List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on May 14, 2024

Status	Dept.	Policy #	Title	Notes
				JCC Follow-up
Revised	LHHPP	22-19	Family Council	1. Added "Upon Admission" section to procedures 2. Deleted "A facility with a family council must" and "any other individual designated by the resident and/or identified on the contract of admission," and ", or in the resident's records" 3. Added "LHH will provide its the family council information to the resident and/or the designated resident representative during the admission process." 4. Added "LHH will provide the family council information to each required within 5 business days after, the resident's admission and will include, in writing, the name and contact information of the family council's designated representative." 5. Deleted "The facility also must" 6. Added "LHH will inform the new resident's family members, representatives, or other designated individuals of their right to have their contact information shared with the family council." 7. Added "LHH will provide the Family Council with the name, email address, and other contact information as provided of anyone who has provided consent to the sharing of their contact information with the Family Council." 8. Added "Family council will be allowed to meet virtually or at an offsite location at its discretion." 9. Deleted "Provide a designated staff person, approved by the family council, who must be responsible for providing assistance and responding to written requests that result from family council meetings." and "A family council must be allowed to meet virtually or at an offsite location at its discretion." 10. Replaced "an alternate staff person to provide assistance and respond to written requests, as needed" with "The designated staff person provided by the facility must be approved by the family council and the family council may request an alternate staff person." 11. Added "i. The Family Council may request an alternate staff person to provide assistance and respond to written requests, as needed." 12. Added "ii. The designated staff person will be responsible for providing assistance and responding to written requests that result from family council meetings." 13. Deleted "The facility must provide the family council with the name, email address, and other contact information of anyone giving written consent to the sharing of their contact information with the family council. These provisions are to be implemented only to the extent not in conflict with state and federal law." 14. Replaced "10 working days" with "14 calendar days" 15. Added "The written responses to the Family Council's written requests, concerns, or recommendations must include whether LHH has taken any action or inaction, and the rationale for that response." Deleted "Prohibited facility actions include willful interference with a family council's participation in governmental surveys or inspection activities performed by any applicable departments or other governmental entities, refusal to comply with the requirements that it publicize family council meetings or to provide appropriate space for meetings and postings, and failure to respond to the family council's written requests, concerns, or recommendations." 16. Added "prominent" and "pertaining to the operation or interest of the" 17. Added "contact information for the Family Council representative, as designated by the" 18. Deleted "the person to contact regarding involvement in the' 19. Added "All Facilities Letter (AFL) 24-08 Updated Information on Family Council Requirements to Include AB 979 – Long-Term Care Family Councils" 21. Added "As per Title 42 Code of Federal Regulations section 483.10(f)(5)-(7), " 22. Added "Family members lead the council and is independently run. The designated LHH staff shall be point of contact for assistance with any identified issues at the Council's request."

Revised	LHHPP	24-10	Coach Use for Close Observation	1. Added "coaching" 2. Added "6. Licensed Nurse must use online portal to request a coach." 3. Added "a. During business hours a request for coach must be submitted via online portal and approved by Director of Nursing or Designee." 4. Added "b. Initial coach assignment for short-term during weekends and off hours can be approved by nursing operations and for ongoing need of a coach, nurse manager must bring this up at morning Stand Up IDT meeting for further discussion and approval by Director of Nursing or Designee." 5. Deleted "6. During regular business hours request for coach still must be submitted via online portal and approved by Director of Nursing or Designee. Nurse Director/Supervisor shall approve all coach assignments based upon the RCT assessment." 6. Deleted "on the job." 7. Deleted "contribute to the electronic health record (EHR)" and "each hour for a" 8. Added "hourly for" and "This documentation must be reviewed by the licensed nurse at the end of their shift and a progress note must be entered in EHR with summary of the findings." 9. Deleted "The Licensed Nurse (LN) shall review EHR coach documentation for their shift and determine if the coach status is initiated, continued, or discontinued." 10. Added "a. RCT must review this documentation during the morning unit level IDT meeting and ensure that PCA/CNA and LN documentation is complete from all previous shifts." 11. Replaced "MD" with "physician" 12. Added "RCT must" 13. Deleted "Implement" and "attempted and have been unsuccessful" 14. Added "Document" and "intervention" and "and prior alternative(s) that have been unsuccessful." 15. Added "Executive review team will provide on-going guidance as needed based on the plan as needed." 16. Replaced "and at least quarterly" with "every two weeks and quarterly" 17. Added "RCT team can utilize the list of sample interventions included in Attachment B." 18. Deleted "The RCT and other consultants may conduct a Focused Review" 19. Deleted "via the EHR" 20. Added "hourly" 21. Deleted the role and responsibility information for "Regular CNA" in Attachment A. 22. Added "Nurse Manager to present the review to morning Stand Up IDT" to the responsibility information for "Resident Care Team" in Attachment A. Also replaced "focused" with "RCT" 23. Added "Appendix B - Sample Interventions" to the end of the policy 24. Added "Coaches are provided education on their duties and expectations at the time of assignment." 25. Added "for the need documented in their individual care plan" 26. Added "Each nurse assigned to a resident requiring close supervision shall provide all resident needs within their scope of practice and not deviate from their roles allowable by law (home health aide, certified nursing assistant or licensed nurse LVN or RN)" 27. Added "This documentation on why the resident was assigned a coach is specific to each resident according to their individualized care plan"
Revised	LHHPP	24-28	Behavioral Health	1. Replaced "Substance Treatment and Recovery Services" with "STARS" 2. Deleted "of Services" 3. Replaced "Therapeutic Activity Programming policies" with "Activity Therapy A02-0 Scope of Services"

Revision	_LHHPP	60-01	Quality Assurance Performance Improvement Program	1. Added ' “Indicator” is a measurement of performance related to a particular care area or service delivered. It is used to evaluate the success of a particular activity in achieving goals or thresholds.' 2. Replaced "Chief Operating Officer (COO)" with "Nursing Home Administrator (NHA)" and "Chief Nursing Officer (CNO)" with "Assistant Nursing Home Administrators (ANHA), Directors of Nursing" 3. Added "Medical Director", "CEO and Nursing Home Administrator" 4. Added "Assistant Nursing Home Administrators i. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems. ii. Participates in and leads performance improvement and patient safety initiatives; and iii. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues." 5. Replaced "Chief Nursing Officer and" with "Directors of Nursing" 6. Abbreviated titles throughout the document' 7. Added "ii. Data collected will represent the care areas considered to be associated with high-risk, high-volume, and/or problem-prone issues. iii. Data collection methodology is to be consistent, reproducible and accurate to produce valid and reliable data, and support all departments and the facility assessment. b. LHH collects data from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the PIPS committee. " to the Use of Data section 8. Added "a. Performance indicators will be established based on data, and will be monitored/evaluated in the QAA Committee meetings. i. A combination of process, outcome, and use measures will be utilized to monitor progress towards goals. The type of measure used will be appropriate to the type of data being collected. ii. Goals will be modified as necessary." the Performance Improvement Methodology section. 9. Added "c. Corrective Action:" details to the Performance Improvement Methodology section. 10. Added "8. Monitoring" section to the document 11. Added "LHHPP 60-04 Unusual Occurrences LHHPP 60-05 Review of Serious Adverse Events" to the reference section.
Revision	_LHHPP	60-03	Incidents Reportable to the State of CA	1. Added "Chief Quality Officer and the Director of Regulatory Affairs in the" 2. Added "Prevention and", "(IPC)" and "Manager" 3. Added "QM, with review by the Chief Executive Officer and Nursing Home Administrator" 4. Added "the Department of Care Coordination Nurse Director " 5. Added "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." 6. Added "Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations. The department shall review Section 70737 of Title 22 of the California Code of Regulations requiring hospitals to report “unusual occurrences” and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement."
Revision	_LHHPP	60-09	Availability of Hospital Reps for Employees Dealing with Regulatory Agencies	1. Added "Administrator on Duty" to the abbreviation. 2. Replaced "legal counsel" with "the City Attorney’s Office (CAO) "
Revision	_LHHPP	60-12	Review of Sentinel Events	1. Replaced "quality improvement coordinator" with "Chief Quality Officer" 2. Deleted "the Administrator on Duty (AOD)," 3. Added "and Nursing Home Administrator" 4. Replaced "Chief Nursing Officer" with "Director of Nursing" 5. Added "/Medical Director" 6. Added "Director of" 7. Deleted "(RM) Nurse Manager " 8. Replaced "AOD" with "Nursing Operations Supervisor and the Chief Quality Officer" 9. Replaced "RM Nurse Manager" with "Director of Risk Management " throughout the document.

Revision	_LHHPP	70-01 C4	Medical Surge Plan	1. Added "LAGUNA HONDA HOSPITAL " 2. Added "To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts during a HICS event when ZSFG is experiencing an acute surge of patients due to a trauma-based mass casualty incident (MCI) or another public health/medical related emergency (PHE)." 3. Added "To identify essential communication and coordination to ensure resident safety." 4. Added definitions for "Condition Yellow" and "Condition Red" 5. Added "ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO or designee when public health emergency conditions exist that require expeditious transfer of patients from ZSFG to LHH." 6. Added "LHH CEO or designee shall confer with Executive leaders to activate LHH Nursing Home Incident Command System (NHICS)." 7. Deleted "LHH will assist in accordance with LHHPP 20-11 Laguna Honda Hospital's Response to ZSFG Condition Code Yellow and Red Alerts." 8. Deleted "The CEO/AOD shall activate NHICS if LHH resident care operations are affected by the response." 9. Deleted all references to LHHPP 20-11 10. Replaced "show up at" with "present to" 11. Added "on the west side of the facility" 12. Deleted the following sections, "LHH Internal Communication and Planning", "Bed Allocation", "External Communication and Coordination", "Documentation" and "Utilization Management (UM) and Billing"
Deletion	_LHHPP	20-11	Laguna Honda Hospital's Response to ZSFG Surge Condition	Content has been merged into 70-01 C4 Medical Surge Plan
Revised Hospital-wide Policies and Procedures				
Revision	_LHHPP	60-04	Unusual Occurrences	1. Added "the" 2. Deleted ", a Committee if the Medical Staff" 3. Replaced "Hospital" with "LHH" 4. Deleted "Charge Nurse" 5. Added "Nursing" 6. Replaced "Administrator on Duty" with "Chief Quality Officer" 7. Added "team" 8. Deleted Laguna Honda On-Line UO Pocket Guide"
Revision	_LHHPP	60-05	Review of Serious Adverse Events	1. Replaced "Department" with "Risk Management team" 2. Replaced "QM" with "Risk Management" 3. Replaced "the AOD" with "QM"
Revision	_LHHPP	60-07	Licensing and Certification Visits	1. Replaced "Risk Management" with "Regulatory Affairs" 2. Added "the LHH" and "team" 3. Replaced "does not" with "is unable to" 4. Added "in a timely fashion"
Revision	_LHHPP	60-08	Risk Management Program	1. Replaced "Hospital-wide" with "facility's" 2. Added "(CAO)" 3. Changed "Department" to "Office" and "SFSD" to "SFSO" 4. Added "Chief Quality Officer and Director of Regulatory Affairs" 5. Replaced "Reporting of Unusual Occurrences to Licensing & Certification (L&C) during regular work hours shall be carried out by the Risk Management Nurses" with "The Risk Management Team shall review UOs during regular work hours and partner with the Regulatory Affairs Team " 6. Replaced "RM Nurse" with "Regulatory Affairs team" 7. Replaced "through established channels" with "as part of the QAPI program" 8. Replaced "DCA" with "CAO" in several places. 9. Added "and Nursing Home Administrator. "10. Replaced "Chief Operating Officer" with "Assistant Nursing Home Administrator, Support Services" 10. Deleted "LHHPP 77-01 Medical or Psychiatric Emergency: Employees, Volunteers, & Visitors" from the reference section.
Revision	_LHHPP	60-10	Environment of Care Program	1. Removed "Employee Health Safety" and " Patient Safety" 2. Changed "Control and Prevention" to "Prevention and Control"

Revision	_LHHPP	60-13	Patient Safety Committees and Plans	1. Added "Environment of Care Committee;", "Pharmacy and Therapeutics Committee;", "Utilization Management Committee; and" and "Nurse Executive Committee Quality and Safety." 2. Deleted "Pressure Ulcer Prevention Performance Improvement Team; Resident Safety and Abuse Prevention Performance Improvement Team; and Occupational Safety and Health." 3. Replaced "Patient Safety" with "PIPS"
Revised Nursing Policies and Procedures				
Revision	NPP	A 1.0	Nursing Policies and Procedures	1. Updated Department titles 2. Aligned P&P with DPH Policy 01-01 3. Removed Nursing Practice Guideline (we now use Standard Work for detailing processes for a desired outcome)
Revision	NPP	E 1.0	Oral Management of Nutritional Needs	1. Added “individualized aspiration precautions” 2. Aligned with HWPP 26-02 3. Removed section on Food Disposal (this is going to be in NPP9.0) 4. Temptrak content removed, already addressed in NPP 9.0
Revision	NPP	D9 9.0	Maintaining Temperatures via Temptrak	1. Clarified that any additional food brought into the facility by residents or for residents consumption is stored in the resident refrigerator located n the Great Room. Nourishments/supplements provided by the facility are stored in the nourishment refrigerator. 2. Clarified to not store food from residents meal trays (opened or unopened) in the nourishment refrigerator
Revision	NPP	RNP	Restorative Nursing Policy	1. Policy on providing maintenance and restorative services designed to maintain or improve a resident’s abilities to the highest practicable level.

JCC Follow-up

FAMILY COUNCIL

POLICY:

As per Title 42 Code of Federal Regulations section 483.10(f)(5)-(7), Laguna Honda Hospital and Rehabilitation Center (LHH) supports the rights of residents and residents' family members, friends, and/or representatives to organize and participate in family groups within the facility.

PURPOSE:

The purpose is to provide a private space in support of residents and residents' family members, friends, and/or representatives to organize and participate in family groups.

DEFINITION:

"Family group" is defined as a group of residents and/or residents' family members, friends, and/or representatives that participate in the Family Council to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.

"Family Council" is defined as the meeting of family members, friends, or representatives of two or more residents to confer privately at the hospital without facility staff present, unless specifically invited.

PROCEDURE:

1. Upon Admission:

   a. ~~A facility with a family council must~~LHH will provide ~~its~~ the family council information to the resident and/or the designated resident representative ~~any other individual designated by the resident and/or identified on the contract of admission,~~ during the admission process~~, or in the resident's records~~.

   b. ~~The facility must~~LHH will provide the family council information to each required ~~individual prior to, or~~ within 5 business days after~~,~~ the resident's admission and ~~must~~will include, in writing, the name and contact information of the family council's designated representative.

   c. ~~The facility also must~~LHH will inform the new resident's family members, representatives, or other designated individuals of their right to have their contact information shared with the family council.

   d. LHH will provide the Family Council with the name, email address, and other contact information as provided of anyone who has provided consent to the

sharing of their contact information with the Family Council.

~~1.~~2. Regular Council Meetings:

a. All residents and residents' family members, friends, and/ or representatives are eligible to participate in family groups.

b. Family Council meetings shall be held at a cadence and time that is requested by the members. LHH will provide a private space at least once a month during the mutually agreed upon hours.

i. Family council will be allowed to meet virtually or at an offsite location at its discretion.

~~Provide a designated staff person, approved by the family council, who must be responsible for providing assistance and responding to written requests that result from family council meetings.~~

~~A family council must be allowed to meet virtually or at an offsite location at its discretion.~~

c. The designated staff person provided by the facility must be approved by the family council and the family council may request an alternate staff person.~~an alternate staff person to provide assistance and respond to written requests, as needed.~~

d. It is the responsibility of the approved and designated LHH staff to coordinate the Family Council meetings, and to make residents and family members, friends, and/ or representatives aware of the upcoming meetings in a timely manner. The LHH designated staff person shall provide the support and services necessary to the Family Council for it to function appropriately.

i. The Family Council may request an alternate staff person to provide assistance and respond to written requests, as needed.

ii. The designated staff person will be responsible for providing assistance and responding to written requests that result from family council meetings.

iii. The designated LHH staff, if approved by the family group, shall serve as a liaison between the group and the LHH staff members.

iv. Family members lead the council and is independently run.~~If the family/resident needs assistance,~~ The designated LHH staff shall be point of contact for assistance with any identified issues at the Council's request.~~'s rwill provide it and will work with the family lead to remove members.~~

~~ii.~~v.

~~b. The designated LHH staff, if approved by the family group, shall serve as a liaison between the group and the LHH staff members.~~

~~c.~~e. The family group may designate a resident or resident's family member, friend, or designated representative to take notes/maintain minutes, or to elect the designated LHH staff to take notes/maintain minutes. Meeting minutes may include, but are not limited to:

i. Names of residents/family members in attendance.

ii. Follow up from previous meetings.

iii. Issues discussed.

iv. Recommendations from the group to facility staff.

v. Names of staff members, speakers, and other guests in the meeting (as invited by the group to attend).

~~The facility must provide the family council with the name, email address, and other contact information of anyone giving written consent to the sharing of their contact information with the family council. These provisions are to be implemented only to the extent not in conflict with state and federal law.~~

~~d.~~f. Staff, visitors, or other guests should only attend if requested by the Family Council.

~~2.~~3. Addressing Concerns or Requests:

a. The Family Council or designated LHH staff shall document concerns or requests in the meeting minutes.

b. LHH shall consider the feedback from the Family Council and act upon the grievances and recommendations concerning proposed policy and operational decisions affecting resident care and quality of life in the facility.

c. The designated LHH staff shall communicate concerns or requests involving other departments to the appropriate department managers.

d. The designated LHH staff shall address the requests or concerns of the Family Council in writing within 14 calendar days~~10 working days~~.

e. The facility shall act promptly upon concerns and recommendations of the council, make attempts to accommodate recommendations to the extent practicable, and will communicate its decisions to the council.

i. The ~~facility's~~ written responses to the ~~family council's~~Family Council's written requests, concerns, or recommendations must include whether ~~the~~

facilityLHH has taken any action or inaction, and the facility's rationale for that response.

e.f. Prohibited facility actions include willful interference with a family council's participation in governmental surveys or inspection activities performed by any applicable departments or other governmental entities, refusal to comply with the requirements that it publicize family council meetings or to provide appropriate space for meetings and postings, and failure to respond to the family council's written requests, concerns, or recommendations.

3.4. Communications:

a. LHH shall provide adequate space on a prominent bulletin board or other posting area to display meeting notices, minutes, newsletters, or other information pertaining to the operation or interest of the family councilofFamily Council interest to the family council.

b. LHH shall include notice of the Family Council meetings in at least a quarterly mailing.

   i. LHH shall inform family members, friends, and/or representatives of new residents who are identified on the admissions agreement, during the admissions process, or in the resident's records, of the existence of the Family Council. The notice shall include the time, place, and date of meetings, and contact information for the family councilFamily Council representative, as designated by the the person to contact regarding involvement in the Family Council.

ATTACHMENT:
None.

REFERENCE:
All Facilities Letter (AFL) 23-16 Clarification on Family Council Requirements
Title 42 Code of Federal Regulations section 483.10(f)(5)-(7)
All Facilities Letter (AFL) 24-08 Updated Information on Family Council Requirements to Include AB 979 – Long-Term Care Family Councils

Revised: 23/09/12 (Year/Month/Day)

Original adoption: 2023/07/11 (Year/Month/Day)

COACH USE FOR CLOSE OBSERVATION

POLICY:

1. Nursing Services at Laguna Honda Hospital and Rehabilitation Center (LHH) is responsible for providing close observation ~~-~~(coaching) of residents when needed. The term "coach" is used to describe 1:1 close observation to any resident who requires additional support and/or supervision. It is synonymous with the term "alternate assignment" The ~~nur~~nurse manager/charge nurse in collaboration with Nursing Operations staff are responsible for allocating staff for coach assignment to provide the appropriate level of supervision.

2. Resident behaviors that may require 1:1 close observation include but are not limited to the following:

   a. High risk for falls

   b. Impulsive behavior

   c. Risk for aggression

   d. Elopement risk

   e. Intrusive behavior

   f. Harm to self or others (See Policy #3)

   g. Other extenuating needs as determined by Resident Care Team (RCT) and with the approval of Nursing Director/Nursing Operations

3. Long-term close observation measures are not intended for residents who are having suicidal ideation (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.

   a. For residents who are having active suicidal ideation and ~~and~~~~has~~have scored at medium risk or higher ~~scored at medium risk,~~ on the Columbia Suicide Severity ~~Rarting~~Rating Scale (C-SSRS) a temporary coach shall be provided while waiting for further psychiatric evaluation. Coaches are provided education on their duties and expectations at the time of assignment.

4. The need of a coach is a nursing decision and is intended as a short-term intervention while developing a long-term plan for resident safety.

5. The RCT is responsible for documentation of the initial assessment and ongoing evaluation/need for close observation measures.

6. The Licensed Nurse ~~must~~will use the online portal to request a coach after agreement from the Resident Care Team.

   a. During business hours a request for coach must be submitted via online portal and approved by Director of Nursing or Designee.

   b. Initial coach assignment for short-term during weekends and off hours can be approved by nursing operations and for ongoing need of a coach, nurse manager must bring this up at morning Stand Up Interdisciplinary Care Team (IDT) meeting for further discussion and approval by Director of Nursing or Designee.

~~During regular business hours request for coach still must be submitted via online portal and approved by Director of Nursing or Designee.Nurse Director/Supervisor shall approve all coach assignments based upon the RCT assessment.~~

~~6.~~7. Coaches shall provide continuous close observation ~~of~~for engage the resident as appropriate for the need documented in their individual care plan and provide all care needs within the scope of their licensure or certification while refraining from the following:

   a. Speaking in a non-business language or a language the resident does not understand,

   b. Using personal cell phone,

   c. Reading,

   d. Sleeping ~~on the job.~~

8. Each nurse assigned to a resident requiring close supervision shall provide all resident needs within their scope of practice and not deviate from their roles allowable by law (home health aide, certified nursing assistant or licensed nurse LVN or RN).

~~7.~~9. LHH Patient Care Assistant (PCA)/ Certified Nursing Assistant (CNA) are expected to ~~contribute to the electronic health record (EHR)~~ documentation ~~each hour for a~~hourly for resident who is provided with a coach. This documentation on why the resident was assigned a coach is specific to each resident according to their individualized care plan. ~~–~~ This documentation must be reviewed by the licensed nurse at the end of their shift and a progress note must be entered in ~~EHR~~her. ~~with summary of the findings~~. Refer to section 3 Documentation below for additional guidance.

~~8.~~10. The team leader/charge nurse is responsible for checking the resident's condition frequently and as needed.~~.~~

~~9. The Licensed Nurse (LN) shall review EHR coach documentation for their shift and determine if the coach status is initiated, continued, or discontinued.~~

PURPOSE:

To provide a therapeutic and physically safe environment with appropriate level of supervision for residents who have been determined to have safety needs that exceed routine care and intervention measures.

PROCEDURE:

1. **Role of the RCT**

~~RCT must review this documentation during the morning unit level IDT meeting and ensure that PCA/CNA and LN documentation is complete from all previous shifts.~~

a. If the RCT determines that a resident's behaviors and condition require close observation, the RCT shall do the following:

i. Assess ~~the~~ needs.

- The RCT (at a minimum, the ~~MD~~physician and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.~~.~~

ii. RCT must ~~D~~ddevelop an observation and intervention plan as follows:

- Possible close observation measures may include, but are not limited to:

- Increasing/decreasing the frequency of observation time periods

- Assignment of staff to provide close observation of ~~/cohort residents~~ residents needing ~~close~~ such observation.

- Develop measurable goal/s related to the use of close observation.

- ~~Implement~~ Document the intervention plan and prior alternative(s)~~-~~ that ~~has~~ have been unsuccessful~~attempted and have been unsuccessful~~.

Executive review team will provide on-going guidance as needed based on the plan as needed.

- The nurse manager/charge nurse shall assign staff as permitted, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse/team leader shall round frequently to check on the resident's condition and for updates.

- Any request for additional staff used as coach shall be made through the Nursing Office.

- When a resident's family member or significant other assists with the resident's care and observation, the care plan shall reflect their participation and education. Nursing staff shall maintain overall responsibility for the care provided to the resident, including appropriate education on safety measures to be given to the resident, family and/or staff providing close observation of the resident.

iii. Evaluate the plan.

- While close observation is implemented, the RCT shall meet regularly, every two weeks ~~and at least quarterly~~and quarterly to:

- Review any changes in resident's condition.

- Assess effectiveness of current interventions.

- Evaluate resident goals and the need for ongoing close observation. ~~RCT team can utilize the list of sample interventions included in Attachment B~~.

- The RCT shall summarize each meeting via EHR.

- If resident is not progressing with support of a one-to-one coach, the Resident Care Team will evaluate and may refer to the Department of Care Coordination for potential transfer or discharge to another appropriate facility.

~~- The RCT and other consultants may conduct a Focused Review~~

~~- If no progress is made, resident case may be referred to clinical leadership for long term placement.~~

2. Role/Expectations of the Coach Providing Close Observation

a. A coach should be made aware of three important aspects of their assignment:

i. Why they are assigned to the resident.

ii. What goals are identified for this resident.

iii. What interventions can be employed with the resident.

b. T~~he coach may provide close observation for one or more residents (cohort/alternate assignment).~~ All staff that are assigned to be coaches ~~coach staff that are LHH employees~~ are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:

i. Reporting to the charge nurse at the start/end of their shift for endorsements and obtaining shift endorsement from outgoing coach.

ii. Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.

iii. Engaging the resident with goal-focused resident-centered interventions and ongoing activities.

iv. Observing, reporting, and documenting resident behavior, including observation antecedents the agitate or improve resident behavior.

v. Providing nursing care as within their scope, which may include feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and pivot transfers as ordered.

vi. Ensuring environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.

vii. Contributing to the RCT discussions and/or plan of care.

viii. Transporting/escorting residents to internal/external scheduled appointments.

ix. Other duties as assigned, including specific responses to certain needs of the resident.

c. Coaches shall not leave residents unattended under any circumstances and are to use call light to summon for help/breaks/etc.

d. Registry coaches shall perform all the duties as outlined above. Registry coaches may assist the LHH nursing assistant or licensed nurse but may not perform the following tasks independently:

i. Feeding residents on a Specialized Feeding Plan

ii. Showering/bathing

iii. Use of any equipment or assistive devices for which they have not been trained.

3. **Documentation** (See Attachment A for table reference)

a. The coach providing the close observation shall identify and report physical changes to the Licensed Nurse such as alterations in gait that may increase risk of falls, changes in urination and bowel patterns, changes in skin, level of weakness, and vital signs. They shall also report any observable non-physical changes in demeanor, appetite, sleep patterns, increased confusion or agitation, and reports of pain and document their observations, as well as any potential antecedents and interventions. ~~via the EHR~~.

b. LHH PCA/CNA who are assigned as coaches are expected to complete~~e EHR~~ documentation hourly.

c. The behavior monitoring flowsheet shall be completed regularly by nursing and other clinical staff as appropriate. LHH Nursing Weekly Summary shall be completed by the LN via EHR to include any changes reported by coaches.

d. The care plan shall be updated by LN on an ongoing basis and include any new interventions for addressing the safety needs of the resident, including the ongoing need for close observation as an intervention.

e. Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.

f. Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

ATTACHMENT:
Attachment A: Coach Use for Close Observation Roles and Responsibilities

~~Attachment B: Sample Interventions~~

REFERENCE:
None.

Revised: 21/07/29,00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10, 21/10/12, 22/12/13, 23/06/13, 23/10/10 (Year/Month/Day)
Original adoption: 98/11/16

Attachment A: Coach Use for Close Observation
Roles and Responsibilities

Role	Responsibility
LHH PCA/CNA	• Responsible for all duties within their scope of practice for assigned resident. • Documents ~~via EHR~~ and communicates resident behaviors to regular CNA and or team. • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Registry Coach	• May assist LHH nursing assistant or licensed nurse but not use any equipment or assistive devices for which they have not been trained
~~**Regular CNA**~~	~~• Completes EHR documentation with input from Coach~~ ~~• Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet~~
Charge Nurse/ Licensed Nurses	• Assigns coach based upon available nursing staff. • Gives report to oncoming coach • Completes rounds frequently for updates • Documents any behaviors in EHR behavior monitoring flowsheet • LN will review EHR coach documentation for their shift and determine was the coach status initiated, continued or discontinued.
Resident Care Team	• Assesses need for Close Observation • Conducts ~~focused~~ RCT review to evaluate continued coach need • May provide focused review with consultants • Nurse Manager to present the review to morning Stand Up IDT

	• May refer to Clinical Leadership for placement

~~Appendix~~ Attachment B –: Sample Interventions

~~INTERVENTIONS:~~

~~Did you introduce yourself and explain why you are there?~~

~~Engage your resident~~

- **~~Stroll with the resident (along side)~~~~Go on a walk with the resident on the floor or around campus (along side at safe distance not behind~~**
- **~~Learn their likes and dislikes~~**
- **~~Ask them questions about themselves (if not aphasic)~~**
- **~~Offer nourishment (after checking dietary plan)~~**
- **~~Play games~~**
- **~~Check in/involve with aActivity Ttherapy to inquire if they have any suggestions to engage your resident's participation or interest~~**

~~ELOPEMENT~~

- **Assess Mental Status for delusions leading to AWOL**
- **Engage resident in meaningful activity.**
  - **What do they enjoy doing?**
  - **Use short attention span to your advantage.**
- **Engage in conversation, if possible.**
- **Ask them if they have a preferable location outside LHH (in care they do elope)**
- **Active Pathfinding on neighborhood, if possible.**
  - **Stroll alongside resident (not behind)**
  - **Avoid visual cues that may prompt behavior (ie: Doors that are frequently used.)**
- **Use of Aeroscout if appropriate**

~~ELOPEMENT~~ AGGRESSIVE BEHAVIOR

- **Use your SMART /CPI Training to ensure everyone's safety.**
- **Do not get pulled into power struggles**
- **Set firm boundaries**
- **Think about how to improve the residents' health and behavior**
  - **Is the current location too stimulating?**
  - **Are changes needed in their room or surroundings?**
- **Mirror positive behaviors**
  - **Sing with the resident**
  - **Walk with the resident**
- **Know your resident; understand the meaning behind their behavior.**
- **Recognize and report changes in behavior**
- **Relieve anxiety, comfort**

~~FALLS~~

- Low bed
- Call light within reach
- Keeping most used items within reach
- Room close to nursing station
- Noise level – reduce noise decreases falls
- Non-Skid marking on floor
- Pad by bed when resident is in bed- Remove when out of bed.

i. Remove room clutter, ensuring cords are out of the way
ii. Ensure adequate lighting in room

- Anticipate needs
    1. Toileting schedule, provide timely incontinence~~t~~ care
    2. Keep favorite items close
    b. Any assistive devices?
    1. Walker – are they using equipment safely?
    2. Glasses etc.
- Check for restorative ambulation program in resident chart through PT/OT.
- Assist with regular ambulation schedule.
- Assess for well-fitting shoes
- Assess for pain to ensure its being addressed and managed appropriately
- Assess for poor vision and poor hearing
- Poor W/C positioning – use of dycem if needed to reducing slipping from cushion
- Assess for BP
- Pharmacy/MD to evaluate meds.
- Assess for medication interactions and side effects from medication
- Visual checks Q2 hours
- Assess use of assistive devices i.e. bedside commode if appropriate
- Proper clothing to prevent tripping
- Assess for any changes in resident behavior/Run labs if necessary
- Assess environment to reduce risk of injury
- Minimize bed rest
- ~~Provide timely incontinent care~~
- Use anti-skid material if appropriate on all surface

~~GRESSIVE BEHAVIR~~ AG~~GRESSIVE BEHAVIOR~~

~~Suicide/Safety~~

~~SUICIDAL IDEATION~~

- **Conduct suicide risk assessment**
- **Perform environment risk assessment and remove features that could be used to attempt suicide**
- **Manage psychiatric symptoms with appropriate treatment**
- **Validate resident's experience of psychological pain and express desire to help without false promises.**
- **Assign room near nursing station**
- **Conduct safety search for any potential weapons or medication if appropriate**
- **Limit access to windows and exits**
- **Place the resident in least restrictive, safe and monitored environment**
- **Create strategies to decrease isolation and opportunity to act on harmful thoughts (i.e. activities, sitter etc.)**
- **Provide plastic cutlery during meals**

BEHAVIORAL HEALTH CARE AND SERVICES

POLICY:

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

PURPOSE:

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

a. Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;

b. Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being;

c. Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;

d. Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;

e. Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated.

DEFINITIONS:

1. Highest practicable physical, mental, and psychosocial well-being:

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

2. Mental Disorder:

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

3. Substance Use Disorder (SUD):

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

4. Trauma:

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

5. Post-traumatic stress disorder (PTSD):

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

6. Depression:

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

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

in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

7. Anxiety and Anxiety Disorders:

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

8. Non-pharmacological Intervention:

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

BACKGROUND:

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

1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment.
3. The facility will ensure that necessary behavioral health care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.
4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.

5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to:

   a. Depression – It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.

   b. Anxiety and Anxiety Disorders – There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder.

   c. Schizophrenia – It is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.

   d. Bipolar Disorder – It is a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly.

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

PROCEDURE:

1. Assessment and Reassessment

a. LHH utilizes the comprehensive assessment and reassessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes, but is not limited to:

   i. PASARR screening.

   ii. Obtaining history and prior level of functioning from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health.

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

   iv. Care plan development and implementation.

   v. Evaluation.

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

2. Care Planning

The care plan shall:

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

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

c. Reflect the resident's goals for care.

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

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

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

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

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

3. Interventions, Monitoring and Documentation

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

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

c. The RCT shall be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress. Identifying the frequency, intensity, duration,

and impact of a resident's expressions or indications of distress, as well as the location, surroundings or situation in which they occur, may help the RCT identify individualized interventions or approaches to care to support the resident's needs.

d. Individualized, non-pharmacological interventions shall be developed and implemented to help meet behavioral health needs of all ages. These may include, but are not limited to:
   i. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);

   ii. Encouraging exercise;

   iii. Providing pain relief;

   iv. Individualizing sleep and dining routines;

   v. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;

   vi. Adjusting the environment to be more individually preferred or homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);

   vii. Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment when possible);

   viii. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns;

   ix. Assisting the resident outdoors in the sunshine and fresh air (e.g., in a non-smoking area for a non-smoking resident);

   x. Providing access to pets or animals for the resident who enjoys pets (e.g., a cat for a resident who used to have a cat of their own);

   xi. Assisting the resident to participate in activities that support their spiritual needs;

   xii. Assisting with the opportunity for meditation and associated physical activity (e.g., chair yoga);

   xiii. Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal

reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;

xiv. Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing;

xv. Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible (see MSPP D1608-07 Clinical Services for Residents and Patients with Substance Use Disorders LHH Substance Treatment and Recovery ServicesSTARS).

xvi. Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy (see MSPP D08-03 Access to LHH Psychiatry services); and

xvii. Providing support with skills related to verbal de-escalation, coping skills, and stress management.

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

f. If indicated, referrals for LHH Psychiatry services can be made (see MSPP D08-02 LHH Psychiatry Scope of Services and Organization; MSPP D08-03 Access to LHH Psychiatry Services).

i. Services by LHH Psychiatry providers (and related policies) include:

- psychotropic medication management (MSPP D01-05)
- mental health services (MSPP D08-09)
- substance treatment and recovery services (STARS, including Non-specialty outreach and engagement of resident with SUDs and specialty substance treatment, MSPP D08-07)
- neuropsychological and psychological testing services (MSPP D08-08)
- behavioral management services (including behavioral consultation, behavioral planning, and Health and Behavior Services, MSPP D08-10)

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

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

approved authorization form for such treatment information to be shared with the RCT (for details see MSPP D08-07 Substance Treatment and Recovery Services, Section 7).

- If the resident gives such consent, LHH Psychiatry providers will document summary information about the resident's specialty SUD treatment in LHH EHR.
- If the resident does not give such consent, LHH Psychiatry providers may only document in Epic behavioral health treatment information that is NOT about specialty SUD treatment, such as:

  - Mental Health Assessment and treatment;
  - Neuropsychological services;
  - non-specialty level SUD services;
  - Psychotropic medication treatment; and
  - Behavioral consultation and planning recommendations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) The resident’s right to have a leave of absence and the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).

2) Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable.

3) Steps the facility may take if substance use is suspected, which may include:

- Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents.
- Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff.
- Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition.
- Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others.

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

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

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

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

4. Staff Training

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

a. Person-centered care and services that reflect the resident's goals for care.

b. Interpersonal communication that promotes mental and psychosocial well-being.

c. Meaningful activities which promote engagement and positive meaningful relationships.

d. An environment and atmosphere that is conducive to mental and psychosocial well-being.

e. Individualized, non-pharmacological approaches to care.

f. Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, substance use disorder, or other behavioral health conditions.

g. Care specific to the individual needs of residents that are diagnosed with dementia.

h. Care specific to residents with ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care.

ATTACHMENT:

REFERENCES:

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

14. MSPP D08-03 Access to LHH Psychiatry Services
15. MSPP D01-05 Psychotropic Medication Management
16. MSPP D08-09 Mental Health Services
17. MSPP D1608-07 ~~Subtance Treatment and Recovery Servicies~~ Clinical Services for Residents and Patients with Substance Use Disorders
18. MSPP D08-01 Psychiatric Emergencies
19. ~~Therapeutic Activity Programming policies~~ Activity Therapy A02-0 Scope of Services
20. HWPP 20-04 Discharge Planning

Most recent review: 2023/01/20 (Year/Month/Day)
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QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPI)

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

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

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

PURPOSE:

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

This is achieved by:

1. Collaboration of the Governing Body, Joint Conference Committee, and Hospital Leadership to establish annual performance goals directly linked to the LHH True North Metrics.

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

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

4. Establishing a "just-culture" framework that addresses both systems issues and human behaviors that can undermine performance and patient safety.

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

6. Review and follow-up on Patient/Resident Safety Events – includes adverse events or potential adverse events that are determined to be preventable; and healthcare-associated infections.

7. Ensuring that proactive risk assessments and process improvements are communicated to managers and those directly involved when appropriate.

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

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

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

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

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

DEFINITION:

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

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

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

"Indicator" is a measurement of performance related to a particular care area or service delivered. It is used to evaluate the success of a particular activity in achieving goals or thresholds.

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

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

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

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

PROCEDURE:

1. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) COMMITTEE

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

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

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

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

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

v. The PIPS Committee is a Joint Hospital Leadership and Medical Staff Committee. The Committee shall consist of the following members: Chief of Medicine or designee, Chief of Physical Medicine and Rehabilitation Services or designee, Chief of Outpatient Clinics or designee, Chief of Psychiatry or

designee, Chair of the Medical Quality Improvement Committee or designee, Chief Dietician or designee, Chief Health Informatics or designee, Director of Social Services or designee, Director of Pharmacy or designee, Director of Activity Therapy or designee, Infection Prevention and Control Officer or designee, Director of Rehabilitative Services or designee Privacy/Compliance Officer or designee, Director of Regulatory Affairs, Director of Risk Management, Director of Performance Improvement, Quality Improvement Coordinators and a Deputy City Attorney. Executive Leadership Team members, including the Chief Executive Officer (CEO)/Nursing Home Administrator (NHA), ~~Chief Operating Officer (COO),~~Assistant Nursing Home Administrators (ANHA), ~~Chief Nursing Officer (CNO),~~ Directors of Nursing and Chief of Staff are committee members. The Chief Medical Officer/Medical Director (CMO) and the Chief Quality Officer (CQO) serve as the Co-Chairs of~~serves as Chair of~~ the PIPS Committee~~, and the Chief Quality Officer serves as Co-Chair~~.

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

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

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

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

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

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

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

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

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

ix. Reviews and approves the QAPI plan.~~;~~

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

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

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

2. THE GOVERNING BODY

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

a. Approves the LHH QAPI Plans for SNF and Acute units.~~;~~

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

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

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

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

3. INDIVIDUAL ROLES AND RESPONSIBILITIES

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

b. LHH Chief Executive Officer/ Nursing Home Administrator ~~and Assiatant Nursing Home Administrators~~

i. Assumes overall administrative accountability and responsibility for the LHH QAPI Program; and

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

c. Assistant Nursing Home Administrators

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

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

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

d. Chief Medical Officer

i. Works with the ~~Chief Quality Officer~~CQO to develop and implement the QAPI Program;

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

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

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

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

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

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

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

e. Chief Quality Officer

i. Develops, implements, and monitors the QAPI Program under the direction of the LHH CEO;

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

iii. Administers the Unusual Occurrence System;

iv. Analyzes data for trends and makes recommendations to reduce or prevent incidents that may adversely affect patient care or the safety of patients/residents, visitors, employees and visitors;

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

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

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

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

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

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

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

f. The ~~Chief Nursing Officer and~~ Director(s) of Nursing: Ensures that Nursing quality improvement activities are clearly delineated and implemented in alignment with the QAPI Plan and True North.

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

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

ii. Develop and implement performance improvement activities in accordance with the QAPI Program;

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

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

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

h. Medical Director for Risk Management

i. As a role covered by the Chief Medical Officer or Assistant Chief Medical Officer, the Medical Director of Risk Management~~P~~ provides medical oversight of the management of SAE, SE, the Unusual Occurrence system and the process for around-the-clock reporting of patient safety events; ~~and~~

i. Director of Regulatory Affairs and Director of Risk Management

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

j. Patient/Resident Safety Osafficer

i. The Patient/Resident Safety Officer collaborates with the ~~Chief Quality Officer~~CQO, Director of Regulatory Affairs, Director Risk Management,

~~Chief Medical Officer~~CMO, Nurse Director of Education and Training in developing and planning the Patient/Resident Safety Plan;

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

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

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

k. Nurse Director of Education and Training

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

~~i.~~

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

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

l. Infection Prevention and Control Nurse

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

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

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

m. LHH Staff and Providers

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

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

ii. participate in performance improvement and patient safety activities;

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

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

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

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

4. COMMUNICATION PATHWAYS AND REPORTING

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

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

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

5. IDENTIFICATION OF POTENTIAL PATIENT SAFETY ISSUES

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

a. Performance improvement data, including performance measures.

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

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

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

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

ii. Comments from Patient Satisfaction surveys, and/or

iii. The grievance process.

6. USE OF DATA

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

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

ii. Data collected will represent the care areas considered to be associated with high-risk, high-volume, and/or problem-prone issues.

iii. Data collection methodology is to be consistent, reproducible and accurate to produce valid and reliable data, and support all departments and the facility assessment.

b. LHH collects data from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the PIPS committee. Once a potential problem is identified, the committee utilizes a systematic approach (e.g., Five Whys, flowcharting, fishbone diagram, etc.) to help identify the root cause of the problem.

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

d. The PIPS Program encompasses data and information collected from the following

established processes:

i. The facility assessment
ii. Grievance logs

iii. Minimum Data Set

iv. Quality measures

v. Survey outcomes

vi. Medication errors, including near misses

vii. Adverse Drug Events

viii. Environment of Care data;

~~viii.~~ix. Patient, family and staff satisfaction surveys;

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

- Medication errors
- Death and complications
- Violence
- Patient/Resident abuse
- Patient/Resident falls
- Absent Without Leave (AWOL)
- Performance measures data
- Restraint and seclusion use
- Core Measures required by CMS and selected by the Hospital's leadership
- Outcomes related to resuscitation
- Mortality and autopsy results
- Infection Prevention and Control Surveillance
- Claims
- Clinical Service and ancillary/diagnostic department performance improvement reports
- SAE and SE Review findings
- Patient/Resident grievances
- Ongoing medical record review
- Other sources as appropriate

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

~~f.~~e. ~~The PIPS Committee selects at least one process annually for proactive risk assessment.~~

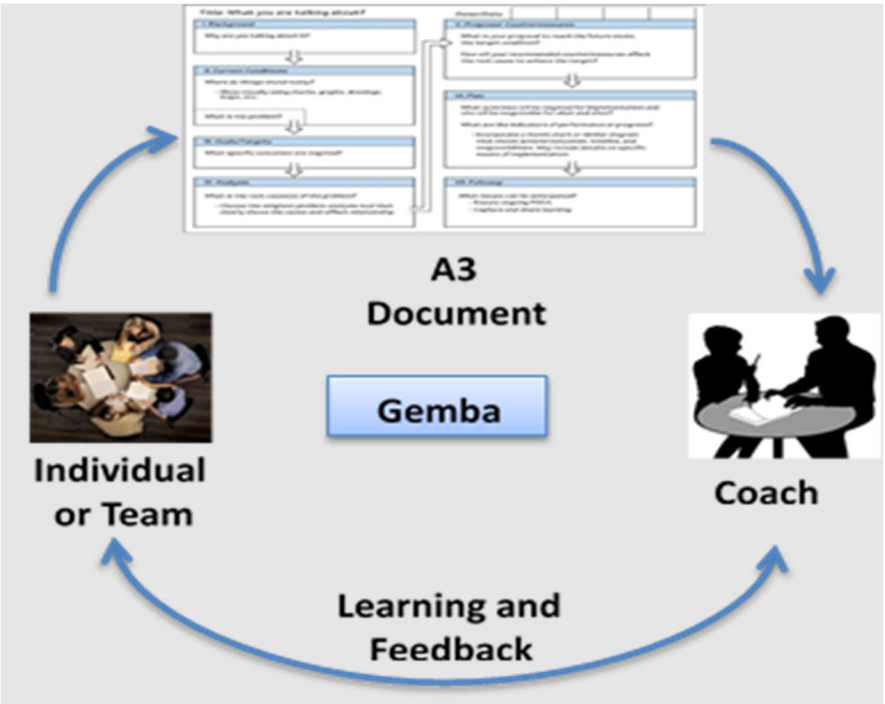
7. PERFORMANCE IMPROVEMENT METHODOLOGY

a. Performance indicators will be established based on data, and will be monitored/evaluated in the QAA Committee meetings.

i. A combination of process, outcome, and use measures will be utilized to monitor progress towards goals. The type of measure used will be appropriate to the type of data being collected.

ii. Goals will be modified as necessary.

~~a.~~b. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. A combination of process and outcome measures are used to measure success following the implementation of change. Performance improvement efforts are conducted and documented by using a Lean improvement strategy A3 Thinking. A3s are a standard language and template for problem solving and improvement plans. A3 thinking includes defining a problem, understanding root causes, considering countermeasures and studying and adjusting for results (PDSA: Plan-Do-Study-Act).



Using A3 thinking, LHH selects measurable gaps and targets to improve that will impact system-wide goals (True North metrics). We learn by sharing our problem

solving and inviting questions. We improve continuously by focusing on performance gaps aligned with True North. In addition to A3 thinking, LHH also utilizes the following tools to improve performance:

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

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

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

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

c. Corrective Action: Once the root cause of a problem is identified, the PIPS Committee shall oversee the development of an appropriate corrective action plan. An appropriate corrective action plan is one that addresses the underlying cause of the issue comprehensively, at the systems level.

i. Corrective action plans include:

- A definition of the problem – which includes determining contributing causes of the problem;
- Measurable goals;
- Step-by-step interventions to correct the problem and achieve established goals; and
- A description of how the QAA committee will monitor to ensure changes yield the expected results.

ii. The PIPS Committee uses the “Plan, Do, Study, Act” (PDSA) cycle of improvement for testing any changes within a Performance Improvement Plan (PIP). Multiple PDSA cycles may be implemented until the desired performance goals have been met.

- Plan: developing a plan related to the change that will be tested
- Do: carrying out the plan

- Study: observing and analyzing data collected, learning from any consequences

- Act: making a decision regarding the change, such as to adopt, modify, or abandon the change and start over

8. MONITORING

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

b. The PIPS Committee selects at least one process annually for proactive risk assessment.

c. Performance indicators are established based on data analysis and monitored/evaluated in the PIPS Committee meetings, which take place on a monthly basis and as needed.

i. A combination of process, outcome, and use measures will be utilized to monitor progress towards goals. The type of measure used will be appropriate to the type of data being collected.

ii. Goals will be modified as necessary.

d. Medical errors and adverse events will be tracked.

i. Residents will be monitored for medical errors and adverse events in accordance with established procedures for the type of adverse event.

ii. An investigation will be conducted on each identified medical error or adverse event to analyze causes.

iii. Preventive actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and education.

iv. Monitoring will be conducted to ensure desired outcomes are achieved and sustained.

~~8.~~9. FEEDBACK

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

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

   i. Staff satisfaction surveys
   ii. Staff meetings
   iii. One on one discussion with management
   iv. Suggestion or comment boxes

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

   i. Resident and family satisfaction surveys
   ii. Resident Council meetings
   iii. Care plan meetings
   iv. Grievance Log
   v. Suggestion or comment boxes

~~9.~~ 10. CONFIDENTIALITY

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

b. Discussions, deliberations, records and proceedings of all medical staff committees having responsibilities for evaluation and improvement of quality of care rendered in this Hospital are confidential to the fullest extent permitted by law.

ATTACHMENT:
Appendix A: LHH QAPI Plan

REFERENCE:
LHHPP 01-03 Hospital Organizational Chart
LHHPP 60-04 Unusual Occurrences
LHHPP 60-05 Review of Serious Adverse Events
LHHPP 60-13 Patient Safety Committees and Plans

Revised: 1998/04/01, 2008/01/08, 2016/07/12, 2018/11/13, 2020/09/08, 2022/03/08, 2022/12/14, 2023/03/14 (Year/Month/Day)
Original adoption: 1995/05/01

INCIDENTS REPORTABLE TO THE STATE OF CALIFORNIA

POLICY:

1. Reportable incidents that occur at Laguna Honda Hospital and Rehabilitation Center (LHH), in either the general acute care or skilled nursing facility units, shall be reported within the required timeframes to the California Department of Public Health (CDPH) or other agencies (e.g., Local Health Officer, Fire Department) as required by:

    a. Title 22 of the California Code of Regulations Section 70737 (a) Reporting and Section 70746 (b) Disruption of Services for general acute care hospitals; as well as Section 72537 Reporting of Communicable Diseases, Section 72539 Reporting of Outbreaks, and Section 72541 Unusual Occurrences for skilled nursing facilities.

    b. California Health and Safety Codes Section 1279.1 related to adverse events or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor that occur in general acute care hospitals.

    c. California Welfare and Institutions Code Section 15610.63 related to allegations of patient/resident abuse.

    d. Title 42 of the Federal Code of Regulations Section 483.13(c) (2) related to allegations of patient/resident abuse.

    e. California Civil Code Section 56.05 (g), Assembly Bill 211 and Senate Bill 541 related to reporting Protected Health Information (PHI) suspected breach.

    f. Title 42 Code of Federal Regulations (42 CFR) Parts 434, 438, 447 and Patient Protection and Affordable Care Act, Section 2702 related to Provider Preventable Conditions.

PURPOSE:

The purpose of this policy is to comply with mandated reporting requirements that govern California acute care hospitals and skilled nursing facilities.

PROCEDURE:

1. LHH staff are mandated reporters and shall promptly report any occurrence described in the policy statement to the Chief Quality Officer and the Director of Regulatory Affairs in the Quality Management (QM) Department, by telephone and through a confidential Unusual Occurrence (UO) report, and to other necessary personnel. The QM staff shall evaluate the occurrence and, if applicable, report the incident to CDPH by telephone or fax within 24-hours/next-business day.

2. The San Francisco Sheriff Office (SFSO) stationed at LHH or the Safety Engineer is responsible for reporting fires to the Fire Department.

3. The Infection Prevention and Control (IPC) Nurse Manager or designee is responsible for reporting communicable diseases, infectious, or parasitic epidemic outbreaks to the local health officer.

4. The SFSO stationed at LHH is responsible for reporting occurrences within the jurisdiction of law enforcement to the local Police Department.

5. QM, with review by the~~The LHH~~ Chief Executive Officer and Nursing Home Administrator~~or designee, through QM~~, shall provide CDPH with a letter notifying them of the occurrence and include a description, investigation results/status, and list of local agencies that were notified. The letter shall serve as an administrative incident report.

6. The CDPH administrative incident report shall be maintained ~~on file~~ in QM~~Administration~~ for one year from the date of the occurrence.

7. The attending physician or designee, in collaboration with the IPC~~Infection Control~~ Nurse~~, Utilization Management~~ ~~Manager, the~~Manager, and the Department of Care Coordination Nurse Director or designee, ~~the Chief Quality Officer or designee,~~ shall complete the Medi-cal Provider Preventable Conditions (PPC) (See Appendix A) reporting form when a resident condition meets the definition of a PPC. QM designee will fax the form to the Department of Health Care Services Audits and Investigations Division.

8. Refer to LHHPP 21-18 Breach Policy for reporting breach of PHI.

9. Refer to LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response for reporting allegations of resident abuse.

ATTACHMENT:
Appendix A: Description of Incidents Reportable to the State of California

REFERENCE:
LHHPP 21-18 Breach Policy
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 60-04 Unusual Occurrences
DPHPP HIPAA Compliance: Reporting of Unlawful or Unauthorized Access of Protected Health Information
CA Health and Safety Code
CA Title 22
CA Welfare and Institutions Code
Federal Title 42

California Civil Code Section 56.05 (g)
Assembly Bill 211
Senate Bill 541

Revised: 08/01/22, 11/09/27, 13/03/26, 17/09/12, 20/10/13, 22/05/09 (Year/Month/Day)
Original adoption: 98/04

Appendix A:

Description of Incidents Reportable to the State of California

1. CA Code of Regulation Title 22 General Acute Care Hospitals

a. Section 70737. Reporting

i. Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require.

b. Section 70746. Disruption of Services

i. The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

2. CA Code of Regulation Title 22 Skilled Nursing Facilities

a. Section 72537. Reporting of Communicable Diseases.

i. All cases of reportable communicable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

b. Section 72539. Reporting of Outbreaks.

i. Any outbreak or undue prevalence of infectious or parasitic disease or infestation shall be reported to the local health officer in accordance with Section 2502, Article 1, Subchapter 4, Chapter 4, Title 17, and California Administrative Code.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

c. Section 72541. Unusual Occurrences.

i. Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

3. California Health and Safety Code

a. Section 1279.1

i. A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

ii. For purposes of this section, "adverse event" includes any of the following:

Surgical events, including the following:

- Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

- Surgery performed on the wrong patient.

- The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that

occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

- Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

- Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or device events, including the following:

- Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient protection events, including the following:

- An infant discharged to the wrong person.

- Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.

- A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

Care management events, including the following:

- A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

- A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdeliverypost-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

- Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

- Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

- A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

- A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

Environmental events, including the following:

- A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.

- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

- A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

- A patient death associated with a fall while being cared for in a health facility.

- A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

Criminal events, including the following:

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
- The abduction of a patient of any age.
- The sexual assault on a patient within or on the grounds of a health facility.
- The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

- The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.
- "(~~(~~"Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.~~.)~~
- Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations. The department shall review Section 70737 of Title 22 of the California Code of Regulations requiring hospitals to report “unusual occurrences” and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement.

4. Title 42 Code of Federal Regulations (42 CFR) Parts 434, 438, 447 and Patient Protection and Affordable Care Act, Section 2702 related to PPC.

   a. Conditions that meet the Health Care-Acquired Conditions (HCACs) definition in general acute care hospital:

      i. Air embolism

      ii. Blood incompatibility

      iii. Catheter-associated urinary tract infection

iv. Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years old)

v. Falls/trauma

- Fracture
- Dislocation
- Intracranial injury
- Crushing injury
- Burn
- Electric shock

vi. Foreign object retained after surgery

vii. Manifestations of poor glycemic control

- Diabetic ketoacidosis
- Nonketotic hyperosmolar coma
- Hypoglycemic coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity

viii. Stage III or IV pressure ulcers

ix. Surgical Site infection

- Mediastinitis following coronary artery bypass graft (CABG)
- The surgical site infections for the following:
  - Bariatric surgery Laparoscopic gastric bypass
  - Gastroenterostomy
  - Laparoscopic gastric restrict surgery

- Orthopedic procedures for spine, neck, shoulder, and elbow

x. Vascular catheter-associated infection

b. Conditions that meet the Other Provider-Preventable Conditions (OPPCs) definition in skilled nursing facility:

i. Wrong surgery/invasive procedure

ii. Surgery/invasive procedure performed on the wrong patient

iii. Surgery/invasive procedure performed on the wrong body part

AVAILABILITY OF HOSPITAL REPRESENTATIVES FOR EMPLOYEES DEALING WITH REGULATORY AGENCIES

POLICY:

Upon request of an employee, Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a facility staff representative to assist an employee who may be asked to participate in an investigation conducted by an external regulatory agency (e.g., Licensing and Certification; CalOSHA, etc.).

PURPOSE:

To provide personal representation as well as LHH presence to employees who request assistance in dealing with regulatory agencies.

PROCEDURE:

1. LHH shall provide a staff representative upon request to assist any employee required to participate in an investigation conducted by any external regulatory agency. The employee shall request representation from his or her supervisor before participating in the investigation.

2. If an employee requests an LHH representative, the division head shall serve as the representative or assign an alternate liaison to serve as the representative. If this person is unavailable, the Administrator on Duty (AOD) shall serve as the employee's representative.

3. Should the regulatory agency insist upon interviewing an employee alone after the employee has requested LHH representation present, the employee may refuse to participate and terminate the interview. Should this occur, the employee shall immediately report that fact to the division head. The division head shall immediately notify the AOD and Chief Quality Officer (CQO).

4. A LHH employee and any requested representative may request a copy of a written declaration prepared for a regulatory agency. Employees may refuse to provide written declarations to any regulatory agency that attempts to prohibit the employee and the requested LHH representative from retaining copies. Should this occur, the employee shall notify the division head who will contact the AOD.

5. The AOD shall consult with the City Attorney's Office (CAO) ~~legal counsel~~ as necessary to protect the rights of employees and the facility.

6. All managers shall advise their staff of this policy and remind them of their rights should they be requested to participate in an investigation conducted by a regulatory agency.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 08/01/08, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 94/07/15

REVIEW OF SENTINEL EVENTS (APPLICABLE TO ACUTE CARE UNITS ONLY)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall report and investigate sentinel events to improve safety and learn from those events occurring on the acute care units. The definition of a sentinel event shall be applied only to incidents that occur on the acute care units at LHH.

For serious events occurring on the skilled nursing facility units at LHH, refer to: LHHPP 60-03 Incidents Reportable to the State of California and LHHPP 60-05 Review of Serious Adverse Events.

PURPOSE:

1. To facilitate the investigation of sentinel events, including performance of a root cause analysis (RCA), to ensure that appropriate corrective actions are taken to minimize recurrences and protect residents.

2. To have a positive impact in improving resident care; treatment and services; and minimize the risk of future adverse events.

3. To focus the attention of the organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures/gaps in processes, or organizational culture).

4. To increase general knowledge about sentinel events, their contributing factors and strategies for prevention.

DEFINITION:

1. Division Heads: Individuals responsible for the following divisions, but not limited to, within LHH include: Nursing Services, Medical Services, Clinical Services, Operations, Finance, Information Services, and Human Resources.

2. Joint Conference Committee: A subcommittee appointed by the Health Commission, which serves as the Governing Body, to oversee administration of LHH.

3. ~~Medical Peer Review/~~Credentials Committee: A committee of the Medical Staff that comprises certain physician members of the Medical Executive Committee (MEC).

4. Performance Improvement and Patient Safety (PIPS) Committee: A committee of the Medical Staff, with interdisciplinary membership representing medicine, psychiatry, rehabilitation, nursing, administration, pharmacy, infection control, nutrition services,

health information services, activity therapy, social services, Deputy City Attorney and the ~~quality improvement coordinator~~Chief Quality Officer.

5. Root Cause Analysis: A systematic process used to identify the causal factors that contributed to the event or problem. The root cause analysis focuses primarily on systems and processes, while understanding how individual performance contributed and is influenced by system factors. It is used to identify opportunities for improvement in systems and/or processes with the goal of reducing the likelihood of recurrence of comparable or related events.

6. Sentinel Event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

    a. Death

    b. Permanent harm

    c. Severe temporary harm* (critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

7. Other Reviewable Events

    a. An event is also considered sentinel if it is one of the following:

        i. Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge.

        ii. Abduction of any patient receiving care, treatment, and services.

        iii. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting, leading to death, permanent harm, or severe temporary harm to the patient.

        iv. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups).

        v. Acts of major security issues or violence such as rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any person while on site at the hospital.

vi. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure.

vii. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.

PROCEDURE:

1. Sentinel Event Notification

a. During regular business hours, LHH employees will report sentinel events to their Division Heads. The Division Head will immediately notify ~~the Administrator on Duty (AOD),~~ the Chief Executive Officer and Nursing Home Administrator (CEO), the ~~Chief Nursing Officer~~Director of Nursing (DON), the Chief Medical Officer/Medical Director (CMO), the Chief Quality Officer (CQO), the Deputy City Attorney (DCA) and the Director of Risk Management ~~(RM) Nurse Manager~~ or designee.

b. After ~~regular~~ business hours, LHH employees will report sentinel events to their Division Heads, if available. If not available, ~~, or if not available,~~ LHH employees will report to the ~~AOD~~Nursing Operations Supervisor.

i. If the employee notifies the Division Head, the Division Head will notify the ~~AOD~~ Nursing Operations Supervisor who will immediately notify the individuals listed above (CEO, DON, CMO, and CQO).

~~i.~~ii. If the ~~AOD~~Nursing Operations Supervisor is notified directly by the employee, ~~the AOD~~they will notify the individuals listed above, as well as the division head.

The ~~Chief Medical Officer~~ CQO or designee will determine whether the event will be treated as sentinel based on the information provided by the preliminary investigation.

~~b.~~c. The ~~RM Nurse Manager~~Director of Risk Management or designee will evaluate the incident and, if applicable, in partnership with the Director of Regulatory Affairs, ~~Nurse Manager~~ report the event timely to the California Department of Public Health (CDPH) as per regulation.

2. Sentinel Event Process

a. The Division Head(s) or designee(s) will complete the initial sentinel event investigation in consultation with the Deputy City Attorney. The Director of Risk Management ~~RM Nurse Manager~~ designee, under the auspices of the PIPS Committee, will appoint an investigation team to gather facts and to perform a root cause analysis.

i. The investigation team will include the Deputy City Attorney and the Chief Quality Officer in addition to appropriate clinical and administrative staff, as necessary.

ii. The initial meeting will convene no later than three (3) business days after the sentinel event. The team will investigate the sentinel event to identify the facts, systems issues and processes that affect the care, services or safety of residents, visitors or staff, to decide preventability and to propose corrective action.

iii. Within 10 days of the initial meeting, the Director of Risk Management ~~RM Nurse Manager~~ or designee will provide documentation of the investigation and corrective measures to the Executive Leadership team.

b. The investigation team, in consultation with the Director of Risk Management ~~RM Nurse Manager~~ or designee, shall develop corrective measures, identify individual(s) responsible for corrective action, and will submit its findings and recommendations for input and approval of ~~to~~ the PIPS Committee.

i. The Director of Risk Management ~~RM Nurse Manager~~ or designee will distribute the plan to the division or department head of the person assigned to carry out the activities and processes toward resolution.

- The Director of Risk Management ~~RM Nurse Manager~~ or designee may inform or consult with other LHH administrative, executive or medical committees.

ii. The Director of Risk Management ~~RM Nurse Manager~~ or designee, in partnership with the Performance Improvement team, will monitor the implementation of the corrective actions until completed and will report findings to PIPS Committee until resolved. The investigation team may meet as necessary, to assure that the corrective measures have been implemented and resolves the issues.

iii. If the PIPS Committee determines that ~~of~~ the corrective measures do~~es~~ not obtain the desired outcomes within specified time frames, the Director of Risk Management or ~~RM Nurse Manager or~~ designee will report the matter to the Executive Leadership.

c. The Director of Risk Management ~~RM Nurse Manager~~ or designee will report to the Chief Quality Officer any changes in the status of the affected party. Throughout this process and within the appropriate time frame, the Chief Quality Officer, in partnership with the Regulatory Affairs team, will ensure that LHH reports the event to external and/or regulatory agencies.

3. Reporting

a. The Director of Risk Management ~~RM Nurse Manager~~ or designee will present the results of all investigations, interviews and corrective measures to the Chair of the PIPS Committee. The Chair of the PIPS Committee or designee will report findings to the Medical Executive Committee and the Joint Conference Committee. These reports will identify systems problems and opportunities for improvement.

   i. If the findings identify an individual responsible for the sentinel event, the PIPS Committee will refer these findings to the appropriate department or to the ~~Medical Peer Review /~~ Credentials Committee for further investigation and appropriate corrective action.

4. Record Maintenance

a. The Director of Risk Management ~~RM Nurse Manager~~ or designee will maintain a confidential file for all documented discussions, meetings and investigations regarding the event in a central repository along with the approved corrective measures and outcome data.

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-03 Incidents Reportable to the State of California
Joint Commission Standards on Sentinel Events (CAMH Update 1, July 2017)

Revised: 00/03/15; 02/03/14, 07/12/17, 08/01/08, 15/01/13, 16/03/08, 16/07/12, 18/05/08, 20/10/13, 22/05/09 (Year/Month/Day)
Original adoption: 97/11/10

LAGUNA HONDA HOSPITAL MEDICAL SURGE PLAN FOR NURSING HOME INCIDENT COMMAND ACTIVATION DUE TO PUBLIC HEALTH EMERGENCY / MASS CASUALTY EVENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents in the event of a city-wide or regional medical surge. LHH is also prepared to participate in a system-wide response to medical surge by receiving appropriate patients from other healthcare facilities who need decompression to manage the surge.

PURPOSE:

To provide continued quality care and participate in a system-wide response to incidents that result in a medical surge exceeding the capacity of the normal medical infrastructure.

To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts during a Nursing Home Incident Command System (NHICS) event when Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) is experiencing an acute surge of patients due to a trauma-based mass casualty incident (MCI) or another public health/medical related emergency (PHE).

To identify essential communication and coordination to ensure resident safety.

DEFINITIONS:

ZSFG Hospital status "Condition Yellow" is instituted when ten (10) or more patients are admitted for acute care at the hospital and waiting for an admission bed.

ZSFG Hospital status "Condition Red" is instituted when only one bed is available in Critical Care with no pending transfers, the Post Anesthesia Care Unit (PACU) is at capacity (The PACU's capacity is relative to the number and acuity of patients at a specific time.), and more than ten (10) patients are waiting for beds; OR the ZSFG Administrator On Duty (AOD)/Hospital Supervisor determines that ~~SFGH~~ ZSFGhas marginal capacity to accept incoming patients.

PROCEDURE:

1. Any time the S~~F~~an Francisco healthcare system is challenged by an increase in emergency calls or healthcare utilization that goes beyond the capacity to provide adequate care due to a public health emergency or mass casualty event, ~~,~~ LHH shall activate NHICS and implement this Medical Surge Plan.

2. The most important goal is the safe care of LHH residents. Therefore, if a medical surge occurs as a result of a disease epidemic that is affecting LHH residents, then

triage and care of these residents is the number one priority and the procedures outlined in LHHPP 70-01 C6 Pandemic Flu Plan or disease specific procedures in LHHPP 72 Infection Control shall be followed.

3. When conditions described in #1 occur:~~When a medical surge occurs specifically at ZSFG:~~

    a. ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO/Nursing Home Administrator or designee (i.e. Assistant Nursing Home Administrator (ANHA), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and/or Chief Quality Officer (CQO)) when public health emergency conditions exist that require expeditious transfer of appropriate patients from ZSFG to LHH.

    b. LHH CEO/NHA or designee (i.e. ANHA, CNO, CMO, or CQO) shall confer with LHH Executive leaders to activate LHH Nursing Home Incident Command System (NHICS).

    ~~a. LHH will assist in accordance with LHHPP 20-11 Laguna Honda Hospital's Response to ZSFG Condition Code Yellow and Red Alerts.~~

    ~~b. The CEO/AOD shall activate NHICS if LHH resident care operations are affected by the response.~~

4. When a medical surge occurs throughout the San Francisco healthcare system:

    a. LHH will participate in a coordinated response with the possibility of receiving patients from hospitals outside of the SF Health Network using the protocols that are in place ~~in LHHPP 20-11~~ to determine bed availability and ensure appropriate level of care.

    b. NHICS shall be activated to manage a response to a city-wide surge.

    c. The NHICS team shall coordinate activities and communication with hospitals and DPH through the DPH Department Operations Center (DOC) or City Emergency Operations Center (EOC).

5. In the case of a city-wide disaster such as an earthquake, there may be a widespread need for first aid treatment throughout the city. If members of the community present to~~show up at~~ LHH for first aid:

    a. NHICS shall be activated to triage and treat these patients.

    b. Triage and treatment shall be provided in the medical clinic if the number of patients is manageable. For larger numbers of injured persons, other clinical staff may be deployed to provide care.

c. If community members arrive to LHH seeking first aid of injuries that surpass the ability of LHH clinicians, 911 will be called to transfer those injured to an acute care facility.

d. For triage and treatment of large numbers of first aid patients, a tent can be set up in the gravel parking lot on the west side of the facility. The tent is stored in storage container #6 in the parking lot and can be assembled if necessary.

~~LHH Internal Communication and Planning~~

~~Communication – the LHH Incident Commander or designee will contact the following:~~

~~LHH Directors of Nursing (DON) or designee – to ascertain/provide current bed vacancies and bed hold situation.~~

~~LHH Patient Flow Coordinator – to provide the current list of patients/referrals already accepted by the LHH Admissions Committee and to appropriately identify priority of patients to be admitted as well as anticipate/plan for their care needs.~~

~~LHH Chief Medical Officer/Medical Director or designee – to confer with the Patient Flow Coordinator and LHH CEO to confirm patients on the LHH Admissions Committee accepted list for current appropriateness for transfer to LHH and then to confer with the Patient Flow Coordinator the appropriate neighborhood assignment and coordinate with Chief of Medicine or designee to plan for the admitting physician assignment.~~

~~ZSFG patients who have not been screened for LHH Admissions previously would need to be evaluated by the CMO, CNO, CQO, and CEO or their designees for appropriateness for LHH admission.~~

~~LHH Patient Flow Coordinator – Once patients are identified and assigned to neighborhoods, Patient Flow Coordinator is responsible for sending a notification to each Resident Care Team (RCT) to inform them of planned admission, including patient's profile. The Coordinator shall obtain the most current medical information and send referral packet(s) to the neighborhood Nurse Manager or designee.~~

~~LHH Chief Quality Officer – coordination with Quality Management to ensure the facility is in compliance with all state and federal requirements. The Chief Quality Officer will manage any required notification to the California Department of Public Health.~~

~~**Bed Allocation**~~

~~Current Bed Holds may be moved to North Mezzanine vacant beds, if available, to accommodate incoming admissions. Review of movement should be done with the Chief Quality Officer or designee.~~

~~Three (3) General SNF Isolation Rooms shall be kept available for the clinical needs of in-house residents during the flu season.~~

~~Three (3) acute care beds (one medical acute, one acute isolation, and one acute rehab) shall be kept available for the clinical needs of in-house residents and a community acute rehab patient.~~

~~If acute care bed(s) will be used for SNF level of care admission, the Chief Quality Officer (CQO) or designee shall notify the California Department of Public Health (CDPH) local office and obtain approval prior to occupancy.~~

~~Subsequent approval from CDPH is required every 72 hours when a SNF level of care resident remains on the acute care unit past 3 days. The CQO or designee shall contact CDPH to obtain subsequent approvals every 72 hours as necessary. Chief Quality Officer – shall coordinate with the California Department of Public Health (CDPH) to inform of the urgent need for the facility to support a surge at ZSFG.~~

~~Nurse Managers and Directors – shall coordinate with the CNO and Patient Flow Coordinator in carrying out any bed relocation(s) needed, preparing for staffing to implement admissions, and prepare any needed special supplies/equipment, and/or staff education.~~

~~LHH Assistant Nursing Home Administrator, Support Services – shall coordinate with EVS Supervisor terminal cleaning of any resident rooms; Facilities and or Materials Management for any special supplies/equipment needed.~~

~~Nurse Manager, Department of Care Coordination – shall coordinate completion of Utilization Management reviews of residents to be admitted.~~

~~Director of Admissions and Eligibility – shall plan to register identified resident(s) for admissions for timely processes of face sheets and blue cards.~~

~~Director of Social Services – shall provide a list of residents who are planned community discharges for the day and following day to better account LHH bed availability.~~

~~Chief Finance Officer – shall assist in resource allocation or funding, to safely implement admissions.~~

- Director of Pharmacy Services – shall be informed of any pharmaceutical products that require pre-planning to ensure timely availability or high-risk medications requiring coordination with nursing and medicine leadership to ensure safe administration, such as TPN.

External Communication and Coordination

- LHH CEO or designee shall communicate with ZSFGH to confirm number of residents LHH will admit.

- ZSFG Coordination

- LHH Patient Flow Coordinator will coordinate with:

  - ZSFG Utilization Management Nurse Manager (UM NM) or designee – to provide names of patients for admission including assigned neighborhood, admitting physician pager number and admitting neighborhood charge nurse phone number.

  - ZSFG Case Manager – confirm time of ambulance pick up

  - ZSFG Attending Physician – shall contact LHH Admitting MD for hand off

  - ZSFG RN – shall contact LHH Charge Nurse for hand off report

- LHH Admission and Eligibility Department – shall coordinate with ZSFG UM Nurses for any documentation or insurance plan information for the identified patients to be admitted.

Documentation

- The Health Information Services (HIS) Department shall be notified of SNF level of care patients that are admitted to the acute care unit (admit type, full name, and bed/room assignment) by the Patient Flow Coordinator.

- When SNF level of care patients are admitted to the acute care unit, an exception shall be made to HIS policy number 7.05 permitting the use of SNF documentation protocols for the SNF patient(s) that are physically placed on the acute care unit. SNF documentation may be continued and follow the patient to the SNF unit when the patient/resident is transferred from the acute care unit to the SNF unit and a new medical record does not have to initiated.

Utilization Management (UM) and Billing

- UM Nurses shall conduct utilization reviews and processes based on the level of care determination and payer requirements.

~~When SNF level of care admissions are placed in an acute care bed, the following processes shall be followed:~~

~~If the resident's primary coverage is a Medi-Cal Managed Care, or other private insurance, notify the managed care organization that the resident is admitted to an acute care bed and that the facility shall submit a claim based on the authorization for a SNF stay that was pre-approved by the health plan.~~

~~If the resident's primary coverage is Medicare, the resident shall be issued a Medicare acute care denial and informed that the resident will not be able to access his/her Medicare SNF benefits while s/he is on the acute care unit. The Billing Department shall not submit Medicare SNF claim(s) for payment of a resident who meets SNF level of care on admission while occupying an acute care bed.~~

~~If the resident's primary coverage is Medi-Cal, Hudman calls shall be initiated by staff from the UM Department. The Billing Department shall submit a claim to Medi-Cal for administrative days.~~

~~A SNF level of care resident who is admitted to an acute care bed is not eligible for bed hold when they are discharged to a community acute care hospital.~~

Post Response Debrief & Performance Improvement

Incident Commander along with help from the Emergency Manager, shall arrange for post activation debrief/hotwash with LHH staff involved in the incident response.

Once gaps and areas for improvement are identified, the Plans Chief is to draft an~~d~~ After Action Report within 180 days of demobilization, that should then be presented to LHH's Quality Council.

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)
LHHPP 70-01 C5 Emergency Responder Dispensing Plan
LHHPP 70-01 C6 Pandemic Influenza Plan
~~LHHPP 20-11 Laguna Honda Hospital's Response to ZSFG Condition Code Yellow and Red Alerts~~
LHHPP 72 Infection Control

Revised: 18/09/11, 23/08/08 (Year/Month/Day)

LAGUNA HONDA HOSPITAL'S RESPONSE TO ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER (ZSFG) SURGE CONDITION

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing quality and timely care and services that are consistent with community and professional standards, and to admit residents that can be safely cared for at the facility~~hospital~~.

PURPOSE:

To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts.

To identify essential communication and coordination to ensure resident safety.

ZSFG's DEFINITION:

~~"Condition Yellow" – activated by ZSFG when ten (10) or more patients are waiting for beds.~~

~~"Condition Red" – activated by ZSFG when only one bed is available in Critical Care with no pending transfers, Post Anesthesia Care Unit (PACU) is at capacity, and more than ten (10) or more patients are waiting for beds at ZSFG.~~

Hospital status "Condition Yellow" is instituted when ten (10) or more patients are waiting for an admission bed.

Hospital status "Condition Red" is instituted when only one bed is available in Critical Care with no pending transfers, the Post Anesthesia Care Unit (PACU) is at capacity (The PACU's capacity is relative to the number and acuity of patients at a specific time.), and more than ten (10) patients are waiting for beds; OR the AOD/HS determines that SFGH has marginal capacity to accept incoming patients.

PROCEDURE:

1. Notification:

a. ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO or designee when conditions exist that require expeditious transfer of patients from ZSFG to LHH.

b. LHH CEO or designee shall confer with Executive leaders and activate LHH ~~Hospital~~ Nursing Home Incident Command System (NHICS) if appropriate.

2. LHH Internal Communication and Planning

a. Communication – the designated Incident Commander or designee will contact the following:

i. LHH ~~Chief Nursing Officer~~ Directors of Nursing (~~CNO~~DON) or designee~~—~~ to ascertain/provide current bed vacancies and bed hold situation.

ii. LHH Patient Flow Coordinator – to provide the current list of ZSFG accepted patients/referrals, and to appropriately identify priority of patients to be admitted as well as anticipate/plan for their care needs.

iii. LHH Chief Medical Officer/Medical Director or designee – to confer with the Patient Flow Coordinator the appropriate neighborhood assignment and coordinate with Chief of Medicine or designee to plan for the admitting physician assignment.

iv. LHH Patient Flow Coordinator – Once patients are identified and assigned to neighborhoods, Patient Flow Coordinator is responsible for sending a notification to each Resident Care Team (RCT) to inform them of planned admission, including patient's profile. The Coordinator shall obtain from ZFGH the most current medical information and send referral packet(s) to the neighborhood Nurse Manager or designee.

~~iv.~~v. LHH Chief Quality Officer – coordination with Quality Management to ensure the facility is in compliance with all state and federal requirements. The Chief Quality Officer will manage any required notification to the California Department of Public Health.

b. Planning

i. Bed Allocation

- Current Bed Holds may be moved to North Mezzanine vacant beds, if available, to accommodate incoming admissions. Review of movement should be done with the Chief Quality Officer or designee.

- Three (3) General SNF Isolation Rooms shall be kept available for the clinical needs of in-house residents during the flu season.

- Three (3) acute care beds (one medical acute, one acute isolation, and one acute rehab) shall be kept available for the clinical needs of in-house residents and a community acute rehab patient.

- If acute care bed(s) will be used for SNF level of care admission, the ~~Quality Management Director~~Chief Quality Officer (CQO) or designee shall notify the ~~San Francisco~~ California Department of Public Health ~~Licensing~~ (CDPH) office and obtain approval prior to occupancy.

- A minimum of 3 follow-up calls to CDPH may be necessary to obtain approval for placing SNF level of care residents on the acute care unit.

- Subsequent approval from CDPH is required every 72 hours when a SNF level of care resident remains on the acute care unit past 3 days. The ~~Quality Management Director~~ CQO or designee shall contact CDPH to obtain subsequent approvals every 72 hours as necessary.

- Priority shall be given to transferring SNF level of care residents who are placed on the acute care unit to relocate to the SNF unit.

ii. LHH CEO or designee – shall activate the NHICS if appropriate *see LHH HW 70-03 Emergency Response Plan.*

iii. Nurse Managers and Directors – shall coordinate with the CNO and Patient Flow Coordinator in carrying out any bed relocation(s) needed, preparing for staffing to implement admissions, and prepare any needed special supplies/equipment, and/or staff education.

iv. LHH ~~Chief Operating Officer~~Assistant Nursing Home Administrator, Support Services – shall coordinate with EVS Supervisor terminal cleaning of any resident rooms; Facilities and or Materials Management for any special supplies/equipment needed.

v. Chief Quality Officer – shall coordinate with the California Department of Public Health (CDPH) to inform of the urgent need for the facility to support a surge at ZSFG.

~~v.~~vi. ~~Director of Quality Management~~Nurse Manager, Department of Care Coordination – shall coordinate completion of Utilization Management reviews of residents to be admitted.

~~vi.~~vii. Director of Admissions and Eligibility – shall plan to register identified resident(s) for admissions for timely processes of face sheets and blue cards.

~~vii.~~viii. Director of Social Services – shall provide a list of residents who ~~could be discharged immediately in addition to~~are planned community discharges for the day and following day to better account LHH bed availability.

~~viii.~~ix. Chief Finance Officer – shall assist in resource allocation or funding, to safely implement admissions.

~~ix.~~x. Director of Pharmacy Services – shall be informed of any pharmaceutical products that require pre-planning ~~arrangements~~ to ensure timely availability or high-risk medications requiring coordination with nursing and medicine leadership to ensure safe administration, such as TPN.

3. External Communication and Coordination

a. Communication

~~v.~~vi. LHH CEO or designee shall communicate with ZSFG CEO or designee to confirm number of residents LHH will admit.

b. Coordination

~~vi.~~vii. LHH Patient Flow Coordinator will coordinate with:

- ZSFG Utilization Management Nurse Manager (UM NM) or designee – to provide names of patients for admission including assigned neighborhood, admitting physician pager number and admitting neighborhood charge nurse phone number.

- ZSFG Case Manager – confirm time of ambulance pick up

~~vii.~~viii. ZSFG Attending Physician – shall contact LHH Admitting MD for hand off

~~viii.~~ix. ZSFG RN – shall contact LHH Charge Nurse for hand off report

~~ix.~~x. LHH Admission and Eligibility Department – shall coordinate with ZSFG UM Nurses for any documentation or insurance plan information for the identified patients to be admitted.

4. Documentation

a. The Health Information Services (HIS) Department shall be notified of SNF level of care patients that are admitted to the acute care unit (admit type, full name, and bed/room assignment) by the Patient Flow Coordinator.

b. When SNF level of care patients are admitted to the acute care unit, an exception shall be made to HIS policy number 7.05 permitting the use of SNF documentation protocols for the SNF patient(s) that are physically placed on the acute care unit. SNF documentation may be continued and follow the patient to the SNF unit when the patient/resident is transferred from the acute care unit to the SNF unit and a new medical record does not have to initiated.

5. Utilization Management (UM) and Billing

a. UM Nurses shall conduct utilization reviews and processes based on the level of care determination and payer requirements.

b. When SNF level of care admissions are placed in an acute care bed, the following processes shall be followed:

~~x.~~xi. If the resident's primary coverage is a Medi-Cal Managed Care, or other private insurance, notify the managed care organization that the resident is admitted to an acute care bed and that the facility shall submit a claim based on the authorization for a SNF stay that was pre-approved by the health plan.

~~xi.~~xii. If the resident's primary coverage is Medicare, the resident shall be issued a Medicare acute care denial and informed that the resident will not be able to access his/her Medicare SNF benefits while s/he is on the acute care unit. The Billing Department shall not submit Medicare SNF claim(s) for payment of a resident who meets SNF level of care on admission while occupying an acute care bed.

~~xii.~~xiii. If the resident's primary coverage is Medi-Cal, Hudman calls shall be initiated by staff from the UM Department. The Billing Department shall submit a claim to Medi-Cal for administrative days.

~~xiii.~~xiv. A SNF level of care resident who is admitted to an acute care bed is not eligible for bed hold when theys~~/he~~ are discharged~~s~~ to a community acute care hospital.

6. Change of Condition from SNF Level of Care to Acute Care

a. In the event that the SNF level of care resident becomes acutely ill and meets acute care criteria; this shall be considered a change of condition and an event that triggers a new admission, and a new medical record shall be initiated per acute care regulations.

b. The attending physician of record or designee shall make the determination of need for acute care services and notify the ~~Patient Flow Coordinator/Operations Nurse Manager~~Department of Care Coordination and Nursing Operations or designee.

a. The following departments shall be notified by the ~~Patient Flow Coordinator/ Operations Nurse Manager~~ Department of Care Coordination or designee as soon as practicable after the physician determines that the resident/patient meets acute level of care:

i. Nursing staff on the acute care unit

ii. Admissions and Eligibility

iii. Health Information Services

iv. Utilization Management

v. Pharmacy Services

vi. Billing Department

7. Post Response Debrief & Performance Improvement

a. ~~Incident Commander (I~~if NHICS was activated, Plans Chief with help from the Emergency Manager, is to ~~)~~ ~~shall~~ arrange for post activation~~HICS~~ debrief/hotwash with LHH and ZSFG~~H~~ staff involved in the incident response~~.~~.

~~a.~~b. Once gaps and areas for improvement are identified, the Plans Chief is to draft an~~d~~ After Action Report within 180 days of demobilization, that should then be presented to LHH's Quality Council.

~~b. LHH Patient Flow Coordinator shall arrange for a debrief with ZSFG UM NM or designee.~~

~~**8. Performance Improvement**~~

~~a. Incident Commander (when HICS is activated) shall identify identified gaps and opportunities, including action plan(s), and report to LHH's Quality Council.~~

~~b. LHH Patient Flow Coordinator shall identify gaps and opportunities, including action plan(s), and report to LHH's Quality Council.~~

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 16/07/12

Revised Hospital-wide Policies and Procedures

UNUSUAL OCCURRENCES

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that staff primarily utilize the electronic Hospital-wide Unusual Occurrence (UO) reporting system to report investigations, communicate with relevant personnel and document corrective actions related to unusual occurrence events.

2. An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.

3. UO reports shall be completed and submitted timely by any LHH employee who witnesses or becomes aware of an unusual occurrence. The initial report shall be completed by the first staff member responding to the event and those who are most knowledgeable about the occurrence.

4. UOs are confidential under Evidence Code 1156/1157. No copies are to be made except by Quality Management (QM) staff.

5. The QM Department shall maintain the UOs as part of Performance Improvement Patient Safety (PIPS) Committee records.

6. Access to the PIPS Committee records and reports shall be strictly limited to QM staff, Departmental and Hospital Performance Improvement Committees, Medical Executive Committee (MEC), and the Joint Conference Committee (JCC).

PURPOSE:

The purpose of the Unusual Occurrence system is to identify those events or conditions and institute corrective action that will address immediate patient safety needs and prevent similar future incidences. The process shall consider and evaluate potential legal exposure and, if necessary, initiate preparations for an appropriate legal response by the City Attorney's Office.

PROCEDURE:

1. General Provisions

a. Filing a UO in no way replaces the ongoing responsibility of individuals to take action as necessary, investigate the occurrence, follow up appropriately, including referral to Human Resources, and report problems as they occur through the normal channels.

b. Malicious reports or reports with punitive intent are not appropriate (i.e., collegial disagreements, issues for Human Resources, etc.). Interdepartmental conflict ~~are to~~will be discussed by the departments involved and reported on a UO only when not resolved in a timely manner.

c. PIPS Committee ~~, a Committee of the Medical Staff,~~ is responsible for reviewing and evaluating UO Reports as part of the ~~Hospital~~ LHH Quality Assurance and Performance Improvement (QAPI) Program.

2. Reporting, Investigation and Follow-up

a. Before the end of the work shift, the ~~Charge Nurse,~~ reporting employee, or designee shall:

i. Complete the on-line UO which is directly transmitted to the QM Department.

- Necessary information for completing the UO:
  - Include the name of patient/resident (if applicable), unit, date of occurrence, time of occurrence, description of incident and person(s) notified.
  - Include the name(s) of staff, visitors, volunteers, students and other residents who were involved in the incident or witnesses to the incident.
  - Specifically identify who said what and/or who witnessed what part of the incident.
  - List what led up to the incident, other pertinent events occurring at the time, and any contributing acts of friends, relatives, or residents that may have led to the event.
  - Describe any equipment involved.
  - Note any injuries and state what medical care has been provided or is planned.

ii. Informs the supervisor on the shift of the occurrence. Follow the reporting protocol as described in LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response.

iii. Notify the attending physician if the incident involves the clinical care of a resident.

iv. Notify the resident's family or surrogate decision-maker of the incident as appropriate.

v. Submit other necessary documents to QM Department.

b. The supervisor or Nursing Operations Nurse Manager on duty shall determine whether immediate additional follow-up or action is required and whether notification of the Chief Medical Officer, Division Head, and ~~Administrator on Duty~~Chief Quality Officer is warranted.

c. If the incident involves a resident, documentation of the event, clinical response, and monitoring activities must be noted in the medical record according to the Hospital-wide Policies and Procedures. Do not document in the medical record the fact that a UO has been completed.

d. A unique log number shall be assigned to each submitted UO. The Risk Management team shall triage the UOs within 24 hours or the next business day and request for follow-up information as necessary using the on-line UO system:

i. Follow-up and investigation of UO reports:

- UO notification shall be sent to managers, supervisors and other relevant staff. UO follow-up and or investigation report(s) are requested from managers as necessary to determine contributing factors, systemic issues, corrective actions taken and/or referrals for follow-up actions.

- The manager and or other relevant staff assigned shall log in to the on-line UO system daily, review their respective worklist and read the UO report and or messages no later than the next business day.

- Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department within four business days of the UO report.

- Risk Management shall be responsible for tracking the return of follow-up and or investigation reports.

- Staff shall use the on-line UO system and not use the email system to address case specific UO issues.

ii. Follow-up of reportable UOs (refer to LHHPP 60-03 Incidents Reportable to the State of California):

- The Regulatory Affairs team may direct further staff actions on reportable occurrences.

- Completed follow-up and/or investigation reports are to be submitted to the ~~QM~~ Regulatory Affairs team no later than the 4th calendar day following the incident.

- Telephone notification of reportable UOs to California Department of Public Health (CDPH) shall be made by the mandated reporter.

e. The Risk Management team shall aggregate UO data to identify patterns/trends. UO summary reports shall be brought to the PIPS committee for further review, evaluation, and recommendations (e.g., if patterns/trends are identified, the PIPS Committee may work with the involved departments to institute further studies and develop a plan of correction, which may include a mechanism for ongoing monitoring).

f. The UO report may be classified as closed by Risk Management or designee after sufficient essential information is gathered and corrective action(s) implemented to minimize risk of occurrence.

g. UO summary reports shall be submitted to the MEC through the PIPS committee and to the ~~Joint Conference Committee~~JCC. Recommendations from these Committees shall be forwarded to the MEC.

3. Downtime procedure for reporting an Unusual Occurrence

a. Before the end of the work shift, the charge nurse, reporting employee, or designee shall:

i. Complete the UO form F-821A “Confidential Report of Unusual Occurrence”:

- Complete Part 2 by using the resident’s plastic ID plate to imprint the forms. If more than one resident is involved, write additional names in Part 2. If the occurrence does not involve a resident, information must be written in regarding any staff or visitors involved.

- Complete Part 3 by stating the facts as outlined in Section 2 above.

ATTACHMENT:
Attachment 1: Confidential Report of Unusual Occurrence.

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 24-06 Resident and Visitor Complaints/Grievances
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-05 Review of Serious Adverse Events in D/P Skilled Nursing Facility
LHHPP 60-08 Risk Management Program
LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)
Laguna Honda Form SOC 341
~~Laguna Honda On-line UO Pocket Guide~~

Revised: 96/07/15, 98/08/10, 00/03/09, 08/01/08, 11/09/27, 15/09/08, 18/11/13, 20/01/14, 22/05/09, 22/12/13 (Year/Month/Day)
Original adoption: 94/08/15

REVIEW OF SERIOUS ADVERSE EVENTS IN ~~-~~SKILLED NURSING FACILITY

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall report and investigate serious adverse events to improve resident, staff and visitor safety and to learn from those events occurring in the Skilled Nursing Facility Units. The review process, regardless of the method of review, focuses on systems and processes, not on individual performance.

For events that occur involving patients in the Acute Care Units at LHH see LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only).

PURPOSE:

1. To facilitate the investigation of serious adverse events, using multimodal investigative methodologies, to ensure that appropriate corrective actions are taken to minimize recurrences and protect residents.

2. To have a positive impact in improving resident care, treatment and services, and minimize the risk of future adverse events.

3. To focus the attention of the organization that has experienced a serious adverse event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures/gaps in processes, or organizational culture).

4. To increase general knowledge about serious adverse events, their contributing factors and strategies for prevention.

DEFINITIONS:

1. **California Department of Public Health Licensing and Certification** (CDPH) External State Licensing body that investigates all Facility Reported Incidents and Complaints. (see LHHPP 60-03 Incidents Reportable to the State of California)

2. **Departmental Root Cause Analysis (RCA)**
   This is a structured review using an abbreviated process of the RCA to investigate causation of errors and events that have potentially led to harm to a resident, staff or visitor. Primarily ***lead by department specific staff*** in collaboration with the Quality Management ~~Department~~ (QM) Risk Management team under the direction and oversight of PIPS. **A QM representative will participate in this process.**

3. **Departmental Investigation Report**

Follow up and/or investigation by the unit manager completed within the UO System to determine contributing factors, corrective actions taken and/or referrals for follow-up actions (see LHHPP 60-04 Unusual Occurrences).

4. **General Acute Care Hospital** (GACH)
~~An Emergency Department or other higher level of care, treatment or service~~A hospital licensed by the California Department of Public Health which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

5. **Joint Conference Committee** (JCC)
A subcommittee of, appointed by, the Health Commission, which serves as Governing Body oversight of quality for LHH.

6. **Organizational Root Cause Analysis**
A systematic process used to identify the causal factors that contributed to the event or problem. The root cause analysis focuses primarily on systems and processes, while understanding how individual performance contributed and is influenced by system factors. It is used to identify opportunities for improvement in systems and/or processes with the goal of reducing the likelihood of recurrence of comparable or related events. ***This process is facilitated and lead by ~~QM~~ Risk Management staff under the direction of the Chief Quality Officer and with oversight of the Performance Improvement Patient Safety Committee (PIPS)***.

7. **Performance Improvement, Patient Safety Committee** (PIPS)
A committee of the Medical Staff, with interdisciplinary membership representing medicine, psychiatry, rehabilitation, nursing, administration, pharmacy, infection prevention and control, nutrition services, health information services, activity therapy, social services, Deputy City Attorney and the quality improvement coordinator.

8. **Serious Adverse Event** (SAE)
This is defined as an error or event that causes the Death or Serious Disability of a resident, staff or visitor, includes events necessitating the transfer to a higher level of care.

9. **Serious Disability**
A physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

10. **Unusual Occurrence** (UO)
An unusual occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or

student. These occurrences are reported through the electronic reporting system as described in policy: LHHPP 60-04 Unusual Occurrences.

PROCEDURE:

1. IMMEDIATE ACTIONS

a. Following the discovery of an event or error that has had or may have had an adverse effect on the health or safety of a resident, staff or visitor, front line staff shall:

i. Initiate immediate risk containment measures to prevent and reduce further adverse outcomes including, but not limited to the following:

- Providing appropriate resident care;
- Notifying the responsible physician if the incident involves the clinical care of a resident; and/or
- Ensuring the environment is safe.

ii. Notify next of kin, decision maker or conservator by a member of the Interdisciplinary Care Team as soon after the event as possible.

2. DETECTION

a. When a LHH employee becomes aware of a SAE (defined above) they will report the event or error in the following ways:

i. During normal business hours, immediately contact their department manager. QM should also be notified as soon as possible.

ii. If the event occurs outside of normal business hours, Nursing Operations and ~~the AOD~~QM may be paged.

iii. The unit manager/supervisor shall ensure a UO has been completed/submitted before the end of the work shift.

3. ASSESSMENT OF SEVERITY & DETERMINATION OF INVESTIGATION METHODOLOGY

a. QM will review the information contained in reports received (UO, secure messages and telephone reports) and the following grid will be used ~~-~~(a flowchart is provided in Appendix A for reference):

		INVESTIGATION METHODOLOGIES		
	Did the event or error result in;	DEPARTMENTAL INVESTIGATION REPORT	DEPARTMENTAL RCA	ORGANIZATIONAL RCA
SEVERITY	Death			X
	Transfer to GACH (exclusions apply, see below)			X
	Serious Disability			X
	Harm or Injury that **IS NOT** Serious Disability		X	
	No Harm or Injury	X		

b. Exclusions To "Transferred to GACH" Criteria

i. If a resident is transferred to a GACH secondary to a deterioration in condition related to an illness or disease that is part of the resident's underlying condition or that has not responded to treatment appropriate to a Skilled Nursing Facility setting.

ii. For a scheduled procedure, such as feeding tube placement, diagnostic procedure.

c. List of Potential Events or Errors

All events that "threaten the welfare, safety or health of residents, personnel or visitors" (T22. DIV 5. CH 3. ART 5. § 72541. Unusual Occurrences) require investigation, the outcome of the event or error will determine the methodology of investigation. For reporting of these events to CDPH and other regulatory bodies see LHHPP 60-03 Incidents Reportable to the State of California.

This policy applies to all SAE, as defined above. Below is a sample list of potential events that may fall into the category of SAE:

i. Unexpected Death not consistent with part of the residents underlying medical diagnosis(es).

ii. Medication error that reached the resident and resulted in harm.

iii. Positive urine toxicology for medications or substances not prescribed to the resident, where there is not a clear explanation (i.e. resident admits substance misuse, self-reported medication error, or other single, confirmed

mechanism of explanation). This category is not dependent upon level of harm.

~~iii.~~iv. Fall resulting in Death or Serious Disability (not serious injuries).

~~iv.~~v. Any significant change in condition where the cause is not part of the residents underlying medical diagnosis(es).

~~v.~~vi. Procedure (ex. tooth extraction) on the wrong site, wrong resident or unintended retention of a foreign body related to procedure.

~~vi.~~vii. Death or serious disability related to the elopement of a resident who lacks capacity.

~~vii.~~viii. Death or serious disability associated with the use of restraints or bedrails.

4. INVESTIGATION

a. Standard works exists for the three types of investigative methodologies identified in this policy

   i. Departmental Investigation Report (see LHHPP 60-04 Unusual Occurrences)

   ii. Departmental RCA (Nursing Department)

   iii. Organizational RCA (Quality Management)

5. REPORTING

a. The results, causation and countermeasures for each investigative method will be reported as described below:

   i. Departmental Investigation Report
   Aggregated into quarterly UO Reporting Data

   ii. Departmental RCA
   Presented at PIPS and/or Nursing Quality Improvement Committee (NQIC).

   iii. Organizational RCA
   Presented at PIPS and Closed Session JCC

6. EMPLOYEE ASSISTANCE FOR STAFF AND PROVIDERS INVOLVED IN A SERIOUS ADVERSE EVENT

a. The SFDPH employee assistance program (EAP) provides confidential counseling and consultation services that promote health and wellbeing. Individual staff

members who have been involved in an adverse or sentinel event will be referred to EAP.

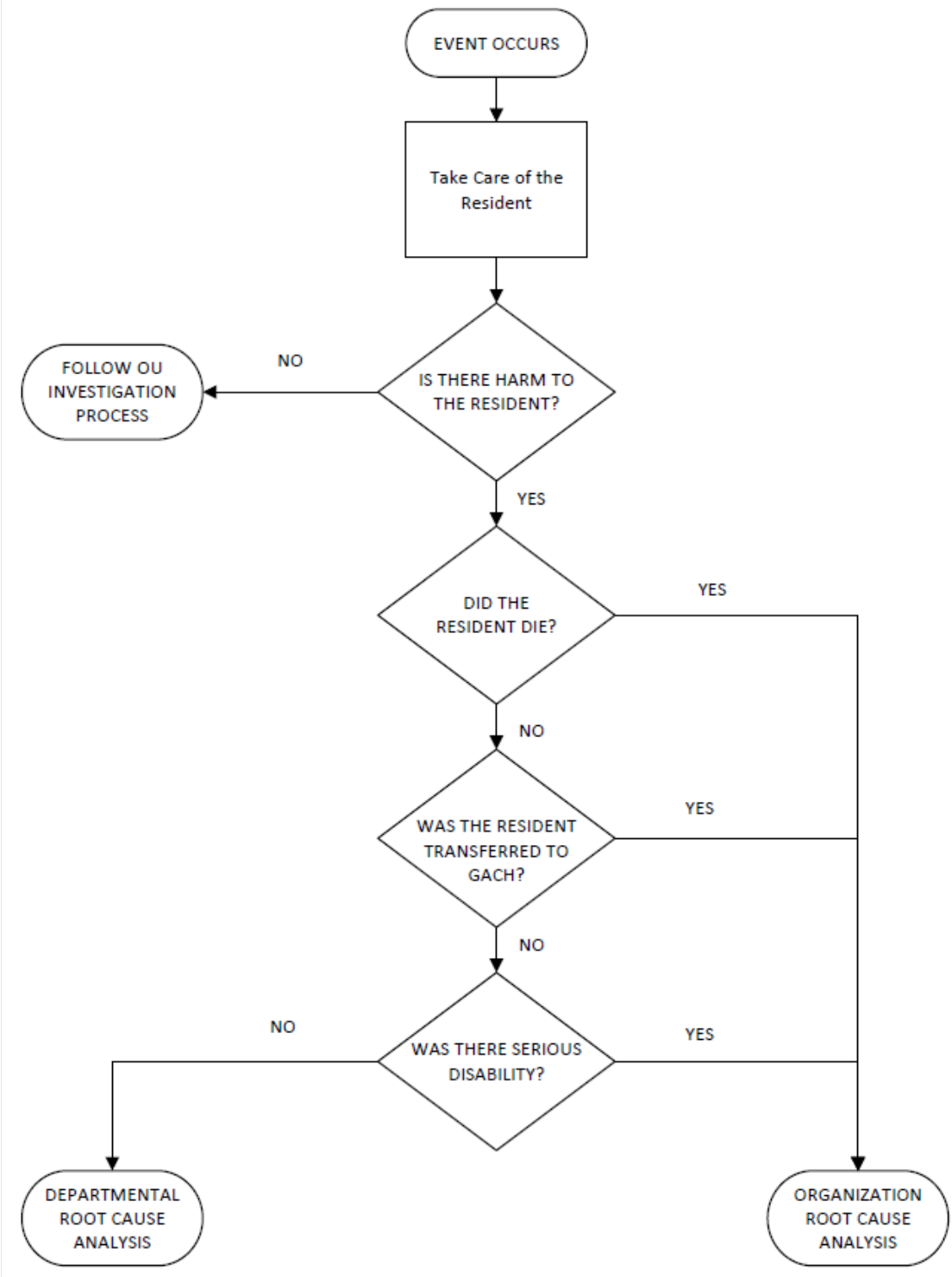
ATTACHMENT:
Appendix A: Flowchart to assist in disposition of investigation methodology

REFERENCE:
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-04 Unusual Occurrences
LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)
Barclays Official California Code of Regulations, Title 22. Social Security, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies., Chapter 3. Skilled Nursing Facilities, Article 5. Administration, § 72541. Unusual Occurrences

Revised: 2022/05/09 (Year/Month/Day)
Original adoption: 2020/09/08 (Year/Month/Day)

APPENDIX A

FLOWCHART TO ASSIST IN DISPOSITION OF INVESTIGATION METHODOLOGY



LICENSING AND CERTIFICATION VISITS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall coordinate Licensing & Certification (L&C) visits, including the annual licensing and recertification survey, through designated staff from the Quality Management (QM) Department who shall act as the L&C liaison.

2. The ~~Risk Management~~Regulatory Affairs team from the QM Department shall serve as the L&C liaison for L&C investigations involving Facility Reported Incidents (FRI) and Anonymous Complaints.

PURPOSE:

To assure appropriate and consistent actions and to keep the LHH Administration team informed of L&C activities on site.

PROCEDURE:

1. L&C representatives are to be directed to Administration to announce their visit prior to conducting official business.

2. The L&C liaison is to be notified when L&C surveyor(s) arrives on hospital premises.

3. The L&C liaison shall meet with the surveyor(s) to determine the purpose of the visit.

4. The L&C liaison shall accompany the surveyors to the appropriate department in which to conduct their investigation and remain with the surveyors if this should be necessary. If the L&C liaison ~~does not~~is unable to remain with the surveyors, the staff working with the surveyors shall notify the L&C liaison of interaction(s) that have occurred with L&C surveyor(s).

5. The L&C liaison shall notify appropriate division head(s) and manager(s) of the outcome of the L&C visit and coordinate any necessary follow-up actions.

6. The L&C liaison is responsible for gathering documents requested by the L&C surveyor(s) in a timely fashion. —Documents received must be reviewed for appropriateness by the L&C liaison before they are submitted to L&C surveyor(s).

7. Requested documents typically consist of resident medical records, policies and procedures, alleged resident abuse investigation reports, manufacturer instructions, employee personnel records, schedules, activity calendars and Residents' Council meeting minutes.

a. Documents or printed material that are confidential and protected under California Evidence Code Section 1157 are not to be submitted to L&C surveyors.

~~a.~~b. Photographs related to Unusual Occurrence (UO) reports are considered protected documents obtained for performance improvement activities and are not to be submitted to L&C surveyors.

~~7.~~8. The ~~Risk Management~~ Regulatory Affairs team from the QM department are responsible for maintaining a log of complaint investigations conducted by L&C surveyors and keeping a copy of documents submitted to the surveyors.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 15/09/08, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 93/10/01

RISK MANAGEMENT PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall utilize and integrate activities of the ~~Hospital-wide~~facility's Quality Assurance and Performance Improvement (QAPI) Program to assure an effective risk management/loss prevention system at the facility.

PURPOSE:

To preserve the resources of the City and County of San Francisco by means of:

1. Identification and prevention of potential risks to the safety and health of LHH ~~residents, staff, volunteers and visitors~~ resident, employee, visitor, volunteer, or student;

2. Alleviation of possible claims and lawsuits through immediate investigation of complaints and/or reported incidents that adversely affect ~~residents, employees, volunteers or visitors~~ resident, employee, visitor, volunteer, or student, positive communication with all involved parties and, if indicated, timely compensation for medical care;

3. Cooperation with the City Attorney's Office (CAO) to evaluate claims made against LHH, by collecting information and coordinating responses to interrogatories, depositions, hearings, court dates and other logistics involved in such claims, and by assuring appropriate documentation of all such activities;

4. Cooperation with local, state and federal reporting requirements;

5. Regular reports to the LHH Performance Improvement and Patient Safety (PIPS) Committee to assure accountability, integration of information and continuity of problem resolution activities.

DEFINITION:

The following types of events represent potential liability for LHH and must be reported:

1. Unusual occurrence (UO): an event or condition, which has had or may have an adverse effect on the health or safety of a resident, employee, visitor, volunteer, or student.

2. Reportable Incidents to the State of California: allegation of resident abuse, missing resident, death from unnatural cause, disease outbreak, major accident/injury, assault, fire, resident burn or suicide attempt.

3. Errors in treatment or procedures that adversely affect or might adversely affect a resident, f~~amily member or visito~~ employee, visitor, volunteer, or student~~r~~.

4. Medical devices or equipment that malfunctions or fails to operate that results or might result in an adverse effect to a ~~resident, family member, employee or visitor~~ resident, employee, visitor, volunteer or student.

5. Accidents that occur to any person or property on the grounds of LHH.

6. Complaints

~~If possible, any complaint from a resident, family member or visitor shall be resolved by the person receiving the complaint to the extent of their authority to do so.~~

   a. Resident, family and visitor complaints that require action other than immediate action or which, for liability or other reasons require documented follow-up, shall be referred to the appropriate division head and documented on an UO report form. ~~Findings of the investigation and action taken shall be documented and maintained on file, along with any written response to the complaint.~~

PROCEDURES:

1. Response Procedure

   a. Any LHH employee who witnesses an occurrence that may result in harm or injury to any person on the premises shall take immediate action to alleviate the situation.

2. Unusual Occurrence Reporting

   a. After assuring that appropriate medical care is provided to the affected party, the employee shall report the incident to his/her supervisor and, and in cases involving visitors to the hospital, a report is also made to the San Francisco Sheriff's ~~Department~~Office (SFS~~O~~O~~D~~).

   b. The facility utilizes the UO reporting system to identify events or conditions that may have an adverse effect on the health or safety of a resident, employee, visitor, volunteer, or student; and institute corrective action that will address immediate needs and minimize risk of future incidences.

   c. The responsible Manager/Supervisor shall promptly report any incidents reportable to the State of California to the Quality Management (QM) Department Chief Quality Officer and Director of Regulatory Affairs, by telephone and through an UO report, and to other appropriate local agencies (also refer to LHHPP 60-03 Incidents Reportable to the State of California). The QM staff shall evaluate the occurrence and report the incident, as appropriate, to the California Department of

Public Health (CDPH) by telephone or fax no later than within 24-hours or next-business day.

d. The Risk Management Team shall review UOs during regular work hours and partner with the Regulatory Affairs Team ~~Reporting of Unusual Occurrences to Licensing & Certification (L&C) during regular work hours shall be carried out by the Risk Management Nurses~~ who will assure that the appropriate telephone report and letter are completed. Copies of letters sent to L&C office shall be filed in the ~~Administrative~~QM L&C file.

e. Weekend/Holiday reporting of ~~Unusual Occurrences~~UOs shall be conducted by the Nursing Operations Supervisor on duty with notification to the L&C liaison on the next business day.

i. The ~~RM Nurse~~Regulatory Affairs team is responsible for assuring that the required follow-up letter is sent and a copy placed in the L&C file.

3. Investigation Procedure

a. The appropriate supervisor shall be responsible for conducting a thorough, documented investigation of the incident, including evaluation of the scene of the accident and possible contributing factors.

i. Investigations of occurrences involving residents shall be completed by the unit nursing and/or medical staff, documented on the UO report and investigation forms, and submitted to the LHH PIPS Committee as part of the QAPI program~~through established channels~~. When an injury is involved or the potential for injury is serious, reports must include all the required elements on the UO investigation form, including details of the investigation and corrective actions taken or planned.

ii. Investigations of occurrences involving employees shall be completed by the employee's supervisor, documented on the Supervisors Incident Investigation Report (SIIR) and submitted to the Human Resources Department through established channels.

iii. Investigations of occurrences involving visitors shall be completed by the supervisor in the area, as well as by SFSO~~D~~, who is responsible for assessing the scene. The UO and investigation reports shall be reported to the LHH PIPS Committee.

b. Additional investigative reports may be requested, as needed, by the Human Resources Department and the QM Department.

4. Claim Procedure

a. All inquiries or claims against the City and County of San Francisco that involve injuries or accidents to residents or visitors shall be forwarded ~~to the Deputy City Attorney (DCA).~~to the CAO.

b. The following types of events shall be reported to the ~~DCA~~CAO:

i. Adverse resident events, i.e. suicide, homicide, abduction, major accident or injury, unexpected or unusual death;

ii. serious privacy breach;

iii. significant security issue(s);

iv. events resulting in attention by the media;

v. incidents resulting in issuance of citations by CDPH; and

~~i.~~vi. communication or contact by external attorneys.

c. The ~~DCA~~ CAO shall coordinate and summarize investigations of incidents and make recommendations regarding the settlement of claims, subject to the agreement and approval of the appropriate division head and the Chief Executive Officer and Nursing Home Administrator.

d. The LHH Deputy City Attorney shall serve as the facility contact person for ~~City Attorneys~~the CAO regarding claims and/or litigation, and respond to interrogatories and coordinate depositions as requested by the ~~City Attorney's Office~~CAO.

e. Claims involving non-injury motor vehicle accidents or other property damage shall be referred to the ~~Chief Operating Officer (COO).~~Assistant Nursing Home Administrator, Support Services.

f. Claims related to employee/volunteer injuries shall be handled through the Human Resources Department.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-06 Resident Suggestions and Complaints
LHHPP 60-03 Incidents Reportable to State of California
LHHPP 60-04 Unusual Occurrences
LHHPP 73-01 Injury and Illness Prevention Program
~~LHHPP 77-01 Medical or Psychiatric Emergency: Employees, Volunteers, & Visitors~~

Revised: 07/12/17, 08/01/08, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 94/08/15

ENVIRONMENT OF CARE PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy environment for patients, visitors, staff, and volunteers through the administration of an Environment of Care (EOC) Program.

2. EOC policies and procedures, Management Plans, and education/training procedures shall be maintained for all components of the EOC Program and shall be created or updated in conjunction with LHH's Mission, Vision, Values, and True North goals of Safety, Quality, Care Experience, and Financial Stewardship.

3. The effectiveness of the EOC Program shall be measured by standards compliance and meeting program objectives by evaluating improvement from established baseline performance metrics.

PURPOSE:

To provide a comprehensive description of the components that comprise the EOC Program.

PROCEDURE:

1. Management Plans

a. Management Plans are essential to the environment of care for supporting strong performance, demonstrating that there are processes in place to provide a safe environment, and minimizing or responding to risk. EOC professionals develop and maintain Management Plans in their respective disciplines. The EOC Program encompasses the following seven areas:
   - Safety Management
   - Security Management
   - Hazardous Materials and Waste Management
   - Medical Equipment Management
   - Utility Systems Management
   - Life Safety Management, and
   - Emergency Management (Note: This program is integrated into the EOC Program and all patient care services, ensuring LHH's overall preparedness for emergencies and disaster response).

b. Management Plans shall include risk assessment, staff development, emergency response and procedures, inspection, testing, and maintenance, information collection and evaluation, performance monitoring, and annual evaluation.

c. Management Plans shall be reviewed annually but may be revised more frequently as needed to ensure that information is consistent with current health care industry standards. Management Plans shall be reviewed and approved by the EOC Committee prior to final presentation to the Performance Improvement and Patient Safety Committee (PIPS).

2. Environment of Care Committee

a. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the Environment of Care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. Committee members represent the following areas:

- Nursing
- Clinical Labs
- Security Management
- Infection Control and Prevention
- Pharmacy Services
- Facility Services
- ~~Employee Health and Safety~~
- Quality Management
- Environmental Services
- ~~Patient Safety~~
- Department of Education and Training
- Workplace Safety ~~and~~
- Emergency Management

b. Activities of the Environment of Care Committee include:

i. Plan, direct, implement, and improve the organization's performance of EOC activities.

ii. Evaluate and assess existing conditions, operations, and practices to determine impact and general regulatory compliance.

iii. Identify and implement improvement opportunities and process change to facilitate safety, security, and comfort of patients, staff, and visitors.

iv. Establish and maintain risk assessments and evaluation criteria to prioritize performance improvements and process changes.

v. Work to ensure that LHH staff are trained to identify, report, and take action on environmental risks and hazards.

~~i.~~vi. Reports to LHH departments and committees to communicate progress.

3. Environment of Care Rounds

a. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills. Rounds are scheduled to cover all patient care areas on a quarterly basis. The EOC rounds team includes representatives from:

- Nursing
- Clinical Labs
- Security Management
- Infection ~~Control and Prevention~~Prevention and Control
- Pharmacy Services
- Facility Services
- ~~Employee Health and Safety~~
- Quality Management
- Environmental Services
- ~~Patient Safety~~
- Department of Education and Training
- Workplace Safety ~~and~~
- Emergency Management

4. Data and Reporting

a. Data obtained from EOC Rounds checklists shall be collected and analyzed to determine improvement and/or identify trends and other challenges. Results shall be reported to the EOC Committee on a quarterly basis.

b. Management Plan owners shall present quarterly reports in their respective areas to the EOC Committee. The scope of the report shall include data metrics, priorities, goals, and objectives to ensure the ongoing effectiveness of the EOC Program.

c. The following EOC Committee components shall report to the PIPS Committee on a yearly basis: Workplace Safety, ~~and~~ Emergency Management, Environmental Health, ~~and~~ Safety/Hazardous Materials, Environmental Services, and Infection ~~Control and Prevention~~Prevention and Control. Other areas, such as Facility Services, and Biomedical Engineering shall report quarterly and, on a rotating/as-needed basis. Security Management shall report on a quarterly basis.

d. The EOC Annual Report highlights all activities of the EOC Program from the current fiscal year and is written to include scope, accomplishments, program objectives, performance metrics, and goals and opportunities for improvement, and is presented to the organization.

e. The EOC Annual Report shall be approved by the EOC Committee prior to being presented to PIPS.

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-11 Environment of Care Committee

Original adoption: 20/11/10 (Year/Month/Day)

PATIENT SAFETY COMMITTEES AND PLANS

POLICY:

Pursuant to SB 158 and Health and Safety Code §1279.6 Laguna Honda Hospital and Rehabilitation Center (LHH) shall establish an annual patient safety plan to improve resident safety and reduce resident suffering resulting from preventable events.

PURPOSE:

The purpose of establishing an annual patient safety plan is to implement a systematic and comprehensive process for reviewing resident incidents and conducting thorough analyses of reported patient safety events.

PROCEDURE:

1. Patient Safety Committees

a. The Performance Improvement and Patient Safety (PIPS) Committee shall serve as the patient safety committee that reviews patient safety events occur within the facility.

   i. PIPS shall serve as the oversight for the performance improvement committees/teams that focus on resident safety incidents that occur within the facility.

b. The performance improvement committees/teams that address patient safety events include the following:

   i. Code Blue Committee;

   ii. Event Analysis/Systems Improvement (EASI);

   iii. Falls Performance Improvement Team;

   iv. Medication Error Reduction Committee;

   v. Environment of Care Committee;

   vi. Pharmacy and Therapeutics Committee;

   vii. Utilization Management Committee; and

   ~~iv.~~viii. Nurse Executive Committee Quality and Safety.

   ~~v. Pressure Ulcer Prevention Performance Improvement Team;~~

~~vi. Resident Safety and Abuse Prevention Performance Improvement Team; and~~

~~vii. Occupational Safety and Health.~~

c. The patient safety plan is a subset of the overall Quality Assurance and Performance Improvement (QAPI) program for the Acute and SNF units that pertain to resident and staff safety related events.

2. Reporting System for Patient/Resident Safety Events

a. The definition of a patient safety event includes adverse events or potential adverse events that are determined to be preventable; and health-care-associated infections, as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee, that are determined to be preventable.

b. The Unusual Occurrence (UO) system is the reporting system that is used to report actual and potential patient safety events, excluding individual patient/resident infections.

c. The Infection Prevention and Control surveillance program is the reporting system for reporting actual and potential health-care-associated infections or healthcare acquired infections (HAIs).

d. The Infection Control Committee (ICC) shall submit, at a minimum, quarterly reports to PIPS.

3. Composition of the Patient Safety Committee

The PIPS~~Patient Safety~~ Committee comprises of various health care professionals including, but not limited to the following members:

a. Physicians

b. Nurses

c. Pharmacists

d. Administrators or designees

e. Other staff members with appropriate competencies to participate in the review of patient safety events.

4. Functions of the Patient Safety Committee

The PIPS~~Patient Safety~~ Committee is responsible for performing the following functions:

a. Review, approve and revise the QAPI program that includes a patient safety plan, at least once a year, but more often if necessary to evaluate and update the plan

b. Receive and review reports of patient safety events during the PIPS Committee meetings.

c. Provide oversight that serious, or potentially serious, patient safety event reviews are being carried out according to facility policies and procedures, ensuring that:

   i. an interdisciplinary investigation team has been assigned to conduct an in-depth review and perform a root cause analysis; and

   ii. the investigative team develops corrective measures, with timeline for implementation of corrective measures, and the persons responsible.

d. Monitor the status and implementation of corrective actions for patient safety events on a monthly basis until complete

e. Make recommendations to eliminate future patient safety events by supporting processes that encourages:

   i. a culture of safety

   ii. the reporting of patient safety events

   iii. interdisciplinary collaborative processes for improving the delivery of safe patient care

   iv. prioritization of safety initiatives

   v. on-going patient safety training for facility personnel

ATTACHMENT:
None.

REFERENCE:
Senate Bill 158
Health & Safety Code Safety Code §1279.6
LHHPP 60-01 Quality Assurance Performance Improvement Program
LHHPP 60-04 Unusual Occurrences
LHHPP 60-12 Review of Sentinel Events

Revised: 16/01/12, 18/11/13, 20/10/13, 22/05/09 (Year/Month/Day)

Original adoption: 10/11/10

Revised Nursing Policies and Procedures

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 Chief Nursing Officer and the Nursing Executive Committee before issuance.

3. NP~~&~~Ps 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.~~ NP&Ps are reviewed at least yearly in accordance with State of California Title 22 requirements.

~~4.~~ ~~NP&Ps are accessible by LHH staff as follows:~~

~~5. online via LHH Intranet~~

~~6.~~5. ~~manual copies are maintained at three sites throughout LHH – Nursing Office, Nursing Education, and Chief Nursing Officer.~~LHH Areas that have access to the San Francisco Health Network (SFHN) internet website are not required to maintain a hard copy of the LHHPP or Nursing DPP

PURPOSE:

To describe the procedure for developing, reviewing, revising, and approving LHH Nursing Policy and Procedures.

CHARACTERISTICS / DEFINITIONS:

The following definitions apply:

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.

~~**Practice Guideline** – a process standard for symptom or resident care management that improves the quality of clinical nursing practice. A practice guideline offers direction accomplishing a desired resident outcome.~~

PROCEDURE:

A. Nursing Policy and Procedure Committee

1. Purpose

The LHH Nursing Policy and Procedure Committee is established by LHH NEC to promote the development and dissemination of nursing policies and procedures and practice guidelines. Within the scope of this charge, the NP~~&~~P Committee coordinates and oversees the development, review and revision of LHH Nursing policies and procedures and practice guidelines.

2. Membership

   a. The LHH NP&P Committee membership shall include, but not be limited to, the following members: ~~Nursing~~ Department of Education and Training (DET) NP~~&~~P Coordinator, Chief Nursing Officer, Advance Practice Nurses, ~~,~~ and ~~Nursing Education.~~DET.

   b. Other clinical and nursing staff as appropriate on ad hoc basis.

3. 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.

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.

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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 ~~ensure~~ 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 ~~Nursing Education~~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). ~~forward to NEC for review and approval.~~

~~5. Following NEC approval, the draft new or revised NP&P that impacts medical practice will be forwarded to Medical Executive Committee (MEC) for review and approval.~~

~~6.~~4. ~~Following the MEC approval, draft NP&P will be submitted to QM for JCC review & final approval.~~

~~7.~~5. Following the JCC approval, the approved NP&P is posted on-line.

~~8.~~6. The following individuals sign the LHH NP&P signature page of the manual confirming approval, on an annual basis:

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

1.

~~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.

2.

3.

4. Nursing leaders including but not limited to Nurse Managers, Nursing Directors, Operations Supervisors, MDS/RAI Program Coordinators, Nursing Education, and Clinical Informatics, are

~~5.~~

3. responsible for informing staff of the revised or new NP&Ps and ensuring that NP&Ps are implemented at the departmental/program/r/unit/shift level.

~~6.~~

~~**E. Nursing Practice Guideline Development or Revision**~~

~~1. A Nursing Practice Guideline may be developed as part of a revision or an addition to a NP&P.~~

~~2. The format of a Nursing Practice Guideline consists of the following sections:~~

~~**TITLE:** Title of the Nursing Practice Guidelines~~

~~**BACKGROUND:** Related physiological, medical, social, psycho-behavioral, and/or nursing information that supports understanding of the practice guideline when applicable.~~

~~**COMPETENCIES:** Skills, knowledge, and abilities required to work with residents dealing with this issue when applicable. Need not be included if covered in related policy statements.~~

~~**ASSESSMENT:** Assessments specific to the practice guideline topic, including the initial assessment and ongoing assessments.~~

~~**PROBLEM IDENTIFICATION:**~~
~~Potentially related problem statements.~~

~~**PLANNING:** Factors that may affect choice of interventions.~~

~~**INTERVENTIONS:** Interventions specific to the practice guideline.~~

~~**EVALUATION:** Criteria used in evaluating the success of interventions.~~

~~**OUTCOME:** Outcome specific statements as follows:~~
~~The resident will:~~

~~The nurse will:~~

~~**REFERENCES:** List literature that supports the practice guideline as well as facility policies, procedures, guidelines, and other documents that have direct bearing on the practice guideline.~~

~~F.~~E. Retention and Destruction of Records

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

2. The Nursing Education 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:

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

ATTACHMENTS

~~n~~None

Adopted 2001/11/~~01~~

Revised: ~~3/~~2005/03, ~~10/~~2007/10, 2012/03/27/~~2012~~; 205/01/13/~~2015~~; 2024/02/26

Reviewed: 01/13/2015

Approved: 01/13/2015

ORAL MANAGEMENT OF NUTRITIONAL NEEDS

POLICY:

1. The facility will provide each resident a nourishing, palatable, well–balanced diet that meets daily nutritional and special dietary needs including adequate hydration.

2. The facility will provide table service to residents who desire it and served at tables of appropriate height.

3. Physician orders are required for diets, nutritional supplements, swallowing evaluation, ~~and~~ standard aspiration precautions and individualized aspiration precautions.

4. Paid feeding assistants such as clerical, housekeeping or administrative staff (does not include licensed nursing staff and nursing assistants) are not permitted to assist residents who have complicated eating problems including but not limited to difficulty swallowing and recurrent lung aspirations. Only trained staff may assist.

5. Menus must meet the nutritional needs of residents in accordance with established national guidelines, be prepared in advance for viewing, and followed by staff.

6. Menus will reflect, to the extent possible, person-centered care including but not limited to the cultural, religious, and ethnic needs of the resident population as well as input from the residents and/or resident groups.

7. The facility will make reasonable efforts to provide food that is appetizing and culturally appropriate for the residents and provide individualized plans of care for those requiring special dietary needs.

8. Physicians and speech therapy will coordinate any additional individualized aspiration precautions recommended by speech therapy to be ordered by the physician and documented in the care plan.

9. The facility utilizes diet liberalization where possible, to minimize dietary restrictions where safe to do so, and to improve nutritional and hydration status where possible, as well as provide for resident preferences.

10. Nursing staff is responsible for monitoring residents' safety related to eating, adequate nutritional and fluid intake.

11. Infection prevention and control measures will be in place to monitor preparation, storage, cooking, serving/feeding, and disposal of the food line service.

12. Nursing staff will monitor and document resident unintended weight loss or gain and inform the dietitian and physician of significant changes~~.~~ (Reference: NPP G 7.0 Obtaining, Recording and Evaluating Residents Weight).

13. Family, volunteers, and visitors will be educated regarding dietary restrictions including for food brought in from outside.

14. Standard aspiration precautions and individualized aspiration precautions will be documented in the resident care plan.

PURPOSE:

This policy will guide staff in ongoing communication and coordination among staff within all departments for the delivery of adequate and safe nutrition and hydration consistent with federal requirements and resident safety, and to meet the resident's daily nutritional needs, dietary needs, and preferential choices to the extent possible within this setting.

PROCEDURE:

1. On admission and throughout the resident's stay, the licensed nurse (LN) will monitor residents for ability to eat safely and for any signs or symptoms of swallowing difficulties or changes in the resident's ability to eat/swallow~~.~~ (Refer to HWPP 26-02 Management of Dysphagia and Aspiration Risk) .

2. A baseline care plan including dietary restrictions and food allergies, is developed within 48 hours of admission with healthcare information that will allow staff to properly care for resident safely while providing adequate nutritional needs until a comprehensive care plan can be developed by the interdisciplinary team.

3. Consideration of diagnosis may serve to guide speech therapy interventions and/or any concerns that staff may have.

4. ~~The physician and dietitian will be notified of any nutrition and/or swallowing difficulties as soon as practicable before next meal service.~~Once a resident is identified as being at risk for aspiration, the physician and dietitian shall be notified as soon as practicable before next meal service.

~~5.~~ The nurse reports significant unintended weight loss or gain to the dietitian and physician. (Reference: NPP G 7.0 Obtaining, Recording and Evaluating Residents Weight).~~Significant weight loss is defined as:~~

~~6.~~
~~7. 5% or greater over 30 days~~
~~8. 7.5% or greater over 90 days~~
~~9. 10% or greater over 180 days~~

~~10.~~5. Nursing staff will verify that the meal/snack is consistent with the resident's diet as ordered by the physician including type, consistency, and fluid viscosity, and that this individualized information is documented in the resident plan of care.

~~11.~~6. Nourishment is to be served by nursing staff between meals, at bedtime and upon resident's request and will be consistent with dietary orders and resident preference, to the extent possible.

~~12.~~7. For those residents on restricted diets, family, volunteers and other visitors will be instructed to speak with the nurse prior to offering the resident any food or beverages to ensure the food is the proper consistency (pureed, soft etc.) and type (diabetic, low salt etc.) in accordance with the physician order.

~~13.~~8. Nursing staff assigned as line of sight staff during meals, will have the following responsibilities:

   a. Designated staff will wear a designated pink vest.

   b. Designated staff will stay in the Great Room during meals (from beginning to end; until the last resident in the great room is finished eating).

   c. Designated staff will ensure that residents are seated at an appropriate table/seat.

d. Designated staff will continuously scan the area of the Great Room to monitor that ~~standard~~ aspiration precautions are being followed.

e. Designated staff will monitor that staff assisting any resident who has recommended individualized aspiration precautions are ~~on a specialized feeding plan, are~~ following the plan. Individualized aspiration ~~P~~precautions are printed on the resident's tray ticket for easy reference and the meal tray has a pink ~~plate cover~~piece of paper.

f. Designated staff will monitor and intervene as necessary when patients are eating unsafely or showing signs/risk of aspiration (e.g., excessive coughing, excessive throat clearing, impulsive eating behavior, etc.).

~~14.~~9. The designated ~~line of sight~~ staff ensuring resident's use of individualized aspiration precautions will not be assigned other responsibilities during meal time nor assist individual residents during meal time as he or she will not be able provide adequate supervision to the other residents.

~~15.~~10. Prior to and after meal service, residents will be provided with hand hygiene opportunities and assisted as needed.

~~16.~~11. Before the resident leaves the dining area (or for in-room dining before the tray is removed) the resident will be assessed for cleanliness of clothing~~es;~~, and ~~towels or other~~ clothing protectors will be removed. ~~Face and hand hygiene will be provided.~~

~~17.~~12. After the meal is completed, the Nursing Assistant will clean the resident's hands, face and clothing as needed. Keep resident sitting upright for at least 20 minutes after the meal. If residents must lie down, position on the side.

~~18. Food disposal~~
~~19.~~
~~20.~~13. ~~Uneaten food from the meal tray will be discarded or sent back to kitchen for disposal. Do not store food from the resident's tray (opened or unopened) in a communal refrigerat~~or.

~~a. Items such as cookies may be securely covered and left at the resident's bedside for later but food or drink that must be refrigerated should be disposed of properly.~~

~~b. Milk is discarded after one hour at room temperature.~~

~~c. Nourishment refrigerators are to be kept secured. Galley refrigerators are secured behind a locked door. Great Room refrigerators will be locked.~~

~~21.~~14. Documentation

a. Nursing staff will determine and document in the electronic health record the resident's meal intake. Report to the LN if meal intake is less than 50%.

b. If a supplement is given per physician's order, the amount of the supplement consumed is documented in the electronic health record.

c. Resident's diet, standard aspiration precautions~~,~~ or individualized aspiration precautions, adaptive equipment used for eating, and dining preferences are documented in the electronic health record.

d. In addition to standard aspiration precautions, the speech pathologist may develop individualized aspiration precautions for some of the residents who are at risk for aspiration. These specific precautions, once ordered by the physician, will be listed on the resident's tray ticket for easy reference by Nursing staff. They will also be recorded in the resident's care plan.

e. If resident is on fluid restrictions, fluid intake is documented in the intake and output section of the electronic health record.

REFERENCES:

CMS Nutrition Critical Element Pathway. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Form CMS-200-75 (5/2017).

CMS Federal Regulatory for Long term care. Standard 483.60 Food and Nutritional Services including but not limited to:

- F800 Provided food meets needs of each resident
- F803 Menus meet resident needs/ prep in advance/followed
- F804 Nutritive Value/Appear, Palatable/prefer temp
- F805 Food in form to meet resident needs
- F806 Resident allergies, preferences and substitutes
- F807 Drinks avail to meet needs/ preferences/hydration
- F808 Therapeutic diet prescribed by physician
- F809 Frequency of meals/snacks at bedtime
- F810 Assistive devices-eating equipment/utensils
- F813 Personal food policy

CAHAN (California Advocates for Nursing Home Reform (2016). Nursing Home Care Standards. Food and Nutrition. http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html

CROSS REFERENCES:

Hospitalwide Policy and Procedure
26-02 Management of Dysphagia and Aspiration Risk
26-04 Resident Dining Service

Nursing Policy and Procedure
B 5.0 Color Codes- Resident Identification
G 3.0 Intake and Output
G 7.0 Obtaining, Recording and Evaluating Resident's Weight

ATTACHMENT/APPENDIX:

NONE

Revised: 2005/09, 20019/10, 2010/01, 2011/07/26, 2014/12, 2015/03/10, 2015/11/06, 2017/05/09, 2019/03/12; 2021/02/09

Reviewed: 2021/02/09

Approved: 2021/02/09

MAINTAINING TEMPERATURE OF MEDICATION and NOURISHMENT REFRIGERATORS VIA TEMPTRAK & CLEANLINESS OF REFRIGERATORS

POLICY:

1. The types of refrigerators in the neighborhoods are: medication, nourishment, and employee's refrigerators.

2. Temperature Ranges:

   - Medication refrigerator: between 36 and 46 degrees Fahrenheit.
   - Nourishment refrigerator: between 33 and 41 degrees Fahrenheit.
   - Galley freezer: between -10 and 0 degrees Fahrenheit.

3. Licensed Nurse is to check the temperature of nourishment refrigerators, medication refrigerators and galley freezers twice a day, on the AM and PM shifts, by logging on to TempTrak.

4. Licensed Nurse is to clean medication refrigerator weekly with facility approved disinfectant.

5. If these equipment go out of range continuously over 2 hours, an additional online check via TempTrak must be done

6. If the nourishment refrigerators and galley freezers are out of range:

   a. Licensed nurse needs to check the refrigerator/freezer and close door if opened or do other corrective action as needed.
   b. The licensed nurse will log into TempTrak database to document action taken.
   c. Licensed nurse shall check the refrigerator after an hour to ensure temperature has been corrected. If still NOT within range, call Facilities and create a work order

7. Medication refrigerators are only used for medication requiring refrigeration. The medication refrigerators are located in the medication rooms and must be kept locked at all times.

8. If the temperature of a refrigerator containing medications is out of range, the licensed nurse is to contact the pharmacy for instructions on what to do with the refrigerated medications.

9. Nourishment refrigerators are only used for storage of resident's nourishments / supplements. provided by the facility The nourishment refrigerators are located in the ~~Great Room and~~ Galley in each neighborhood. Any additional food brought into the facility~~,~~ by residents or for residents consumption is stored in the resident refrigerator located in the Great Room - ~~Nourishment~~Resident refrigerators in the Great Room must be kept ~~locked at all times~~always locked. The key is kept in the nursing station.

10. All food in refrigerators should be stored in covered containers. Food not in original container is to be clearly labeled and dated.

11. Licensed Nurses, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) must check the dates of refrigerated foods before serving and discard immediately if outdated.

12. Employees must store their food in the designated refrigerator in the staff lounge.

PURPOSE:

To store substances that require refrigeration in a hygienic refrigerator environment at the correct temperature.

BACKGROUND:

Temperature readings are displayed in the monitor located at the bottom of the refrigerator doors. Temperatures are also displayed online ~~on~~ in real time on TempTrak.

PROCEDURE:

A. Equipment

Obtain from ward supply: clean basin, mild soap, clean cloths

B. Cleaning of the Refrigerator

1. Remove food containers and medications prior to cleaning the refrigerators. Using warm water and mild soap wash inside refrigerator with clean cloth.
2. Wipe dry with clean cloth.
3. Racks or shelves must be thoroughly washed and dried.
4. After cleaning and drying inside of refrigerator, return contents.
5. Wipe off the outside of refrigerator.

C. Maintenance of the Refrigerator

1. It is the responsibilities of the A.M. and P.M. shift Licensed Nurses to check for correct temperature.
2. It is the responsibility of the A.M. shift Licensed Nurses to check for any outdated food or medications in the medication and nourishment refrigerators. The A.M. Nursing Supervisors and Nurse Managers will monitor for ongoing compliance for timely removal of outdated foods.
3. The A.M. shift assigned C.N.A. or P.C.A. is responsible for cleaning the nourishment and employees refrigerators. Cleaning of these refrigerators is neighborhood based as scheduled by the Nurse Manager or Charge Nurse.
4. All nursing staff are responsible for discarding any unlabelled or expired foods found during their shift.

D. Food Storage

Food sent by Food and Nutrition Services for nourishments are stored only in ~~the Great Room or~~ Galley refrigerators. All containers must be labeled with expiration~~ed~~ dates. Outdated and unmarked foods are to be discarded immediately.
DO NOT store food from residents meal trays (opened or unopened) in the nourishment refrigerators

E. Reporting and/or Documentation

1. On the Emergency Checklist, the AM and the PM shifts will initial TempTrak to signify that they logged on to TempTrak.

2. Report any malfunctions or incorrect temperature settings to Facility Services, Licensed Nurse to complete an online work requisition for repair.

REFERENCES:

TempTrak Reference Guide (Revision H, January 2010) © 2003-2010 Cooper-Atkins Corporation.

CROSS REFERENCES:

Food and Nutrition Services Policies and Procedures
File: 1.1 Food from Home or Outside Sources Served Directly to Residents

Hospital Policies and Procedures
~~LHHPP~~ File: 31-01 Wireless Refrigerator and Freezer Temperature Monitoring System
~~LHHPP File: 72-01 E8 Nutrition Services~~
~~LHHPP~~ File: 72-01 F5 Standard for Refrigeration Equipment

ATTACHMENTS:

Attachment 1: Emergency Equipment / Wireless Temperature Monitoring System Checklist
Attachment 2: TempTrak: Quick Reference Guide for Nurses

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Policy:

It is the policy of Laguna Honda to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.

Definition:

"Restorative nursing program" refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Policy Explanation and Compliance Guidelines:

A. Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols.

B. Any member of the Resident Care Team (RCT), with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences. The Restorative Nursing Program (RNP) does not require a physician's order and can be initiated by a licensed nurse. However, for residents with complex clinical conditions such as fractures or severe contractures, a consultation with a physician and/or licensed rehabilitation therapist may be appropriate.

C. Nursing personnel, Certified Nursing Assistants (CNAs) and Patient Care Assistants (PCAs), are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to:

1. Maintaining proper positioning and body alignment.
2. Encouraging and assisting residents, as needed, in turning and position changes.
3. Encouraging residents to remain active and assisting with any exercises according to the plan of care.
4. Promoting independence in Activities of Daily Living (ADLs), performing tasks for residents only as needed to ensure completion of tasks.
5. Assisting residents in adjustment to their disabilities and use of any assistive devices.
6. Assisting residents with range of motion exercises, performing passive range of motion for residents who lack active range of motion ability.
7. Promoting continence with various toileting and/or bowel and bladder training activities.

~~B.~~

~~C.~~

~~D.~~**B.** All residents will receive maintenance nursing services as described above, as needed, by CNAs and PCAs during daily routine care and ADLS.

~~E.~~**C.** The Restorative Nurse and restorative aides receive additional training on Restorative Nursing Program (RNP) activities upon hire and as needed.

~~F.~~**D.** Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include:

1. Technique: Restorative activities provided by nursing staff and trained staff.

a. Active Range of Motion (AROM): exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
  i. AROM: performance of an exercise to move a joint without any assistance or effort of another person to move the muscles surrounding the joint.
  ii. AAROM: the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.

b. Passive Range of Motion (PROM): provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.

c. Splint or Brace Assistance: provision of:
  i. verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
  ii. a scheduled program of applying and removing a splint or brace.

2. Training and Skill Practice: Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

a. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses.

b. Activities of Daily (ADL) Training
  i. Bed Mobility: activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning self in bed.
  ii. Transfer: activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
  iii. Walking: activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
  iv. Dressing and/or Grooming: activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing, and washing, and performing other personal hygiene tasks with or without assistive devices.
  v. Eating and/or Swallowing: activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

c. Communication: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

d. Bowel and Bladder Training:
  i. Urinary Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex:

bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)

ii. Bowel Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

~~G.~~E. Residents may receive Restorative Nursing Program (RNP) services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy.

~~H.~~F. Potential candidates for restorative nursing services may be identified through one or more of the following processes:

1. Physical assessments
2. MDS assessments
3. Specialized rehabilitation assessments
4. In-house referrals due to unusual occurrence/event

~~I.~~G. The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented.

~~J.~~H. A resident's Restorative Nursing Program (RNP) plan will include:

1. The problem, need, or strength the restorative tasks are to address.
2. The type of activities to be performed.
3. Frequency of activities.
4. Duration of activities.
5. Measurable goal and target date.

~~K.~~I. The discharging therapist, Restorative Nurse, or designated licensed nurse will communicate to the appropriate restorative aide, the provisions of the resident's Restorative Nursing Program (RNP) plan, providing any necessary training to carry out the plan.

~~L.~~J. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Flowsheet in EPIC.

~~M.~~K. The Restorative Nurse, or designated licensed nurse, will complete periodic evaluation of restorative activities is demonstrated by routine documentation in summaries and resident care conference (RCC) notes. The nurse evaluates the effectiveness of the restorative treatments by documenting the progress towards restorative goals and describing the resident's related clinical status or changes to the interventions or goals as needed.

1. CNAs/PCAs are responsible for weekly summaries that must be reviewed and co-signed by the restorative LN. The note will include any changes in performance, participation or changes in clinical status identified during Restorative Nursing Program session.
2. CNAs/PCAs may initiate a monthly summary that must be reviewed and co-signed by the restorative LN.
    a. The note will include progress towards goals, activities provided, the response to treatment, level of assistance and functional status.
    b. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.).
    c. Restorative LN evaluates the care plan effectiveness, and initiates any changes in treatment, interventions, or goals as needed.

3. If resident exhibits a lack of progress, a decline, or the achievement of goals, the treatments or program may be reevaluated for discontinuation or modification to be more appropriate for the resident.

~~N.~~**L.** When restorative nursing services are no longer warranted, or the resident is appropriate for being transferred to nursing assistants, the restorative aide, Restorative Nurse, and/or designated licensed nurse will train the appropriate nursing assistants on the maintenance care or activities that need to be provided on an on ongoing basis.

~~O.~~**M.** MDS

1. The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.
2. The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program

References:

Centers for Medicare & Medicaid Services. *Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11.* (October 2023) Chapter 3, Section O, Item O0500.