List of Hospital-wide/Depsrtmental Policies and Procedures submitted for Approval on June 11, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
				JCC Follow-up
Revised	_LHHPP	25-08	Management of Parenteral Nutrition	1. Added "goals and preferences as listed in the" 2. Added "A trained Registered Nurse (RN) may administer Total Parenteral Nutrition (TPN)" and "primarily on units Pavilion Mezzanine, Pavilion Mezzanine Acute and South 2, or other units as needed." 3. Deleted "administration is limited to neighborhoods" 4. Added "weekly, or per goals of care," 5. Added "such as BMP/CMP, magnesium, phosphorus, triglycerides, zinc, transferrin, prealbumin, c-reactive protein, trace elements, and urea nitrogen." 6. Deleted "using the Parenteral Nutrition Order Set" 7. Deleted "Only TPN formulations are Intralipid (fat emulsion 20%) and Clinimix. Other lipids and SMOF are not administered at LHH." 8. Added "A trained and competent Registered Nurse (RN) may administer TPN." 9. Added "only via Central Venous Access Device (CVAD)" 10. Added "labeled with date/time and " 11. Replaced "dedicated" with "delicate" 12. Added "and must be labeled, preferably the distal lumen if multiple lumen catheter" 13. Added "TPN must be weaned per physician order and cannot be discontinued abruptly." 14. Added "and glucose" 15. Deleted "Monitoring activities performed by nurses include strict daily intake and output recording, weekly weights, vital signs, assessment and management of the CVC, blood sugar checks and assessing the resident's response to PN. Details for PN Management administration, monitoring and documentation by registered nurses are written in Nursing Policy E 6.0 Parenteral Nutrition." 16. Added " Procedure..." to delete duplicitous nursing policy NPP E 6.0 Parenteral Nutrition 17. Added " Weinstein and ASPEN" references 18. Removed E6.0 reference 19. Added "Urine" 20. Update to "TPN lines are delicate" 21. Updated link.
Revised	LHHPP	60-10	Environment of Care Program	1. Added "the organization's leadership, which includes the Nursing Executive Committee, the Medical Executive Committee, and" 2. Added "Services, Biomedical Engineering,Patient Safety and Food & Nutritional Services" 3. Added "Biomedical Engineering, Fire/Life Safety, Food and Nutrition Services, Hazardous Materials and Waste, and Leadership" 4. Added "the organization's leadership committees, which include the Nursing Executive Committee, the Medical Executive Committee, the"

Revised	LHHPP	60-11	Environment of Care Committee	1. Replaced "Safety Officer" with "Assistant Nursing Home Administrator, Support Services" throughout the document. 2. Added "Laguna Honda Hospital and Rehabilitation Center" and "the San Francisco Department of Public Health" 3. Added "and to define specific duties of the EOC Committee and any necessary sub-committees" 4. Added "including: Infection Prevention and Control (IPC) and the Department of Education and Training (DET)" 5. Added "Services" and "Biomedical Engineering" 6. Deleted "Environmental Health & Safety", "Infection Control and Prevention," and "and the Department of Education and Training" 7. Replaced "Department" with "Office" throughout the document 8. Added "EOC" and "(at least ten times per year)" 9. Replaced "Environment of Care" with "EOC" 10. Added "at least monthly via summary of findings from EOC Rounds (emails) and" and added "trends will be reported through the EOC quarterly reports to the PIPS Committee" 11. Replaced "hospital" with "facility" and "from each of the EOC management programs" with "Quarterly Reports to PIPS" 12. Deleted "on the state of the Environment of Care of LHH" 13. Replaced "in each of the EOC management programs." with "by the EOC Committee." 14. Added "patient safety, or" 15. Replaced "Safety Management" with "EOC" and replaced "in the hospital" with "of the facility" 16. Deleted "Inspection Team" 17. Replaced "quarterly" with "monthly" and "specific" with "serious" 18. Added "need to provide a plan of correction to the EOC Committee. The plan of correction must be approved by their associated executive management team representative" 19. Deleted "be re-inspected after the original inspection." 20. Added "serious injuries as defined by CAL/OSHA" 22. Deleted "Facility's" "(Department of Education and Training)" and "Facility wide" 22. Deleted "The EOC Committee will review critiques of each implementation, or drill, of the facility's emergency preparedness and fire plans to identify possible safety or education issues." 23. Deleted "through the Hazardous Materials and Waste Subcommittee Program Manager," and "Utilities Management information will be reported quarterly." 24. Deleted "Aspects of the Infection Prevention & Control program will be monitored and reviewed regularly by the EOC Committee." 25. Deleted "and the LHH Violence Prevention Team" throughout the document. 26. Added "and medical equipment that cannot be located." 27. Added "Routine Monitoring", "Nitrous oxide, waste anesthetic gases and formaldehyde personal exposure monitoring are reported to the EOC Committee," and "as conducted by the ZSFGLHH Industrial Hygienist." 28. Deleted "through the Hazardous Materials and Waste Sub- Committee," 29. Added "Non-Routine Monitoring" and "i. Non-routine monitoring conducted by the Industrial Hygienist will be reported to the EOC Committee when completed." 30. Deleted "Safety Management Report" and "AUTHORITY" sections 31. Deleted "'s" 32. Deleted "FROM"

Revised	Biomedical Engineering	CPP-011	PLANNED MAINTENANCE AND ON-TIME COMPLETION	1. Added DEFINITIONS: -PM -High Risk -UTL -NAV -PM Completion Rate -PM Window -Time Frames 2. Added section 3-d 3. Added section 4. On-Time Completion 4. Section includes UTL, NAV, sticker, and other procedures. 5. Changed and updated other minor typographical and grammar errors. 6. Replaced "passed" with "past"
Revised	EVS	VIII	SAFETY	1. Replaced "Housekeeping" with "Environmental Services (EVS)" and "EVS" throughout the document 2. Replaced "to help ensure the safety of" with "provide a safe environment to" 3. Replaced "Storage of Usage" with "Porter Carts" 4. Added "must be locked all the time, and shall" 5. Deleted "All porters will return their carts to the designated storage area when going to break or lunch. Those porters who obtain their cart from Housekeeping Office area will return the cart to this area." 6. Added "All porter carts must be parked at one site of the hallway, not blocking Egress Exits, extinguishes/pull stations, fire doors, corridors, by following the Fire Life Safety guidelines." 7. Deleted "Porter supervisors will monitor for compliance. Disciplinary action for both supervisor and porter could result for failing to comply." 8. Deleted "Issued. 5/97; Rev. 8/06" 9. Replaced "in the Linen" with "of Soiled Utility" 10. Added "All linen chutes doors are kept locked when not in use." 11. Deleted "Disciplinary action will be taken against both Supervisor and Porter/Linen staff if this is not followed. Issued 5/97; Rev. 8/06" 12. Replaced "time" with "times" 13. Replaced “extinguishes” with “extinguishers”
Revised	EVS	IX	IX.Waste Management Policy	1. Deleted "checked and" 2. Added "B.C.Comply with hospital Hand Hygiene and Standard Precautions when handling wastes. 3. Added Attachment and reference sections. 4. Replaced "placed" with "replaced"
Revised	EVS	X	X.EQUIPMENT, SUPPLIES AND CHEMICALS	1. Replaced "The EVS porters are expected to" with "Porter Carts shall be kept" 2. Deleted "at all times" 3. Deleted "and dropped through the soiled linen chutes" 4. Replaced "Janitor Closets" with "Soiled Utility Rooms" 5. Replaced "the end of shift" with "they are transferred to the central location to be picked up by the laundry vendor." 6. Added "All EVS chemicals are ready-to-use, no dilution needed." 7. Added "After apply the chemicals, the surfaces shall be left to air dry." 8. Replaced "Porter Carts shall be kept keep cleaning carts clean and organized" with "Porters shall keep cleaning carts clean and organized" 9. Replaced "on" with "in" and "apply" with "applying"

Revised	EVS	XII	XII.TRANSMISSION-BASED PRECAUTIONS Cleaning Policy	1. Moved "Materials Recommended" section to the top. 2. Added "Initial Terminal Cleaning Procedure Includes:" 3. Replaced "wastebasket" with "waste bins" throughout the document 4. Deleted "clean everything in room except bed, stand and over-bed table, as this is for nursing"
Revised	MSPP	D16	Clinical Services for Residents and Patients with Substance Use Disorders	Major Changes: 1. Added language about addiction medicine services (in addition to SUD services by Psychiatry providers, hence changing policy number to MSPP D16, instead of MSPP D08-XX which are all Psychiatry policies); 2. Deleted language about behavioral health EHR and Drug MediCal, as LHH will not pursue Drug MediCal certification and Psychiatry will not keep separate SUD documentation in AVATAR. This new model promotes service integration and communications with RCTs. 3. Clarified language about consent for release of information (ROI) re SUD treatment. 4. Broadened “residents” to “residents and patients.”
Revised	NPP	C 1.0	Resident Admission and Readmission	Removed Sacred Moment interview since this is no longer being used 1. Removed “Equipment” section (no longer using addressographs) 2. Removed “Resident Care Team Notifications” due to notifications done via EPIC. 3. Admissions and Re-admissions Procedures revised to reflect current practice. Confirmed with A&E 4. Nursing Admission Assessment revised to reflect changes since EPIC/current practice, also referencing other policies for specific procedures (e.g., Scabies, Pressure Injury Assessment, Vital Signs, etc)
Revised	NPP	D1 2.0	Resident Activities of Daily Living	Added that residents on a low air loss mattress shall require 2 person assist for all mobility activities
Revised	NPP	D6 2.0	Transfer Techniques	Added that residents on a low air loss mattress shall require 2 person assist for all mobility activities
Revised	NPP	F 3.0	Assessment and Management of Bowel Function	New policy #2 1. Bowel management procedures that are considered invasive and require insertion/removal of a finger or device into the resident’s rectum may only be performed by a licensed nurse 2. Reference to Elsevier for procedures enema, rectal, fecal impaction Added documentation of rectal tube use in EHR
Revised	NPP	G 7.0	Obtaining, Recording and Evaluating Resident’s Weight	1. Removed policy #2 (redundant) 2. Clarified that weight variation greater than 5 lbs and is unanticipated weight change requires notification to physician and dietitian
Revised Biomedical Engineering Policies and Procedures				
Revised	Biomedical Engineering	CPP-004	DEFECTIVE EQUIPMENT AND DEVICE REPORTING, TAGGING, AND REMOVAL FROM SERVICE	1. Updated section 1-c to include service requestor link and service email contact information. 2. Updated section 3-b-i to remove the TBD determination for equipment removal responsible persons. 3. Updated other minor typographical and grammar errors.
Revised EVS Policies and Procedures				
Revised	EVS	XI	Standard Cleaning Procedure	Formatting changes.

Revised	EVS	XVI	XVI. ICE MACHINE CLEANING	1. Added "Perform hand hygiene and" 2. Added "All chemicals are stored in Galleys at each unit" 3. Added Attachment and reference sections. 4. Deleted "Previous Revision: May 2009, August 2013, August 2015"
Revised	EVS	XVII	XVII.Transport and , Delivery Biohazard, Trash and Linen Staffing	1. Deleted "Trash and Recyclables" 2. Replaced "Biohazard Room" with "Soiled Utility Room" and "pick up" with "transport" throughout the document 3. Added "at the South loading dock" 4. Deleted "NOTE: Bin(s) must be covered with a lid during transport at all times." 5. Rearranged "Trash & recycles" section.
Revised	EVS	XXI	Rejected Linen Procedures	Added Attachment and reference sections.
Revised Nursing Policies and Procedures				
Revised	NPP	C 1.2	Relocation Between Laguna Honda Neighborhoods	Updated to reflect current practice (e.g., steps for sending unit, documentation requirements.
Revised	NPP	D 8.0	Post Mortem Care	Updated to reflect current practice (e.g., hours for pickup of body, contents in post-mortem kit, etc) 1. Recommend deleting appendix and including it in the section for “Preparing the body for viewing” 2. Updated documentation requirements to reflect current practice and EPIC (compared with standards of care)
Revised	NPP	F 1.0	Assistance with Elimination	New policy #5 1. “Invasive elimination procedures that require insertion/removal of a finger or device into the resident’s body (i.e., rectal tubes, urinary catheter insertion) may only be performed by a licensed nurse.“
Revision	NPP	K 4.0	Applications: Heat or Cold Therapy	1. Reference Elsevier for procedure 2. Removed Therapy Aides from being able to apply heat/cold therapy

JCC Follow-up

MANAGEMENT OF PARENTERAL NUTRITION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide parenteral nutrition (PN) therapy services to patients/residents:

   a. Consistent with their goals and preferences as listed in the advance directives,

   b. After an assessment that their clinical condition makes this treatment necessary,

   c. And implement safe administration procedures.

~~c.~~2. A trained Registered Nurse (RN) may administer Total Parenteral Nutrition (TPN) ~~administration is limited to neighborhoods~~ primarily on units Pavilion Mezzanine, Pavilion Mezzanine Acute and South 2, or other units as needed.

PURPOSE:

To minimize the risk of complications from parenteral nutrition.

INFORMATION:

1. Total Parenteral Nutrition (TPN) is administered intravenously to provide nutrients when enteral feeding is contraindicated/refused or unable to provide adequate caloric intake.

   ~~2.~~ A TPN typically contains a 24 ~~-~~hour supply of dextrose, amino acids, electrolytes, vitamins, and minerals. When lipids are added to a TPN it is sometimes referred to as a "3 in 1" PN. When a TPN does not contain lipids, it is sometimes referred to as a "2 in 1" PN.

3. TPN is infused into a central line of the upper body via a central venous catheter (CVC). Femoral lines should be avoided secondary to risk of infection. PPN (peripheral parenteral nutrition) is not available at LHH.

4. LHH CANNOT provide compounded custom TPN solutions.

5. LHH Pharmacy is only able to supply commercially available pre-mixed TPN solutions and has a limited selection of additives such as: Lipids, Multivitamin, trace elements, and some micronutrients.

6. Medications CANNOT be added to pre-mixed TPN solutions.

7. Complications related to PN

a. Infectious complications:

   i. Catheter-related
   ii. Non-catheter related

b. Metabolic complications

   i. Hyper or hypoglycemia
   ii. Electrolyte Imbalance
   iii. Elevated AST, ALT, and Alkaline Phosphatase from high glucose load stored in the liver
   iv. Non-ketotic hyperosmolar state

c. Mechanical complications

   i. Air embolism
   ii. Fat embolism
   iii. Subclavian Vein Thrombosis
   iv. Peripheral Vein thrombosis
   v. Kinks
   vi. Clots

PROCEDURE:

1. Assessment

   a. The Resident Care Team, which at a minimum includes the physician and dietitian, shall assess the resident's need for parenteral nutrition (PN) and associated risks.

   b. The care team shall consult a clinical pharmacist to discuss TPN formulation and dispensing logistics prior to ordering.

2. Ordering

   a. The physician will prescribe PN via the electronic health record (EHR)

   b. The order must be completed by the physician and received in the pharmacy by 10:00 am Mon-Fri for a new bag to be delivered the next business day. No changes to TPN formulation will be accepted on weekends.

   c. Laboratory monitoring is ordered weekly, or per goals of care, by the physician: such as BMP/CMP, magnesium, phosphorus, triglycerides, zinc, transferrin, prealbumin, c-reactive protein, trace elements, and urine urea nitrogen~~.~~. ~~using the Parenteral Nutrition Order Set.~~

   ~~c. Only TPN formulations are Intralipid (fat emulsion 20%) and Clinimix. Other lipids and SMOF are not administered at LHH.~~

3. Preparation and Dispensing

   a. Pharmacy shall assess the order for appropriate indication, completeness, and safety and contact the provider with procedural and clinical concerns.

   b. Pharmacy will evaluate the rate of administration and contact the provider based on any of the rate limits listed here:
      i. Dextrose rate should not exceed 7mg/kg/min to avoid inducing metabolic lipogenesis, unless the provider documents rationale and risk/benefit assessment
      ii. Lipid emulsion rate should not exceed 0.125gm/kg/hour due to risk for adverse metabolic and electrolyte changes
      iii. Intravenous potassium shall not exceed a rate of 10meQ/hour from all intravenous sources

   c. Pharmacy shall procure/prepare PN and deliver the PN solution to the neighborhood.

4. Administration and Monitoring

   a. A trained ~~and competent~~ Registered Nurse (RN) may administer TPN.

   ~~a.~~b. The registered nurse will administer PN solution only via Central Venous Access Device (CVAD) using aseptic technique.

   ~~b.~~c. All Parenteral Nutrition infusions are regulated on a pump; the infusion and tubing are labeled with date/time and changed every 24 hours.

   ~~c.~~d. TPN lines are delicat~~edicated~~. They ~~while the TPN is infusing and~~ must be labeled, preferably at the distal lumen if multiple lumen catheters. Other infusions, solutions, or medications should NOT be piggybacked into a TPN line without first consulting a pharmacist due to possible incompatibilities.

   e. TPN must be weaned per physician order and cannot be discontinued abruptly.

   ~~d.~~f. Continuous TPN solutions should not be abruptly stopped due to risk for rebound hypoglycemia. The TPN rate should be decreased by 50% for one hour prior to stopping infusion. If a TPN must be stopped abruptly for medical reasons, then a 10% dextrose solution should be started at an equivalent rate based on the original TPN dextrose content.

   ~~e.~~g. The frequency of recommended laboratory and glucose monitoring is outlined on the PN order set.

   ~~f. Monitoring activities performed by nurses include strict daily intake and output recording, weekly weights, vital signs, assessment and management of the CVC, blood sugar checks and assessing the resident's response to PN. Details for PN~~

~~Management administration, monitoring and documentation by registered nurses are written in Nursing Policy E 6.0 Parenteral Nutrition.~~

~~g.~~h. TPN labs shall be monitored by the clinical pharmacist in addition to the provider for safety, but the electrolyte content of the pre-mixed TPN solution cannot be adjusted. Electrolyte repletion in addition to TPN is only available by intermittent infusion as a “piggyback” or “rider” and is limited to potassium, magnesium, and calcium.

~~h.~~i. TPN rate adjustment based on patient clinical status or lab monitoring should include consultation with clinical dietitian and clinical pharmacist

5. Procedure

a. Preparation
   i. Refer to “Central Parenteral Nutrition” on Elsevier Clinical Skills for detailed information: https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco
   ii. Remove TPN solution from the refrigerator 1 hour before use ~~but leave in light protective cover.~~
   iii. Inspect TPN solution for cloudiness or precipitate. For lipids, inspect for signs of destabilization or separation. Notify Pharmacy immediately if present and do not hang bag.
   iv. Use Filter: 0.22 micron or 1.2 micron (lipids)
   v. Two RNs will double check TPN prior to administering, comparing the solution label with the physician’s order for correct components and expiration date.

b. Monitoring
   i. Observe for, and instruct patient/resident when appropriate, to report signs and symptoms of infection, fluid overload and hyper- or hypo-glycemia, such as CVAD site pain, redness, swelling, feeling febrile, chills, shortness of breath, edema, headache, change in mental status, thirst, increased urination, sweating, etc.

c. Documentation
   i. Progress note: every shift for 72 hours and when clinically indicated for the following: tolerance of TPN (e.g., abnormal vital signs, nausea/vomiting, elevated blood glucose), response to TPN, and any physician notification or patient education if provided.
   ii. Vital signs: every shift for 72 hours, then weekly or per unit protocol (Acute), and when clinical indicated. Notify physician for T > 100.4 °F. Refer to G 1.0 Vital Signs.
   iii. Intake and output: every shift
   iv. Weights: weekly, or per physician order or unit protocol (Acute). Notify physician for weight gain > 1kg/day.

v. Monitor labs and glucose per order
vi. Medication administration record: 2 nurse check, solution, administration times, rate, volume infused during shift or when discontinuing the bag.
vii. Refer to NPPs J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Catheters

ATTACHMENT:
None.

REFERENCE:

Weinstein, S.M. & Hagle, M.E. (2014). Plumer's principles and practice of infusion therapy, 9th edition. Chapter 16, Lippincott Williams & Wilkins, Philadelphia, Pennsylvania.

ASPEN – Parenteral Nutrition Safety Consensus Recommendations 2014

~~**CROSS** :~~

Clinical Nutrition Policy and Procedure 1.16 Nutrition Screening and Assessment Documentation in the Electronic Health Record (EHR)
~~NPP E6.0 Parenteral Nutrition~~
NPP J6.0 Intravenous Infusion
NPP J7.0 Central Venous Catheters (CVC) Management
NPP J7.1 Peripherally Inserted Central Catheter (PICC) Management
Nutrition Services Policy and Procedure 2.6 Nutrition Assessment – Charting in the Medical Record

Revised: ~~22/11/21~~19/07/09 (Year/Month/Day)
Original adoption: 11/09/27

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.

4. The Environment of Care Program complies with Joint Commission accreditation for deemed status purposes standard EC 01.01.01.

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 organization's leadership, which includes the Nursing Executive Committee, the Medical Executive Committee, and 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 Services
- Biomedical Engineering
- Patient Safety
- Food & Nutritional Services
- Clinical Labs
- Security Management
- Infection Control and Prevention
- Pharmacy Services
- Facility Services
- Quality Management
- Environmental Services
- Department of Education and Training
- Workplace Safety
- Emergency Management

b. Activities of the Environment of Care Committee include:

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

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

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

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

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

v.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 Prevention and Control
- Pharmacy Services
- Facility Services
- Quality Management
- Environmental Services
- Department of Education and Training
- Workplace Safety
- Emergency Management
- Biomedical Engineering
- Fire/Life Safety
- Food and Nutrition Services
- Hazardous Materials and Waste
- Leadership

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, Emergency Management, Environmental Health, Safety/Hazardous Materials, Environmental Services, and Infection 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 the organization's leadership committees, which include the Nursing Executive Committee, the Medical Executive Committee, the PIPS.

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-11 Environment of Care Committee

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

ENVIRONMENT OF CARE COMMITTEE

POLICY:

1. A multi-disciplinary Environment of Care (EOC) Committee shall work with the ~~Safety Officer~~Assistant Nursing Home Administrator, Support Services to provide for the safety and health of visitors, staff, patients and volunteers through an effective Environmental Health and Safety Management Program.

2. The Assistant Nursing Home Administrator, Support Services~~Safety Officer~~, in conjunction with the EOC Committee, compiles information to form the basis for periodic reports to the Governing Body (submitted through the Performance Improvement and Patient Safety (PIPS) Committee to the Joint Conference Committee (JCC)).

3. A multi-disciplinary EOC Committee ensures the program remains in alignment with the core values and goals of Laguna Honda Hospital and Rehabilitation Center (LHH) and the San Francisco Department of Public Health (DPH), by providing direction, determining priorities, and assessing the utility and efficacy of change.

4. The EOC Committee meets regularly and, as part of the standing agenda, receives and reviews reports and summaries of action taken relative to the various Environment of Care management programs.

PURPOSE:

To delineate the responsibilities of the EOC Committee for the development and implementation of ~~Laguna Honda Hospital and Rehabilitation Center (LHH)'s~~LHH's Environmental Health and Safety Management Program -and to define specific duties of the EOC Committee and any necessary sub-committees.

CHARTER

1. Organization

The EOC Committee is a standing committee of LHH. The EOC Committee is charged with safely and effectively managing the environment of care using processes and activities to:

a. Reduce and control environmental hazards and risk;

b. Prevent injuries and illnesses and maintain safe conditions for patients, visitors and staff;

c. Maintain an environment which is sensitive to resident needs;

d. Maintain an environment which minimizes environmental stresses for residents, visitors, and staff.

2. Membership and Attendance

a. Required members of the EOC Committee shall be appointed by the Assistant Nursing Home Administrator, Support Services~~Safety Officer~~ and/or the EOC Committee ~~Chair~~, and shall represent the following areas:

i. Administration

ii. Nursing including: Infection Prevention and Control (IPC) and the Department of Education and Training (DET)

iii. Pharmacy Services

iv. Laboratory Services

v. Support Services including: Biomedical Engineering, Emergency Management, Environmental Services~~, Environmental Health & Safety~~, Facility Services, and Materials Management.

vi. Quality Management including: Patient Safety, ~~Infection Control and Prevention,~~ Risk Management, and Regulatory Affairs~~, and the Department of Education and Training~~

vii. San Francisco Sheriff's ~~Department~~Office.

b. The EOC Committee shall meet regularly (at least ten times per year), and the Assistant Nursing Home Administrator, Support Services~~Safety Officer~~ will serve as the chairperson.

3. Coordination and Communication

The ~~Environment of Care~~EOC Committee shall coordinate the following:

a. Hazard Identification and Control

i. Review of the following data reports recommendations to reduce the risk of incidents and exposures:

- Occupational injury and illness reports
- Environmental rounds reports
- Reports on safety concerns submitted by staff

~~i.~~ii. Receive and review of recommendations for plans of correction.

~~ii.~~iii. Prioritize plans of corrections based on severity and probability of issues identified.

~~iii.~~iv. Implement interim controls and corrective actions.

~~iv.~~v. Track corrective actions to completion.

~~v.~~vi. Discontinue operations that may cause bodily harm to residents, visitors or staff until an interim control or corrective actions can be implemented.

b. Communication and Information
Communicate the facility's environment of care status, identified needs and committee recommendations to staff, department heads and executive leadership ~~via~~ at least monthly via summary of findings from ~~Environment of Care~~EOC Rounds (emails) and quarterly reports and committee minutes.

c. Opportunities for Improvement

i. Develop and implement a data collection and tracking system for identified environment of care performance indicators and other metrics to identify trends and opportunities for improvement; trends will be reported through the ~~Environment of Care~~EOC quarterly ~~newsletters~~reports to the PIPS Committee.

ii. Develop a communication system to share information on corrective actions and plans for improvement on ~~Environment of Care~~EOC Safety concerns with staff, department heads and ~~hospital~~ facility leadership.

4. Reporting Responsibilities

The EOC Committee shall provide the following reports:

a. Meeting minutes.

b. Quarterly Reports ~~from each of the EOC management programs~~to PIPS.

~~a.~~c. Annual reports ~~on the state of the Environment of Care of LHH~~ to the PIPS Committee and Governing Body.

5. Evaluation of Committee Effectiveness

The effectiveness of the EOC Committee will be evaluated based on the following performance indicators:

a. Accomplishment of identified goals ~~in each of the EOC management programs.~~by the EOC Committee.

b. Meeting or exceeding specified performance metrics in each management program plan.

PROCEDURE:

1. The EOC Committee, shall develop policies and procedures to define its role, establish safety standards, establish performance standards, establish performance indicators, and respond to issues identified by:

   a. The results of monitoring, hazard surveillance and/or other review activities

   b. New local, state, or federal regulations and/or standards, or court decisions

   c. Government or accrediting agency standards

   d. Risk Management, patient safety, or performance improvement (quality outcomes),

   ~~d.~~e. ~~or i~~Infection control functions.

   The EOC Committee will review the ~~Safety Management~~EOC Program policies and procedures at least annually, or more frequently if indicated by changes in regulations or standards, or facility's needs.

2. Hazard Surveillance and Abatement

   a. An inspection team will conduct Environmental, Health and Safety Inspections of each unit and department (patient care and non-patient care) ~~in the hospital~~of the facility buildings to identify actual or potential hazards and safety issues.

   b. The EOC Committee~~'s Inspection Team~~ will report the findings of its inspections on a quarterly basis to the Committee and to department heads and the PIPS Committee.

   c. Areas found with significant hazards or safety issues will need to provide a plan of correction to the EOC Committee. The plan of correction must be approved by their associated executive management team representative ~~be re-inspected after the original inspection~~.

3. Review of Occupational Injury / Illness Reports

   a. The EOC Committee through the Employee Health and Safety Subcommittee will review reports of ~~specific~~ serious occupational injury/illness investigations filed by the department manager/supervisor;

serious injuries as defined by CAL/OSHA.~~.~~

i. The Employee Health and Safety Subcommittee will examine trending reports compiled from data collected by the Safety Officer using the Incident Investigation Reports.

b. The Employee Health & Safety Sub-committee will review the reports in order to identify trends relative to the type of injury, personnel classification, shift day of week and hour, unit or department, equipment or material involved, if any, and physical location. Recommendations will be made to the PIPS Committee through the EOC Committee.

c. The EOC Committee will take action or make recommendations identified as appropriate from analysis of the data and will document the action in the minutes.

i. Recommendations may include, but are not limited to, modifications in work procedures, substitution of less hazardous agents, or improved department-specific in- service/training.

d. Significant observations, conclusions, recommendations, actions, and results of monitoring activities or safety referrals will be sent to the PIPS Committee on a semi-annual basis.

e. The EOC Committee will continue to analyze data collected in order to identify trends and monitor actions taken to verify that actions have been effective.

4. Development of Safety Education and Training Programs

a. The EOC Committee will review the safety-related content of the ~~Facility's~~ New Employee Orientation annually; and/or whenever significant changes are planned.

i. The EOC Committee will make recommendations on changes or additions to the safety education and training programs to the DET ~~(Department of Education and Training)~~, whenever new safety-related information is made available or when necessary as indicated by the results of monitoring, investigative, or review activities.

b. The Safety Committee will review documentation demonstrating that ~~Facility wide~~ safety programs are being presented to all LHH employees on at least an annual basis, and that department-specific programs are on-going and appropriate to the needs and environment of each department.

~~4.~~5. Safety Program Evaluation

a. The EOC Committee will conduct an annual evaluation of the objectives, scope, performance and effectiveness of the documented Safety Management Program.

b. The evaluation will include the review of aggregate data from meeting minutes, Safety Referral Tracking System individual ~~Environment of Care~~EOC program reviews, findings from EOC rounds, occupational injury reports, quality outcomes/risk management activities, hazard surveillance activities, safety education, hazardous materials and waste program, participants' evaluations and critiques, and recommendation.

c. A summary report of this evaluation will be sent to the PIPS Committee and JCC. This summary is included in the annual EOC/Safety report to the JCC via the PIPS Committee.

~~5.~~6. Oversight Functions

a. The EOC Committee will review status reports regarding the equipment management, life safety, and utility management programs. Reviews are to verify that electrically powered, patient-care equipment, life safety, and utility systems are being maintained within established time frames and related problems are being properly addressed.

~~The EOC Committee will review critiques of each implementation, or drill, of the facility's emergency preparedness and fire plans to identify possible safety or education issues.~~

b. The EOC Committee ~~through the Hazardous Materials and Waste Subcommittee Program Manager,~~ will review the ~~Facility's~~ Hazard Communication annually to verify that all elements of the program are being performed satisfactorily and that efforts are maintained to reduce the number and amounts of hazardous materials in use.

i. Annual review to include review of individual hazardous materials and wastes incidents, hazardous materials and wastes monitoring programs, and waste reduction alternatives.

~~c. Aspects of the Infection Prevention & Control program will be monitored and reviewed regularly by the EOC Committee.~~

INFORMATION COLLECTION AND EVALUATION SYSTEM

1. Standing Committees

a. Quality Management will report quarterly to the EOC Committee a summary of safety-related unusual occurrences, which will include patient falls, fires, assaults

involving patients and staff, and other significant safety-related issues.

b. Infection Control Committee will report safety-related information to the EOC Committee as needed that is a result of its regular committee and monitory activities. The report will identify data regarding pre-identified performance indicators and other significant safety-related issues.

c. Employee Health and Safety Information will be reported quarterly to the EOC Committee any trends identified in occupational injuries/ illnesses reported at the facility, the result of ergonomic assessments, ergonomic training, fit testing, and information regarding the types and numbers of occupational injuries and illnesses occurring at the facility.

d. The San Francisco Sheriff's Office~~Department and the LHH Violence Prevention Team~~ will report quarterly to the EOC Committee any trends or significant issues identified involving aggressive behavior, the security assessment plan, or health and safety of patients or visitors & volunteers.

   i. The San Francisco Sheriff's ~~Department~~ Office ~~and the LHH Violence Prevention Team~~ will perform a risk assessment that proactively evaluates potential security risks for patient and public safety of the buildings, grounds, equipment, occupants, and internal physical systems.

e. Life Safety information will be reported quarterly.

~~f. Utilities Management information will be reported quarterly.~~

~~g.~~f. Biomedical Equipment Management information will be reported quarterly to the EOC Committee, including training reports, any changes in the equipment inventories, department- specific "high risk" equipment lists, recommended training needs, trends in equipment malfunctions, incidents of operator errors or abuse and medical equipment that cannot be located.

2. Regular or Standing Reports

a. Security Services will report quarterly to the EOC Committee pertinent safety-related information based on pre identified performance indicators in addition to information regarding:

   i. Safety incidents related to visitors, staff, and patients.

   ii. Safety hazards observed in the course of security activities and rounds conducted throughout Medical Center buildings and grounds.

   iii. Results of investigations or studies which have an impact on the Safety Management Plan.

iv. Events of workplace violence or other significant events.

b. Occupational Injuries/Illnesses

i. The Safety Officer will provide information ~~from~~ related to occupational injuries/illnesses to the Employee Health and Safety Sub-committee for review and follow-up if needed.

ii. The Employee Health and Safety Sub-committee will report as needed to the EOC Committee the findings and actions taken as a result of occupational injury investigations.

- Any significant trend or occurrence identified will be reported to the EOC Committee by the Safety Officer immediately.

c. Hazard Surveillance

i. Environmental, Health and Safety ~~Inspection~~ results/findings will be reported quarterly by the Safety Officer to the EOC Committee.

ii. Any hazard surveillance reports will be submitted regularly to the EOC Committee as a result of individual departments conducting department-specific surveys.

iii. Hazard notification (hazard alerts) will also be reported regularly from individual employees as a result of personal observation. These reports will go directly to the Safety Officer, and if significant for tracking, get logged into the Safety Referral Tracking system, and then be reported to the EOC Committee.

d. Medical Device Recall and Hazard Notification

i. Biomedical Engineering and Materials Management will report notices of medical device alerts and recalls received. The Safety Officer, through the EOC Committee, will track and monitor reports on all related status reports and corrective actions taken.

3. Environmental Monitoring Reports

a. Routine Monitoring

i. Nitrous oxide, waste anesthetic gases and formaldehyde personal exposure monitoring are reported to the EOC Committee~~, through the Hazardous Materials and Waste Sub- Committee,~~ as conducted by the ~~ZSFG~~LHH Industrial Hygienist.

b. Non-Routine Monitoring

i. Non-routine monitoring conducted by the Industrial Hygienist will be reported to the EOC Committee when completed.

c. Quarterly

i. Utility Management. Facility Services Engineering will report pertinent safety information quarterly including, but not limited to:

- Hazards, significant shutdowns, interruptions, near accidents
- Utility failures.
- Significant results from testing of key systems
- Pertinent safety information related to the ongoing preventive and corrective maintenance of the facility's utility systems which may have a bearing on the Safety Management Plan.

ii. Equipment Management. Facility Services and Biomedical Engineering will report pertinent safety information on quarterly basis including:

- Major problems, incidents, or trends
- Incidents, including user errors and equipment failure / malfunctions; operator abuse or recommended training.
- Pertinent research or literature findings that are important to Safety Management but have not resulted in hazard recall/notification.
- Pertinent safety information related to the ongoing preventive and corrective maintenance of the Medical Center's equipment inventory.
- Hazards, lost equipment reports, changes to inventory or evaluation criteria.
- Corrections, recommendations, actions taken.
- Events of medical device incidents which may be included under the Safe Medical Devices Act.

iii. Life Safety Management

- The Facility Manager and Fire Marshal report to the EOC Committee quarterly the results of all fire drills held in the hospital and medical offices and reports of any Interim Life Safety needs or inspections made at

remodeling and construction sites.

- The Facility Manager will report to the EOC Committee quarterly the following significant Life Safety Management information:

- Fire Protection System: Changes and upgrades, failures and problems with system, number of false alarms, reports of circuit testing, and reports of annual preventive maintenance and testing of automatic extinguishing systems.

- Review Statement of Condition. (As needed)

- Life Safety correction projects; assessment of deficiency and plan of corrective action.

- Results of inspections and surveys: fire, insurance, or accreditation agencies.
-

~~Safety Management Report~~

~~a. The Safety Officer will report to EOC Committee quarterly. The report may include:~~

~~i. Hazard alerts provided by staff.~~

~~ii. Safety issues (old and new) being tracked through the Safety Referral Tracking System.~~

~~iii. Reports and results of regulatory inspections or visits.~~

~~iv. Results of investigation studies (environmental, health and safety rounds, accidents, and incidents) and committee monitoring activities.~~

~~v. New and revised Safety Management, policies, and procedures.~~

~~vi. New regulations or standards.~~

~~vii. Significant communications with department managers/ supervisors and employees, including regulatory violations or significant occupational injuries.~~

- ~~Communications with outside agencies.~~

- ~~Recommended corrective action and the result of actions taken.~~

- ~~Interventional or emergency actions taken.~~

- ~~Accreditation, licensure safety issues and status;~~

- ~~Results of scheduled reviews of department-specific EOC safety plans and the annual evaluation of the Hospital's Safety Management Plan.~~

RESPONSIBILITY OF THE EOC COMMITTEE REGARDING SAFETY INFORMATION AND DATA GATHERING

1. To actively collect and assimilate safety-related data and information.

2. To analyze and assess safety-related data and reach conclusions.

3. Make recommendations for corrective actions and disciplinary action in the event of regulatory/policy violation.

4. To take appropriate action based on recommendations.

   a. Assign issues and items to be tracked to an established sub-committee, with stated objectives and time frames.

   b. Inform and communicate formally and informally to the JCC, through the PIPS Committee, and outside agencies, department managers/supervisors, and employees.

5. To monitor and evaluate actions taken and then report results of such activities back into the safety information, collection and evaluation system.

6. Monitor significant safety issues until closed.

~~**AUTHORITY**~~

~~The EOC Committee will report all safety-related discrepancies and/or recommend improvements to LHH's Safety Officer. Copies of any significant recommendations or findings will be forwarded to the PIPS Committee and JCC.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-10 Environment of Care Program

Original adoption: 2020/11/10 (Year/Month/Day)

PLANNED MAINTENANCE AND ON-TIME COMPLETION

POLICY:

To ensure all medical equipment is properly maintained, compliant, and documented.

PURPOSE:

To provide guidelines for the planned maintenance program. ~~-~~To ensure that all medical equipment included in the PM program is inspected, calibrated, and electrical safety inspections are performed in a timely manner while giving Clinical Engineering staff latitude and time to complete the total job with the resources that are available to the hospital.

DEFINITIONS:

1. **PM:** Planned Preventive Maintenance
2. **High Risk~~/Critical Equipment~~:** Medical equipment that could cause serious injury or even death to a patient or staff member should it fail, including life support equipment.
3. **Unable to Locate (UTL):** A device or system that is unable to be located during the scheduled PM window. These devices are not included in the PM completion rate calculation.
4. ~~**Device In Use (DIU)**~~**Not Available (NAV):** A device or system that is not available due to being in clinical use and cannot be exchanged or removed without causing a negative clinical impact during the scheduled PM window, or unavailable due to being in repair or other situations. These devices are not included in the PM completion rate calculation.
5. **PM Completion Rate:** The percentage of devices that had a PM completed ~~devided by the amount of available equipment (Available = Scheduled – UTL –~~ divided by the amount of available equipment (Available = Scheduled-UTL-NAV) during the scheduled PM window.
6. **PM Window:** The predetermined Time Frame when a scheduled service must be completed.
7. **Time Frames:** Each medical device has a schedule for PM
    a. Semi-annually: During the scheduled month +/- 10 days of grace period.
    b. Annually: During the scheduled month +/- 15 days of grace period.

~~Each medical device has a schedule for PM:~~
~~* Semi-annually: During the scheduled month +/- 10 days of grace period.~~
~~1. * Annually: During the scheduled month, +/- 15 days of grace period.~~

Commented [HN(1]: This doesn't align with TJC and CMS. It is +/- 30 days from last completed, not last month completed. So for a device completed in July, if we consider mid-July as average, this will allow us to do the PM between June 15 and August 15 (+/- 30 days from July 15)

PROCEDURES:

1. Clinical Engineering will maintain a comprehensive PM Program that includes a computerized maintenance management system (CMMS) for all equipment or systems included in the Clinical Engineering inventory. Clinical Engineering will be

responsible for maintaining an accurate inventory.

2. Documentation for the Planned Maintenance Program will be kept in the Clinical Engineering CMMS and will be available for viewing at any time.

3. Planned Maintenance

   a. The PM Compliance goal for all medical equipment ~~including both Critical (High Risk) and Non-Critical (Non-High Risk) is 100%~~, including both ~~Critical (~~High Risk~~)~~ and ~~Non-Critical (~~Non-High Risk~~)~~, is 100%, which includes the "documented status" of devices when maintenance cannot be completed in the month scheduled.

   b. All Clinical Alarms will be tested for proper audible and visual functions. Results will be documented in the work order.

   c. If equipment must be removed from service due to a PM, ~~deliver~~ delivery of a loaner or replacement device will be coordinated as requested if possible. All rental equipment will be tracked and removed as soon as the equipment has been returned to service.

   d. A PM is performed in accordance with information from the equipment manufacturer and documented procedures in the work order system. The engineer or technician completing the PM will document the maintenance performed, including any pertinent observations in the appropriate fields.

4. On-Time Completion

   a. Required activities and associated frequencies for maintaining, inspecting, and testing medical equipment completed in accordance with manufacturers' recommendations must have a 100% completion rate within the allowable time frame.

   b. Permitted exceptions that do not affect PM completion rate are UTL, ~~DIU~~NAV, and awaiting vendor documentation work orders.

   c. Devices scheduled for a PM that cannot be located shall have each attempt to locate that device documented in the work order. Will use last known locations and Real Time Location System (RTLS) where available to aid in locating the device. A reasonable ~~amount~~number of attempts to find the equipment and communication with the documented owning department will be made before labeling the device UTL.

   d. Devices scheduled for a PM that cannot be accessed due to being in clinical use (~~DIU~~NAV) shall have each attempt documented in the work order.

   e. Clinical engineering will provide notification of devices and systems that are

classified as "UTL" or "~~Device in Use~~NAV" to the owning department manager/director at the end of the scheduled due month ~~due~~.

f. In the event that any devices or systems have been classified in a PM work order as UTL after the second scheduled PM due date, the device will be deactivated from having a scheduled PM, but will be retained in the Medical Equipment Management Program Inventory. A status of Inactive will be associated with the device and dated appropriately. In the event the devices or systems, which were classified as Inactive, are located, a manually generated PM work order will be completed and the original scheduled PM Due Date will be reactivated and status changed to Active.

g. A PM sticker showing the next due month will be tagged to the device once a PM is completed. ~~PM is not considered overdue unless it is passed its due Month~~PM is not considered overdue unless it is past its due month in addition to the grace period as defined in “Time Frame”.

~~6.~~

ATTACHMENT:
www.jointcommision.org/standards_information
Clinical Alarms Safety and Management
Joint Commission Standard EC.0204.01 EP 3; EC.02.04.03 EP 2; NFPA 99-2012 10.5

REFERENCE:
None

VIII. SAFETY

Policy:

The Environmental Services (EVS) ~~Housekeeping~~ Department staff will act and work in a fashion which recognizes good safety practices. Department management will encourage and promote a safety conscious attitude among the staff.

Purpose:

To avoid accidents and ~~to help ensure the safety of~~provide a safe environment to patients, staff and visitors.

A. Procedure:

The ~~Housekeeping~~EVS~~.~~ Department staff will observe established guidelines concerning ~~housekeeping~~ EVS safe work practices.

The ~~Housekeeping~~EVS Department staff will report safety hazards to their respective supervisor. Department management will inform the responsible department.

The Department ~~will~~ report~~s~~ ~~-~~repairs or equipment needed~~problems~~ to Plant Services for

action.

The Department ~~will~~ maintain~~s~~ ~~-~~adequate records of repair requests.

B. Safety Related Policies & Procedures:

Policies and procedures relating to safety specific to Environmental Services. Listed below are the policy titles related to safety policies and procedures.

1. ~~Storage of~~ Porter Carts Usage

a. ~~For safety reason~~ All porter carts ~~, both locking and non-locking,~~ with cleaning solutions and materials must be ~~locked all the time~~locked at all times~~,~~ and shall ~~will~~ not be left unattended in patient or public areas.

~~b. All porters will return their carts to the designated storage area when going to break or lunch. Those porters who obtain their cart from Housekeeping Office area will return the cart to this area.~~

b. All porters shall ~~will~~ return their carts to the designated storage area when leaving their work area for any reason.

c. All porter carts must be parked at one site of the hallway, not blocking Egress Exits, extinguishers~~es~~/pull stations, fire doors, corridors, by following the Fire Life Safety guidelines.

~~d. Porter supervisors will monitor for compliance. Disciplinary action for both supervisor and porter could result for failing to comply.~~

~~Issued. 5/97; Rev. 8/06~~

2. Porter Closet Doors & Door Wedges

a. ~~Doors to porter~~Porter ~~c~~Closets and supply room~~s~~ must be ~~kept closed at all times and~~ locked all the time when not in use.

b. Use of door wedges or any items to prop doors open ~~-~~is prohibited.

~~Issued 6/88; Rev. 8/06~~

3. Locking of Linen Chute Doors

a. All doors of Soiled Utility~~in the Linen~~ Room are to be ~~secured~~ locked ~~when not working in the area~~all the time.

~~a.~~b. All linen chutes doors are kept locked when not in use. ~~Night~~PM shift ~~personnel~~personnel (3:30PM-Midnight) have the additional responsibility of making a final round at approximately 11:3045~~45~~pm to ~~assure~~ check all linen chute doors are secured before their shift ends.

~~Disciplinary action will be taken against both Supervisor and Porter/Linen staff if this is not followed. Issued 5/97; Rev. 8/06~~

4. Covered Toe Shoes

All staff must wear covered toe shoes during work hours. One pair of steel-toe safe shoes is provided to all 2700 classification staff annually. ~~This is not a new policy, rather a reminder of an existing Department Infection control and safety policy. Open toe shoes are unsafe and can contribute to injury.~~

Employees who choose not to comply may face disciplinary action or be refused permission to work. ~~Issued 5/97; Rev. 8/06~~

5. Moving of Furniture & Equipment

~~The following are~~Below safety practices shall be followed when moving furniture and equipment.

a. Flatbed carts should not be overloaded so that items fall off the cart.

b. Large loads that impair vision should be transported with assistance to ensure traffic is cleared out of the way.

c. Large and heavy items, including folding tables, should only be lifted and moved with assistance.

~~d. When lifting heavy items use the a~~Appropriate work gloves or requested PPE are provided to perform the move.

~~Request for Furniture Move:~~

~~a. Telephone routine requests (44624)~~

d. ~~Submit project requests by memo or the appropriate form well in advance of the date the work is to occur. Rev. 5/97, 8/06~~

~~6.~~ **Mopping Procedure**

~~6.~~

a. Perform Hand Hygiene and wear proper PPE.

~~a.~~b. Mop floors in sections, leaving a dry area for traffic.

~~b.~~c. Mop small areas at a time. Mop one room at a time utilizing a wet floor sign at each room. Remove the wet floor sign when the floor is dry completely.

~~c.~~d. Damp mops the floors without excessive cleaning solution.

~~d.~~e. Wet floor signs must be ~~utilized at all times~~always utilized~~,~~ and placed visibly to secure the wet area, not blocking the doors from closing. ~~.~~

~~e.~~f. Communicate with the nursing team/residents about the wet floors.

All Hospital staff has an obligation to contribute to a safe work environment.

~~Issued 5/97; Rev. 8/06~~

~~7.~~ **Trash/Waste Disposal**

~~7.~~

The EVS Department is responsible for the transport and disposal of Wastes, Trash, Compose, and Recycles.

Transfer and dispose ~~Procedure:~~

a. ~~A~~all Hospital trash/waste ~~will be disposed of~~ in accordance with all applicable City, State and Federal regulations.~~, including Title 22, Proposition 65 and Title 8.~~

~~a.~~ EVS employees shall wear proper PPE, perform Hand Hygiene, and/or utilize equipment to handle wastes (Biohazard, Pharmaceutical, and Chemotherapy)

b.

c. The EVS Department management maintains all hazardous waste manifests for annual inspection.

ATTACHMENT:

None.

REFERENCE:

EVS Policy IX Waste Management Policy

EVS Policy XVII Transport, Delivery Time for Biohazard, Trash and Linen

LHHPP 72-01 B1 Standard Precautions

LHHPP 72-01 B2 Hand Hygiene

LHHPP 72-01 F4 Management of Hospital – Provided Line

Revised: May97, Jan07, Aug08.

~~The Department management will forward to Industrial Hygiene Department/Safety Engineer for central filing, all hazardous waste manifests.~~

~~b. Policy:~~

~~The Housekeeping Department is responsible for the disposal of dry and contaminated trash/waste generated in the Hospital (except Laundry contaminated waste), and for the removal of hazardous waste generated by the Department.~~

~~c. Purpose:~~

~~To maintain the Hospital in a clean, sanitary, orderly, and attractive condition, and to ensure the correct disposal of each type of trash/waste.~~

~~d. Procedure:~~
~~All Hospital trash/waste will be disposed of in accordance with all applicable City, State and Federal regulations, including Title 22, Proposition 65 and Title 8.~~

~~The Department management will forward to Industrial Hygiene Department/Safety Engineer for central filing, all hazardous waste manifests.~~

IX. Waste Management Policy

POLICY:
The department shall have and enforce a policy/procedure following the required process for the collection, handling, storage and disposal of biohazardous, chemotherapy, and pharmaceutical waste.

PURPOSE:
To ensure the safety and well-being of staff, residents, and visitors. To ensure compliance with all regulatory agency standards.

PROCEDURE:

A. Medical Waste is contained separately from all other wastes at the point of generation. Employees are to wear PPE when handling all medical waste at all times during transport. Non-Medical Waste such as trash, and or compost is not to be disposed in medical waste containers. All medical waste is to be placed into the correct container. See the following below:

a. **Biohazardous waste** must be placed in red liners/red container, including the sharp containers in residents' rooms. Red bins are kept in medical waste rooms throughout the hospital. Red bins are placed in waste storage rooms when ¾ full.
   - Sharp containers (Red) in residents' rooms are ~~checked and~~ replaced when ¾ full.

b. **Chemotherapy waste** must be placed in yellow liners/container. Yellow bins are kept in medical waste rooms throughout the hospital. Yellow bins are replaced in waste storage rooms when ¾ full.

c. **Pharmaceutical waste** is kept in the pharmacy or med rooms on the unit. When ¾ full hospital staff dispose of containers located in the medical waste rooms throughout the hospital. When pharmaceutical waste is inside the white bin, it is placed in the waste storage room.

B. Medical waste containers are scheduled for pick up by our medical waste vendor. These containers are kept in our medical waste storage rooms located in two separate locations in the hospital. The medical waste vendor is to complete the appropriate manifest indicating type and volume of waste. A copy of this manifest is to be provided to the Environmental Services Office. The Environmental Services department will maintain all tracking documents.

~~**B.**~~**C.** Comply with hospital Hand Hygiene and Standard Precautions when handling wastes.

ATTACHMENT:
None.

REFERENCE:
LHHPP 73-11 Medical Waste Management Program

LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene

Previous Revisions: May 97, April 1, Jan. 07, June 2010, January 2022

X. EQUIPMENT, SUPPLIES AND CHEMICALS

POLICY:
The Environmental Services Department will maintain adequate supplies, equipment and cleaning chemicals for the efficient operation of the Department and Hospital.

PURPOSE:
To allow the Environmental Services Department to carry out its function and to maintain a clean and safe Hospital environment.

PROCEDURE:

All cleaning chemicals used will be purchased and approved by the Infection Control Committee and procured from sources approved by the City. Cleaning chemical use, disposal and/or diluted disposal will comply with all City, State and Federal regulations.

Records will be kept of requisitions for supplies and equipment. Equipment operating instructions and warranties will be kept until that piece of equipment is replaced or discarded. Equipment will be maintained at all times.

Records will be kept of requisitions for cleaning chemicals. SDS (Safety Data Sheets) will be maintained for all chemicals in use and for chemicals used, but not currently in use.

Equipment supplies and cleaning chemicals shall not be removed from the Hospital.

A. Cleaning Cart Set-Up
To provide the EVS porter with a checklist of equipment and supplies that will be needed to complete a routine job assignment. (Project work assignments will require different and/or equipment and supplies).

1. The following items should appear on a properly equipped cleaning cart:

Materials

- 1 Wet Mop Handle
- 1 Microfiber Dust Mop Handle with 1
- 1 string mop handle with 1 microfiber string mop
- 14 microfiber Mops
- 2 Mop Buckets with Wringer
- 1 High Duster Handle
- 2 High Duster Heads
- 6Wet Floor Signs
- 1 Toilet Bowl Swab
- 1 Toilet Brush
- Hand Paper Towels
- Toilet Paper
- Toilet Seat Covers
- Trap Duster

Materials

- 1 Caddy
- 1 Dustpan with Broom
- Microfiber rags
- Putty Knife
- Gloves
- Plastic Bags (clear)

Chemicals (Ready to use)

- Glance: Glass & Surface Cleaner
- Virex 256 Disinfectant Cleaner
- Stride: daily cleaner for floors and other hard surfaces
- Crew: Non-Acid Bowl and Bathroom Disinfectant
- Oxivir 1: Disinfectant Wipes
- Micro-Kill Bleach Germicidal Bleach Wipes/Solution: Sporicidal, fungicidal, bactericidal and virucidal disinfectant

2. ~~The EVS~~Porter Carts shall be kept ~~porters are expected to keep cleaning carts clean and~~

~~organized at all times.~~Porter Carts shall be kept clean and organized.

- Top shelf of cart must be kept clear of cleaning supplies. No large containers, personal belongings or food are allowed on the cart.
- Two mop buckets with wringers should be on the cleaning cart.
- Soiled cleaning rags and mops should not be seen on the cart or allowed to accumulate. They should be wrapped ~~on~~ in ~~clear plastic~~ soiled linen bags ~~and dropped through the soiled linen chutes~~ or stored in the ~~Janitor~~ Soiled Utility Rooms ~~Closets~~ until ~~the end of shift~~ they are transferred to the central location to be picked up by the laundry vendor.
- Extra plastic bags should be kept in the pouches on the exterior of the cart bag. Do not drape bags on the exterior of the cart.

3. All cleaning solutions shall~~ould~~ be in properly labeled bottles that are clear and readable. All Ready-to-use cleaning products should be in bottles with flip-top caps for dispensing cleaning products.
4. Carts ~~will be~~are inspected randomly by a supervisor or manager. All carts will be checked for proper cleanliness, assigned/tagged equipment and operation.

B. Cleaning Chemical Products. All EVS chemicals are ready-to-use, no dilution needed.

Product	Color	Usage	PPE	Disposal
Virex 256 Disinfectant Cleaner	Light Blue	One-Step Disinfectant Cleaner and Deodorant to clean all high touch areas, bed/bed frame, mattress, bedside stands, doors, floors and walls. 10-minute contact time.	Gloves Goggles	In accordance with local codes
Oxivir 1	Wipes	Disinfectant wipe used for horizontal and vertical surfaces. One minute contact time.	Gloves	In accordance with local codes
Micro-Kill Bleach Germicidal Bleach	Wipes/ Solution	A disinfectant with sporicidal activity against Clostridium difficile spores. 3 minutes contact time	Gloves	In accordance with local codes
Crew	Green	Non-Acid Bowl and Bathroom Disinfectant Cleaner to clean restroom toilets, sinks, urinals, under-pipes, etc. 10-minute contact time	Gloves Goggles	In accordance with local codes
Glance	Blue	Glass and multi-Purpose Cleaner NON-Ammoniated to clean mirror, chrome and glass surfaces.	Gloves Goggles	In accordance with local codes
Stride	Light red	Citrus Neutral Cleaner to clean daily use on floors, walls. and other hard surfaces	Gloves Goggles	In accordance with local codes

❖ **After applying the chemicals, the surfaces shall be left to air dry.**

Addendum: In the event of an emergency, the department may use approved disinfectants and cleaners as an alternative to our standard.

XII. TRANSMISSION-BASED PRECAUTIONS Cleaning Policy

Purpose:

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

Material Recommended:
For Floor surfaces: Bleach Germicidal Cleaner
For Hand Hygiene: hospital grade alcohol hand sanitizer and/or hand soap, following Infection Prevention & Control Precaution
High Touch Surfaces: Neutral Cleaner and Bleach Germicidal Wipes.
PPE- Perform Hand Hygiene and don appropriate PPE'S for contact, droplet, or airborne precaution.

1. **Minimum Cleaning Procedure Includes:**
   On a daily basis, Environmental Services participates as follows:
   Trash Pick Up:
   - The Porter removes trash from room.
   - If a special pick up of Biohazardous trash is needed (apart from scheduled pick up) it may be arranged by phoning request to EVS Office.

~~**Material Recommended:**~~

~~**For Floor surfaces: Bleach Germicidal Cleaner For Hand Wash: Provon Soap**~~

~~**High Touch Surfaces: Neutral Cleaner and Bleach Germicidal Wipes.**~~

~~**PPE- Perform Hand Hygiene and don appropriate PPE'S for contact, droplet, or airborne**~~**precaution**

~~precaution~~

2. **Initial Terminal Cleaning Procedure Includes:**

   a. Trash removal and Dusting
      - High Dusting of the room, starting from top of the walls and windows
      - Dusting vertical surfaces onto floor.
      - Remove trash liner from ~~wastebasket~~waste bins.
      - Tie off trash ~~liner~~liner.
      - Wash interior and exterior of ~~wastebaskets~~ waste bins with Neutral Cleaner and Bleach Germicidal Wipes
      - Allow time for wastebaskets to completely air dry.
      - Reline ~~wastebaskets~~waste bins.

   b. Furniture/High Touch areas~~- clean everything in room except bed, stand and over bed table, as this is for nursing. .~~
      - Clean all high touch surfaces twice. Light switches, walls, doors and ~~door knobs~~doorknobs, wall mounted items, Clean with Neutral Cleaner, and after 1 minute clean again with germicidal beach wipes.

   c. Bathroom or Toilet
      - Follow Seven Step procedure when Cleaning Bathrooms. Clean all high touch areas noted in section b, along with mirrors, fixtures, pipes, toilet seat, and dispensers in bathroom twice with Neutral Cleaner and after 1 minute and Germicidal Bleach Wipes

   d. Floor Care

- Sweep resident room and mop with Germicidal Bleach.
- Sweep bathroom and mop with Germicidal bleach.

e. Leaving Room
- Using proper doffing technique to reduce pathogen transmission and avoid contamination, remove gown, mask, and glove, and place in trash container.
- ~~Wash~~Performing ~~-~~hand~~s~~ hygiene ~~thoroughly~~ with hospital graded alcohol hand sanitizer and/or ~~Proven~~hand ~~-S~~soap, following the Infection Prevention & Control ~~Precaution~~Precaution, ~~-~~before proceeding to next station or assignment.

- Clean bucket and wringer in porter closet dispose of mops in soil mop container in biohazard room.

Addendum: In the event of an emergency, the department may use approved disinfectants and cleaners as an alternative to our standard.

ATTACHMENT:

None.

REFERENCE:

LHHPP 72-01 b1 Standard Precaution.
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHH EVS P&P XI Hospital Cleaning Steps

CLINICAL SERVICES FOR RESIDENTS AND PATIENTS WITH SUBSTANCE USE DISORDERS LAGUNA HONDA PSYCHIATRY SUBSTANCE TREATMENT AND RECOVERY SERVICES (STARS)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) provides comprehensive treatment and recovery services Substance Treatment and Recovery Services (STARS) for its residentsresidents and patients with substance use disorders (SUD), service needs. These services include both non-specialty resident outreach and engagement services, as well as specialty substance use treatment services, in alignment with community best practices. San Francisco Health Network Behavioral Health Services (SFHN-BHS) and Medicare/MediCal standards.

PURPOSE:

1. To establish Policies and Procedures through which LHH providers Psychiatry clinicians deliver clinical services for LHH residentsresidents and patients with SUDsubstance use disorders (SUDs)..

1.

2. To ensure that specialty substance treatment services are evidence-based, including the use of co-occurring service models.

2. , modeled after a Drug Medi-Cal (DMC) Organizational Delivery System (ODS) Outpatient Program, and meet SFHN-BHS requirements. (The specialty substance treatment portion of STARS shall be referred to as "DMC program" below.)

3. To ensure that the results of services to residentsresidents and patients with SUDs are meaningful and helpful to the residentsresidents and patients and are communicated where appropriate to the referring attending physician and resident care team (RCT)or the referral party.

OVERVIEW:

Substance treatment services are delivered via collaboration between LHH STARS program is part of LHH Psychiatry providers and LHH Medicine providers, including addiction medicine specialists. , which is a Clinical Service under LHH Medical Staff Services. Services The STARS program providesinclude outpatient level non-specialty outreach efforts to engage LHH residentsresidents and patients with SUDs in services, as well as specialty substance use treatment services, such as medication treatment, individual and group counseling (DMC program). The DMC program portion of STARS is modeled after the regulatory guidelines of Drug-Medi-Cal (DMC), SFHN-BHS of San Francisco Department of Public Health, and The Department of Health Care Services of California (DHCS).

PHILOSOPHY:

All STARS services for residents and patients with SUD are provided in alignment with community best practices and the SFHN-BHS philosophy of care. ; eElements include but are not limited to:

- Person centered
- Non-judgmental
- Evidence based
- Strengths based
- Individually tailored
- Trauma informed
- Culturally sensitive
- Harm Reduction
- Promoting autonomy, optimism and hope
- Integrating care for bio-psycho-social-spiritual aspects of the whole person.

PROCEDURE:

I. Non-specialty outreach and engagement of resident with SUDs

All LHH Psychiatry providersstaff shall incorporate low barrier and welcoming approaches with the above philosophical principles in clinical encounters with residentsresidents and patients with SUDs. This means that any door is the right door, i.e. regardless of the types of clinical services providersstaff are providing, (i.e. psychotropic medication management, mental health services, neuropsychological and psychological services, behavioral consultation and planning, health and behavioral interventions), screening and checking in about substance use concerns (if any), whenever relevant, are an integral part of clinical workthe service. Depending on the resident's/patient's stages of change, providersclinicians may discuss with residentsresidents and patients about their substance use concerns under the context of the these existing Psychiatry services, provideing brief interventions if indicated and appropriate, as well as referring the resident to specialty DMC programsubstance treatment if indicated.

Documentation for such non-specialty services for residents with SUDs shall be entered into the electronic health record (EHR) section designated for LHH Psychiatry, under non-substance treatment related service areas (i.e., specialty mental health, non-specialty mental health, or primary care behavioral health service areas), in the LHH EHR. Such documentation can be accessed by LHH Resident Care Team members.

II. Specialty Substance Treatment Program (DMC Program)

SpecialtyDMC program treatment services (including but not limited to: screening, assessment, treatment planning, individual and group counseling services, medication treatment, contingency management) and other substance recovery related services (e.g.

motivational interviewing, harm reduction discussionscounseling)) are those provided by clinicians who hold themselves out as substance treatment providers. These include a team of LHH Addiction Medicine specialist and Psychiatry providersstaff who are registered, licensed, or certified to provide substance use and/or mental health treatment services in California. For Psychiatry providers, the These services are provided under the direction of Chief of Psychiatry, Behavioral Health Program Director, orand designeeated STARS psychiatrist, and coordinated on a day-to-day basis by the Behavioral Health Program Director or designee. The practice procedures outlined below are the general service delivery process. Staff will follow the steps as they are implemented during the program development process.

1. Referral

a. Any LHH residentsresidents and patients with known, suspected, unresolved or history of substance use, or residentsresidents and patients who exhibit substance use behavior, with or without history of treatment, that may meet DSM-5 criteria for a SUD diagnosis (excluding nicotine-only use) shall be referred by the LHH Primary Physician for SUD screening and/or treatment services via the E-Consult process for LHH Psychiatry and/or addiction medicine.

b. AAny LHH resident and patient and/or family can request a substance use treatment screening/assessment for the resident/patient. The resident/patient and/or family shall notify the resident's/patient's primary physician who shall make the referral to LHH Psychiatry and/or addiction medicine. They may also notify their currently assigned LHH Psychiatry provider, who can provide the service or make an internal referral, as appropriate.

c. ResidentsResidents and patients may decline services by LHH Psychiatry clinicians for SUD related services, including screening, assessment or treatment. Resident participation in treatment in the specialty SUD treatment program (DMC program) is voluntary unless otherwise specified in their legal status.

d. For referral to Psychiatry, dDesignated LHH Psychiatry triage staff will review the referral within one business day of the E-consult entry. For referral to Addiction Medicine, the provider will review the referral within three business days.

e. The assigned clinician will review the resident's/patient's medical record and complete a screening within five (5) business days after being assigned, sooner if clinically indicated, unless the residentsresident's/patient's special medical or other conditions warrants otherwise (the reasons for delayed screening and assessments need to be documented in the LHH electronic health record (EHR) section designated for LHH Psychiatry.

e.f. Psychiatry providers and addiction medicine specialist may cross refer residents and patients to each other.

2. Follow Up Information Gathering– Referrals to Psychiatry

a. The assigned clinician will collect information from the resident/patient, medical records, staff, the LHH primary physician, and other entities authorized by the resident.

b. The clinician will screen the following areas:

i. The resident's/patient's history of using one or more substances (excluding nicotine-only use) including prescription medications or medicinal cannabis, whether such use meeting criteria for a DSM-5 substance use disorder diagnosis. This may include mild use disorders, SUD in remission, and if the resident/patient is at risk for return to uselapse without outpatient treatment.

ii. Motivation for Treatment (stages of change model).

iii. Physical and cognitive capacity to participate and benefit from receiving substance treatment.

c. The SUD screening can be done by any LHH Psychiatry provider.

d. Documentation for non-specialty outreach and engagement work for residents and patients with SUDs shall be entered into the electronic health record (EHR) section designated for LHH Psychiatry, under primary care behavioral health service area, unless the screening is done in the context of mental health services, in which case the documentation shall be entered under mental health service areas. Documentation for SUD screening can be accessed by LHH Resident Care Team members.
iii.

ec. If Until the resident/patient is diagnosed with a substance use disorder and is assessed to be appropriate for and able/willing/ready to receive agrees to specialty treatment for SUD, the assigned Psychiatry clinician will all initial documentation will be entered into the EHR section designated for LHH Psychiatry, non-substance treatment related service areas (i.e., specialty mental health, non-specialty mental health, or primary care behavioral health service areas), in the LHH EHR.

d. For residents who are assessed to be appropriate for and who are able/willing and ready to participate in the specialty DMC program, the resident will be internally refer red (within LHH Psychiatry) the resident/patient for SUD treatment (within LHH Psychiatry)to and enrolled in the DMC program. The enrolling/treating SUD treatment provider may or may not be the same clinician who completes the initial SUD screening.

f. SUD treatment provided by Psychiatry clinicians include:Substance use treatment modalities at LHH may include: admission and intake and treatment plan reviews

i. assessment/reassessment
ii. person-centered treatment planning
~~i. (and when appropriate, couples or family)~~
iii. individual and/or group therapy and psychoeducation
iv. crisis intervention
v. collateral sessions (meetings with family or others in the resident's natural support network)
vi. medication support and management
vii. coordination with hospital-based case management (RCT and medical social worker), including assistance with discharge planning and developing community-based substance use recovery plans. (See LHH HWPP 20-04 Discharge Planning)

g. For residents and patients receiving SUD treatment, the clinician will ask the resident/patient to sign the consent for Release of Information (ROI) (Form Name: Permission To Share Your Substance Use Disorder (SUD) Treatment Records) for the SUD treatment provider to share specialty SUD treatment information with the RCT (see Section 4 below). Documentation of substance treatment services shall be entered into the electronic health record (EHR) section designated for LHH Psychiatry, under primary care behavioral health service area, with ROI signed by the resident.

h~~d~~. ~~For residents~~residents and patients who are assessed to be appropriate for but who decline ~~SUD treatment to participate in the specialty DMC program during the initial encounter~~:

i. The clinician shall explain to the resident/patient, that the~~y~~ resident/patient can request to be re-assessed and start ~~enrolled in the specialty DMC program~~SUD treatment at any time during their LHH stay.

ii. The clinician will leave their contact information and SUD treatment~~STARS~~ related information materials with the resident/patient, if acceptable to the resident/patient.

iii. The ~~LHH Psychiatry~~ clinician will make at least one more attempt based on their clinical judgment to engage the resident/patient in SUD treatment ~~specialty DMC program~~ through outreach efforts and other recovery services (that are not treatment per se). Additional attempts may also be made as clinically indicated.

iv. The ~~LHH Psychiatry~~ clinician shall notify the referring primary physician ~~and STARS Clinical Coordinator~~ regarding the ~~residents~~resident's/patient's decision to decline SUD treatment~~not participate in the specialty DMC program~~. The clinician shall document the communication in the EHR.

3. Admission to specialty DMC program

a. Inclusion Criteria:

i. The resident meets criteria for a DSM-5 Substance Use Disorder diagnosis (including in sustained remission), excluding nicotine-only use.

ii. The resident is interested in, or is ambivalent but still willing to participate in, the specialty DMC program.

iii. The resident has the basic cognitive and physical capacity to participate in and benefit from treatment.

b. Once admitted to the specialty DMC program, the resident must be opened in the designated behavioral health EHR for LHH specialty DMC program.

4. **For residents who are admitted to the specialty DMC program, the clinician will:**

i. Complete an Intake assessment (this may be extended over multiple sessions if preferred by the resident).

ii. Complete necessary treatment consent.

iii. Ask the resident to sign the consent for Release of Information (ROI) (Form Name: Permission To Share Your Substance Use Disorder (SUD) Treatment Records) for the SUD treatment provider to share specialty SUD treatment information with the RCT (see Section 7 below).

iv. Have the designated STARS psychiatrist review the physical exam (must be within the past 12 months),

v. Have a licensed clinician review and approve (as indicated) the clinical elements per the current DMC guidelines, such as: DSM-5 diagnosis(es) and medical necessity of admission, the screening and Intake Assessment by the primary clinician (if non-licensed).

a. **Specialty DMC program Treatment Plan of Care**

5. Upon completion of the Intake Assessment, the primary DMC program clinician shall develop a Treatment Plan of Care with the resident, as per DMC requirements. Necessary signatures shall be obtained as per DMC requirements.

6. The resident's assessment and treatment plan are shared among the DMC clinicians for review and comment.

a. Treatment plan reviews and renewals will be documented according to DMC requirements.

7. The treatment plan is developed using person-centered principles.

Substance Use Treatment

8. **Substance use treatment modalities at LHH may include:**

i. admission and intake assessment/reassessment
ii. person-centered treatment planning and treatment plan reviews
iii. individual and/or group (and when appropriate, couples or family) therapy and psychoeducation
iv. crisis intervention
v. collateral sessions (meetings with family or others in the resident's natural support network)
vi. medication support and management
vii. coordination with hospital-based case management (RCT and medical social worker), including assistance with discharge planning and developing community-based substance use recovery plans. (See LHH HWPP 20-04 Discharge Planning)

b. All services are to be provided with a wellness recovery approach.

3. Follow up – Addiction Medicine

a. Similar to psychiatry, the assigned clinician will collect information from the resident/patient, medical records, staff, the LHH primary physician, and other entities authorized by the resident/patient.

b. The clinician will screen the following areas:

i. The resident's/patient's history of using one or more substances (excluding nicotine-only use) including prescription medications or medicinal cannabis, whether such use meeting criteria for a DSM-5 substance use disorder diagnosis. This may include mild use disorders, SUD in remission, and if the resident/patient is at risk for return to use without outpatient treatment.

ii. Motivation for Treatment (stages of change model).

iii. Physical and cognitive capacity to participate and benefit from receiving substance treatment.

iv. SUD Treatment offered by addiction medicine include motivational interviewing, harm reduction counseling, and medication treatment.

c. Documentation in the medical record will be allowed after the resident/patient has provided written consent for ROI. Notes marked as "Sensitive" cannot be accessed by CareEverywhere.

~~c.~~

~~9. Documentation~~

~~a. Documentation of LHH specialty substance treatment services will be completed in the designated behavioral health EHR. Paper records including the resident's signature will be kept in a separate DMC program medical record. Upon the resident's discharge from LHH, such records will be forwarded to SFHN-BHS Medical Record.~~

~~b. All specialty substance treatment documentation will follow the most current instructions for documentation, including but not limited to timing and content, based on the current Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual. Provision of the instructions is the responsibility of the LHH Psychiatry Behavioral Health Program Director (or designee).~~

~~10.~~4. Privacy and Authorization to Disclose Substance Treatment Information

a. LHH providers ~~Psychiatry clinicians~~ will follow federal and state laws that govern the disclosure and re-disclosure of specialty substance use treatment information.

b. LHH provides team-based services and the Resident Care Team concept is central to LHH's holistic approach to care. Communication between the Resident Care Team (RCT) and providers providing SUD treatment ~~LHH Psychiatry staff~~services is critical to this process.

~~11.~~c. In order to facilitate care coordination, whenever appropriate, any LHH providers ~~(DMC program clinicians, Psychiatry providers~~ or RCT members~~)~~ shall encourage the resident/patient to give consent for ROI, i.e., permission for the resident's specialty substance use treatment information to be disclosed to the RCT. The ~~specialty~~ SUD treatment provider will go over the DPH form "Permission To Share Your Substance Use Disorder (SUD) Treatment Records" with the resident. Once a resident signs the form indicating authorization for disclosure, the ~~original~~ signed form will be ~~filed in the resident's DMC program chart, with a copy~~ uploaded to the resident's record in the LHH EHR.

~~12.~~d. Providers are encouraged to explain to the resident/patient the importance, benefits, and risks (if any) of care coordination, while understanding that authorizing disclosure of substance treatment information is voluntary, and that the ~~residents~~resident/patient have the right to revoke the authorization, verbally or in writing, at any time. Providers are encouraged to inform ~~residents~~residents and patients of the legal exceptions to confidentiality.

~~13.~~e. In cases where the resident/patient gives consent for ROI:

i. LHH Psychiatry SUD treatment provider will document summary information of the resident's SUD treatment in LHH EHR.

i. LHH RCT incorporates the SUD treatment information into the resident's care plans.

ii.

iii. LHH Psychiatry SUD providers will periodically (at least annually) ask residents and patients whether they would like to continue consent for ROI, for the benefit of care coordination. LHH Psychiatry SUD treatment provider will still document detailed SUD treatment information in the behavioral health EHR.

ii.

iii.iv. If the resident/patient changes their mind and revokes their consents for ROI at some point, no further entries will be made in LHH EHR about SUD treatment until the resident/patient consents for ROI again. (Follow section g. below.) by LHH Psychiatry specialty SUD treatment providers.

b.f. Recipients of such disclosed substance treatment information are responsible for complying with legal requirement to refrain from re-disclosing substance treatment information except with the resident's written authorization or as specifically required by law.

14.g. In cases where a resident/patient desires and participates in specialty SUD treatment but does not consent for ROI:

i. LHH Psychiatry SUD treatment provider will NOT document SUD treatment information in LHH EHR.

i.ii. The resident/patient shall be referred to other resources for specialty SUD treatment.

ii.iii. SUD treatment information will be documented in the behavioral health EHR only and LHH Psychiatry SUD treatment provider will note in the behavioral health EHR that the resident does not consent (or has revoked prior consent) to disclosure of records.

iii. iii. LHH Psychiatry SUD iii. LHH treatment providers may still document in LHH EHR behavioral health treatment information that is NOT about specialty SUD treatment, such as:

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

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

v. LHH RCT will care plan for the resident's/patient's SUD condition(s) based on available clinical information and observations.

vi. If the resident/patient changes their mind and consents for ROI at some point, LHH Psychiatry SUD treatment providers shall follow steps c-e above.

vii. LHH Psychiatry SUD providers will periodically (at least annually) ask residents whether they would like to consent for ROI, for the benefit of care coordination.

15.h. As SUD treatment the DMC program is part of the comprehensive behavioral health program of LHH Psychiatry, and LHH Psychiatry providers provide clinical cross-coverage for each other, a resident's SUD DMC clinician may share the resident's substance treatment information with other LHH Psychiatry providers. Minimum necessary requirements of HIPPAA will be followed.

16.5. Quality Assurance

LHH Psychiatry and Medicine leaders shall collaborate with LHH Quality Management on gathering, tracking and analyzing data related to SUDSTARS services for quality assurance and improvement purposes. Areas of improvement and countermeasures shall be identified and implemented following the LEAN quality improvement framework.

III. Other Substance Use Recovery Related Groups and Activities

1. In addition to treatment services, SUD providersLHH STARS program may also provide include outreach, engagement and educational services for the general resident population and for those who are not ready to commit to active treatment. These services are focused on reduction of active use and harm. They may be provided if feasible based on resources and Infection Control protocols.

2. Outreach may include peer support services such as AA (Alcoholics Anonymous), NA (Narcotics Anonymous), and others.

   a. Appropriate approval and clearance by the LHH Chief Medical Officer must be obtained before such groups may start.

   b. Coordination of these groups and activities will be through the LHH Psychiatry Behavioral Health Program Director or designee.

   c. Information about participation in peer support services for admitted residentsresidents and patients may be will be collected from the resident/patient by the RCT and/or SUD clinicians. during individual and/or group sessions. This information will be documented by STARS clinicians in individual and/or group counseling progress notes.

IV. Active Use, Contraband and Searches for Illicit Drugs and Paraphernalia

1. SUD treatmentLHH Psychiatry providersclinicians are NOT to participate in any clinical searches for the purpose of maintaining milieu safety. This is to ensure that the therapeutic alliance formed between the LHH Psychiatry clinician and the resident, which is the foundation for effective therapeutic interventions, can be preserved, so that the resident would not suffer from breaking the trust in their treatment provider (which may lead to negative treatment outcomes).

2. For residentsresidents and patients with behavioral issues related to active use and negatively impacting care, LHH Psychiatry clinicians will collaborate with the RCT on behavioral management services. See LHH MSPP D08-10 Behavioral Management Services by LHH Psychiatry.

3. For other aspects involving resident active substance use and contraband presence, see LHH Policy 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By ResidentsResidents or Visitors.

V. Education about Substance Use Treatment

1. All LHH Psychiatry and Medicine providers clinicians have a role in helping hospital staff, family members and/or the general resident population at LHH to learn about substance use disorders, wellness and recovery principles, and harm reduction principles.

2. The purpose is to reduce stigma, promote greater understanding of these disorders and potential consequences, and to increase the skills of staff and family especially in participating in treatment planning and helping to promote residentsresidents and patients' recovery.

3. Such educational activities may include but are not limited to: input in staff training, family psychoeducation, consultation to the RCTs for specific residentsresidents and patients, Learning Circles, and other means for increasing and improving communication, learning and understanding about SUDs.

ATTACHMENT:
None

REFERENCE:

1. 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By ResidentsResidents or Visitors
2. Community Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual, 2015
3. MSPP D08-03 Access to LHH Psychiatry Services
4. MSPP D08-10 Behavioral Management Services by LHH Psychiatry.
5. HWPP 20-04 Discharge Planning
5.6. HWPP 24-25 Harm Reduction

Most recent review: 20234/021/280 (Year/Month/Day)
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Original adoption: 2016/02/04

RESIDENT ADMISSION AND READMISSION FOR SKILLED NURSING FACILITY

POLICY:

1. The responsible ~~P~~physician, ~~N~~nurse ~~M~~manager (NM), ~~C~~charge ~~N~~nurse (CN), and the ~~N~~nursing ~~D~~director (ND) will be notified of any new admissions.

~~1. The Charge Nurse, or designee, will conduct the Sacred Moment welcoming interview before the data collection and other admission processes begin.~~

2. ~~2.~~ The ~~L~~licensed ~~N~~nurse is to ~~perform~~ document admission and readmission assessments and other documentation into the electronic health record. If the licensed vocational nurse (LVN) has collected data for the admission nursing assessment, the RN must co-sign to verify the accuracy of data.

3. The Minimum Data Set (MDS) RN is responsible for completing Resident Assessment Instrument (RAI)/MDS Tracking Assessment related to an admission or readmission {Cross Reference LHHPP File: 23-02 Completion of Resident Assessment Instrument (RAI/MDS)}.

PURPOSE:

To ensure that resident is ~~made~~ welcomed ~~here~~ at Laguna Honda Hospital and to develop a comprehensive plan of care for the resident and the family~~,~~ and/or significant others.

PROCEDURE:

A. Decision to Accept the Referral

1. The p~~P~~hysician and/or the NM must contact the ~~Bed Control Coordinator/~~Patient Flow Coordinator (PFC) before the end of the day with a decision to accept or deny the resident to the ~~household~~neighborhood.

2. The ~~Department Head~~Director of Social Services must be kept informed of pending ~~discharges~~admissions.

~~3. Vacationing MD or NM must have coverage to keep this process timely.~~

~~B. **Equipment**~~

~~1. 1.Delivered to the Neighborhood by Admissions and Eligibility on admission/readmission:~~

~~Addressograph name card~~

~~Registration and Admission Record (Face Sheet)~~
~~Discharge Summary from previous facility~~

~~2.Obtain from Unit Supply as needed:~~

~~Bed card~~
~~Color-code Adhesive Dots~~

~~Color-coded ribbons~~

~~**C. Resident Care Team Notifications:**~~

~~1. The physician is to be notified at the time the resident arrives.~~

~~2. Notify Admissions and Eligibility of admission time and request the addressograph cards. Also notify when the resident information is incorrect.~~

~~3. Notify Food Services to order the first meal tray after the physician provides diet order.~~

~~D.~~B. **Admissions and Re-admissions Procedures:**

1. Upon new admission, resident will stop by A&E to have admission photo taken and uploaded onto EPIC.

2. The resident will receive a copy of the Resident's Rights Form from the admitting clerk or A&E staff with a receipt of acknowledgement by the signature of the receiving party. (Refer to HWPP 22-03 Resident/Patient Rights)

~~1. The resident is to be greeted and made to feel welcome according to the Sacred Moment interview.~~

~~2.~~3. The resident will receive the LHH Resident Handbook from Social Services.

~~3. The resident will receive a copy of the Resident's Rights Form from A&E staff with a receipt of acknowledgement by the signature of the receiving party.~~

4. The nurse manager/charge nurse is to notify the resident and/or surrogate decision maker that the Resident Care Team (RCT) will be assessing resident's level of nursing care upon admission and throughout the stay. The resident will be advised on their ongoing evaluation of level of care needs and possible discharge/relocation.

~~5. Upon admission, all residents are offered a shower/bath and nail trim, unless condition does not warrant, or the resident prefers bathing at a later time.~~

~~6.~~5. Medication brought with resident from outside will be sent home with the resident's family or guardian. Otherwise, medications are taken to ~~the~~ ~~P~~pharmacy or placed in the pharmacy pick-up tray. in a paper bag labeled with the resident's name, unit and date. Record disposition on the electronic health record. Pharmacy may dispose of medications as necessary.

~~7.~~6. Resident Identification

a. Apply identification band to wrist. If resident is allergic or refuses, note on the electronic health record and use alternate method of identification (Cross reference to ~~NPP J 1.0~~HWPP 25-15: Medication Administration).
b. A current resident photograph is to be placed in the resident's electronic health record.
c. Place resident's first name, initial of the last name (e.g. John S.) and appropriate colorcoded stickers on the ~~B~~bed ~~Identification C~~card (above bed), hallway card, and mobility devices.
d. Precautions identified by colored ~~ribbons~~ sticker (Refer to NPP B 5.0: ~~Color Codes –~~ Resident Identification and Color Codes).

~~8.~~7. Resident's Property

a. Refer to LHHPP File: 22-05 "Handling Resident's Property and Prevention of Theft and Loss" before itemizing clothing, property and valuables on the Inventory of Property Sheet. Ask resident to sign both sides, including the "Acknowledgement and Waiver".

~~E.~~C. Nursing Admission ~~Nursing~~ Assessment ~~(MR 321)~~

1. Upon admission, all residents are offered a shower/bath and nail trim, unless condition does not warrant, or the resident prefers bathing at a later time.

~~1.~~2. Upon admission the skin and hair of all residents is to be carefully inspected for possible infestation of head or body lice and scabies. The ~~Nurse Manager~~NM, Infection Control Nurse (ICN), and the ~~P~~physician are to be notified immediately if symptoms such as itching scratch marks, rashes, small white granules (nits) on hair shafts or living lice are present. (Refer to HWPP 72-01 Infection Control Manual – C16 Scabies Management)

~~2.~~3. ~~Take~~ Obtain and document vital signs (Refer to NPP G 1.0: Vital Signs)~~– including pain level score. Screen resident for orthostatic hypotension by taking BP and pulse after resident lies supine for 5 minutes. Assist resident to their most upright position, either sitting upright or standing, according to the resident's ability. Immediately take the upright BP and pulse. While still in the upright position, repeat BP and pulse after 3 minutes. Record BP and pulse readings on Nursing Admission Assessment form. Record all vital signs and pain intensity level for 72 hours from admission day on the electronic health record.~~

~~3.~~4. Measure height and weight~~.~~; and record on the electronic health record. (Refer to NPP G 4.0: Measuring Resident's Height and NPP G 7.0 Obtaining, Recording and Evaluating Residents Weight).

5. Complete the Braden Scale and a skin assessment in the EHR (Refer to NPP K1.0: Assessment, Prevention and Management of Pressure Injury, and NPP K 2.0: Wound Assessment and Management). ~~Examine skin for ulcers, lesions, bruises or unusual markings and indicate location(s) on the Lines, Drains, and Airways section avatar within the electronic health record.~~

~~a. Document pressure ulcers or suspicious bruises or markings on Unusual Occurrence Report (U.O.) and forward to Quality Management. Include description, measurement and site as well as admission date and former residence or institution.~~
~~b. Initiate wound assessment.~~
~~c. Schedule weekly monitoring on the Treatment Administration Record (TAR) for any wounds.~~

~~F.~~D. Admission Documentation:

~~The Medical~~Electronic Health Record (EHR):

1. Allergies
   ~~a.~~ If resident has any known allergies, document allergies ~~onto electronic health record.~~
   ~~b.~~a. ~~Fill in information to identify allergies and reactions.~~ and include any known reactions

2. Admission Assessment ~~Forms~~

i. Complete ~~Admissions Assessment Flowsheet~~ nursing admissions assessment
~~i.~~ii. Licensed nurse to add applicable standard work list tasks for both LN and nursing assistants

3. Notes
   a. Licensed Nurses will document a nurses note once each shift for at least the first 72 hours after admission assessment, or longer if condition warrants.
   b. ~~Weekly summaries are completed for the first four weeks, then progress to monthly summaries.~~ Comprehensive weekly summaries will be documented for all residents (Refer to NPP C 3.0: Documentation of Resident Care/Status by the Licensed Nurse).

~~4.~~ Care Plan
~~5. Interview resident and/or family and incorporate their input into the resident care plan.~~
   ~~a. Ensure that immediate care needs are care planned and that concerns regarding falls, elopement, pressure ulcers, behavior, pain, health problems are addressed.~~
~~6.~~4. ~~Note precautions such as allergies, wandering, smoking safety or special approach, any special equipment such as Bi Pap, special bed or mattress used (may include the distributors name and contact telephone number).~~ Refer to HWPP 23-01 Resident Care Plan, Resident Care Tea, & Resident Care Conference

~~7.~~5. Medicare Coverage:
~~During~~ For the duration of Medicare coverage, document a daily nurses' note at minimum. ~~residents are to have at least daily nurses' notes to document the~~. ~~f~~Focus documentation on~~f~~ skilled nursing care, in addition to routine physical assessment. When no longer covered by Medicare, select charting frequency per policy as indicated by resident's condition.
   a. Initiate MDS Assessment process.
   b. Initiate the ~~C~~care planning process **within 8 hours** (Refer to LHHPP File: 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference).

~~G.~~E. Re-admission Chart:

1. Submit Help Desk Request to request closed chart from Health Information Services if discharged more than 7 days ago.

2. Initiate a new Care Plan upon re-admission. IDT should review and revise the new care plan on the first IDT meeting.

CROSS REFERENCE

LHHPP File: 20-01 Admission to Laguna Honda Acute & SNF Services & Relocation Between Laguna Honda SNF Units
LHHPP File: 22-03 Resident/Patient Rights
LHHPP File: 22-05 Handling Residents Property & Prevention of Theft and Loss
LHHPP File: 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
LHHPP File: 23-02 Completion of Resident Assessment Instrument (RAI/MDS)
LHHPP File: 25-15 Medication Administration
LHHPP File: 72-01 Infection Control Manual – C16 Scabies Management

Nursing P&P B 5.0 ~~Color Codes~~ Resident Identification & Color Codes
Nursing P&P C 3.0 Documentation of Resident Care/Status by the Licensed Nurse - SNF

~~Nursing P&P C 5.0 Maintaining Accurate Neighborhood Census~~
Nursing P&P F 2.0 Assessment and Management of Urinary Incontinence
Nursing P&P G 4.0 Measuring the Resident's Height
Nursing P&P G 7.0 Obtaining, Recording and Evaluating Residents Weight
~~Nursing P&P J 1.0 Medication Administration~~

ATTACHMENT/APPENDIX

~~Appendix I: Admission Nursing Assessment Guideline~~

Revised: 2002/08, 2008/04, 2009/01, 2009/09, 2016/09/13; 2019/07/09

Reviewed: 2019/07/09

Approved: 2019/07/09

RESIDENT/PATIENT ACTIVITIES OF DAILY LIVING

POLICY:

1. Registered Nurse assesses the functional ability of each resident/patient to perform the activities of daily living (ADL) upon admission, quarterly, annually and when a significant change in condition occurs.

2. The Licensed Nurse in collaboration with the resident care team (RCT)/interdisciplinary team meeting (IDT) develops a plan of care to meet the resident's/patient's ADL needs, while promoting as much functional independence as possible.

3. All nursing staff, except Home Health Aides, may be assigned to provide assistance with ADL care.

4. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

5. Non-medicated personal hygiene items may –be stored at the bedside in a bag and placed in a closed drawer. Non- medicated personal oral hygiene items must be kept in another bag separate from topical personal hygiene items. (Refer to B 6.0 Items Allowed at The Bedside)

6. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

~~6.~~7. Residents on a low air loss mattress require 2 person assist for all bed mobility activities (e.g., perineal care, transfers).

PURPOSE:

1. To promote resident/patient comfort and hygiene.

2. A program of ADLs is provided to residents/patients to maintain or prevent decrease in functional status and/or return resident/patient to their highest level of independence.

PROCEDURE:

A. Preparation of Resident/Patient – The resident's**/patient's** care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's**/patient's** dignity, privacy, safety and confidentiality.

1. Gather all anticipated hygiene and grooming supplies before approaching the resident/patient.
2. Knock before entering the room and introduce yourself to the residen/patient.
3. Explain care activities to the resident/patient and engage their participation.
4. Maintain privacy during care and keep the resident/patient warm and covered as much as possible during care.
5. Engage the resident/patient in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aides as needed.
6. The individualized resident/patient care plan is followed by all nursing staff, and updated as needed.

B. Activities of Daily Living – Activities of daily living are tasks related to personal care: bed mobility, ambulation, locomotion, dressing, eating, toileting, eating, transferring, personal hygiene, and bathing. Basic nursing care procedures are to be followed utilizing Mosby's Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.

1. **Personal Hygiene**

    a. Individualized restorative nursing programs, for Skilled Nursing residents, for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident's abilities.
    b. Resident/patient is positioned at the sink or bedside with all necessary equipment within reach.
    c. Equipment and instruction provided to maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
    d. Skin care routinely includes teaching and assisting the resident/patient to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.

2. **Dressing**

    a. Residents/patients are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
    b. Residents/patients are encouraged to choose their clothing.
    c. Adaptive equipment is provided and used as needed.
    d. Alternative methods of dressing are taught as needed.
    e. Occupational therapy consultation is requested as needed through the primary physician.

3. **Eating**

    a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
    b. Residents/patients are encouraged to eat preferably in the dining room.
    c. Residents/patients are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
    d. Specialized feeding plans, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
    e. Dentures and adaptive devices are provided and utilized as needed.
    f. Oral care after each meal is strongly encouraged. When residents/patients do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

4. **Toilet Use**

a. Cognizant residents/patients are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing caregiver may reinforce this information within their scope of practice and related policies.
b. Privacy and comfort during elimination must be maintained during toileting whether in resident/patients rooms or while in tub, shower and toilet rooms.
c. When placing resident/patient on the toilet or commode, the employee is to ensure resident/patient safety until resident/patient is ready to leave, then assist resident/patient to stand and walk or transfer as needed.
d. Incontinent residents/patients are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.
e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident/patient need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.
f. Residents/patients with indwelling urinary catheters receive perineal care each shift and as needed.
g. Bedpans, urinals, and bedside commodes are emptied and cleaned in toilets when soiled and replaced when needed,

5. **Transfer, Ambulation**

a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing.
b. Follow basic safety principles for transfer and ambulation such as coaching the resident /patient to rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.
c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the care plan and is to be followed.

6. **Bed Mobility**

a. Nursing standards for every two-hour turning/ repositioning of dependent residents/patients are to be followed.
b. Exceptions to the above-noted standard related to resident/patient preferences not to be disturbed during hours of sleep are to be discussed with the Resident Care Team (RCT)/Interdisciplinary Team (IDT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.
c. Resident/patient may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident/patient has limited weight bearing status.

C. Organization of Resident/Patient Care Assignments

1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.

2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents/patients on the neighborhood to let each resident/patient know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.

a. Rounds are to include the resident's/patient's rooms, bathrooms, and other areas on the neighborhood where residents/patients are residing.

b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.
c. To ensure safety, reassure dependent residents/patients to request for assistance to move or get up.
d. Before beginning a lengthy procedure with a resident/patient, it is usually appropriate to check on the other residents patients first to promote regular monitoring of residents.

3. **Time preferences:** Check in with residents/patients for preference of bathing time. Refusals of care or resident/patient requests that place an undue burden on the staff are negotiated to achieve a reasonable compromise with RCT/IDT members' support as needed.

D. Environment of Care

1. **Personal supplies**- Refer to B 6.0 Items Allowed At The Bedside. Personal supplies or items may include, non-medicated personal hygiene items, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, bedpans and urinals. Electric shavers and personal razors are not allowed to be kept at the bedside. These items shall be stored in a locked drawer in the unit after each resident's/patient's use for safety.

    a. Items such as oral hygiene equipment, washbasins, and adaptive eating utensils are labeled with the resident's/patient's initials, rinsed after each use, allowed to air dry and returned to resident's/patient's bedside.
    b. Clean urinal, bedpan, and bedside commode with facility-approved disinfectant.
    c. Clean bedpans or urinals may be kept in the lower drawer of bedside cabinet. If resident/patient prefers, clean urinals may be kept within reach of resident/patient.
    d. Oral hygiene equipment, bedpans or urinals are changed as needed.

2. **Combs and brushes** are to have hair removed and are to be cleaned as needed and replaced when broken or worn.

3. **Resident's/Patient's area** is to be kept orderly and clean including:

    a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
    b. Spills or unclean floors are brought to the attention of EVS staff. Nursing shall clean the spill, then EVS shall mop and disinfect spill area.
    c. Resident/patient preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's/patient's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents/patients unnecessarily, for example:

        i. Provide containers for non-perishable food.
        ii. Offer regular snacks and provide a realistic means for able residents/patients to obtain nutritious snacks independently.
        iii. Offer assistance in tidying up with the resident/patient/family/responsible party.
        iv. Offer assistance in prioritizing items if resident/patient feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.

v. Communicate regularly with residents/patients regarding which items they value so that items are not inadvertently discarded as trash.
vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are **not** permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents or Patients / Visitors.)

4. Resident's/patient's **personal clothing** is laundered per facility . See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.

5. **Linen** and other **personal care items** are not to be brought to another resident's/patient's area once such items are brought into a resident's/patient's room.

    a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
    b. The soiled linen hamper is to be covered at all times and is to be emptied before it is more than ¾ full or when it is malodorous.
    ~~c.~~ Linens carts are distributed to each neighborhood by laundry staff once a day.
    d. Gather supplies needed for each resident/patient prior to beginning care.

E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.

2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents/patients.

3. IADL programming that specifically supports resident/patient comfort and hygiene and may be provided in whole or in part by nursing may include:

    a. Manicures
    b. Make-up application
    c. Walking, including walk to dine programs
    d. Exercise programs
    e. Practice folding garments or linen
    f. Grooming activities
    g. Off neighborhood visits, strolls, and activities

F. Reporting and/or Documentation

1. **Electronic Health Record (EHR):)**
CNA or PCA: Record level of function for each ADL. Report any physical or behavioral changes to the charge nurse and document.

2. Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident/patient ADLs and additional entries and document resident/patient status on the weekly summary, as directed by the documentation policy.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure
22-03 Resident Rights

Nursing Policy and Procedure
B 5.0 Color Codes –Resident Identification
B 6.0 Items Allowed at the Bedside
C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
C 3.2 Documentation of Resident Care Nursing Assistant
E 1.0 Oral Management of Nutritional Needs
Section F: Elimination Procedures

Facility Services Policy and Procedure
EM-6 Laundry Equipment Repairs and Clean Up

Revised: 2005/12, 2006/01, 2009/09, 2010/04, 2016/07, 2019/03/12; 2022/11/08; 2023/04/11; 2023/09/12

Reviewed: 2023/09/12

Approved: 2023/09/12

TRANSFER TECHNIQUES

POLICY:

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. All residents who require battery-operated lift transfer must have their own assigned sling for transfer and bathing. Each sling must have resident's name and room number.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. ~~Any member of nursing~~Nursing staff {licensed nurse (LN), nursing assistant (CNA~~, or~~ /PCA)} may perform transfer procedure. Check care plan for required number of staff assistance during transfer.

~~5.~~6. Residents on a low air loss mattress shall require 2 person assist for all transfers

PURPOSE:

To ensure resident's and staff's safety when moving the resident from one surface to another.

PROCEDURE:

A. Prior to Transfer

Review care plan prior to transfer of resident

B. Transfer Techniques

1. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)

   a. Place the gurney parallel to the bed.
   b. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.
   c. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.
   d. Set all brakes on all equipment in a "locked" position after the equipment is positioned. Lock all bed brakes.
   e. Use a draw sheet or slider sheet to assist with transfer.
   f. Always have drainage bags lower than the area being drained.

2. Pivot transfer Technique

   a. At the time of transfer, resident should have shoes and socks on.
   b. Position wheelchair or chair at head of bed, parallel to the bed. If the resident has one non-functioning upper or lower extremity, place the chair on the resident's unaffected side.
   c. Lock all bed and wheelchair brakes and fold wheelchair footrests back.
   d. Adjust height of the bed to what is appropriate for the resident.
   e. Help the resident sit on the side of the bed with feet touching the floor.
   f. Use a gait belt as needed.
   g. If transferring resident without the gait belt, support the resident by placing your hands under the arms and around the shoulder blades of the resident.

h. During transfer, block resident's feet and knees with your feet and knees to prevent falling.

3. Sliding Board Transfer Technique

a. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.
b. Lower the bed to the same height as the seat of the chair or wheelchair.
c. Assist the resident in a seated position.
d. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.
e. Slide the resident along the board to reach the chair.
f. Lock all bed and wheelchair brakes and fold wheelchair footrests back.

4. **Transfer Techniques using Mechanical Lift** (Refer to NPP D6 1.1 Battery Operated Lift Transfer and NPP D6 1.4 Battery Operated Ceiling Lift)

C. Reporting and/or Documentation

1. Reporting

All care team will communicate to the physician and rehab staff when further transferring training is warranted.

2. Documentation

a. Electronic Health Record (EHR)

i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer.
ii. The Licensed Nurse documents on weekly summary any change in functional level.

b. Care Plan

i. The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer.
ii. All residents who require battery-operated lift transfer must be documented on the Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.
iii. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry.

REFERENCES:

Transfer of Patient, Manual: Bed to Chair/Commode or Gurney. 2013. Smith, N. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 – electronic access on February 14, 2014

Transfer of Patient: Use of Assistive Devices. 2013. Smith, N. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 –electronic access on February 14, 2014

CROSS REFERENCES:

Hospitalwide Policy and Procedure

24-19 The C-625 Battery Operated Ceiling Lift and

Procedure

D1 1.0 Restorative Nursing Program
D6 1.1 Battery Operated Lift Transfer Nursing
D6 1.4 Battery Operated Ceiling Lift
D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

None

Revised: 2000/08, 2008/01, 2014/07/22, 2016/09/13, 2019/03/12; 2023/09/12

Reviewed: 023/09/12

Approved: 023/09/12

Assessment and Management of Bowel Function

POLICY:

1. License Nurse shall evaluate all residents for bowel function at admission and whenever clinically indicated.

2. Bowel management procedures that are considered invasive and require insertion/removal of a finger or device into the resident's rectum may only be performed by a licensed nurse.

~~2.~~3. After other interventions for constipation relief have been unsuccessful, licensed nurses may remove a fecal impaction with a physician's order.

~~3.~~4. Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) will monitor and record bowel movements each shift.

PROCEDURE:

1. Upon admission and as needed, the licensed nurse will observe the following:
   - Inspect, palpate and auscultate abdomen
   - Indications of tenderness
   - Verbal and nonverbal signs or symptoms of gas, pain and/or discomfort
   - Characteristics of stool
   - Frequency of bowel movements
   - Presence of blood or mucus
   - Presence of continence
   - Mode of elimination (e.g., commode, toilet)
   - Last bowel movement

2. Licensed nurse will complete bowel and bladder assessment.
3. Refer to Elsevier for procedures related to enemas and rectal tubes: https://point-of-care.elsevierperformancemanager.com/skills/616/quick-sheet?skillId=GN_33_3&virtualname=lhh
~~2.~~4. Refer to Elsevier for fecal impaction removal: https://point-of-care.elsevierperformancemanager.com/skills/11034/quick-sheet?skillId=HC_058&virtualname=lhh

DOCUMENTATION:

1. The licensed nurse completes the bowel and bladder assessment in the electronic health record

2. The CNA or PCA records bowel function in the Activities of Daily Living section each shift.

~~2.~~3. The licensed nurse documents rectal tube use in the EHR~~HER~~.

~~3.~~4. Licensed nurse develops, evaluates and revises related care plans when indicated for actual or potential bowel problems.

CROSS REFERENCES:

Nursing Policy and Procedure
F 1.0 Assistance with Elimination
F 2.0: Assessment and Management of Urinary Incontinence

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St.

Louis, MO: Elsevier
Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadelphia, PA: Lippincott Williams & Wilkins
Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

Revised: 2006/07, 2008/09, 2010/10, 2016/12, 2018/07/10, 2019/03/12
Reviewed: 2019/03/12
Approved: 2019/03/12

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff, except for Home Health Aide, may obtain residents' weights.

~~2. All residents will be weighed on admission, then monthly. Should obtaining weights have a negative impact on the resident's comfort causing undue pain or stress, the weight will not be taken and the reason will be documented.~~

~~3.~~2. Resident weight is obtained on the day of admission/readmission, monthly, upon relocation by the receiving neighborhood, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order.

~~4. Residents are weighed by the receiving neighborhood upon relocation.~~

~~5.~~3. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).

~~6.~~4. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.

~~7.~~5. Monthly weights shall be obtained by the 7th of each month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.

2. To obtain accurate weight, weigh resident in the day shift at a consistent time and have resident wear consistent clothing and/or devices.

3. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.

   a. Use the scale's manufacturer's instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR)
   b. If the manufacturer's instructions are not readily available, contact Facility Services.
   c. Improperly functioning scales are reported to Facility Services through a work order.

4. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.

2. Continue to reweigh resident daily for the next 2 consecutive days.

C. Frequency of Weights

1. On admission/readmission, nursing will obtain resident weights on the day of admission/readmission.

2. Residents shall be weighed weekly for 4 weeks after admission, then monthly, unless otherwise prescribed by physician.

3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained

2. If the weight variation is greater than ~~or less than~~ five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:
   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   c. 10% or greater over 180 days

4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of resident's for discussion at the next Resident Care Team meeting.

E. Documentation

1. The type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted on Care Plan

2. Nursing Staff documents all weights~~, in kilograms,~~ on the resident's electronic health record.

3. Licensed nurse will document on the electronic health record the assessment and actions taken for unintended weight changes.

REFERENCES

NONE

CROSS REFERENCES:

NONE~~Nursing Policy and Procedure~~
~~G 4.0 Measuring the Resident's Height~~

ATTACHMENT/APPENDIX:

NONE

Revised: 2018/01/09, 2019/03/12, 2019/09/10; 2023/08/08; 2024/04/08

Reviewed: 2023/08/08

Approved: 2023/08/08

Revised Biomedical Engineering Policies and Procedures

DEFECTIVE EQUIPMENT AND DEVICE REPORTING, TAGGING, AND REMOVAL FROM SERVICE

POLICY:

All defective and or unsafe medical equipment identified will be tagged appropriately and removed from service immediately by the Clinical Engineering Department.

PURPOSE:

To ensure that defective and/or unsafe equipment will be processed and removed from clinical care to ensure appropriate patient care. To identify and warn potential users of equipment problems or hazards and ensure an efficient response to the problem.

PROCEDURE:

1. Laguna Honda Hospital (LHH) staff who discover problem equipment will immediately remove the equipment from patient use. The LHH staff will then:
    a. Tag the defective or unsafe equipment as Defective/Out of Service.
    b. In the “Problem” field of the tag, specifically state the problem, not just “broken.”
    c. Inform the Clinical Engineering Department of their findings through the “Biomed Medical Equipment Services Request” online service requestor link on the LagunaNet Homepage (https://sfdphintranet/sites/lhh/sitepages/home.aspx) or emailing LHHBiomed@sfdph.org
2. The Clinical Engineering Department will immediately address and assess the malfunctioning or unsafe medical equipment.
3. Following an assessment from the Clinical Engineering Department, the identified medical equipment will:
    a. Be repaired by the Clinical Engineering Department and returned to service.
    b. Be labeled as “Defective/Out of Service in the computerized maintenance management system and disposed of accordingly.
        i. Disposal will be determined by the Clinical Engineering Department and the clinical department Manager or Director.
4. Staff shall not operate or permit others to operate hospital equipment deemed to be “Defective/Out of Service.”

5. No other staff may remove “Defective/Out of Service” tag. Only the Clinical Engineering Department may remove a “Defective/Out of Service Tag.”

6. The Clinical Engineering Department is not responsible for cleaning equipment. Therefore, the department reporting the issue is responsible for ensuring the cleanliness of the device per their department’s guidelines.

ATTACHMENT:
None

REFERENCE:
None

Revised EVS
Policies and Procedures

XI. Standard Cleaning Procedure

The cleaning steps outlined below applies to all areas of the facility daily including Resident, Staff, and Public Areas.

The following is based on Unit Cleaning Procedures as cleaning procedures may slightly differ in offices of the hospital and administration building.

Procedure:

1. **Trash Removal /Walkthrough**: Collection of trash, relining of receptacles, and restock supplies.

2. **High Dusting**: High dust everything above shoulder level, this includes the following: Televisions, ceiling vents, door frames, blinds, and windowsills.
   - ❖ This practice will be performed when the residents are not present in the rooms.

3. **Surface Cleaning (high and low touch)**: damp wipe the following with disinfectant: light switches, phones, doorknobs, and desks, chairs, desk, handrails, furniture surfaces, elevator button, and other high touched areas.

4. **Restroom Cleaning**: Cleaning of all fixtures, wall-mounted items, walls, doors, floors, restock restroom supplies. Flush the toilets and keep the water of the sinks and showers running for 2 minutes.
   Spa rooms: Clean and disinfect the Arjo bathtubs following the manufacture guidelines.

5. **Floor Cleaning**: sweeping, mopping, vacuuming, carpet cleaning/floor buffing when needed.

6. **Policing of Room/Area**: Making a second round to your assignment, ensuring supplies are stocked, trash is removed, spot mop as needed.

Reference: Arjo Parker Quick reference guide- - Cleaning and Disinfecting

XVI. ICE MACHINE CLEANING

POLICY: The Environmental Services Department will clean ice machines on the unit great room.

PROCEDURE:

Daily:

a. Perform hand hygiene and put on hand gloves and other protective equipment.
b. Use Chemical (25 ppm) to sanitize and clean exterior of ice machine by using the three-bucket method. All chemicals are stored in Galleys at each unit.
    1. **Cleaning Procedure (Green Bucket)**: Mix the detergent, with 1 oz. per gallon of hot water. Wipe with clean cloth.
    2. **Rinse Procedure (Blue Bucket)**: Thoroughly rinse all surfaces being cleaned with the warm., use Wipe with clean cloth.
    3. **Sanitizing Procedure (Red Bucket):** Fill sanitizer bucket with 3 qt. sanitizing solution from dispenser. Apply with clean cloth to all surfaces previously cleaned. Allow to air dry.

Weekly:

a. Perform above procedures.
b. Polish stainless-steel panels if needed.

Materials:

- Detergent
- Sanitizing Solution
- 3 Bucket
- Clean Cloths
- Hand Gloves

Note: Outbreak of infection: Use Infection Control guidelines such as bleach solutions to wipe clean all surfaces.

ATTACHMENT:
None.

REFERENCE:
26-04 Resident Dining Services
P & P 1.91 General cleaning and sanitizing work surfaces and kitchen or galley equipment

Previous Revision: May 2009, August 2013, August 2015, April 2022

XVII. Transport and Delivery for Biohazard, Trash and Linen

Staffing: Staff is scheduled 7 days per week to perform above duties routinely

North Building - 6:30am-3:00pm and 3:30pm-12:00am
South Building/Pavilion Mezzanine - 6:30am-3:00pm and 3:30pm-12:00am

South Residence Building

Soiled linen – Staff shall collect soiled linen from the chute, wrap the cart with a plastic bag and transport to the 2nd floor loading dock for pick up by the vendor.

Biohazards– Staff shall transport biohazards from the Soiled Utility Room to the temporary storage located at the G-Wing of the Administration Building for vendor pickup.

Trash & recycles – Staff shall transport trash and recycle from the Soiled Utility Room during their shift, and dispose of items at the appropriate collection bins at the South loading dock.

North Residence Building:

Soiled linen – Staff shall collect soiled linen from the chute, wrap the cart with a plastic bag and store in the North Mezzanine temporary storage room for pick up by the vendor.

Biohazards – Staff shall transport biohazards from the Soiled Utility Room to the North Mezzanine temporary storage for pick up by the vendor.

Trash & recycles – Staff shall transport trash and recycle from the Soiled Utility Room during their shift, and dispose of items in the appropriate compactor at the North Mezzanine loading dock.

NOTE: Bin(s) must be covered with a lid during transport at all times.

Clean linen delivery:

1. Clean linen will be delivered daily by the laundry vendor.
2. EVS staff will transport the clean linen to the designated clean linen/utility rooms.
3. Clean linen is to be stored in the designated clean utility rooms or carts.
4. Clean linen is to be kept covered for storage at all times and during transportation of clean linen.

Note: Service corridor in the Pavilion Building will be utilized whenever possible
(a) Unit storage has Biohazard symbol on the door.
(b) Biohazard Temporary storage – loading dock has two languages.

XXI. REJECTED LINEN PROCEDURES

POLICY: It is the policy of the Environmental Services Department to handle and store and dispose reject linen.

PURPOSE: To ensure the quality of linen meets hospital standards.

PROCEDURE:

A. All linen deemed unserviceable by the vendor will be laundered, separated, and returned to the facility in separate packaging for disposal.

B. This linen should be packaged and identified as “rejected”.

C. Rejected linen will be placed in storage for disposal or department usage.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 F4 Management of Hospital-Provided Linen

Revised Nursing Policies and Procedures

Nursing Guidelines for Relocation Between Laguna Honda SNF Neighborhoods

POLICY:

1. The resident will be processed as "Relocation" when the resident is moved from one SNF unit to another SNF unit~~, or, one bed to another bed in the same unit~~.

2. The decision to relocate a resident is made by the Resident Care Team (RCT) based on the resident's clinical needs.

PURPOSE:

To outline Nursing Policies and Procedures for resident relocation and to provide a smooth resident transition within Laguna Honda.

PROCEDURE:

A. Sending Neighborhood

1. ~~1 to 2 days b~~Before the relocation

   a. Licensed Nurse (LN) obtains Relocation Order from the physician
   ~~a.~~b. LN or Nurse Manager (NM) or designee enters the relocation referral in Epic
   ~~b.~~c. LN or Social Worker (SW) or designee Informs the resident/family/SDM of the relocation
   ~~c.~~d. LN or SW or designee offers tour of receiving neighborhood to the resident and/or responsible party.
   e. LN completes a Transfer of Room Notification form.
   ~~d.~~f. Accepting Resident Care Team (RCT) to review the resident's record in order to make sure that resident's needs will be met in the new unit and notify the referring unit of acceptance.

2. On the day of relocation, the Licensed Nurse (LN) or designee will:

   a. Gather all resident's ~~medical records (old and current) including the addressograph cards,~~ medications, personal belongings, and other special equipment to be sent to the receiving neighborhood.
   b. Check all personal belongings that are listed in the property inventory sheet to ensure all resident's belonging are accounted for prior to relocation.
   c. Complete a new inventory / property sheet by reviewing current personal belongings.
   d. Complete LHH Relocation Checklist – Sending Unit section.
   ~~e. Complete the Chronological Sheet.~~
   ~~f.~~e. Inform the receiving neighborhood for any future clinic appointments, if indicated.
   ~~g.~~f. Notify Food Services to cancel meals.
   ~~h.~~g. Notify the dialysis transportation if applicable.
   ~~i.~~h. LN will document a brief summary of resident's physical and mental condition including vital signs, time of relocation, mode of transportation
   ~~j.~~i. The LN from both the sending and receiving units will review resident's skin condition together and update on EHR if needed.
   ~~k.~~j. Notify EVS to clean the room.

3. The MDS Coordinator will inform the receiving neighborhood MDS Coordinator the status of any MDS assessment.

B. Receiving Neighborhood

1. Upon arrival, the receiving staff will welcome the resident to the neighborhood. Staff will introduce resident to the Nurse Manager, other nursing staff and Resident Care Team (RCT), roommates and other residents in the neighborhood.

2. The LN or designee must orient the resident to his room, review meal time, activities offered, and pass policies.

3. The NM or designee will tour the resident and/or Surrogate Decision Maker (SDM) in the neighborhood per request.

4. The LN or designee will:

   a. Notify the physician and update electronic health record.
   b. Verify the identification wristband is in place and legible, change ID wrist when appropriate.
   ~~c. Call Admission and Eligibility for a new addressograph cards and to electronic health record.~~
   ~~d.~~c. Notify Food Services as soon as the relocation has occurred to ensure resident will receive meal tray on time.
   ~~e.~~d. Place name card over the resident's bed and outside the room.
   ~~f. Complete LHH Relocation Checklist – Receiving Unit section.~~
   ~~g.~~e. ~~Arrange medications on the medication cart cassette drawer with label.~~
   ~~h.~~f. Inform the SDM of the new room of the resident.

5. Documentation:

   a. LN will document in the electronic health record the notification of physician and SDM of relocation, orientation to the neighborhood, resident's status and response to neighborhood relocation, and complete the LHH Body Diagram.
   b. LN or designee will update the Property Inventory Sheet.
   c. For the next 72 hours, LN will document assessment of general condition and adjustment to the new environment at least once per shift~~; then weekly for at least one month. Then progresses to monthly summary.~~
   d. LN or designee document vital signs and pain score for the next 72 hours if stable in the electronic health record.
   e. If applicable, LN will complete a Behavior Risk Assessment , initiate a care plan if needed.

6. Inform resident and/or SDM about the Resident Care Conference schedule and encourage for the resident and/or SDM to attend and participate with plan of care.

ATTACHMENT:

NONE

CROSS REFERENCES:

Hospitalwide Policy and Procedure
- 20-01 Admission to LHH Acute SNF and Relocation between SNF Units
- 22-05 Handling Residents Property & Prevention of Theft and Loss
- 50-02 Resident Trust Account

Nursing Policy and Procedure

~~C 5.0 Maintaining Accurate Neighborhood Census~~
D9 3.0 Bed Stripping and Terminal Cleaning

Revised: Revised: 2002/08, 2009/01, 2015/10/30, 2017/09/12, 2019/03/12; 2024/03/01

Reviewed: 2019/03/12

Approved: 2019/03/12

POST-MORTEM CARE

POLICY:

1. Following physician pronouncement of~~-~~ death, any nursing staff member may provide respectful, mindful post mortem care which is in accordance with resident/families' religious and cultural practices.

2. Death notification of the family or designated significant other is completed by the physician who has pronounced the death; in rare cases notification may be completed by the nurse or social worker.

Once the resident's death is pronounced, the licensed n~~N~~urse (LN) will notify the family or decision-maker to contact the private prearranged ~~(pre-need)~~ funeral service. If funeral arrangements were not completed, the deceased body will be transported to the LHH morgue as soon as possible unless otherwise indicated~~during usual business hours (0800 until 2300).~~
3.

~~3.~~
~~4. Refer to hospital policy LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates for information about access to death certificates.~~
~~5.~~
4. ~~Note:~~ If requested, when a resident, living in a semi-private or shared room, is nearing the end of his/her life, every effort will be made to relocate the resident into a private room for private and dignified terminal care.

~~6.~~5. Body must be picked up or placed in the morgue within 8 hours of death unless there are special accommodations or prearrangements.

PURPOSE:

To describe the procedures for care of the resident after death.

CHARACTERISTICS:

Refer to *Laguna Honda Hospital Policy and Procedure (LHHPP)* ~~*hospital policy LHHPP*~~ *29-06: Caring for the Deceased, Use of Morgue, and Provision of Death Certificates* for information about access to death certificates.

Refer to *LHHPP 50-02: Resident Trust Fund* for information about resident trust fund.

PROCEDURES:

A. Equipment

1. Each neighborhood will have

   a. "Post-Mortem ~~care pack~~Kit" ~~including~~ (includes ~~shroud, tape,~~ tags ~~&,~~ body bag ~~if necessary)~~
   b. Property envelopes/packing boxes

B. Notifications

1. Physician will pronounce the death of resident, notify family and determine if any prearrangements exist.~~t~~

2. After the resident has been pronounced by the physician, the licensed nurse will ~~notify~~:
   ~~a.~~ Verify physician completed the Discharge Deceased Navigator
   a.
   b. Verify physician completed the Discharge order
      i. Disposition: Expired
      ii. Comments: disposition location
   ~~b.~~c. Notify RCT members if the physician was unable to contact the family/surrogate decision maker (SDM)/conservator ~~or significant other~~
   ~~c.~~d. Nurse Manager or Nursing Operations Manager during nights/weekends ~~(when not weekday)~~
   ~~d.~~e. Social Worker
   ~~e.~~f. Clergy if requested by resident or family
   ~~f.~~g. Admissions and Eligibility on weekdays between 0800 and 1630

C. Preparing the body for viewing

1. Be attentive to preferences listed on the Resident Care Plan
   a. Are there any religious or cultural practices we should know about in order to honor you or your loved one dying?
   b. Religious/spiritual services (anointing of the sick, chanting)
   c. Cleaning or preparation of the body
   d. Gender of caregiver who is caring for the body
   e. Particular or special clothing that the resident should wear
   f. Timeliness of burial

~~1. . Refer to Attachment 1.~~

2. Bathe the body, apply clean dressings (if needed), and comb hair. ~~-~~Align the body on the bed with the head on a pillow. Cover the resident, from chest level to toes, with a clean sheet or bedspread. Put bed in low position ~~and side rails down~~. Close bedside curtains or door when appropriate for privacy.

3. Remove jewelry if possible unless family/surrogate decision-maker (SDM) request otherwise. Place wedding ring or other jewelry in a storage envelope with label and locked securely in Nurse Manager Office for safe keeping. Update the ~~Property Inventory~~Inventory of Resident's/Patient's Property (MR 311 and MR 311b). ~~-~~ Tape wedding ring on finger if it cannot be removed easily.

4. Leave the resident's hands outside of the bedspread unless visitors prefer that they be tucked under bedclothes.

5. If lips will not stay closed, use a small towel or soft collar under the chin to help close lips~~, especially if dentures will not stay in place~~. Scarf may be placed around neck to hide collar or towel for viewing.

~~6. A scarf may be placed around neck to hide collar or towel, and quilt or comforter and special pillow case placed for viewing.~~

~~7.~~6. If eyes will not remain closed, use a tiny dot of Vaseline between lids.

~~8.~~7. Remove medical/hospital equipment in bedside/room.

~~9.~~8. Bring ~~one or two~~ extra chairs for family comfort. ~~Leave~~ Provide tissue box, water pitcher, and cups. Display family photographs and flowers if available. ~~and water pitcher and cups.~~

D. Viewing of the Body

1. If the family requests to view the resident's body, inform the family that the viewing may occur in the resident's room up to 8 hours after the death pronouncement, or after transport to the new morgue ~~to the morgue~~ in the adjacent viewing room ~~adjacent to the new morgue~~.

2. If special cultural/religious traditions require extended hours beyond the 8 hours, the unit will communicate with Nurse Manager or Nursing Operations ~~Nurse Manager~~ Supervisor so that special arrangements are accommodated.

3. If the deceased resident is in an open double or triple room and has roommates, relocate the deceased's body to a private room for privacy for the family/friends if available. Otherwise the deceased can be transported to the morgue; ~~there is a viewing room for family/friends next to the new morgue.~~where the adjacent viewing room can be used.

4. When funeral arrangements have been made (as per medical record/care plan), the nurse/designee, family or decision maker will be asked to contact mortuary to pick up body from LHH and to arrange an appropriate time for the body removal that does not occur during group activities in the Great Room.

~~4.~~5. Instruct funeral home to sign the release in the nursing office prior to going to the morgue or unit. Notify nursing office when the funeral home has removed the body from the unit.

~~5.~~6. If funeral arrangement has not been made, the deceased would be transported to the morgue.

~~6.~~7. If family members or friends are unable to come to the unit for viewing in a reasonable timeframe, staff from the unit of the deceased, may assist with viewing in the room adjacent to LHH new morgue. Gurney and other supplies are available in the LHH new morgue if needed to clean the face.

E. Preparation of the Body for Transport to the Morgue or Mortuary

1. Lay the body flat in bed. ~~-~~Do not remove identification band.

2. If there is any drainage from the mouth or rectum, place an abdominal pad over orifice.

3. A ~~shroud~~ body bag will be used to transport the body to the morgue after completing the following:

   a. Place arms at sides, remove dressings and tubes (except those that could impact body's condition, such as colostomy or gastrostomy tube), and remove and clean dentures.
   b. Fill out tag for the toe and attach to resident's toe.
   c. Wrap body in a bed sheet and secure sheet with tape. Place dentures on top of sheet.
   ~~a.~~d. Place body in post-mortem body bag~~insert clean dentures. If unable to insert dentures, place dentures in welllabeled property envelope (name, hospital number, date of expiration) and tape to shroud over chest.~~
   ~~b.~~e. Make ~~three~~ tag~~s~~ for outside and attach to the post mortem body bag zipper.~~, each containing the person's name, date and time of death pronounced by Dr._____~~. Remark on tag if wedding band is taped to finger and if dentures are in mouth. ~~Stamp addressograph on the reverse side of tags.~~

      ~~i. Tie string of one tag on right big toe or to another extremity.~~
      ~~ii. Tie second tag to zipperpull on the outside of the body bag.~~

~~iii. Secure the 3rd tag to the LHH morgue refrigerated unit if not picked up by funeral director.~~

~~c. Place shroud under body in diamond fashion, so that the head is at one point and the feet at the opposite point:~~

~~i. Fold bottom of shroud over feet.~~
~~ii. Then fold both sides towards the center of the body. Tape shroud closed.~~
~~iii. Fold top corner loosely over the face. Tape shroud closed.~~

~~4. Once the funeral home attendant arrives to pick up the body, accompany the funeral home attendant to the room.~~

~~5. From 2300 to 0800, the deceased body will remain in their room and will not be transported to the LHH morgue. If absolutely necessary to transport the body to the morgue during that time, because of roommate discomfort or awareness, contact Nursing Operations Manager to assign 2-3 staff members from other units to assist the sending unit staff.~~

4. If the body is to be transported to LHH morgue, at least 3-4 staff members are required to safely transfer the body from the unit's gurney to the refrigerated unit, via the 2nd floor service corridor ~~unit~~ while maintaining the dignity of the deceased.

5. Retrieve morgue key from nursing office. Nursing office directs staff to which morgue to place body in.

~~6.~~

6. After the body has been transported, strip and wash the resident's bedside, unless it is at night and the cleaning of the bedside unit would disturb other residents.

7. Notify nursing office which morgue cabinet the patient was placed in.

F. Viewing Room

1. Prepare the viewing room (2nd floor, A2510, next to new building morgue) and the patient per the family's request or prearrangement.

2. Patient's body cannot be left unattended in viewing room.

~~F~~G. Release of Body to the Funeral/Mortuary Services

1. If there are prearrangements, the nurse/designee or family will call the funeral home to arrange pick up.

2. Body must be picked up or placed in the morgue within 8 hours of death unless there are special accommodations or prearrangements.

3. Print a face sheet (from Print Forms) for the funeral home.

4. Instruct the funeral home to stop by the nursing office to sign the release prior to going to the morgue or unit.

5. Instruct the funeral home to pick up the patient from the morgue or unit.

6. Notify the nursing office when the funeral home has removed the body from the unit.

~~1. If Nursing receives information about pre-need or prearranged Funeral plans, the nurse will notify the MSW for follow-up. If confirmed, the MSW will provide copies to A&E and place a copy in resident's chart.~~

~~2. The resident with "Pre-Need" or prior funeral arrangements will have their medical record flagged as followed:~~

~~a. A&E will fill in the "Pre-Need" field in Invision and flag the A&E file by writing or stamping "PRE-NEED" on the front of A&E file.~~
~~b. Nursing or Social Worker will placed the "PRE-NEED" in the Advanced Directives section in the resident's/patient's medical chart and will document in the front card of the RCP under preferences.~~
~~c. "Pre-Need" (prior to funeral arrangements) form will be stamped "Do Not Remove".~~

~~3. During business hours 0800 to 1630, funeral home/mortuary attendant will go to A & E to sign on death registry for body pickup.~~

~~4. During non-business hours, weekends and holidays, funeral home/mortuary attendant will go to Operations Nursing Office to sign on death registry prior to body pickup.~~

~~5. For pickup by funeral home/mortuary attendant, a form with family signature releasing the body to the mortuary is to be submitted.~~

~~6. Staff from the unit of the deceased, are required to go to the morgue to unlock door for morgue attendant.~~

~~G~~H. Disposition of *Properties* *(Refer to LHHPP 22-05 Resident's Property and Prevention of Theft and Loss)*

~~1. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.~~

~~2.~~1. Assemble resident's property. Obtain a packing box and storage envelopes as needed. Check the resident's bedside stand and wardrobe. Assure that property is safely stored in the designated storage room (K-5).

~~3.~~2. Update property checklist:

a. Print a copy of the property sheet from EHR
b. Document property disposition on the printed copy.
c. Have responsible party sign form
d. Place form in the HIS bin for scanning
e. Store valuables or money in an envelope with label and locked securely in Nurse Manager office.
~~a. Make certain property sheet is stamped with resident's name, neighborhood number, and hospital number.~~
~~b. b. Write on the original form in the "Remarks" section: date, time, pronounced expired by Dr._____. Itemize property and its disposition to either Admissions and Eligibility or the Nursing Neighborhood Station.~~

~~c. c. Make a photocopy. Place original property sheet in resident's chart and securely attach the photocopy to the property.~~
~~d. Store valuables or money in an envelope with label and locked securely in Nurse Manager Office.~~

~~4.~~3. Check with the Nurse Manager or Charge Nurse if there are any other properties stored in the Nurse Manager's office or storage room.

4. Responsible party can sign the property sheet and take the valuables before they leave after viewing the body or may return during the following few days.

~~Resident Trust's Funds: Refer to LHHPP 50-02 Resident Trust Fund~~

H. Documentation

~~1. Electronic Health Record~~
~~2.~~
~~1.~~ Document resident's condition/decline prior to the death, the time of death, the name of the physician who pronounced the death, and disposition of the body (record if this is a coroner's case).
1.
2. Record whether or not family/SDM/conservator were notified of death by the physician
3. Document information regarding resident's dentures, ring(s), and other property
4. Document time when body was picked up by the mortuary or brought to LHH morgue
5. Update "Inventory of Resiident's/Patient's Property," provide information regarding disposition of property and valuables, including any rings and dentures. Attach duplicate copy to property
6. Discharge resident from Unit Manager on the EHR
~~3. Record whether or not family or decision maker were notified of death by the physician.~~
~~4. b. Document information regarding resident's dentures, ring(s), and other property.~~

~~5. c. Record if this will be a coroner's case.~~
~~6. d. Document the time when the body was picked up by the mortuary to brought to the LHH morgue.~~

~~7. 2. Complete Chronological Record of Admissions, Transfers, and Discharges~~
~~8.~~
~~9. 3. Property Sheet (See also Section G)~~
~~10. Itemize list of property and information regarding disposition of property and valuables, including any rings and dentures. Make duplicate copy to attach to property.~~
~~11. Discharge resident from Unit Manager on the EHR~~

~~4. Invision/LCR: Update census.~~

~~5. Resident Trust's Funds: Refer to LHHPP 50-02 Resident Trust Fund~~

ATTACHMENT:

Attachment 1 - Understanding Cultural and Religious Preferences for Care of the Dying and the Deceased

CROSS REFERENCES:

Hospital Policies and Procedures
- ~~LHHPP File:~~ 22-05 Handling Resident's Property and Prevention of Theft and Loss
- ~~LHHPP File:~~ 24-11 Notification of Family/Surrogate Decision-Makers and/or Conservators of Change in Condition and/or Death
- ~~LHHPP File: 50-02 Resident Trust Fund~~
- ~~LHHPP File:~~ 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates
- ~~LHHPP File:~~ 50-02 Resident Trust Fund

Medical Staff Policies and Procedures
- ~~MSPP File:~~ C01-01 Patient Expiration
- ~~MSPP File: C~~C01-02 Autopsy Policy & Procedures
- ~~MSPP File:~~ C01-03 Organ Tissue Donation ~~Request~~ Program

Revised: 2003/08; 2009/03, 2010/10, 2012/03/27, 2015/09/08, 2018/03/06; 2024/02/28

Reviewed: 2018/03/06

Approved: 2018/03/06

Attachment 1 - Understanding Cultural and Religious Practices/Preferences for Care of the Dying and the Deceased –

During Resident Care Conference or in one to one conversations with resident, family or legal decision makers inquire about the following:

1. Are there any religious or cultural practices we should know about in order to honor you or your loved one dying? For example:

    a. Religious/spiritual services (anointing of the sick, chanting)
    b. Cleaning or preparation of the body
    c. Gender of caregiver who is caring for the body
    d. Particular or special clothing that the resident should wear
    e. Timeliness of burial

New: 2015/09/08

Reviewed: 2018/03/06

Approved: 2018/03/06

ASSISTANCE WITH ELIMINATION

POLICY:

1. All nursing staff, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA), except Home Health Aide (HHA), may assist residents with elimination needs.

2. Residents who require assistance with toileting will be supervised when using the bathroom and/or commode.

3. Perineal care is provided to all residents who are incontinent and unable to perform toileting self care.

4. Each bedpan or urinal will be labeled with the resident's last name and first name initial.

4.5. Invasive elimination procedures that require insertion/removal of a finger or device into the resident's body (i.e., rectal tubes, urinary catheter insertion) may only be performed by a licensed nurse.

PURPOSE:

1. The resident will be clean, dry, comfortable and odor-free.

2. Assistance with elimination will be provided in a manner that conveys respect, promotes dignity, functional independence, and safety.

PROCEDURE:

A. Assistance with Toileting

1. Refer to current reference text for Nursing Assistants for procedural information about use of bedpan, commode and urinal.
2.

3.2. Privacy shall be maintained during toileting whether in resident patient rooms, or while in tub, shower and toilet rooms.

4.3. Bedpans, urinals, and bedside commodes are emptied into toilet and cleaned when soiled and replaced when needed. A urinal may be kept within the resident's reach.

5.4. See Cross-References below for nursing-related procedures with management of incontinence and restorative programs.

B. Documentation

1. The CNA or PCA documents elimination in the electronic health record (EHR).

2. The licensed nurse (LN) documents any unusual physical or behavioral observations related to elimination. Interventions implemented to address these will be included in the EHR progress notes.

3. The LN records resident specific elimination interventions for the CNA or PCA to implement on the health record.

4. The LN documents the effectiveness of the resident care plan in meeting elimination needs in the Resident Care Plan.

REFERENCES:

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Nursing Policy and Procedure
D1.0 Restorative Nursing Program
F2.0 Assessment and Management of Urinary Incontinence
F3.0 Assessment and Management of Bowel Function

Revised: 2000/08; 2005/03; 2008/09; 2010/10; 2014/07/22; 2019/03/12; 2023/09/12

Reviewed: 2023/09/12

Approved: 2023/09/12

APPLICATIONS: HEAT OR COLD THERAPY

POLICY:

1. The licensed nurse, may apply dry heat for comfort unless medically contraindicated (, e.g., history of burns or radiation therapy, heat intolerance, impaired circulation, or decreased sensation to heat).

2. The licensed nurse, may apply cold to reduce edema not associated with volume overload, control superficial bleeding, reduce feverish symptom, and to relieve musculoskeletal pain unless medically contraindicated, (e.g. peripheral vascular disease, cold intolerance, or decreased sensation to cold).

3. Therapy aides may apply dry or moist heat to relieve musculoskeletal pain or tension prior to a treatment. (Refer to Restorative Policy)

4.3. Resident's response to heat or cold applications will be evaluated and complications reported promptly to the physician.

PURPOSE:

To describe procedure for the safe use of heat or cold for symptom relief.

PROCEDURE:

A. Equipment

For Cold/Heat Application: Obtain prepackaged cold and heat packs from CSR.

B. Heat or Cold Applications

1. Follow manufacturer's instructions for use of pre-packaged heat or cold packs.

2. Heat or cold application shall be limited to no more than 20 minutes/application. Monitor resident after application for any discomfort, if present, remove application.

3. The resident should never lie on the pack, as the body weight could break the pack and potentially cause a burn (heat).

4. Wrap the pack with towel or pillow case to prevent direct skin contact with heat or cold source. Increasing the towel thickness will reduce the heat/cold and delays heat/cold penetration.

5.1. Inspect skin for redness or injury after application, or if resident reports skin discomfort.Refer to Elsevier: Skills (elsevierperformancemanager.com)

C. **Documentation DOCUMENTATION:**

1. Document application of heat or cold therapy on the Treatment Administration Record (TAR) as nursing order.electronic health record (EHR)

2. Describe Document resident's tolerance of treatment and overall effectiveness of procedure in electronic health record.

3. Include heat/cold application interventions in the appropriate care plan.

REFERENCES:

Skills (elsevierperformancemanager.com)
https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco
~~Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins~~

CROSS-REFERENCES:

~~Nursing P&P D 1.0 Restorative Nursing Porgram~~
~~Nursing P&P K 2.0 Wound Assessments and Management~~None

Revised: 2000/08; 2008/08; 2012/07/31; 2014/07/22, 2018/03/06; 2023/12/21

Reviewed: 2018/03/06

Approved: 2018/03/06