Platter** **K. Toth** **J. Berke**	1. Change TPN to more general term Parenteral Nutrition, which includes both PPN and TPN (*Kept the PN panel components instead of listing out since it was repetitive) 2. Included IV Fluid Orders per recommendation from CDS with goal to improve patient safety 3. Specified that IV Fluid Orders were for ZSFG Dietitians Only (leaving PN and Nutrition Monitoring Orders universal as LHH may accept stable PN patients in the future)
					1. Deleted "client/" and " (hereafter "resident") " 2. Deleted "under the state plan" 3. Replaced "the facility" with "LHH, they shall return" 4. Replaced "Previous" with "prior" 5. Added "Should the room not be available," 6. Deleted "or immediately upon the first availability of the bed in a" 7. Added "the resident will be re-admitted to the next available" 8. Deleted "if the resident requires the services provided by" 9. Added "within" 10. Deleted "and is eligible for Medicare, Medi-Cal, or other commercial insurance with prior authorization for skilled nursing facility services." 11. Deleted "Intensive discharge planning support and skills training shall be provided to the resident to assist them to transition from an institutional setting to community living. The resident's goals of care and treatment preferences will be incorporated." 12. Deleted "Clinical Leadership Committee" 13. Replaced "and a sense of hope for future possibilities" with "that promotes the resident's health and wellbeing." 14. Replaced "consider unwise" with "may not agree with" 15. Deleted "A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers."

Revised	Hospital-wide	20-04	Discharge and Transfer Process	**N. Zahir**	16. Added "A resident who participates in whole person care, which may include a history of homelessness, may be offered additional resources and community reintegration opportunities prior to discharge." 17. Deleted "The RCT members shall seek positive collaborations with members of the resident's informal and formal support systems, encouraging face-to-face meetings prior to and after discharge." 18. Replaced "Utilization Management Nurse Manager" with "Chief Medical Officer (CMO)/Medical Director" 20. Replaced "the Chief Medical Officer" with "Director of Nursing (DON)" 21. Deleted "The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate" 22. Updated "5.RCT Roles and Responsibilities" 23. Added "Notification of Resident Regarding Discharge/Transfer from Facility" section 24. Updated the ""Discharge Appeal" section 25. Deleted "physician, social worker, nurse, activity, dietitian, rehabilitation specialist, occupational therapist, physical therapist, and/or speech therapist" 26. Deleted "Identifies differences of opinion among RCT members in regard to the resident's transfer and encourages open discussions based upon professional assessments." 27. Added "resident and or SDM decide to transfer prior to the indicate" and ", no new notice is provided. Resident preference shall be documented in the HER. If the discharge date is extended beyond the original discharge date," 28. Deleted "Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning." 29. Deleted "Provides resident and family education to support self-care and independence, based on the care plan." 30. Replaced "Residents Leaving Against Medical Advice (AMA)" section with "Residents Leaving Against Medical Advice (AMA): refer to LHHPP 20-07 Against Medical Leave (AMA)" 31. Added ", then LHH shall assist the resident in discharging to a facility or transferring to a SNF" 32. Deleted "does not have an agreement with LHH, then LHH shall assist the resident in discharging to a facility or transferring to a SNF that" 33. Deleted "1 Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single 'appropriate' setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers." (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p.291)." 34. Deleted "2 The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff."

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Revised	Hospital-wide	24-16	Code Blue	**N. Zahir**	1. Added instructions for immediate Code Blue. 2. Added unresponsiveness to the experience list. 3. Removed location of cervical spine immobilizer board. 4. Added "Code Leader"
Revised	Hospital-wide	27-02	Referrals for Rehabilitation Services	**D. Swiger**	1. Updated policy introduction and purpose paragraphs for clarity. 2. Updated #3 for specificity for response time based on type of referrals. 3. Removed appendix reference as this is converted to departmental standard work document.
Revised	Food Services	1.101	Amounts of Food to Produce	**E. Lavarreda**	1. Deleted- Moved ‘ to the end for residents 2. Deleted – To 3. Added Chef and 4. Capitalized S in supervisor. 5. Removed space in down load 6. Added them , /she 7. Deleted s in chefs 8. Capitalized C in chef
Revised	Food Services	1.102	Daily Food Production Meetings	**E. Lavarreda**	1. Added – the , or designees. 2. Replaced meetings with huddles, helpers with staff 3. Deleted s in assistants 4. Changed are to is 5. Added hyphen to follow through , last minute 6. Replaced assistants with staff. 7. Added production

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Revised	Food Services	1.104	Blast Chiller Operational Procedure	**E. Lavarreda**	1. Replaced- (165 190) with (min 135 ºF) 2. Deleted- for a minimum of forty-five minutes. 3. Deleted - above 40* & within forty-five minutes. 4. Replaced 0* with 41ºF. 5. Added- must be cooled from 135ºF to 70ºF (within 2 hours) and then from 70ºF to 41ºF or colder (within 4 hours) for a total of 6 hours. 6. Deleted- above 40 must be lowered to an internal temperature of 40 or lower within four (4) hours. 7. Decapitalized - W in When, B in Blast, C in Cool, D in Down, L in Log, B in Binder, S in Sheets, 8. Replace- cover of the product in the refrigerator with cooling log report. 9. Deleted – production. 10.Replaced - Management with Assistant food service director. 11. Deleted- on a basis. 12. Replaced 165* with 165ºF.
Revised	Nursing Services	A 1.0	Nursing Policies and Procedures	**C. Figlietti**	1. Removed “Clinical Nurse Specialists” 2. Clarified that policies are reviewed, and if appropriate, revised. Policies are reviewed and, if appropriate, reviewed by DONs, DET Educators, and/or other nursing staff as appropriate on an ad hoc basis prior to final approval by NEC.
New	Pharmacy Services	To Be Determined	Attendance and Punctuality	**D. Smith**	New policy
Revised	Environmental Services	XII	Transmission-Based Precautions Cleaning Policy	**S. Wu**	Material Recommended: Update High Touch Surfaces: 2-step methods-Oxivir 1 Wipes and bleach germicidal wipes. 1.ii, Update "calling the EVS main line extension 4-4624 or submitting an EVS work order." 1. iii, iv, and 2. c, d, Update the high touch surfaces disinfecting in the rooms and bathrooms to use "2 step methods: First disinfect with Oxivir 1 Wipes; Second disinfect with bleach germicidal wipes. Add contact times, and "keep visible wet for the required contact time. Let air dry." 2.b, Update "disinfect interior and exterior of trash can with the 2-step method" 2. e, Add "Place soiled mops into the white soiled linen bag" 2. f, Add "drop the bagged soiled mops down the linen chutes in the Soiled Utility Room." Addendum: Add the "Laguna Honda Hospital approved disinfectants: ....." Add "Quaternary ammonium with TB kill claim and sporicidal on EPA K list" behind "Oxivir 1 Wipes"

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Revised	Food Services	1.103	Menu Changes and Substitutions	**E. Lavarreda**	1. Added- , or designee 2. Removed – space between log book, last minute 3. Deleted -the, production and s in chefs 4. Decapitalized- first letter in department, menu meetings.
Revised	Food Services	1.105	Returned Food from Tray or Gelley Service	**E. Lavarreda**	1. Decapitalized- P in Production, A in area. P in personal, T in Tray, S in Service, G in Galley throughout document. 2. Replaced- are with is. 3. Added- Food Service. 4. Added – Food and
Revised	Nursing Services	Acute 01.0	Nursing Staff Education – Acute Unit	**C. Figlietti**	1. Added to procedure C: “Acute Unit Nurse Manager and Nursing Director will maintain a list of RNs who have received Acute Unit orientation and training.” 2. Updated references
Revised	Nursing Services	A 2.0	Nursing Services: Organization, Authority/Responsibility, Operations	**C. Figlietti**	1. Removed “Clinical Nurse Specialists” 2. Updated references
Revised	Nursing Services	D9 7.0	Wheelchair and Geriatric Chair Cleaning	**C. Figlietti**	1. Added policy #3 “Charge Nurse will check that wheelchairs and geriatric chairs are clean and labeled as pat of the environment of Care.” 2. Referred to Facility Services Policy and Procedure EM-10 Manual Wheelchair Maintenance and Repair for reporting of broken or defective equipment. 3. Updated to indicate a work order is submitted online.
New	Pharmacy Services	To Be Determined	Sick Leave and Tardy call in	**D. Smith**	New policy
New	Rehabiliation Services	To Be Determined	Aquatic Services	**D. Mullin**	New policy

JCC Follow-up

San Francisco Department of Public Health

Policy & Procedure Detail*

Policy & Procedure Title: 18.04 ORDER ENTRY	
Category: General Administration	
Effective Date: 10/24/2025	**Last Reissue/Revision Date:** 7/2025
DPH Unit of Origin: ZSFG	
Approval Date: 10/23/2025	
Distribution: DPH-wide ☒	**If not DPH-wide, other distribution:**

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 use abbreviations prohibited by the Joint Commission (Managing Health Information: Use of Abbreviations, Acronyms, Symbols and Dose Designations - Understanding the Requirements | Joint Commission) will not ~~have~~ ~~do not use abbreviations~~ ~~will not~~ be transcribed or carried out.

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 refer 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

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

Appendix A: List of orders that can be placed by non providers, 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 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.

Order	Order Mode	Who can write, modify, and/or delete this order?	Details
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~~
Ppharmacist 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 ~~*ZSFG Dieticians Only~~	Pended Orders	Dietitians	In order~~s~~ to meet nutrition therapy goals, the following orders may be pended: • Oral Nutrition Supplements • Tube Feeding (TF) and TF Panel Components • ~~TPN and TPN Panel Components~~ • ~~*~~*Parenteral ~~N~~Nutrition (PN) and PN Panel Components~~Orders~~ ~~*Nutrition Monitoring Orders (including labs, weight, I/O's, HOB, GRV)~~ • ~~*~~*IV Fluid Orders* • • Vitamin and Mineral Supplements • Nutrition Related Labs • Weight Monitoring • Calorie Count • Other~~s~~ nutrition related orders as indicated * ZSFG Dietitians Only

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." Peds/NICU uses code pink, not code green

~~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)

Status Pending PolicyStat ID 21037251

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination	07/2003
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2026
Next Review	1 year after approval

Owner	Nawzaneen Zahir: LHH Chief Quality Officer
Area	LHH 20 Admission Discharge, Transfers/ Relocation
Applicability	Laguna Honda Hospital & Rehabilitation Center

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Skilled Nursing Facility (SNF) Discharge and Transfer Process, 20-04

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, LHH continually facilitates timely and safe resident discharges or transfers to the appropriate level of care.

POLICY:

1. LHH strives to assist every ~~client/~~resident ~~(hereafter "resident")~~ to achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the Resident Care Team (RCT) shall continue to support maximal social integration and document who made the determination that discharge is not feasible and why. In addition, LHH may also transfer residents to another skilled nursing facility to continue the current level of care of skilled nursing needs if appropriate based on hospital operation. ~~Laguna Honda~~LHH allows readmission into the facility following hospitalization or therapeutic leave. When a resident whose hospitalization or therapeutic leave exceeds the bed hold period ~~under the state plan~~and returns to ~~the facility~~LHH, they shall return to their ~~previous~~prior room, if available. Should the room not be available, ~~or immediately upon the first availability of the bed in a~~the resident will be re-admitted to the next available semi-private room ~~if the resident requires the services provided by~~within the facility ~~and is eligible for Medicare, Medi-Cal, or other commercial insurance with prior authorization for skilled nursing facility services~~.

2. LHH provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences. This ~~orientation~~ must be ~~provided~~done in a form and manner that the resident or surrogate decision maker can understand.

3. Residents who no longer meet skilled nursing facility (SNF) level of care and/or whose ~~SNF~~ needs can be met at a lower level of care shall be prepared for discharge into the community with supportive services.

   ~~Intensive discharge planning support and skills training shall be provided to the resident to assist them to transition from an institutional setting to community living. The resident's goals of care and treatment preferences will be incorporated.~~

4. The RCT shall recognize that residents with decision-making capacity and/or their surrogate decision-maker (SDM), have the right to decline recommended discharge/transfer options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge/transfer plan.

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5. Residents with decision making capacity who ~~repeatedly decline~~declines discharge/transfer options, or refuse to participate in discharge/transfer planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, and safe ~~and orderly~~ post-discharge plan of care has been formulated by the RCT. The notice requires that a discharge/transfer address and discharge/transfer date be obtained prior to issuance.
6. This policy does not apply to residents who are being relocated to another SNF as a "Facility Closure Transfer," only when LHH is subject to a facility closure plan, as described in LHHPP 01-16 Facility Closure Plan. Facility Closure Transfers are subject to the requirements and procedures described in LHHPP 01-16 Facility Closure Plan. Residents who are discharged to the community, including their home or a lower level of care facility, when LHH is subject to a facility closure plan will be discharged according to the procedures outlined in this policy, LHHPP 20-04 Discharge and Transfer Process
7. For residents who qualify for Medicare and wish to elect for hospice care services, LHH will either arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices or, if such an agreement(s) has not been arranged, then LHH will assist the qualifying resident to transfer or discharge to a facility that will arrange for the provision of hospice care services when the resident requests a transfer or discharge.

PURPOSE:

To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer need SNF services, and/or are able to be cared for at a lower level of care. To implement a safe and orderly transfer process for residents who require transfer to an emergency department or for residents who desire to be transferred to another SNF, but in this specific instance, only when LHH is not subject to a facility closure plan.

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DEFINITION:

"Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. (See §483.5) Specifically, transfer refers to the movement of a resident from a bed in one facility to a bed in another facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another facility or other location in the community, when return to the original facility is not expected.

"Anticipated Discharge": A discharge that is planned and not due to the resident's death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation).

"Bed-hold": Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.

"Continuing Care Provider": the entity or person who will assume responsibility for the resident's care after discharge. This includes licensed facilities, agencies, physicians, practitioners, and/or other licensed caregivers.

"Recapitulation of Stay": a concise summary of the resident's stay and course of treatment in the facility.

"Reconciliation of Medications": a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.

"Reserve Bed Payment": Payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility.

"Therapeutic Leave": Absences for purposes other than required hospitalization.

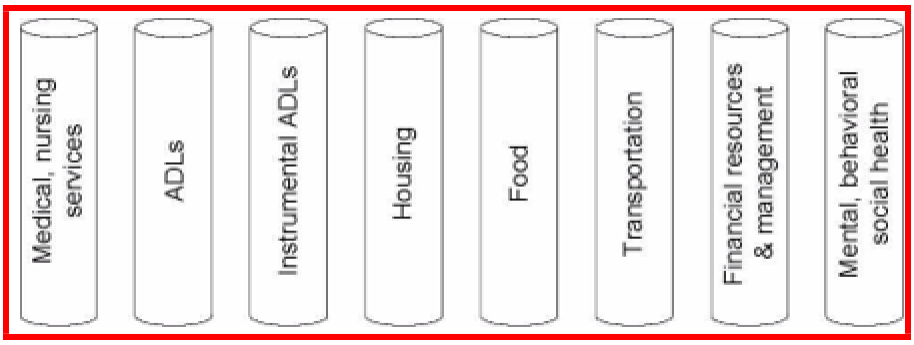
Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:

ADLs	IADLs
Dressing	Shopping
Eating	Housework
Ambulating	Accounting/finances
Toileting	Food preparation
Hygiene	Transportation

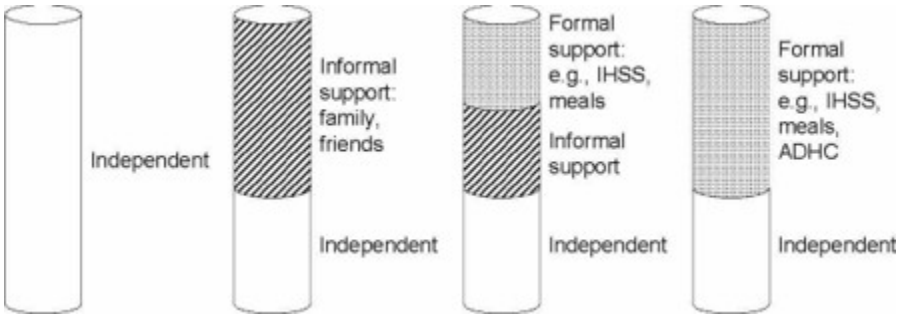
Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work.

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Safety issues often arise in many of these domains.



Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).



PROCESS GUIDELINE:

1. Discharge assessment process considers:

a. The resident's characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).

b. The resident's values and preferences.

    i. These values and preferences remain central to the assessment process even when

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they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.

ii. The resident's self-assessment of needs and priorities may legitimately differ from that of the RCT~~-~~.

2. Discharge planning:

a. Begins during the resident's admission assessment.

b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.

i. A resident may need to progress through several stages of increasing independence prior to discharge.

c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.

i. Informed choice is a fundamental principle of service delivery.

ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

iii. Residents, SDMs, caregivers, and RCT members may enlist the ~~Clinical Leadership Committee,~~ ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. Utilization Resources:

a. Resident independence and resource stewardship are LHH values that inform discharge planning.

i. Residents shall be discharged to the lowest possible level of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, and self-care readiness~~, and a sense of hope for future possibilities~~ that promotes the resident's health and wellbeing.

4. Conservatorship and decisional capacity:

a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

b. Unless otherwise specified in a written advance health care directive or absent legal adjudication, the primary physician bears responsibility for determining if a resident lacks or has recovered capacity to make health care decisions, including informed choices about interventions and discharge planning.

c. A resident with capacity retains the right to make decisions that RCT members ~~consider~~

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~~unwise~~may not agree with.

i. RCT members shall educate the resident (or ~~conservator or other~~ SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining ~~his/her~~their well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall ~~nevertheless~~ elicit, document, and consider the resident's current and/or past values and preferences relevant to discharge.

e. ~~A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.~~A resident who participates in whole person care, which may include a history of homelessness, may be offered additional resources and community reintegration opportunities prior to discharge.

5. Collaboration:

a. LHH is committed to developing collaborative relationships with other organizations in order to meet the residents' needs.

b. The RCT members shall be familiar with community-based services appropriate to their disciplines.

c. ~~The RCT members shall seek positive collaborations with members of the resident's informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.~~

PROCEDURE:

Discharge to the Community

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner; or when the resident's condition improves, and they no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.
2. Upon admission and periodically during admission, designated members of the RCT shall educate the resident and/or their SDM that when their health condition sufficiently improves, or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be prepared and finalized to transition the resident back to the community.
3. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Director of Social Services or designee, the ~~Utilization Management Nurse Manager~~Chief Medical Officer (CMO)/Medical Director or designee, ~~the Chief Medical Officer~~and Director of Nursing (DON) or designee, ~~and Chief Nursing Officer or designee,~~ shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.
4. RCT Roles and Responsibilities
   The RCT members are expected to bring perspectives unique to their disciplines to discussions related to discharge planning.
   a. Communication with outside caregivers should occur with appropriate permission

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from the resident and or SDM.

5. Notification of Resident Regarding Discharge/Transfer from Facility

    a. The UM Nurse shall conduct a review of the resident's medical record and determine if the facility has met the conditions for discharging/transferring the resident to the community. A Discharge Plan Review form is available for use to assure that a comprehensive review is carried out.

    b. The UM Nurse shall notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge/Transfer Notice.

    c. The resident shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge by the social worker. The social worker will be accompanied by a witness. If the resident falls into the six categories listed below, the notice may be less than 30 days.

    d. The social worker, nurse, or physician shall notify the resident and/or SDM, of the discharge/transfer. The reasons for the discharge/transfer should be in writing and in a language and manner they understand. The reasons for the discharge shall be documented in the resident's medical record. A resident or SDM is entitled to written 30-day notification except under the following conditions:

        i. The transfer or discharge is necessary as resident needs cannot be met in the facility. Documented attempts to meet the resident's specific needs and an assessment at the time of discharge indicating what needs cannot be met.

        ii. Improvement in medical condition requiring a lower level of care. Documentation to show the resident's health has improved.

        iii. The health or safety of individuals in the facility is endangered. The RCT shall ensure examples of behaviors that have the potential to endanger the safety or health of individuals in the facility have been documented in the EHR.

        iv. Resident has resided in the facility less than 30 days.

        v. Resident has failed after reasonable and appropriate notice to pay for a stay at the facility. Documented that the facility offered the resident to pay

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privately or apply for medical assistance, or documentation that the resident refused to pay or have their stay paid for by Medicare or Medi-Cal. Medi-Cal eligible residents will be provided oral and written information on how to apply for Medicaid.

vi. The facility is ceasing to operate.

e. A resident or SDM is entitled to written notification on the day of transfer based on the conditions below:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

f. The social worker will forward a copy of the Notice of Transfer/Discharge provided to the resident or legal representative and Ombudsman.

g. Written notice (MR 707) to the resident or SDM shall include:

i. Name of resident

ii. Date resident notified

iii. Reasons for discharge/transfer.

iv. Date the discharge/transfer will occur.

v. Discharge/transfer destination.

vi. Name, address, and phone number of the State ombudsman.

vii. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

viii. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act

ix. Resident's right to appeal to the California State Department of Health Services.

x. Witness signature, and explanation if resident or resident's representative did not sign the written notice.

h. Residents may choose to waive their notice period if they wish to be discharged/ transferred prior to the conclusion of the notice period. If the resident elects to be discharged/transferred sooner than the notice period, this shall be documented in the EHR.

6. ~~Notification of Resident Regarding Discharge/Transfer from Facility~~

Discharge Appeal

a. ~~The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge/transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or SDM~~

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~~is entitled to written 30-day notification except under the following conditions:~~

i. ~~The transfer or discharge is necessary as resident needs cannot be met in the facility. Documented attempts to meet the resident's specific needs and an assessment at the time of discharge indicating what needs cannot be met.~~

ii. ~~Improvement in medical condition requiring a lower level of care. Documented to show the resident's health has improved.~~

iii. ~~The health or safety of individuals in the facility is endangered. Documented instances of examples of behaviors that have the potential to endanger the safety or health of individuals in the facility.~~

iv. ~~Resident has resided in the facility less than 30 days.~~

v. ~~Resident has failed after reasonable and appropriate notice to pay for a stay at the facility. Documented that the facility offered the resident to pay privately or apply for medical assistance, or documentation that the resident refused to pay or have their stay paid for by Medicare or Medi-Cal. Medi-Cal eligible residents will be provided oral and written information on how to apply for Medicaid.~~

vi. ~~The facility is ceasing to operate.~~

b. ~~The nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of a transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or SDM is entitled to written notification on the day of transfer based on the conditions below:~~

i. ~~Medical emergency.~~

ii. ~~Deterioration in medical condition requiring a higher level of care.~~

c. ~~The social worker will forward a copy of the Notice of Transfer/Discharge provided to the resident or legal representative and Ombudsman.~~

d. ~~Written notice (MR 707) to the resident or SDM shall include:~~

i. ~~Name of resident~~

ii. ~~Date resident notified~~

iii. ~~Reasons for discharge/transfer.~~

iv. ~~Date the discharge/transfer will occur.~~

v. ~~Discharge/transfer destination.~~

vi. ~~Name, address, and phone number of the State ombudsman.~~

vii. ~~For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.~~

viii. ~~For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act~~

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ix. ~~Resident's right to appeal to the California State Department of Health Services.~~

x. ~~Witness signature, and explanation if resident or resident's representative did not sign the written notice.~~

e. ~~Residents may choose to waive their notice period if they wish to be discharged/ transferred prior to the conclusion of the notice period.~~

f. If the resident or SDM is opposed to discharge/transfer, they will be encouraged to discuss it with the RCT and ombudsman.

i. Utilization Management leadership (UM) will alert the Medical Director/CMO, ~~Chief Nursing Officer~~DON or designee, Chief Quality Officer, and Chief Executive Officer/Nursing Home Administrator (~~or their~~CEO/ NHA) or designee~~)~~, prior to issuance of the written notification of discharge/transfer.

ii. One or more of these executive leaders will meet with the resident or ~~surrogate if so desired~~SDM if the resident and/or SDM would like to.

iii. When the Resident Care Team (RCT) identifies that a resident's health has improved sufficiently to allow discharge/transfer to the community, ~~and the resident verbalizes that they disagree with the plan to be discharged/ transferred to the community and refuses reasonable placement options,~~ the Social Worker ~~shall~~may request for a level of care review by UM.

iv. ~~The UM Nurse shall notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge/ Transfer Notice within 3 – 5 working days.~~

v. When a resident chooses to appeal ~~his or her~~their discharge from the facility, the facility may ~~not~~ **not** discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals.

- The RCT shall document the danger(s) that failure to transfer or discharge would pose.

vi. The Social Worker shall notify the UM Department as soon as ~~s/he is~~they are aware that the resident has filed a complaint to contest the discharge/ transfer.

vii. The UM leadership or designee shall gather pertinent resident information

and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.

viii. When the facility is notified of a scheduled discharge hearing date, the UM leadership or designee shall coordinate with the RCT, UM Nurse and if necessary, the Deputy City Attorney to prepare oral and written testimony for the discharge hearing to demonstrate compliance with resident discharge planning requirements.

ix. Any and all documents prepared for the discharge hearing shall be provided to the resident and/or SDM prior to the scheduled discharge hearing date.

x. ~~The RCT shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.~~

The RCT shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.

xi. The resident may not be involuntarily discharged from the facility prior to the discharge hearing or issuance of the Decision and Order, but may choose to be voluntarily discharged and s/he can request for assistance with discharge planning arrangements from the RCT.

xii. While the appeal is pending, the facility can proceed to discharging the resident when failure to transfer or discharge endangers the health or safety of the resident or other individuals in the facility. The facility must document the danger the resident poses to self and/or others that the failure to transfer or discharge would pose.

- The UM leadership shall coordinate a meeting to discuss the safety risk with the LHH Executive team and, if necessary, the City Attorney's Office.
- ~~The facility's Administrator or designee~~UM leadership at the direction of the CEO/NHA is required to provide DHCS Office of Administrative Hearings and Appeals written notification as soon as possible if the resident is transferred or discharged prior to the hearing under this exception.

xiii. The RCT shall clearly document that such discharge planning arrangements were made based on the resident's request.

xiv. If the resident is voluntarily discharged from the facility while the hearing is pending, the Quality Management (QM) designee is responsible for notifying the California Department of Public Health Office of Regulations and Hearings and the local Licensing and Certification Office.

xv. Following the discharge hearing, the State of California will issue a Decision and Order and the facility shall proceed with the issued directions contained in the document.

7. After Visit Summary (AVS) and Discharge Summary
    a. For Anticipated Discharges, the physician shall develop a discharge summary for the resident and shall include:
        i. An overview of the resident's stay including, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results;
        ii. A final summary of the resident's status including items from the resident's most recent comprehensive assessment (Refer to LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), Procedure 1(c)(ii).) that may be available to authorized persons and agencies upon consent of the resident or resident's representative;
        iii. A reconciliation of the resident's pre-discharge medications with ~~his/her/~~their post-discharge medication, both prescribed and over the counter; and,
        iv. A post-discharge plan of care that is developed with consideration to the resident's and/or the resident's representative preferences, which shall include where the resident shall live, information on the resident's follow-up care, any necessary medical and non-medical services, and information on how and when to contact the continuing care provider(s).
    b. The discharge summary shall be complete and conveyed, with the resident's permission, to the receiving provider at the time the resident leaves the facility.
8. Transfer to an Emergency Department (ED)
    a. Physician
        i. The physician will assess the need for higher level of care. If appropriate, the physician will place the LOA order ~~the LOA order~~ for transfer to the ED.
        ii. Document in the EHR of the medical assessment and need for higher level of care.
        iii. Complete the Interfacility Transfer Record.
    b. Nursing
        i. Document that Change of Condition in the EHR.
        ii. Place the resident on LOA in the EHR.
        iii. Print out necessary transfer documents from the EHR to send with the resident.
9. Discharge to an Acute Care Facility
    a. Bed Hold (refer to LHHPP 20-14 Leave of Absence and Bed Hold Policy)
    b. Nursing
        i. Contacts the acute facility to determine if the resident was admitted.

c. Physician

i. Writes a discharge summary in the EHR.

10. Involuntary Discharges

a. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. ~~Legal counsel~~City Attorney's Office shall be consulted in circumstances when the resident and or SDM ~~refuses~~refuse to participate in discharge planning efforts (e.g., refuses to sign release of information forms or complete housing applications, etc.).

b. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with ~~two~~a safe and appropriate housing ~~options~~option that the RCT considers to be the best viable discharge option available in the community.

11. Transfer to Another Skilled Nursing Facility

a. The ~~physician~~RCT, ~~social worker, nurse, activity~~ ~~therapist~~ with others as needed will work in collaboration to complete the transfer assessment process according to the transfer plan.

b. Physician

i. Addresses the resident's continued skilled nursing needs as transfer potential in the progress note.

ii. Communicates with the resident (or SDM), caregivers, and with other RCT members regarding the resident's conditions and expected course so that the goals of care can be adjusted as needed.

iii. Attempts to simplify the resident's medication regimen, preferably months or weeks prior to transfer, if appropriate.

iv. Ensures that appropriate post-transfer medical follow-up needs are communicated through physician -to- physician report prior to resident transfer.

v. Writes transfer order.

c. Social Worker

i. Coordinates the transfer assessment process and plan. Documents the assessment and plan in the EHR.

ii. Contacts the resident's caregivers and community-based support services to inform them of the transfer, to invite them to care conferences, and to seek their collaboration.

iii. Updates the EHR discharge section as needed due to pertinent changes~~ or upon readmission to LHH~~.

iv. If transfer is not currently a viable option and is not included in the formal care plan, documents the reason(s).

v. ~~Identifies differences of opinion among RCT members in regard to the resident's transfer and encourages open discussions based upon~~

~~professional assessments.~~

vi. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

vii. Makes referrals to other skilled nursing facilities.

viii. Discusses the transfer plan with the resident (or surrogate) and caregivers, ~~preferably months or weeks prior to~~in advance of the discharge date.

ix. Prepares and provides the resident and Ombudsman with a ~~preliminary~~ copy of a Notice of Proposed Transfer/Discharge. If the resident and or SDM decide to transfer prior to the indicated date ~~changes~~, no new notice is provided. Resident preference shall be documented in the EHR. If the discharge date is extended beyond the original discharge date, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

x. Documents transfer planning efforts and resident preparation and orientation to the transfer plan to ensure a safe and orderly discharge from the facility.

d. Nurse

i. ~~Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.~~

ii. ~~Provides resident and family education to support self-care and independence, based on the care plan.~~

iii. Prepares resident's personal belongings prior to the transfer. Conduct inventories to ensure that all belongings are transferred to the receiving facility.

iv. Completes and prints out the AVS on day of transfer for the resident. Include additional medical records requested by ~~a~~the receiving facility.

12. Residents Leaving Against Medical Advice (AMA): refer to LHHPP 20-07 Against Medical Leave (AMA)

a. ~~When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.~~

b. ~~If the resident is conserved or does not understand the nature and consequences of a decision to leave LHH without permission, the physician will immediately attempt to contact the SDM.~~

c. ~~If leaving LHH would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.~~

d. ~~If the consultant deems the resident a danger to self or others due to mental illness, the consultant will initiate a psychiatric hold and transfer the resident to acute care.~~

e. ~~The nurse or physician will present the form MR 804, "Request to Leave the Hospital Against Medical Advice," to the resident (or surrogate) in the presence of a witness.~~

~~If the resident or surrogate refuses to sign, the nurse or physician will write on the form, "Resident refuses to sign." Nurse/physician and witness will~~

~~sign.~~

f. ~~The nurse or physician will complete an Unusual Occurrence form.~~

g. ~~When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.~~

Residents Leaving Against Medical Advice (AMA): refer to LHHPP 20-07 Against Medical Leave (AMA)

13. Residents Qualifying for Hospice Care Services

    a. If a resident qualifies for hospice care services and chooses a hospice provider, then LHH shall assist the resident in discharging to a facility or transferring to a SNF that ~~does not have an agreement with LHH, then LHH shall assist the resident in discharging to a facility or transferring to a SNF that~~ uses the hospice chosen by the resident.

    b. If a resident requests to discharge or transfer to a facility that provides hospice care, LHH will follow the procedures detailed in this policy for transfers or discharges and is not required to provide a notice of discharge or transfer.

ATTACHMENT:

Attachment A: Residential Substance Use Treatment and Dual Diagnosis Treatment Placement for LHH Residents
Attachment B: LHH Referral Protocol for Opiate Replacement Treatment

REFERENCE:

LHHPP 20-06 Out on Pass
LHHPP 20-07 Against Medical Leave (AMA)
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
NSPP C1.0 Resident Admission and Readmission for SNF

~~physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.~~

Attachments

None.

Approval Signatures

Step Description	Approver	Date
QM Confirmation	Eusi Pease: LHH Data Analytics	Pending
Owner	Nawzaneen Zahir: LHH Chief Quality Officer	07/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

Standards

No standards are associated with this document

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*06/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*08/2026*
Next Review:	*1 year after approval*
Owner:	*Nawzaneen Zahir: LHH Chief Quality Officer*
Area:	*LHH 24 Daily Care Management*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Code Blue, 24-16

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide all residents/patients with cardiopulmonary resuscitation (CPR) in the event of an acute cardiac or respiratory arrest if appropriate, including clinic, pavilion acute and rehabilitation department.
2. The Code Blue process shall also be utilized for choking events, unless specific directive has been expressed in the resident's/patient's Advanced Directive, stating otherwise. Refer to the NPP L 1.0 Emergency Intervention for Choking Policy and Procedure.
3. The Code Blue process shall be utilized in the event of a resident/patient experiencing Autonomic Dysreflexia (AD), seizure, signs and symptoms of a stroke, unresponsiveness, or when staff feels that the medical emergency could be life threatening.
4. The Code Blue process can be used for residents/patients who are DNR/DNI for emergent, reversible situations and the DNR/DNI status will be confirmed immediately and reported to staff and providers at the bedside, unless Advanced Directive states otherwise and/or resident/patient is on comfort care
5. CPR and interventions for choking and possible opioid overdose shall conform to the American Heart Association's standards approved for Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS).
6. All licensed nurses and patient care assistants (PCA) shall be trained and remain current in BLS.
7. All physicians with primary care or general on-call duties shall be trained and maintain current ACLS certification.
8. All LHH staff are responsible for initiating Code Blue activities when cardiac or respiratory arrest occurs for residents/patients who do not show obvious clinical signs of irreversible death and:
    a. Who have requested CPR in their advance directives or declared CPR in their code status; or
    b. Who have not formulated an advance directive, or declared a code status; or
    c. Who do not have a valid DNR order.
9. Personnel responding to code blue calls will follow current LHH infection prevention guidelines for resident/patient isolation status.
10. LHH shall maintain staff preparedness by conducting periodic Code Blue drills.

a. Code Blue Drills will be conducted quarterly.

   i. All disciplines that respond to code blue situations will be required to participate in code blue drills, including physicians, nurse managers, nurse directors, pharmacist, Licensed Nurses (LNs), Respiratory Therapists (RTs) & PCAs/Certified Nursing Assistants (CNAs).

b. The Code Blue Committee, in collaboration with Education & Training, shall develop and implement a schedule identifying the location, shift, and time of the drills and scenarios.

11. Each resident/patient with a documented cardiac arrest who has been resuscitated shall be discharged for further care, unless otherwise expressed via their surrogate decision maker (SDM) or physician. If discharge to another acute hospital is planned, 9-1-1 shall be called for emergency transport. Refer to Appendix 3: 9-1-1 Code Blue Activation Information.
12. A Code Blue Record and Code Blue Checklist shall be completed for every Code Blue event (i.e., whether or not the event is full cardiac or respiratory arrest) and shall be reviewed by the Code Blue Committee.
13. A Code Blue "All Clear" will be called when the resident/patient has either been transferred by EMS, or the medical condition has been stabilized and resident/patient will remain at LHH, or resident/patient has expired and MD has declared death.
14. Any medical emergency which occurs outside the LHH building, or in the Administration building (except Serenity Park, the Chapel, and Gerald Simon Theater), will be a 9-1-1 call (See Attachment 1).
15. In the event of a medical emergency involving a non-resident, (employee, visitor or volunteer), staff should call 911 and a Code Blue immediately. (Refer to Laguna Honda MSSP-001-01 Primary Care Procedures, Appendix A.)
16. ~~A code blue that has been called and is a false alarm, such as resident/patient has been determined to be DNR/DNI and resuscitation efforts will not be performed, alarm was called/pushed in error, or resident/patient does not require emergency intervention. A code blue "cancelled" will be announced overhead.~~

    A code blue that has been called and is a false alarm, such as resident/patient has been determined to be DNR/DNI and resuscitation efforts will not be performed, alarm was called/pushed in error, or resident/patient does not require emergency intervention. A code blue "cancelled" will be announced overhead.
17. CPR data is collected and managed via the defibrillator into a software system for quality improvement purposes. Access to the software system is limited to code blue committee team leaders. No PHI is to be entered into the data system. The system will be audited monthly to ensure no PHI data has been entered.

PURPOSE:

1. To provide clinical care during a medical emergency.
2. To establish guidelines for LHH staff members to respond to a Code Blue event in a rapid, competent, and coordinated manner.

DEFINITION:

Code Blue: Rescue efforts including activating the emergency response system (chain of survival) and CPR activities in the event of a cardiopulmonary arrest or choking.

CPR: An emergency procedure that shall be done without delay to attempt to restore or maintain circulation or

respirations during cardiac and/or respiratory arrest.

PROCEDURE:

1. **Equipment**
    a. Crash Carts
        i. Crash Carts on units will be plugged into red outlets.
        ii. Locations
            - South Tower: Nurse Station 1 with exception of South 4 where it is located in Nurse Station 2.
            - North Tower: Nurse Station 1
            - Pavilion Mezzanine SNF: Nursing Station
            - Pavilion Mezzanine Acute: Nursing Station
            - Clinics: Behind the medical nurses' station
            - Pavilion Ground Floor: Rehabilitation Department exam room
            - Central Supply: Spare crash cart
        iii. Maintenance
            - The crash carts on each SNF neighborhoods, acute units, clinic, and rehab during open hours shall be checked daily by a licensed nurse and maintained in operational condition.
                - If the crash cart seal is broken, or the cart has been used, the cart shall be returned to Central Supply (Materials Management), and a new crash cart shall be provided. When a crash cart is opened during an emergency, if a pharmacist has responded to the code blue, the pharmacist will return the medication tray to pharmacy.
        iv. If a crash cart lock is found unsecured, or if a pharmacist is not present at the code blue, nursing will remove the medication tray and return the tray to pharmacy if pharmacy is open, or place medication tray in the supplemental drug room if pharmacy is not open.
    b. ~~If a crash cart lock is found unsecured, or if a pharmacist is not present at the code blue, nursing will remove the medication tray and return the tray to pharmacy if pharmacy is open, or place in supplemental drug room if pharmacy is not open.~~Automated External Defibrillator (AED)
        i. Locations
            - Respiratory Department (Esplanade Level 1)
            - Wellness Center: behind the front desk
            - Sheriff's Desk – Main Lobby, Pavilion
            - Moran Hall
            - Gerald Simon Theater (Hallway)
            - Cafeteria (Hallway)
            - Kanaley Center
        ii. Maintenance
            - The AEDs are checked, at a minimum weekly, excluding holidays, by designated

department staff.

c. AD Kit (see Appendix 1)

i. Location

- The AD Kit is located in the bottom drawer of the crash cart.
- AD emergency medications shall be placed in the medication drawer of the crash cart in a labeled plastic bag.

d. Magill Forceps (8" and 10"): Stored in the respiratory drawer of the crash cart.

e. Intraosseous access (EZ-IO) and supplies: Stored in the intravenous section of the crash cart.

f. EKG Machine: Stored in Pavilion Mezzanine Acute across from nurses' station.

~~Cervical spine immobilizer board and collar are stored in Pavilion Mezzanine SNF.~~

2. **Initial Code Blue Response**

a. Initiating a Code Blue

i. Activating the Emergency Response:

- If in the resident's/patient's room or clinic exam room, ~~activat~~activate the Code Blue by pressing the Code Blue button behind the head of the bed or on the wall in the clinic room. After pressing the Code Blue button, call 4-2999.
- The ceiling dome lights in front of the resident's/patient's room and zone lights located at the end of each household shall illuminate flashing lights (scrolling of all bulbs).

ii. If the location of the Code Blue is not in the resident's/patient's room, or occurs in Moran Hall, the Chapel, Gerald Simon Theater or other areas of the hospital, or the Clinic, call 4-2999.

iii. Accessing 9-1-1 for Code Blue (see Appendix 3)

- Activate 9-1-1 call from the unit where the emergency is occurring.
- Once the 9-1-1 operator answers, follow the operator's instructions.
- Stay calm and speak clearly.
- State your name and your role.
  "My name is _____and I am a nurse on (state your location) at Laguna Honda Hospital".
- State the nature of the emergency.
  "We have a medical emergency. A patient is in cardiac arrest and is not breathing".
- State the location of the emergency.
  "The patient is located in room _____or location _____".
- State what interventions are in process.

  "A Code Blue has been called and the nurses are starting CPR".
- Wait for further instructions or questions from the 9-1-1 operator. Have the EHR open with this ~~patients~~patient's/resident's chart to provide other demographic information.
- If additional information is asked by the 9-1-1 operator, and you do not have the information, it is okay to tell the operator "I do not have that information right now". Ask the operator if she/he would like you to try to get the information.

- DO NOT HANG UP OR DISCONNECT THE CALL. Wait for further instructions from the 9-1-1 operator.

b. Nursing and Medical Staff Response

i. If emergency medical assistance is needed the first responder (personnel who first arrives on scene~~,~~ or witnesses the change in condition) shall initiate a code.

ii. Staff shall assess for resident's/patient's responsiveness, breathing and pulse per BLS Guidelines.

iii. If no pulse, begin Chest **C**ompression, open **A**irway, and assist **B**reathing using the bag/valve/mask connected to oxygen (**C-A-B**).

iv. Apply the defibrillation/STAT pads and use AED function on Zoll Defibrillator.

v. Check for patient's advanced directive code status. If the resident's /patient's code status is designated a Do Not Resuscitate (DNR), notify the physician.

vi. Resuscitation efforts shall be initiated for all persons experiencing a medical emergency in the Wellness Center.

c. Nursing Office Response

i. Once a Code Blue activation call is received, the Nursing Office personnel shall:

- Announce the overhead "Code Blue" page three times.
- Send a text to the Code Blue pagers with the location of the Code Blue.
- Two staff shall be assigned by the supervising nurse to guide the emergency response team to the location of the emergency.
  - 1 – One to wait near the elevator at the site of the emergency
  - 2 – One to wait at the Pavilion Ground Floor Lobby entrance
- Announce the overhead page "Code Blue All Clear" when notified by the neighborhood or location that the Code Blue has been cancelled.

3. **Physician Response/Coverage for the Site of Emergency**

a. Physician Staff Response during daytime 0800 to 1700, Monday through Friday

i. Both physicians carrying urgent care pagers will respond to all emergencies throughout the hospital.

ii. All physicians in the tower with emergency.

- For Pavilion Mezzanine SNF, Pavilion Mezzanine Acute, Pavilion Mezzanine Acute Rehab and Wellness Center, all Pavilion Mezzanine physicians and South 2 physicians will respond to emergencies.

iii. Code Blue Committee Physicians

b. Physician Staff Response Nights/Weekends

i. All in house physicians

4. **Nursing Response/Coverage for the Site of Emergency**

a. North and South Building

i. Nursing staff from the unit are required to respond to all emergencies on their respective unit/

floor, including elevator and hallway areas.

ii. North Tower: One licensed nurse from North 2 and North 4 shall respond to emergencies in the North Tower. ~~the~~ South Tower: One license nurse from South 2 and South 4 shall respond to the emergencies in the South Tower and all other hospital areas.

iii. A licensed nurse from Pavilion Mezzanine SNF shall respond to each code.

b. Pavilion ~~[including~~including Pavilion Mezzanine SNF, Pavilion Acute Medical and Acute Rehabilitation (also known as the Inpatient Rehabilitation Facility "IRF"), Rehabilitation Department

i. Nursing staff from Pavilion the unit are required to respond to all emergencies on Pavilion.

ii. One licensed nurse from each neighborhood on North 2, and South 2 shall respond to the emergency.

c. Wellness Center

i. A licenses nurse from Pavilion Mezzanine SNF, North 2 and South 2 shall respond

ii. When a Code Blue occurs in the Wellness Center, the Pavilion Mezzanine licensed nurses, or Rehabilitation Department personnel shall bring the crash cart to the site.

d. Clinic

i. Nursing staff from the clinic will be required to respond to all emergencies in the clinic.

ii. A licensed nurse from Pavilion Mezzanine SNF, South 2 and South 4 shall respond to the emergency in the clinic.

e. Serenity Park (previously known as Harmony Park)

i. One licensed nurse from North 2 and North 4 and Pavilion Mezzanine SNF shall respond to the emergency.

ii. The Pavilion Mezzanine SNF licensed nurse shall bring the crash cart to the site.

f. The Chapel, Gerald Simon and all other indoor areas of main hospital building not addressed above

i. One licensed nurse from South 2, South 4 and Pavilion Mezzanine SNF shall respond to the emergency.

ii. The South 2 licensed nurse shall bring the crash cart to the site.

g. Outside the building (see attachment 9)

i. One licensed nurse from Pavilion Mezzanine SNF and licensed nurses from each neighborhood carrying code blue pagers will respond to the emergency.

ii. If enough staff are present, licensed nurse staff will confirm with supervisor if they may return to their assignment. If determined the person in distress is a resident/patient on your unit, remain at emergency to assist and provide any available information.

h. Calls requiring additional assistance

i. When additional assistance is required, unit staff will call the nursing office to page overhead "additional nursing and/or physician support is needed for Code Blue 'at location'."

ii. Nurses within the tower should go to the unit and assess if they are needed.

5. **Roles and Responsibilities**

a. Physician: The first ACLS physician to arrive shall:

i. ~~Be the command physician of the code.~~Code Leader

ii. Announce that they have assumed command of the Code Blue.

iii. Coordinate the resuscitation efforts.

iv. Confer with the unit physician, if available, regarding treatment of the patient.

v. Prescribe mode of treatment and medication.

vi. If present, a second physician shall assist the command physician.

vii. Insertion of intraosseous access, when appropriate if unable to obtain IV access or as determined to be the most effective route for rapid treatment. Refer to LHHPP 24-21 Insertion and Maintenance of Intraosseous Device.

b. Nursing:

i. Performs standard roles, including chest compressions, airway, breathing, obtaining intravenous supplies and insertion of IV by RN, preparing medications, administering medications, applying STAT pads to prepare for defibrillation, recording Code Blue events.

ii. Management of the EZ-IO once access is established and placement verified by the physician.

iii. See Appendix 2: Guideline for Code Blue for Nursing Response for further description of nursing roles and responsibilities.

iv. The licensed nurse from the neighborhood with the Code Blue is responsible for ensuring that the crash cart, emergency box, Workstation on Wheels (WOW) and glucometer is brought to the site of the emergency.

c. Pharmacy:

i. If present during Monday through Friday (non-holidays), a pharmacist shall assist the RN in preparing medications as ordered by the physician.

d. Respiratory Therapy:

i. If present, the Respiratory Therapist shall assist SNF units in maintenance of airway, ventilation, 12-lead EKG, and arterial puncture to obtain arterial blood gas as appropriate.

e. Elevator Access

i. Code Blue team members have keys to call for and to override the elevator in a code blue response.

ii. To use the key to the elevator:

- From outside the elevator, insert key and turn the key to the right to the "ON" position. A period of 90 seconds is given to override the elevator. Remove the key before entering.
- Once inside the elevator, insert the same key and turn right to the "ON" position. Press "CLOSE DOOR". Wait until the doors are completely closed, then press the desired floor number, while continuously pressing the button for the desired floor (i.e., hold your finger on the button). Leave key in the switch until the desired floor is reached. Turn key to left to the "OFF" position and remove key.

6. **Post-Code Blue Activities**

a. Unit Charge Nurse & Nursing Operations

i. Notify Central Supply (CSR) at 759-3349 or 4-2760 that a used crash cart is being exchanged

for a fully stocked crash cart.

- During off shift hours, nursing operations or designee will bring opened crash cart to Central Supply and retrieve back-up cart and bring to unit.
- Crash cart clip boards remain on unit.

ii. If the emergency drug box was used, the Charge Nurse, or licensed nurse designated by the Charge Nurse, shall return it to the pharmacy to be restocked. If the pharmacy is closed, the nursing supervisor shall sign out a replacement emergency drug box from the supplemental drug room.

iii. Gather staff involved in the Code Blue for a Post Code Huddle (debrief), to discuss what went well during the Code Blue and what areas need improvement.

b. Central Processing and Distribution (CPD)

i. CPD shall fax a notification to the pharmacy to replace the used medication tray and to lock the cart. If the pharmacy is closed, CPD shall notify the nursing supervisor to sign out a sealed complete tray of crash cart medications from the supplemental drug room to replace the used tray. CPD shall then lock the cart with a temporary lock and fax a notification to the pharmacy to check the cart and relock. (See Appendix 4-A: Crash Cart Supplies and Equipment and Appendix 4-B: Crash Carts Medications)

c. Team Physician

i. Notifies the family or legal representative, or delegates this responsibility to the attending physician, and shall document this notification/delegation in the medical record.

ii. If the resident/patientis to be transferred to the acute care hospital, the physician shall notify the emergency department physician regarding the resident's/patient's status.

7. **Documentation**

a. Designated Recorder (Preferably Registered Nurse):

i. Complete the Code Blue Record (see Appendix 5: Code Blue Record – MR317).

ii. If available, obtain a printout of the rhythm strip during the Code Blue, place name and MR # on strip and attach to Code Blue Record. Place Code Blue Record with rhythm strip in box for scanning to medical record.

b. Physician:

i. Reviews and signs the Code Blue Record and the Post Code Blue Checklist.

ii. Writes summary of the Code Blue in the Physician Progress Notes.

c. The Nursing Supervisor, Nurse Manager, or Charge Nurse:

i. Ensures that a designated Licensed Nurse is recording the Code Blue events in the Code Blue Record.

ii. Ensures that the Code Blue Record is complete and signed by the recording nurse and the command physician.

iii. Ensure that the code blue huddle has occurred, then completes the Post Code Blue Checklist (See Appendix 7).

iv. Places original copy in HIM scanning bin and sends a copy of code blue record and post code checklist to DPH-LHHCodeBlueCommittee@sfdph.org.

d. Unit Licensed Nurse:

i. Documents the events leading up to the Code Blue, interventions, and resident/patient outcome in the EHR using the significant event nursing note.

8. **Code Blue Drills**

a. Each shift shall have a quarterly Code Blue Drill coordinated by Nursing Education.

b. At the beginning of the drill, the Nursing Office Personnel shall announce three times "Code Blue Drill" identifying the location and, at the same time, shall activate pagers of the Code Blue team members.

c. After completion of the drill the Nursing Office Personnel shall be notified to announce "Code Blue drill all clear" three times.

d. A nursing educator or other designated observer shall use two checklists developed by the Code Blue Committee to monitor the Code Blue Drill process.

i. One checklist shall be used to monitor the initial neighborhood response.

ii. The Post-Code Checklist / Medical Quality Assurance (see Appendix 7) shall be used to monitor the process after the Code Blue responder arrive.

e. The Code Blue Drill Record (see Appendix 6), along with comments from the staff, shall be used by the Code Blue Committee to evaluate the drill.

9. **Quality Review**

a. Nursing Education shall summarize the Code Blue drill records and post-code checklists to review the events, analyze trends, identify problem areas, develop corrective plans, and submit to the Code Blue Committee.

b. The Code Blue Committee shall receive copies of Code Blue drill records and post-code checklists to review during the Code Blue Committee meeting to analyze trends, identify problem areas, and develop corrective plans.

c. The Code Blue Committee Chair shall refer Code Blue events that need additional review to Medical and Nursing QI Committees, Medical Executive Committee, and Performance Improvement and Patient Safety Committee regarding the drills and Code Blue events.

ATTACHMENT:

Appendix 1: Automatic Dysreflexia Protocol
Appendix 2: Guideline for Code Blue for Nursing Response: Roles and Responsibilities
Appendix 3: Accessing 9-1-1 for Code Blue (Script)
Appendix 4-A: Crash Cart Supplies and Equipment (PDF format)
Appendix 4-B: Crash Carts Medications
Appendix 5: Code Blue Record (MR317)
Appendix 6: Code Blue Drill Record
Appendix 7: Post Code Blue Checklist
Appendix 8: Crash Cart Injection Reference Sheet
Appendix 9: Code Blue Outside the LHH Building
Appendix 10: Resident Code Blue Events – Quick Reference
Appendix 11: Emergency Box Contents
Appendix 12: Crash Cart Medication Drawer Contents

REFERENCE:

AHA BLS
ACLS Manuals 2015
Code Blue Record MR317 (3/86; 4/09)
LHHPP 24-21 Insertion and Maintenance of Intraosseous Device
NPP L 1.0: Emergency Intervention for Choking
LHH Pharmacy P&P: 02.03.00 Emergency and Supplemental Medication Supplies
MSPP 001-01 Primary Care Procedures & Policies - Physician Services

MSSP-001-01 Primary Care Procedures, Appendix A

Attachments

- Appendix 01: Autonomic Dysreflexia Protocol
- Appendix 02: Guideline for Code Blue for Nursing Response: Roles and Responsibilities
- Appendix 03: Accessing 9-1-1 for Code Blue (Script)
- Appendix 04: Adult Crash Cart Contents Form
- Appendix 05: Code Blue Record
- Appendix 06: Code Blue Drill Record
- Appendix 07: Post Code Blue Checklist
- Appendix 08: Crash Cart Injectable Medication Reference
- Appendix 09: Medical Emergency on Hospital Grounds, Outside of Hospital Building
- Appendix 10: Resident Code Blue Events
- Appendix 11: Emergency Drug Supply from Pharmacy
- Appendix 12: Crash Cart Medication Drawer Contents

Approval Signatures

Step Description	Approver	Date
NEC	Eusi Pease: LHH Data Analytics	pending
QM Confirmation	Eusi Pease: LHH Data Analytics	08/2026
Owner	Nawzaneen Zahir: LHH Chief Quality Officer [EP]	08/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center





San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

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Owner:	*Dureshehwar Swiger: SFHN ACOO Integrated Rehab and Health at Home*
Area:	*LHH 27 Rehabilitation Care Management*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Referrals for Rehabilitation Services, 27-02

IN-HOUSE REFERRALS FOR REHABILITATION SERVICES

POLICY:

~~It is the responsibility of~~ Laguna Honda Hospital and Rehabilitation Center (LHH) ~~to provide~~provides residents and/or patients with ~~a full range of~~ physical therapy, occupational therapy, and speech pathology services.

PURPOSE:

To assure that each referral is processed and addressed ~~in a timely and efficient manner~~per departmental procedures.

PROCEDURE:

1. Requests for rehabilitation services or evaluations shall be made by the referring physician via the electronic health record (EHR).
2. The evaluation, recommendations and/or subsequent treatments shall be documented in the EHR.
3. Physical therapy, occupational therapy, speech pathology, will respond to referrals within 24 hours for the inpatient acute rehab program, and within 24 – 48 hours for the inpatient short-term rehab program, including new admissions and readmissions.
4. ~~In the event that staffing volume is unable to meet all in-house referrals, physical therapy, occupational therapy, speech pathology, will follow rehabilitation services prioritization guidelines (see Appendix A).~~All other referrals will be addressed according to the department's prioritization standard work and available capacity.

ATTACHMENT:

~~Appendix A: Prioritization Guidelines~~

REFERENCE:

None.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
NEC	Eusi Pease: LHH Data Analytics	pending
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Owner:	*Elvis Lavarreda: Food Service Director*
Area:	*LHH Food and Nutrition Services*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Amounts of Food to Produce, 1.101

Policy:

Service Summary Sheets and Diet Office Tallies are used for production orders in the ~~resident~~residents'~~s~~ meal services.

Purpose:

- ~~To~~ Provide accurate information for determining material necessary to produce the meal.
- To control costs of the institution.
- Insure proper amounts of food are prepared for patients.

Procedure:

1. Two weeks in advance of meal service, the Diet Office downloads the menus into Service Summary Sheets. The ~~supervisor~~Chef and Supervisor will review the ~~down load~~download menus and compare them to last month's tallies. If they need to be updated, he/she will make the appropriate adjustments.
2. One week in advance of meal service ~~service~~ summary sheets are generated through the CBORD systems. They are reviewed by the Chef. Along with the service summary sheets, standardized recipes are generated. They are placed in a binder, located in the Chef's office.
3. The day before meal service, Diet Office Tally will be generated after Selective Menus have been entered into Diet Office. This will be available to the ~~chefs~~chef and supervisors.
4. The Chef will compare the Tally and Service Summary Sheets and update the Service Summary Sheets to match the Tally. If there is a discrepancy, the ~~chefs~~Chef will follow the Tally and discuss it with the Chief Dietitian or Food Service Manager.
5. The ~~chefs~~Chefs or cooks will fill in the amount prepared according to the forecasted amount. Please make note of any added amounts other than forecasted.
6. After the meal service, the diet clerk will download *Accruals* from the Diet Office System into the Post Cost Service Summary Sheets which may be reviewed by the Director.

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Attachments

No Attachments

Approval Signatures

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QM Confirmation	Eusi Pease: LHH Data Analytics	09/2026
Owner	Elvis Lavarreda: Food Service Director [MA]	09/2026

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Laguna Honda Hospital & Rehabilitation Center

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Area:	*LHH Food and Nutrition Services*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Daily Food Production Meetings, 1.102

Policy:

It is important for ~~Chefs~~the Chef or designee to have daily food production ~~meetings~~huddles with cooks and ~~assistants~~assistant kitchen ~~helpers~~staff.

Purpose:

- To ensure that pertinent information concerning the production needs, use of unused portions ~~are~~is communicated through routine production ~~meetings~~huddles.
- To provide a vehicle for follow ~~-~~through on all production decisions.
- To provide reinforcement for communication of production specifications.
- To assure proper utilization of CBORD printed reports.

Procedure:

- Before the start of each shift, the chef in charge will go through the Diet Office Tallies, Service Line Worksheets, Advance Preparation Sheets, Standardized Recipes, and Advance Storeroom Picklist Sheets with all cooks and production ~~assistants~~staff.
- Any production concerns that a cook or ~~assistant~~production staff may have can be brought up at this time and be clarified.
- Any last~~-~~minute changes or update changes can be communicated at this time.
- Updated Standardized Recipes or Service Line Worksheets should be printed, if needed.

Attachments

No Attachments

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Blast Chiller Operational Procedure, 1.104

HACCP STANDARDS – COOLING, HOLDING AND REHEATING OF FOOD

Policy- To maximize nutrient retention of foods after preparation and cooking all hot foods will be held at the designated serving temperature (min 135 ºF).

~~To maximize nutrient retention of~~Purpose - All hot foods ~~after preparation and cooking all hot foods~~that have been cooked or heated that will not be ~~held at the designated serving temperature (165* - 190*) for a maximum of forty-five (45) minutes. All hot foods that have been cooked or heated above 40* that~~served will ~~not~~ be ~~served within forty-five minutes will be~~ cooled rapidly in a 2" (inch) deep metal insert inside the blast chiller until the internal temperature is ~~40*~~41ºF or less. ~~To cool large cuts of meat each piece of meat will be cut into five (5) pound pieces, then cooled in the blast chiller. The temperature of all foods cooked or heated above 40* must be lowered to an internal temperature of 40* or lower with in four (4) hours.~~

Procedure-

1. To cool large cuts of meat each piece of meat will be cut into five (5) pound pieces, then cooled in the blast chiller. The temperature of all foods cooked or heated must be cooled from 135ºF to 70ºF (within 2 hours) and then from 70ºF to 41ºF or colder (within 4 hours) for a total of 6 hours.

2. The PM Cook will coordinate with the AM Cook as ~~to~~to when the meats will be removed from the Baxter or slow cooked ovens and place into the blast chiller. The cook will ensure that the probe(s) be inserted into the meat (or product) that is going into the blast chiller. The cook will start the blast chilling process per manufacturer's operating guide posted on the Blast Chiller. The cook will ID contents of blast chiller. The Chef is accountable to replace Blast Chiller tape if out, when blast chiller is in use, tape must be printed at the end of the cooling process and must be attached to the cooling log report. When ~~Blast chiller is in use, tape must be printed at the end of the cooling process and must be attached to the cover of the product in the refrigerator. When~~ smaller quantities of meat and poultry (under 50#) are cooked and chilled, properly store this meat in the #6 walk-in on the designated shelves and date, label, and cover it.

3. Other staff who use the ~~Blast Chiller~~blast chiller to cool down other food items (~~ie~~i.e: custard) other than meats, should follow the same procedure as described.

4. The Chef~~- Production~~ will take the ~~Blast~~blast chiller tape, review the outcome to ensure that it meets the standards for cooling down the product, label the tape and document it in the ~~Cool Down Log Binder~~cool

down log binder located in the Chef's office. ~~Management~~The Assistant Food Service Director will review the ~~Cool Down Log Sheets on a~~cool down log sheets monthly~~ basis~~.

5. The re-heating of food by means of steam (or other methods) shall commence **not more** than one and one half (1 ½) hours prior to the start of meal service. The recipe will be followed for specific instructions. The reheating of food by steam (or other methods) will not commence until:

5:30am – breakfast

9:45am – lunch

3:45pm – dinner

6. All foods will be reheated to a minimum internal temperature of 165*ºF commencing not more than one and one half-hours prior to meal service.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
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Applicability

Laguna Honda Hospital & Rehabilitation Center

B. Nursing Policy and Procedure Development or Revision

1. The format of a nursing policy and procedure includes the following sections:

   TITLE: Title of the NP&P.

   POLICY: Statement of action to be followed, who has the authority to do it, and where and under what circumstances the action occurs.

   PURPOSE: Statement describing what the policy and procedure is to accomplish.

   CHARACTERISTICS / DEFINITIONS (as indicated):
   Definitions, statements of regulatory basis for policy, delineation of exceptions, or clarifications when applicable.

   PROCEDURE: Describe in concise detail steps required. Procedure can be link to appropriate on-line resources for detailed step by step procedure; and can be referred to equipment and manufacturer's guidelines.

   REFERENCES: Current reference supporting practices preferably evidence-based practice.

   CROSS REFERENCES:
   Reviews and cites hospital-wide and/or other department's policy and procedures that have direct bearing on the nursing policy and procedure.

   ATTACHMENTS / APPENDICES:
   Documents that support or directly relate to implementation of the policy and procedure. May include related nursing practice guidelines, algorithms, tables, product information, documentation tools or reference materials.

2. Utilize the NP&P template on Microsoft Word document for developing/revising a policy and procedure includes track changes.

C. Review and Approval Process

1. LHH NP&P Committee determines the priorities for review of NP&P.

2. The individual or group originating or reviewing a policy is responsible for ensuring comprehensive review of the policy. This may include sending it to the appropriate individuals, committees, departments, or services for review to ensure that the nursing policy is consistent with current standards.

3. Reviewers are expected to participate in this process within time frames for response. Reviewers must consider these factors:
   a. current scientific / evidence-based knowledge
   b. relevance to other policies and procedures (hospital wide and/or departmental)
   c. relevance to and support of practice guidelines
   d. ethical and legal concerns

4. Policy originators or individuals coordinating review shall forward a final draft to the Department of Education and Training NP&P Coordinator, who will move policy forward in the policy approval process (Refer to HWPP 01-01 Approval and Format of Hospital-wide and Departmental Policies and Procedures).

5. Following the JCC approval, the approved NP&P is posted on the intranet..

6. The following individuals sign the LHH NP&P signature page of the manual confirming approval, on an annual basis:
    a. Directors of Nursing
    b. Chief of Medical Staff
    c. Medical Director
    d. Executive Administrator
    e. Director of Public Health as the Chief Executive Officer of the Governing Body

D. Implementation of Nursing Policies and Procedures and Nursing Practice Guidelines

1. Department of Education and Training, and other nursing leaders when appropriate, are responsible for coordinating the training, and/or notification, to nursing personnel regarding new or revised NP&Ps.

2. Nursing leadership, committee chairs, and other manual holders are responsible for updating their NP&P manuals and/or reviewing the updated NP&Ps online.

3. Nursing leaders including but not limited to Nurse Managers, Nursing Directors, Operations Supervisors, MDS/RAI Program Coordinators, and Department of Education and Training are responsible for informing staff of the revised or new NP&Ps and ensuring that NP&Ps are implemented at the departmental/program/unit/shift level.

E. Retention and Destruction of Records

1. The DET NP&P Coordinator is responsible for securely maintaining an up-to-date computer file of all approved NP&Ps.

2. The DET NP&P Coordinator is responsible for retaining the original archival copies of the NP&Ps and related documentation. These original archival electronic copies are maintained for a minimum of seven (7) years.

REFERENCES:

State of California, Title 22, Section 72523

CROSS REFERENCES:

Hospital-Wide Policies and Procedures
01-01 Format and Approval of Hospital-Wide and of Departmental Policies

ATTACHMENT/APPENDIX:

None

Adopted 11/2001

Revised: 03/2005, 10/2007, 03/27/2012; 01/13/2015; 02/26/2024; 07/31/2026

Reviewed: 2024/05/14

Approved: 2024/05/14

Laguna Honda Hospital
Department of Pharmaceutical Services

Policy Number: TBD
Title: Attendance and Punctuality

Policy:

All employees of the Department of Pharmaceutical Services (DPS) will adhere to the guidelines for attendance and punctuality described by the CCSF Employee Handbook.

Per the Employee Handbook (page 13):

> "Regular and prompt attendance is an essential requirement of your job. As a City employee, you are to report to your workstation at your scheduled work time. Your time records must accurately reflect the time you start work and the number of hours worked in every workday.
>
> All planned absences must be requested and approved in advance. If illness or some other emergency causes an unplanned or unforeseeable absence, you must notify your department as soon as possible on the first day of absence, and keep the department advised daily during the absence. In the case of an extended unforeseeable absence, you may be asked to complete forms and submit medical certifications as appropriate during your leave. Improper use of sick leave, failure to present medical certification when required, excessive absenteeism, tardiness, unauthorized absence or failure to notify your department when you are unable to report to work, may result in sick leave restriction, disciplinary action or termination"

Each staff member is responsible for managing their worktime effectively and within the standards described in this policy.

Definitions:

Excessive Absenteeism is when there is more than one day off work per month over a period of time (such as six months or a year). Absences in relation to days off will be critically evaluated. This excludes absences due to approved protected leaves such as FMLA/CFRA, the California Kin Care law, and other protected leaves.

Excessive Tardiness: Excessive tardiness does not refer to an occasional excusable occurrence. Consistent application of a reasonable standard by the supervisor, such as more than once per payroll period, is required.

Absent Without Official Leave (AWOL) - An employee may be considered Absent Without Official Leave if the employee does not contact the designated supervisor within 30 minutes of the beginning of their regularly assigned shift and/or does not report to work at their assigned shift.

Patterns of Unscheduled absence is defined as a pattern of absences occurring before or after holidays, weekends, vacations, regularly scheduled days off; recurrence on the same day of the week.

Unscheduled absence is defined as absences not approved in advance by your supervisor due to illness, emergencies or other unplanned and unforeseeable circumstances, including tardiness and *same day leave requests*

Procedure:

1. Attendance
    a. The DPS Senior Clerk or other designee will maintain an attendance record for each employee.
    b. Use of FMLA and other protected leaves must be indicated when an employee contacts pharmacy management and documented on the timesheet.
    c. Sick pay can only be used for absences (scheduled or unscheduled) according to the sick leave document in the City and County Employee Handbook (page 32-33). Once an employee has exhausted accrued sick pay other accrued time off cannot be used (vacation, floating holiday, compensation time, holidays in lieu, etc) and the timesheet will be coded as unpaid sick leave (USL).
    d. Medical verification of sick leave does not necessarily protect one from being determined to meet criteria for excessive absenteeism or abusive pattern.
    e. Other accrued time off (vacation, floating holiday, compensation time, holidays in lieu, etc) can only be used, in addition to approved leaves, for absences due to scheduled or unscheduled non-medical emergencies.
    f. Accrued time off MAY NOT be used for unscheduled tardiness unless there is a city-wide announcement or emergency that impacted transportation. Your timesheet will be coded as unpaid leave (UPL) for the time you were absent.
    g. Management will review employee's attendance record annually or more frequently when an employee incurs three (3) or more instances of unscheduled absences for a shift in a 3-month period.
    h. If, upon review, the supervisor determines an employee's attendance is excessive and/or a pattern is indicated, the supervisor will initiate coaching and counseling sessions. If improvement is not noted, the supervisor may initiate progressive disciplinary action.

2. On-call Pager Duty
    a. Pharmacists assigned to cover on-call pager duty are not permitted to concurrently use benefited time (i.e. vacation, comp, etc.).
    b. It is the responsibility of the staff pharmacist to communicate directly with the pharmacy supervisor and/or Director of Pharmacy if there is a conflict arises with their on-call pager assignment. For voluntary 'swaps' of on-call assignments (e.g.- for a newly requested vacation), it is the responsibility of the staff pharmacist to coordinate the proposed swap with their colleagues, and communicate the request via email to management for pre-approval .

   Pharmacists who call out sick or otherwise have an emergency while on pager/ standby must inform management as soon as possible, prior to the start of the shift, and the City will reach out to all available staff to volunteer for coverage. If there are no volunteers, the City will use reverse seniority to draft backup coverage,
3. Attendance Review
    a. A review of unscheduled absences and tardiness will be conducted at least once annually and as often as necessary to encourage good attendance.

b. For those individuals who are borderline or already excessive in absenteeism or demonstrate an abusive pattern of absenteeism, supervisors may require that they contact the Leave Department to secure leave if appropriate. Employees who continue to be excessively absent or tardy may be further subject to progressive discipline

4. Sick Leave in Excess of 5 (five) Days
    a. Request for Leave form, or as appropriate a Request for FMLA form, must be submitted and approved for leave in excess of 5 days, including sick leave. The employee is responsible for contacting the Leave Department. After 5 days, the manager may contact the Leave Department to determine the leave status of the employee. Staff should attempt to communicate with the supervisor with any estimations of when they may be able to return to work, whenever possible.

5. Bereavement Leave
    a. Refer to Employee Handbook and MOU for guidance.

6. Abandonment of Post
    a. Abandonment of post is an occurrence where an employee is not in their assigned work area as scheduled without permission from or communication to an area supervisor or designee. This can include an unauthorized break. Abandonment of post is a serious infraction, which will be reviewed on a case-by-case basis.

7. Punctuality
    a. Tardiness is defined as not being at your job station and ready to work when your shift begins, at the end of a meal period or break. Refer to Pharmacy Sick Leave and Tardy Call In policy for Tardy Call in process.

    b. The supervisor or DPS Senior Clerk or other designee will note tardiness or unscheduled early departure on the time sheet.

    c. Upon an initial occurrence, if warranted, the employee will be counseled as to the importance of punctuality and be made aware of other resources, such as EAP and reasonable accommodations, that may meet their individual needs at the time due to a life occurrence.

    d. Management will review employee's punctuality record no less than every year, and more frequently when an employee incurs three (3) instances of tardiness for a shift within a 3-month period.

    e. If, upon review, improvement is not noted, the supervisor will initiate coaching and counseling and, as needed, progressive disciplinary action.

Cross Reference:
Pharmacy Sick Leave and Tardy Call In Policy
CCSF Employee Handbook
MOU SIEU 1021 Misc 2024-2027
Uniform Disciplinary Guidelines, SF DPH

Policy Dates:
ADOPTED:
REVIEWED:

REVISED:

Revised EVS
Policies and Procedures

Current Status: *Pending* **PolicyStat ID:** *21392407*

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*01/2007*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*09/2026*
Next Review:	*1 year after approval*
Owner:	*Shuyan Wu: LHH Director of Environmental Services*
Area:	*LHH Environmental Services*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Transmission-Based Precautions Cleaning Policy, XII

Purpose:

- To reduce the likelihood of transmission of infection by actual contact, direct or indirect.
- To reduce exposure to ~~resident~~residents and staff from potentially harmful pathogens and to provide a clean environment that promotes health and a sense of well-being for the resident.

Material Recommended:

~~For Floor surfaces: Bleach Germicidal Cleaner~~

For floor surfaces: bleach germicidal solution

For Hand Hygiene: hospital grade alcohol hand sanitizer and/or hand soap, following Infection Prevention & Control Precaution

High Touch Surfaces: ~~Neutral Cleaner and Bleach Germicidal~~2-step methods — Oxivir 1 Wipes and bleach germicidal wipes.

PPE- — Perform Hand Hygiene and follow the Infection Prevention and Control Precaution to don/doff appropriate PPE's.

1. **Minimum Cleaning Procedure Includes:**
   On a daily basis, Environmental Services participates as follows:
   i. Perform hand hygiene and don on proper PPEs,
      - Following the Transmission Precautions signs.
   ii. Trash Pick Up:
      - The Porter removes trash from the room.
      - If a special pick-up of ~~Biohazardous~~biohazardous trash is needed (apart from the scheduled pick-up), it may be arranged by ~~phoning request to~~calling EVS ~~Office~~main line extension: 4-4624 or submitting an EVS work order.
   iii. Furniture/High Touch areas
      - All high-touch surfaces, including but not ~~limit~~limited to light switches, walls, doors and

doorknobs, wall-mounted items, must be disinfected with the ~~germicidal beach wipes, and kept visible wet for 3 minutes~~2-step method — Oxivir 1 Wipes (1 minute contact time) and bleach germicidal wipes (3 minutes contact time), and kept visible wet for the required contact time. ~~Let the surfaces air dry.~~

iv. Bathroom or Toilet

- All high-touch areas in bathrooms, including but not ~~limit~~limited to mirrors, fixtures, pipes, toilet seat, and dispensers must be disinfected with ~~germicidal bleach wipes, and kept visible wet for 3 minutes~~the 2-step method — Oxivir 1 Wipes (1 minute contact time) and bleach germicidal wipes (3 minutes contact time), and kept visible wet for the required contact time. Let the surfaces air dry.

v. Floor Care

- Sweep the resident's room and mop with ~~Germicidal Bleach~~germicidal bleach solution.
- Sweep the bathroom and mop with ~~Germicidal~~germicidal bleach solution.

vi. Doff off PPEs and perform hand hygiene before exiting the room.

2. **The Initial Terminal Cleaning Procedure Includes the steps below ~~steps~~. This procedure will be performed when the residents come off the isolation or are discharged from the room.**

a. Perform hand hygiene and don on proper PPEs,

- Following the Transmission Precautions signs.

b. Trash removal and Dusting

- High Dusting of the room, starting from the top of the walls and windows
- Dusting vertical surfaces onto the floor.
- Remove trash liner from waste bins.

  ~~Tie off trash liner.~~

- ~~Wash~~Disinfect the interior and exterior of waste bins with ~~Neutral Cleaner and Bleach Germicidal~~Oxivir 1 Wipes and bleach germicidal wipes if the bins are soiled.
- Allow time for wastebaskets to completely air dry.
- Reline waste bins.

c. Furniture/High Touch areas

- ~~Clean~~Disinfect all furniture and high-touch surfaces ~~twice~~with the 2-step method, including but not ~~limit~~limited to light switches, walls, doors and doorknobs, wall-mounted items, ~~bed side~~bedside tables, inside drawers, etc. ~~Clean~~First, disinfect with ~~Neutral Cleaner~~Oxivir 1 Wipes (1 minute contact time), ~~and after 1 minute clean again~~second, disinfect with bleach germicidal ~~beach~~ wipes (3 minutes contact time). Keep visible wet for the required contact time. Let air dry.

d. Bathroom or Toilet

- Clean and disinfect the bathrooms. ~~Clean~~Disinfect all high-touch areas with the 2-step method, noted in section b, along with mirrors, fixtures, pipes, toilet seat, and dispensers in the bathroom ~~twice~~. First, disinfect with ~~Neutral Cleaner and after~~Oxivir 1 Wipes (1 minute ~~and Germicidal Bleach Wipes~~contact time), second, disinfect the bleach germicidal wipes (3 minutes contact time). Keep visible wet for the required contact time. Let air dry.

e. Floor Care

- Sweep the resident's room floors and mop with ~~Germicidal Bleach~~bleach germicidal solution.
- Sweep bathroom floors and mop with ~~Germicidal~~ bleach germicidal solution.
- Place soiled mops into the white soiled linen bag.

f. Leaving Room

- Using proper doffing ~~technique~~techniques to reduce pathogen transmission and avoid contamination, remove the used gown, mask, and ~~glove~~gloves, and place ~~in~~them in a trash container.
- Performing hand hygiene with hospital graded alcohol hand sanitizer and/or hand soap, following the Infection Prevention & Control Precautions before proceeding to the next station or assignment.
- Clean the bucket and wringer in porter closet ~~dispose of~~and drop the bagged soiled mops ~~in soil mop container in biohazard~~down the linen chutes in the Soiled Utility room.

Addendum: In the event of an emergency, the department may use approved disinfectants and cleaners as an alternative to our standard. Laguna Honda Hospital approved disinfectants: Oxivir 1 Wipes (Quaternary ammonium with TB kill claim and sporicidal on EPA K list), MicroKill Bleach Germicidal Bleach Wipes & Solution, CLOROX Bleach Germicidal Wipes & Solution, and Sani-Cloth Bleach Germicidal Wipes.

ATTACHMENT:

None.

REFERENCE:

LHHPP 72-01 b1 Standard Precaution.

LHHPP 72-01 B2 Hand Hygiene

LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement

LHH EVS P&P XI Hospital Cleaning Step

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
PIPS	Eusi Pease: LHH Data Analytics	pending
QM Confirmation	Eusi Pease: LHH Data Analytics	09/2026
Owner	Shuyan Wu: LHH Director of Environmental Services	09/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

Revised Food and Nutrition Policies and Procedures

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*03/1981*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*09/2026*
Next Review:	*1 year after approval*
Owner:	*Elvis Lavarreda: Food Service Director*
Area:	*LHH Food and Nutrition Services*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Menu Changes and Substitutions, 1.103

Policy:

When menu items are unavailable, a substitution of equal nutritive value will be made.

Purpose:

- To provide for emergencies when scheduled menu items are unavailable.
- To ensure that each resident will receive a nutritionally adequate diet.

Procedure:

- When a menu item is unavailable, the change is made by the Assistant Food Service Director ~~or~~, Chef, or designee with prior approval by the Chief Dietitian.
- Whenever possible, the change will be noted on the menu (tray ticket) and it is properly documented in the Quality Assurance ~~Logbook~~Log-book.
- If it is a last -minute change or substitution and tray tickets are already printed, a note card that indicates that a substitution has been made will be placed on the resident's assigned place.
- The menu change is communicated to the Dietitians, ~~the~~ Food Service Supervisors and ~~Production Chefs~~Chef.
- Any follow ups will be made by the Assistant Food Service Director and Chefs so that the substitution or change does not frequently occur. If needed, it can be further discussed at the ~~Department~~department's ~~Menu Meeting~~menu meeting.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
PIPS	Eusi Pease: LHH Data Analytics	pending

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Step Description	Approver	Date
QM Confirmation	Eusi Pease: LHH Data Analytics	09/2026
Owner	Elvis Lavarreda: Food Service Director [MA]	09/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

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San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*05/1980*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*09/2026*
Next Review:	*1 year after approval*
Owner:	*Elvis Lavarreda: Food Service Director*
Area:	*LHH Food and Nutrition Services*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Returned Food from Tray or Gelley Service, 1.105

Policy:

Food will be returned to the production area after every meal service.

Purpose:

To control food cost.

Procedure:

- At the end of each meal service all unused hot and cold food items will be returned to the ~~Production Area~~production area.
- It is responsibility of the Chef or designated cook to make sure that the unused food ~~are~~is properly stored.
- It is the responsibility of the Assistant Food Service Director to see that the unused food is utilized properly.
- Food and Nutrition Service ~~Personnel~~personnel will not take food from ~~Tray Service or Galley Service~~tray service or galley service; meals are available in the cafeteria.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
QM Confirmation	Eusi Pease: LHH Data Analytics	pending
Owner	Elvis Lavarreda: Food Service Director [MA]	09/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

Revised Nursing Policies and Procedures

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*12/2022*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*09/2026*
Next Review:	*1 year after approval*
Owner:	*Crystal Figlietti: LHH Nursing Director*
Area:	*LHH Nursing*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Nursing Staff Education – Acute Unit, Acute-01.0

POLICY:

1. The Laguna Honda Hospital (LHH) Acute unit are defined as the Acute Medical and Acute Rehab units.
2. It is the policy of LHH to maintain an effective training, orientation, and education program to maintain and improve staff competence and support an interdisciplinary approach to patient care. The acquisition, maintenance, and improvement of competency in nursing staff supports the facility's goal to continuously improve the outcomes of patient care, promote patient and employee safety, encourage employee self-development and serve the public. LHH promotes participation in educational activities by all levels of nursing staff.
3. Acute Unit nursing staff must all complete all orientation, education, training, and competencies required by the distinct part SNF.
4. All Acute Unit nursing staff are oriented to their job performance expectations and pertinent organization and unit policies and procedures prior to independent performance.
5. Successful completion of the Acute Unit Orientation is achieved when assessment of performance indicates that the orientee is competent to perform Acute Unit duties, as evidenced by demonstration of job-related skills and completion of other learning activities.

PURPOSE:

To delineate the responsibilities and procedures related to the provision of nursing staff education and training for the Acute Unit.

To ensure that LHH Acute Unit nursing staff are competent to provide care and services in accordance with current standards and within their scope of practice.

DEFINITIONS:

A. **Competency**: the ability to perform a particular job in specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, skills and/or behaviors.

B. **Orientation**: time specific period introduction to the work setting or job for newly hired and transferred employees. The purpose of orientation is to ensure that all new employees meet minimum standards for health and safety, environment of care, and job specific competencies.

C. **Training**: the provision of knowledge and demonstration of skills related to a particular job or assignment.

D. **Required Elements**: defined criteria by job classification, regulatory requirements, and San Francisco Department of Public Health (SFDPH) and LHH policies, programs or initiatives that are evaluated and documented during the annual performance appraisal cycle. These elements are defined at:

E. **Required Competencies**: defined criteria by specific role that are determine through the evaluation of patient care needs, performance improvement measures, procedures performed, conditions and disease processes, equipment and technology, and professional practice. Like Required Elements, these competencies are differentiated at the organizational, department, and unit level, and are assessed and documented during the annual performance appraisal cycle.

F. **Core Staffing**: Staff that have a regular assignment on or routinely float to the Acute Unit.

G. **Float Staffing**: Staff that do not have a regular assignment on or routinely float to the Acute Unit.

PROCEDURE

A. All nursing staff must complete all education, training, and competencies required by the distinct part SNF at orientation and annually.

   a. New employee orientation will be conducted in accordance with policy 80-05 Staff Education Program.

   b. Nursing orientation occurs for all nursing staff in accordance with policy A6.0 Orientation of Nursing Personnel.

   c. Competencies are completed during orientation, annually and as needed, in accordance with policy A 4.0 Nursing Clinical Competency Program.

B. Acute Unit specific orientation

   a. Acute Unit Nurse Manager or Nursing Director will ensure that all newly assigned core Registered Nurses (RN) to the Acute Unit will receive job-specific training and orientation.

   b. Staff receive training to new competencies within their scope of practice and ability to perform per standard is validated prior to performing the competency unsupervised. Refer to policy Acute-02.0 Documentation of Care – Acute Unit.

   c. All float staff, including RNs, Licensed Vocational Nurses (LVN), and Patient Care Assistants (PCAs), new to the Acute Unit receive a unit-specific orientation to environment of care and unit routine prior to providing patient care. LVNs and PCAs have a limited scope of practice in the Acute Unit and will be supervised by an RN. Refer to policy Acute-02.0 Documentation of Care – Acute Unit.

   d. Documentation of Acute Unit specific orientation and competencies will be completed consistent with policies A 6.0 Orientation of Nursing Personnel and A 4.0 Nursing Clinical Competency Program.

   e. Acute Unit Nurse Manager and Nursing Director will maintain a list of RNs who have received Acute Unit orientation and training.

C. Acute Unit specific annual performance appraisal

   a. Required Elements and Required Competencies may be evaluated throughout the year. Documentation of the annual required elements evaluations and competency assessment is attached to the performance appraisal for incorporation into the personnel record.

   b. Criteria for these competencies may include, but not are not limited to:

      i. Low volume, high risk activities

ii. Regulatory changes
iii. Performance improvement and patient safety data
iv. Practice changes
v. New equipment or technology
vi. Problem prone processes

CROSS REFERENCES

Nursing Policies and Procedures

~~Nursing Policies and Procedures~~
~~Nursing Educational Programs~~
A 4.0 Nursing Clinical Competency Program
~~A 6.0 Orientation of Nursing Personnel~~

A 6.0 Orientation of Nursing Personnel

Nursing Educational Programs

Hospitalwide Policy and Procedure
~~80-05 Staff Education Program~~

File #80-05 Staff Education Program

REFERENCES

~~California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on September 24, 2022~~

~~§70217 – Nursing Service Staff~~

Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 482 — Conditions of Participation for Hospitals. Retrieved from eCFR :: 42 CFR Part 482 -- Conditions of Participation for Hospitals - on September 1, 2026

California Code of Regulations, Title 16, Division 14, Article 4 — Grounds for Discipline, Disciplinary Proceedings and Rehabilitation, §1443.5 - Standards of Competent Performance. Retrieved from Cal. Code Regs. Tit. 16, § 1443.5 - Standards of Competent Performance | State Regulations | US Law | LII / Legal Information Institute on September 1, 2026

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California Code of Regulations, Title 22, Division 5, Chapter 1 §70217 - Nursing Service Staff. Retrieved from Cal. Code Regs. Tit. 22, § 70217 - Nursing Service Staff | State Regulations | US Law | LII / Legal Information Institute on September 1, 2026

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing. Retrieved from Nursing Practice Act on September 1, 2026

~~Standards of Competent Performance, California Code of Regulations, Title 16, Section 1443.5 Department of~~

~~Health and Human Services 42 CFR Part 482 Conditions of Participation for Hospitals~~

San Francisco Civil Service Commission Policies

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
NEC	Eusi Pease: LHH Data Analytics	pending
QM Confirmation	Eusi Pease: LHH Data Analytics	09/2026
Owner	Crystal Figlietti: LHH Nursing Director [JS]	09/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

NURSING POLICIES AND PROCEDURES

POLICIES:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing Executive Committee (NEC) is responsible for coordinating the development, review, and revision of LHH Nursing Policies and Procedures (NP&P).

2. All NP&P require the approval of the Directors of Nursing (DON's) and the Nursing Executive Committee (comprised of LHH Nursing Directors) before approval by additional committees.

3. Nursing Policies and Procedures focus on the structure, function, systems, and processes related to the practice of Nursing at LHH. NP&Ps define nursing administrative and staff performance responsibilities related to specified resident care, operations, and/or administrative functions.

4. Nursing Policies & Procedures are reviewed at least every year in accordance with State of California Title 22 requirements.

5. Laguna Honda Hospital areas that have access to the San Francisco Health Network (SFHN) intranet website are not required to maintain a hard copy of the Hospitalwide Policies & Procedures (HWPP) or NP&P.

PURPOSE:

To describe the procedure for developing, reviewing, revising, and approving LHH NP&P.

CHARACTERISTICS / DEFINITIONS:

Policy – a structure standard that defines the service, practice, and governance rules of an organization or department. A policy indicates what is allowed or expected, who has the authority to do it, where, and under what circumstances.

Procedure – a process standard that delineates a series of actions for the completion of a specific task. Actions are usually performed in a specified sequence to accomplish a specific goal. A procedure provides direction on how to accomplish what is allowed or expected.

PROCEDURE:

A. Nursing Policy and Procedure Committee

LHH Nursing Policy and Procedures are reviewed to promote the development and dissemination of nursing policies and procedures and practice guidelines. Prior to final review and approval by the Nursing Executive Committee, policies are reviewed and, if appropriate, revised by the DONs, Department of Education and Training (DET) Educators, and/or other nursing staff as appropriate on ad hoc basis.

1. Responsibilities
   a. The role of NP&P Committee members is to:
      i. attend meetings and actively participate in the review of NP&Ps
      ii. participate in subcommittees and task forces related to NP&Ps
      iii. provide advice in identified areas of expertise.
      iv. review NP&Ps appropriate to their specialty in consultation with representative nursing staff
      v. review evidence-based practice literature specific to NP&P topics
      vi. ensure that NP&P agree with current nursing practice.
      vii. reviews and sends proposed revisions to the NEC for approval.

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Origination:	*10/2007*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*09/2026*
Next Review:	*1 year after approval*
Owner:	*Crystal Figlietti: LHH Nursing Director*
Area:	*LHH Nursing*
Tags:	
Applicability:	*Laguna Honda Hospital & Rehabilitation Center*

Nursing Services: Organization, Authority/ Responsibility, Operations, A2.0

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.

1. The Directors of Nursing (DON's) {(1) South Tower and (1) North Tower}, or designee:
    a. Report to the Chief Executive Officer/Nursing Home Administrator;
    b. Holds an active Registered Nurse license and is employed by San Francisco Department of Public Health (SFDPH) as a DON on a full-time basis, defined as 40 or more hours per week.;
    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;
    d. Ensures the continuous and timely availability of nursing services to residents/patients;
    e. Ensures that Nursing Practice Guidelines and Nursing Policies and Procedures are consistent with current evidence-based practice and nationally recognized professional standards;
    f. Implements the findings of current research from nursing and other literature into policies and procedures that govern the provision of nursing care;
    g. Ensures that Nursing Services staff carry out applicable processes in resident/patient care and organization wide functions;
    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;
    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;

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;

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

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

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

n. May serve as a charge nurse 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. {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 Executive Officer (CEO)/Nursing Home Administrator (NHA)
- Directors of Nursing Services (DONs)
- Chief Nursing Officer (CNO)
- Nurse Directors
- Nursing Operations Nurse Managers
- Nurse Managers
- Nursing Leadership which supports nursing management and/or resident/patient care functions (e.g., ~~Clinical Nurse Specialists,~~ Minimum Data Set/Resident Assessment Instrument (MDS/RAI) Program Coordinators, MDS Coordinators, Clinical Liaison, EPIC Super-Users, Nursing Recruitment and Hiring Manager, Nursing Orientation Coordinator, and Educators)

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

AUTHORITY/RESPONSIBILITY

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

1. Authority for Nursing Services is specified in the job descriptions of the nursing leadership staff.
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.
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 Directors of Nursing Services, Nursing Operations Supervisors, ~~Clinical Nurse Specialists,~~ 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 in 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 LHH Leadership Organizational Chart. 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 DONs and members of the NEC are responsible for the identification of qualifications required for each classification of nursing positions. The DONs, in collaboration with the Nursing 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 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 Assurance and Performance Improvement 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. Directors of Nursing (Co-Chairs)
        ii. Chief Executive Officer/Nursing Home Administrator
        iii. Chief Nursing Officer
        iv. ~~Nurs~~Nurse Directors
        v. Chair of Nurse Manager Council
        vi. Operations Supervisors

            ~~Clinical Nurse Specialists~~
        vii. Patient Flow Coordinator
    c. The Directors of Nursing 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, and Certified Nurse Assistants who are licensed or certified to practice in the State of California. 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.

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), Patient Care Assistants (PCAs).
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/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 Assurance and Performance Improvement:**

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.

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:~~

CROSS-REFERENCES:

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=I6F56A7E1-D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)~~

REFERENCES:

California Code of Regulations. (2026). Title 22, Division 5, Chapter 3 — Skilled Nursing Facilities. Retrieved from Browse > Title 22. Social Security > Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies > Chapter 3. Skilled Nursing Facilities - California Code of Regulations - last accessed September 2, 2026

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
NEC	Eusi Pease: LHH Data Analytics	pending
QM Confirmation	Eusi Pease: LHH Data Analytics	09/2026
Owner	Crystal Figlietti: LHH Nursing Director [JS]	09/2026

Applicability

Laguna Honda Hospital & Rehabilitation Center

WHEELCHAIR AND GERIATRIC CHAIR CLEANING

POLICY:

1. A. M. Charge Nurse will schedule regular weekly cleaning of wheelchairs and geriatric chairs for A.M. shift Nursing Assistant (CNA/PCA). Any nursing staff, on any shift, may perform spot cleaning as needed.

2. Weekly cleaning of wheelchairs and geriatric chairs are cleaned in neighborhood's bathrooms.

3. Charge Nurse will check that wheelchairs and geriatric chairs are clean and labeled as part of the Environment of Care.

PURPOSE:

To clean wheelchair and geriatric chairs.

PROCEDURE:

1. Use facility-approved disinfectants when cleaning wheelchairs and geriatric chairs.

2. Clean wheelchair & geriatric chairs from top to bottom including all canvas and plastic seats and backs including pressure relieving devices, as well as wheels and pedals.

3. Staff may use soap and water when cleaning wheels to remove dirt.

4. Reporting and/or Documentation:
   a. Any nursing staff must legibly label a tag with the resident's initials. Change label as needed.
   b. Report any broken or defective equipment to Facility Services by submitting an online Facility Services Work Order. (Refer to Facility Services Policy and Procedure EM-10 Manual Wheelchair Maintenance and Repair)
   c. Tag all defective or broken equipment as "Out of Service" until equipment is repaired.

REFERENCES:

Facility Services Policy and Procedure #EM-10 Manual Wheelchair Maintenance and Repair

CROSS-REFERENCES:

None

ATTACHMENTS/APPENDICES:

None

Revised: 08/2000; 02/2010; 09/14/2014; 07/31/2026

Reviewed: 04/15/2025

Approved: 2014/09/09

New Pharmacy
Policies and Procedures

Laguna Honda Hospital

Department of Pharmaceutical Services

Policy Number: TBD
Title: Sick Leave and Tardy call in

Policy:
Employees are required to notify Pharmacy Management when unable to work at their assigned time

Procedures:

1. All employees should call in, whenever possible, and inform the area supervisor and/or Director of Pharmacy at least two (2) hours before the beginning of their scheduled shift to work and provide reasons (e.g Kin Care, SLP) for the absence. Vacation time or comp time cannot be used to cover any sick leave.

2. In *non-emergent* situations, call at least two hours before the start of the assigned shift. If calling between 10pm to 6am please leave a message that will be retrieved in the morning (as there will be no one to receive or act on this information). Exceptions to calling in at least two (2) hours before shift starts are when communication is not feasible or practical (i.e. emergencies, access to phone, etc).

3. Pharmacy staff calling in sick in non-emergent situations shall perform two notifications as noted below:
    a. Notification 1:
        i. Call the Pharmacy Sick Line and leave voice message using the following template.
            Name:
            Shift assigned:
            General details of absence. For example: "sick", "late for shift", "FMLA" etc.

    b. Notification 2:
        i. Communicate the sick call via telephone to area supervisor and/or Director of Pharmacy. If the Supervisor/Director phone accepts texts, that is acceptable. If you don't make contact via telephone, please leave a message.

4. If the employee becomes ill at work, they shall inform the area supervisor or Director of Pharmacy before leaving the work area. If management is not readily available, all reasonable efforts will be made to contact appropriate pharmacy management or pharmacist in the operational area in which you are working.

5. Employees who anticipate being late for the start of the shift or return from a meal break must contact the area supervisor or Director of Pharmacy. The exact time of arrival must be recorded on their time sheet. If an employee is unable to contact the appropriate area supervisor or Director of Pharmacy in advance (e.g. No access to telephone), the employee is to notify pharmacy management upon arrival to the pharmacy. The exact time of arrival must be recorded on their time sheet.

6. Pharmacy management may recognize rare circumstances to authorize an employee to "flex" time by staying late or adjusting time taken lunch. Employees may also flex time if outlined in an approved reasonable accommodation or modified duty. In general, employees are not allowed to "flex" time from their scheduled shift.

    An employee is considered AWOL if the employee does not report to work or communicate to their supervisor or Director of Pharmacy at their assigned shift within 30 minutes of their original shift start time

7. Employees not following these policies and procedures may be coached and counseled or subject to progressive disciplinary actions.

Punctuality

1. Tardiness is defined as not being at your job station and ready to work when your shift begins, at the end of a meal period or break. Refer to Attendance and Punctuality policy.

Cross Reference:

- CCSF Employee Handbook (After You Are Hired: Attendance & Punctuality. Leaves of Absence: Sick Leave)
- LHH Pharmacy Attendance and Punctuality Policy

Policy Dates:
ADOPTED:
REVIEWED:
REVISED:

New Rehabilitation Services Policies and Procedures

AQUATIC SERVICES

POLICY:

1. The Rehabilitation Services Department is responsible for implementing a skilled aquatic therapy program which offers the residents of Laguna Honda Hospital and San Francisco Health Network (SFHN) Clients skilled and restorative therapeutic procedures in an aquatic environment.

PURPOSE:

To define Rehabilitation Service's role in the LHH Aquatics Program.

CHARACTERISTIC:

1. **Definitions:**
    a. "Special Use Pool," as defined in the California Health and Safety Code, Chapter 20, is a "pool designed and used exclusively for a single purpose…" At Laguna Honda Hospital, the pools are therapy pools. They are used for skilled treatment and recreational services for special populations.
    b. "Rehabilitation" refers to the Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) that offers skilled evaluation and treatment services for the aquatic therapy program.
    c. "Restorative Nursing Staff" refers to Restorative Nurse Assistant or licensed nurse of the Restorative Nursing Program that may provide recreation services for applicable residents.
    d. "Therapy Aide" refers to therapy aide of Rehabilitation Department
    e. "Aquatic Services staff" as it relates to Rehabilitation Department refers to physical therapists, physical therapy assistants, occupational therapists, and therapy aides.
    f. "RCT" is the resident care team. This includes multiple disciplines that are responsible for the care of each resident.

2. **Description of Facility:**
    a. The small pool is 12 x 24, with a maximum capacity of eight people (20 sq. ft. per swimmer), and a temperature range of 88°–92°. Its depth ranges from 3 to 5 feet, with a step down into each new level. Access into and out of the pool is by steps or an overhead lift. This pool is used primarily for skilled aquatic therapy programs.
    b. The large pool is 39.6 x 20, with a maximum capacity of 40 people (20 sq. ft. per swimmer), and a temperature range of 85°–90°. There are rails on three sides of the pool for added safety for users. Its depth ranges from 3 to 5 feet, with a sloped bottom. Access into and out of the pool is by a six-step staircase with handrail, by an overhead lift, or hydraulic lift. This pool is used primarily for recreational aquatic programs.

PROCEDURE:

1. **Types of Service:**

a. The Rehabilitation Services skilled aquatic therapy program provides a wide range of services to enhance and facilitate the patient's highest physical, mental, and psychosocial well-being.
    i. Residents must be referred by their attending physician, per the Rehabilitation Services Department P&P 50-03 (Admission and Eligibility Criteria and Referrals to Rehabilitation Services Sources and Forms used for Referral of Patients), and assessed for appropriateness for aquatic therapy.
    ii. Skilled aquatic therapy services include but not limited to, rehabilitation services interventions that require the clinical judgment, assessment, and ongoing modification of a licensed rehabilitation professional (physical therapist or occupational therapist). Aquatic therapy is indicated when the properties of water (buoyancy, hydrostatic pressure, viscosity, and resistance) are medically necessary to achieve functional goals that cannot be safely or effectively addressed with a land-based program alone.

2. Patients may be referred to Restorative Nursing aquatic therapy program and Activity Therapy program as per the respective departments' and/or applicable hospital-wide policies . **Laundry and Cleaning Services**

The Aquatic Services staff will work in conjunction with EVS (Environmental Services, or Housekeeping) to ensure all required regulations are met. See LHHPP 72.01.

3. Pool Maintenance and Safety

The Aquatic Services staff will work collaboratively with Facility Services to ensure that the pool is safe for use and that all health and safety codes are met. See LHHPP 28-04.

4. Infection Control

a. Any person having an infectious or communicable disease that is at risk for transmission in the pool environment is excluded from use of the pool(s). This includes, but is not limited to, anyone with:
    i. Fluid/secretion precautions
    ii. Rashes of unidentified origin
    iii. Fungal infections
    iv. Fever or flu symptoms (must be symptom free for 48 hours)
    v. Untreated communicable disease, or symptoms of a communicable disease (e.g., conjunctivitis, strep throat, respiratory infection)
    vi. Resident/patient is on transmission-based precautions
    vii. Untreated UTI (urinary tract infection)
    viii. MRSA or VRE
    ix. Diarrhea
    x. Wounds
    xi. G-tube, J-tube
    xii. Any draining stoma
    xiii. Colostomy appliances
    xiv. Suprapubic catheters
    xv. Tracheostomy
    xvi. Gastrostomy
    xvii. PICC

xviii. Current suicidal or aggressive ideations
xix. Active tuberculosis
xx. Active stages of Rheumatoid Arthritis
xxi. Hemophilia
xxii. Uncontrolled seizure activity
xxiii. Active Tuberculosis disease

b. Persons having any considerable area of exposed subepidermal tissue (open cuts, blisters, etc.) are excluded from using the pool(s), except if the area is not draining and can be covered by a waterproof adhesive barrier that remains covered and sealed while in a pool and the locker rooms.
    i. Bandages (e.g., band-aids, corn pads, bunion pads) must be removed before entering the pool(s).
    ii. Prescribed Patches must be removed by licensed nursing assigned to the patient/resident before entering the pool. Generally, residents with suprapubic, indwelling, gastrostomy or central line catheters should not enter the pool due to the risk of infection. However, persons with well-established long term invasive tubes may be permitted to use the pool under certain circumstances with physician approval and supporting documentation.
    iii. The benefits of hydrotherapy must be carefully weighed against the risk for infection and discussed with the resident/ decision maker.

c. Incontinence:

    i. Participants must be continent of bowel and bladder, or must be successful and consistent on a bowel/bladder program for at least two weeks.

d. Spitting, spouting water, and blowing the nose in the pool(s) shall be strictly prohibited.

5. Medical Emergency Procedures:

a. If participant has a medical emergency in the water, Aquatic services staff will:
    i. Remove victim from the water using back board if necessary.
    ii. Initiate Code Blue Protocols for inpatient patients as described in reference to LHHPP 24-16.
    iii. Call 911 for outpatient patients
    iv. Monitor participants, stop sessions, and remove others from the water.

REFERENCE:

California Code of Regulations, Title 22, Chapter 20, Public swimming pools

Rehabilitation Services Department P&P 50-03, 60-02

LHHPP 24-16 Code Blue Policy.

LHHPP 28-04 Pool Maintenance

LHHPP 28-03

LHHPP 72-01