List of Hospital-wide/Depsrtmental Policies and Procedures submitted for Approval on August 13, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
JCC Follow-up				
Revised	LHHPP	01-14	Compliance Program Discipline	1. Deleted "The Compliance Officer's discipline recommendation shall be based on the DPH Uniform Disciplinary Guidelines ("Disciplinary Guidelines")." 2. Added "All confirmed compliance violations will be referred to " 3. Deleted "4. Recommendations of discipline for violations of the following compliance standards shall be made considering the Disciplinary Guideline of "Stealing/Dishonesty:" 4. Deleted "a. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment to any payer." 5. Deleted "b. Failing to disclose known excluded status on any regulatory sanctions list." 6. Deleted "c. Failing to disclose known pending or confirmed disciplinary actions by a licensing body." 7. Deleted "d. The Compliance Officer shall follow the Disciplinary Guideline of "any reasonable cause not listed" for recommendations of discipline for all other compliance standards violations." 8. Removed section 3e.
Revised	MSPP	001-02	Night and Weekend Physician Services	1. Updated workflow for current EHR 2. Expanded list of specific clinical responsibilities 3. Updated Pharmacy availability times to include expanded weekend hours 4. Updated schedule for Phlebotomy and Radiology services. 5. Added new overnight on-call radiology technician for after-hours services. 6. Updated expanded admissions on weekends to include Saturday and change in physician admission shift hours 7. Revised Summary of Physician duties to reflect current EHR workflow. 8. Updated policy references throughout document 9. Updated Code Blue section
Revised Hospital-wide Policies and Procedures				
Revision		NA	Laguna Honda Hospital Adult Intravenous Vancomycin Per-Pharmacy Dosing Protocol	
Deletion Medical Services Policies and Procedures				
Deletion	MSPP	003-04	BILLING FOR PHYSICIAN SERVICES: ACUTE	Request to delete.
Deletion	MSPP	003-05	BILLING FOR PHYSICIAN SERVICES: SNF	Request to delete.
Deletion	MSPP	003-06	BILLING FOR PHYSICIAN SERVICES: CONSULTATION	Request to delete.
Revised Nursing Policies and Procedures				
Revised	NPP	C 1.3	Discharge Procedure to Acute	1. Added a policy statement clarifying that send to acute are LOA, not "discharge" on EPIC 2. Included definition of Discharge 3. Updated notifications of discharge 4. Referred to HWPP re: bed hold, loa, and handling of resident properties
Revised	NPP	L 1.0	Emergency Intervention for Choking	1. Revised policy to match Code Blue policy. 2. Clarified that PCA shall be current with CPR
Deletion Nursing Policies and Procedures				
Deletion	NPP	A 10.0	Utilization and Monitoring of P103 and Per Diem	Suggest deleting since covered by HR guidelines and the Collective Bargaining Agreement
Deletion	NPP	A 11.0	Utilization of OT Staff	Suggest deleting since covered by HR guidelines and the Collective Bargaining Agreement
Deletion	NPP	STANDARDIZED PROCEDURE	ADVANCED PRACTICE NURSE (NP/CNS) PREAMBLE	Suggest deleting as we do not have a Wound CNS
Revised Social Services Policies and Procedures				

Revised	Social Services	7.5	Discharges to the Acute Care Unit (PMA)	1. Added "within 48 hours of admission" to Procedure 6. 2. Updated the "Last Reviewed Date".
Revised	Social Services	7.6	Documentation of Care Plans	1. Removed "are not required to write in the", "if there are no", "other than a discharge care plan" to Procedure 4. 2. Added "will create a" and "with" to Procedure 4. 3. Updated the "Last Reviewed Date".
Revised	Social Services	7.7	Discharge Planning and Implementation	1. Removed "1) a care plan will be completed under the Care Plan tab in the EHR, 2)" in Procedure 1. 2. Added "A care plan under the Care Plan tab in the EHR will be updated accordingly. " in Procedure 1. 3. Updated the "Last Reviewed Date".
Revised	Social Services	7.9	Readmission Assessments	1. Removed "on the discharge track" and "for short stay codes and 5 business days for General SNF codes. " from Procedure 4. 2. Added "of readmission" to Procedure 4. 3. Updated the "Last Reviewed Date".

JCC Follow-up

COMPLIANCE PROGRAM DISCIPLINE

POLICY:

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

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

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

PURPOSE:

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

PROCEDURE:

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

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

3. Discipline Procedure

    a. An employee who commits a violation of any compliance standard or who becomes aware of information regarding any violation or potential violation by an employee or contractor of any compliance standard has a duty to report the violation or potential violation to the Office of Compliance and Privacy Affairs (OCPA) Compliance and Privacy Hotline, to the Compliance Officer, or to a supervisor or manager.

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

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

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

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

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

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

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

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

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

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

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

~~e.~~g. Nothing in this policy shall abridge an employee's union and/or civil service rights.

~~5.~~4. If the investigation findings do not substantiate the allegation or matter:

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

~~b.~~a.

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

~~6.~~5. If a compliance violation is found:

a. All documentation related to the investigation will be maintained as an "open" investigation until a corrective action plan has been completed and the matter has been resolved, at which time the investigation will be closed by the Compliance Officer.
~~a.~~
b. Once closed, the investigation file will be filed and OCPA for a minimum of seven (7) years after the investigation has been closed.

~~7.~~6. Prohibition on Retaliation against Whistleblowers

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

ATTACHMENT:
None.

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

Original adoption: 19/05/14 (Year/Month/Day)
Revised: 22/06/14, 23/03/14, 24/05/30

NIGHT AND WEEKEND PHYSICIAN SERVICES

Policy: Physician services will be provided to Laguna Honda Hospital residents with onsite physician coverage 24/7.

Purpose: To provide continuity and consistency of physician services that are evidence based and meet or exceed community standards.

Procedure: As needed night and weekend physicians provide hospital coverage during off hours in compliance with the hospital procedures and protocols outlined ~~in Appendix's~~ below.

~~Appendix A –~~ General Information

Hospital coverage – two physicians are scheduled for off hours coverage. One physician is assigned to the North Tower, PM SNF, and PMA medical unit, (pager 327-4914) and the other to the South Tower and PMA rehab unit (pager 327-4912). On Saturdays and Sundays there is an admitting physician (pager 327-0754) scheduled for 4 hours to do new admissions from ZSFG or readmissions from ~~ZSFG or UCSF~~ acute care hospitals. If there are no admissions, the admitting physician will assist the North and South tower physicians.

In person sign out and pager transfer is required. Daily sign out will take place in the Medical Staff Lounge at the start and end of each shift, at 8am and 5pm, and will consist of verbal sign out with review of the physician sign out log. The nursing supervisor will also attend sign out. ~~Appendix F~~

Logistics

1) There are 2 on call rooms, one on Pavilion Mezzanine (extension 4-~~5755~~5759) and one on South 4 (extension 4-1272).
2) Lab, Respiratory and Radiology are located on Pavilion 1.
3) The Medical Staff Lounge is located on Pavilion 2, at the north end of the hall.
4) The cafeteria is on Pavilion ~~1, and~~1 and is open from 7am until 2pm. Vending machines are located on Pavilion 1 and can be accessed 24/7. There is an ATM in the vending machine area. An evening snack is delivered to the Medical Staff Lounge each evening. The Medical Staff Lounge has a coffee machine and hot/cold water. Weekend physicians are entitled to a free lunch in the cafeteria, and physicians working overnight are entitled to a free breakfast the following morning. ~~Inform the cashier in the cafeteria that you are the on call physician.~~On-Call physicians are issued individual charge cards to present to the cashier for meal credit.
5) ~~Keys~~ Badge access to the call room~~,~~ and Medical Staff Lounge~~,~~ Keys to ~~e~~exam

rooms on each neighborhood and elevator code blue keys are kept in the nursing office on the north end of the

Pavilion Building. Keys must be signed out and returned at the end of each shift; if passed on over the weekend, keys must be returned to the nursing office on Monday morning.

6) Parking is in designated areas – please arrange issuance of a Black parking permit through Medical Services office. Park only in Black or purple designated areas. Blue decal can park anywhere except Red and Visitor parking spots.

Schedule

The night and weekend schedule for each month is finalized and ~~distributed~~ posted on-line by the N/WE supervising physician no later than day 20 of the preceding month. While as needed physicians will not be guaranteed any specific shifts or minimum number of shifts, a template will be maintained that identifies shifts routinely covered by specific physicians. After the schedule is finalized, it will be the responsibility of the physician to arrange any needed shift changes.

~~Weekend back~~ Back up schedule – this is covered by a rotating pool of Permanent Exempt (PEX-)~~daytime primary care~~ physicians who also work nights and weekends. The back up coverage begins each evening ~~Friday~~ at 5pm and ends ~~Monday~~ at 8am the next morning. Back up physicians must be available to come in within 2 hours of being called. Back up is used when the scheduled covering physician is ill, or if a coverage shift is uncovered. Back up is not used for the admitting shift. ~~Back up should not be used for the admitting shift or a second overnight physician shift. There is no back up provided for holiday coverage or weeknight coverage.~~

Clinical Responsibilities

Follow up on any issues identified at sign out.

Daily evaluation and progress notes for any patient on PM Acute, either medical or rehab

Admissions to acute medical unit as needed; these require full H&P ~~and,~~ admissio~~n~~ n orders and Advanced Care Planning (ACP) documentation.

Evaluate residents as needed for medical or behavioral issues that arise and follow up on evolving issues. Document each resident visit and complete ~~an encounter form~~ an appropriate billing charges for each visit. All EHR notes ~~must be locked and all dictations~~ and verbal orders must be signed by the end of each shift.

Pages must be answered promptly, within 10 minutes. Patients requiring evaluation should be seen within 30 minutes, or sooner if they are unstable.

Conditions including (but not limited to) the following need in-person physician evaluation:

1) Fever over 100.5 F/38 C
2) Shortness of breath/hypoxia
3) Change in mental status

4) Chest pain
5) Seizure
~~Fall with injuryAny fall~~
~~6)~~ ~~6) F~~Falls -. (refer to HWP 24-13 Falls~~-~~)
~~6)~~

6)
7) Syncope
8) Unstable vital signs
9) Vomiting more than twice within a ~~in shift a~~ shift
10) Abdominal pain
11) Visual changes
12) Unrelieved or persistent pain despite interventions
13) Resident to resident altercation or resident to staff physical altercation
14) ~~14)~~Emergent use of psychotropic medications
15) New Neurologic changes/deficits
16) Any incident of Abuse
17) Any risk of Suicidal ideation
~~13) Any state resulting in a change in vital signs or change in condition.~~

Orders – all medications, nursing and other orders, labs and imaging ~~except topical medications~~ are ordered in the EHR. ~~Labs, x-rays, topical medications and nursing orders are ordered on the paper physician order sheet~~. All verbal orders must be signed by the end of the shift.

Pharmacy

The pharmacy is open from 8:00 a.m. until 6:00 p.m. on weekdays and 8:00 a.m. until 4:00 p.m. on ~~Sundays, and closed on Saturdays~~weekends. A supply of the most commonly used medications may be accessed by the nursing supervisor if needed from the supplemental drug room. A pharmacist is available on call ~~on~~ during off hours and may be contacted by the nursing supervisor if a medication is urgently needed that is not available in the supplemental drug room. Review the supplemental drug list carefully before calling in the pharmacist.

Psychotropic medications

OBRA guidelines and Laguna Honda Hospital policy require that all new medication orders being used for psychoactive effects, including sleeping agents, have a signed consent prior to administration of the medication. Include diagnosis and specific target symptoms when ordering a psychotropic medication. For ~~example~~example, “Seroquel 250 mg q 12 hours for schizophrenia, target symptoms auditory hallucinations resulting in refusal of dialysis”. When ordering an emergent one-time psychotropic medication, the patient must be evaluated, and the emergent psychotropic order ~~form must~~form must be reviewed and signed by the physician. Clearly and specifically document the behavior requiring emergent psychotropic use, make sure to re-evaluate in a timely manner and document your follow up evaluation.

Respiratory Therapy

Respiratory Therapists are available 7 days a week, from 8am to 4:~~30pm~~00pm. They will assist with respiratory emergencies, code blues, perform ABGs, sputum inductions and nasal swabs for viral screens.

Radiology

Radiology is available in-house on weekdays, Saturdays and Sundays from 7:30am to 4pm. If x-rays are urgently needed at other times, the Radiology tech on-call should be contacted and will arrive within 2 hours (See Radiology On-Call Standard Work) ~~arrangements should be made to have them done at ZSFG~~. Radiology results are available in the EHR and images can be reviewed on ~~IMPAX~~ PACS on all computer terminals. Radiology is not available on ~~Saturdays or~~ holidays.

ECG

ECGs are ordered ~~by completing the paper form~~in the EHR and are done by the respiratory therapists, or, when they are not available, by the nursing staff. ECGs are transmitted daily to ZSFG for formal interpretation, and results are available on the EHR. Covering physicians will do preliminary ECG interpretations.

Laboratory Services

Phlebotomists are available ~~from~~ starting at 6am ~~to 6pm on weekdays~~ until variable afternoon hours on weekdays, ~~–~~and from 10am to 2pm on weekend days. When phlebotomists are not available, the nursing staff will obtain the blood specimen. All specimens are transported to ZSFG to be analyzed in there. Results are available on EHR. Turnaround time for STAT labs is 2 to 3 hours. Scheduled courier service pick~~-~~up times are:

Monday through Friday - 8:30am, 11am, 2:30pm and 6pm

Saturday/Sunday/Holidays 11:30am and 2pm

A courier is available to take STAT labs to ZSFG at times other than scheduled if needed.

Code Blue

1) All code blues are announced overhead. The ~~on call~~on-call physicians will also receive a code blue page with the location of the code.
2) Every ~~on call~~on-call physician should respond immediately to every code blue. ~~The physician with the most ACLS experience should run the code.~~
~~3) The code blue team nurse will transport the crash cart to the code blue location~~location~~. The licensed nurse from the neighborhood with the Code Blue is responsible for ensuring that the crash cart, emergency box, Workstation on Wheels (WOW) and glucometer is brought to the site of the emergency.~~
~~4)~~3) All residents who survive a respiratory or cardiac arrest should be discharged via 911 ambulance to an outside acute care facility –usually UCSF as the closest facility.~~-~~
~~5)~~4) Termination of resuscitation efforts is at the discretion of the code blue team leader.
~~6)~~5) Residents with “Do Not Resuscitate” orders who choke will have a code blue

called and interventions initiated.

~~7)~~ Documentation after a code blue includes completion of the code blue record which is reviewed and signed by the physician~~,~~, and a detailed code blue ~~/~~progress note. If the resident expires, the death pronouncement progress note should be dictated or typed in the EHR

6) and no billing submitted.

~~and no encounter form~~billing ~~is submitted.~~ If the resident survives the ~~resuscitation, documentation~~resuscitation documentation should be done in the EHR.

~~8)~~7) The resident's family, surrogate decision maker (SDM) or conservator should be notified by the physician.~~.~~

Discharge to LHH Acute Medical Unit

Review advance~~d~~ directives prior to discharge to acute care. LHH PMA is licensed as an acute care hospital, separate from the skilled nursing facility. All patients admitted to PMA require discharge from SNF (including note in the EHR documenting evaluation and reason for discharge and an LOA ~~discharge~~ order) and admission to acute (including H&P documented in the EHR). The SNF discharge summary will be completed by the primary care physician.

Discharge to outside acute care hospital

If outside acute transfer is within goals of care, r~~R~~esidents who ~~have~~ develop an acute illness or change in condition that cannot be managed at LHH will be discharged to an outside acute care hospital, generally ZSFG. Medically unstable residents will be transported to UCSF which is the nearest hospital. When transferring a resident to an outside facility, an Interfacility transfer form must be completed and sent with the resident, along with pertinent information from the medical record such as the H&P, Advance~~d~~ Directives, MAR, Face Sheet and contact number for the covering and primary physician. Progress note documentation must be completed and signed in the EHR. Prior to transfer the provider at the receiving hospital must be contacted and given sign out. Notify the resident's family, SDM or conservator of the transfer.

Sentinel Event

Notify the Chief Medical Officer or designee and the Administrator on Duty (AOD) in the event of a sentinel event (~~Appendix B)~~Refer to HWP 60-12 ~~-~~Review of Sentinel Events and HWP 60-05 Review of Serious Adverse Events in Skilled Nursing Facility)

Death

All residents who expire must be pronounced by a physician. The Medical Examiner's Office must be contacted for any death that meets criteria listed on the "Expiration Check List" (~~Appendix C~~Refer to Epic Discharge Navigator "Deceased" template for list of Medical Examiner reporting criteria)

Any possible aspiration event or trauma (even remote trauma) that may have contributed to the death must be reported to the Medical Examiner's Office, even for patients on end of life or comfort care. If the case is declined, the deputy's name and badge number should be documented on the expiration check list.

The physician must notify the next of kin, SDM or conservator and document notification. Ask the family if they would like to come in to view the body and notify the nursing staff if they intend to come.

The organ donor network must be called within one hour for any patient who expires in the acute medical or acute rehab unit (180055DONOR). Tissue donation forms must be completed for all deaths occurring on the acute medical or acute rehab units. Refer to HWP 29-03 Organ/Tissue Transplant Donation Policy.

Medical Emergencies for non-residents (staff, visitors or volunteers)

When an employee, visitor or volunteer has a potentially life- threatening emergency, 911 and a code blue should be called immediately, and the first physician to arrive will evaluate the victim and provide appropriate emergency medical care until the emergency medical crew arrives. The physician will contact the receiving hospital provider. Documentation shall be done on an Unusual Occurrence form. Physician response is intended only for provision of emergency medical care and stabilization. Physicians should not provide routine care for non-residents.

Psychiatric Emergencies

A psychiatrist is available at all times for psychiatric emergencies. The psychiatry on call schedule is posted on the Intranet under “Psych/Calendars/Current Calendar Year”. The psychiatrist on call can be called or paged directly. The ~~on call~~on-call psychiatrist can provide telephone consultation, come in to do an evaluation in person, and/or facilitate transfer to inpatient psych unit or psych emergency ~~department~~ services (PES). Requests for on call psychiatry services are only to be made by the ~~on call~~on-call physician. Covering physicians should not accept return of any patient who has been sent for psychiatric evaluation prior to assessment by LHH psychiatry.

Weekend Admissions

All weekend admissions are arranged by the ~~proceeding~~ preceding Friday by 3pm. Weekend admissions are ~~only accepted on Sundays~~accepted on Saturday and Sunday, and only if an admitting physician is scheduled. New admissions are accepted from ZSFG only., Rreadmissions may be accepted from ~~ZSFG or UCSF. Admissions or readmissions from~~ any ~~other~~ hospital~~s cannot be accepted~~ on weekends. Readmissions from within LHH (PMA to SNF unit) do not require pre-arrangement~~,~~ and should be done as soon as the patient no longer requires acute care.

The admit shift hours are ~~11am~~ 12pm to ~~3pm~~ 4pm on ~~Sundays~~Saturday and Sunday. The admitting physician is responsible for the H&P, admitting orders, and initial management of ~~Sunday~~ weekend admissions. ~~from ZSFG or UCSF~~. There will be a maximum of 2 admissions ~~on Sundays~~ daily on weekend days. If there are

no admissions scheduled, or if the admitting physician has free time, ~~s/he~~they will assist the other weekend physicians as needed,

~~Appendix B –~~ Summary of Night and Weekend Physician description of duties. Basic duties include but may not be limited to:

1) Assess, diagnose, treat and follow up on residents with new or evolving medical or behavioral issues.
2) Arrange discharge to acute care, including the LHH acute care unit as appropriate, when appropriate level of care cannot be provided on the SNF unit~~,~~ and acute care transfer is ~~-~~consistent with a resident's advance~~d~~ directives and goals of care. ~~Appendix E~~(MSPP 001-03 Acute Medical Unit Admission Guidelines)
3) Respond immediately to all code blue and medically urgent situations.
4) Pronounce death and contact Medical Examiner's Office when indicated. Notify family, SDM or conservator in the event of resident expiration.
5) Evaluate and write daily progress notes on all patients on A~~a~~cute medical and Acute rehab units.
6) Complete a H&P and admission orders on newly admitted or readmitted patients.
7) Perform special procedures as needed and in keeping with delineated privileges. Obtain consent for any invasive procedure performed and for blood transfusions.
8) Communicate with residents and/or families, surrogate decision makers or conservators regarding change in resident condition or plan of care.
9) Communicate with consultants as needed.
10) Review all signed out, urgent, STAT or critical lab reports, document interpretation of results and appropriate treatment plan.
~~10)~~11) Complete follow-up of any tasks requested by the PCP, outgoing on-call physician or Medical Leadership.
~~11)~~12) Maintain a complete~~,~~ and accurate ~~and legible~~ electronic medical record.
~~12)~~13) Sign verbal orders~~,~~ and all ~~lock~~ EHR notes~~, and review, edit and sign all dictations~~ prior to the end of each shift.
~~13)~~14) Accurately complete ~~an encounter form~~billing charges for each resident/patient encounter. Ensure the billing is supported by level of service and documentation. ~~Appendix D~~ (MSPP 003-03, 003-04, 003-05 Billing for Physician Services)
~~14)~~15) Address concerns or questions of the nursing staff, including clarification of orders and evaluation of residents.
~~15)~~16) Conform to the Medical Staff Bylaws and Rules and ~~Regulations, and~~Regulations and adhere to all hospital policies and procedures.

~~Appendix C - Sentinel Events, HWP&P 60-12~~
~~Appendix D - Billing and Coding, MSP&P 003-03, 003-04, 003-05, 003-06~~
~~Appendix E - Acute Medical Unit Admission Guidelines, MSP&P 001-03~~
~~Appendix F - Sign Out~~

Laguna Honda Hospital Adult Intravenous Vancomycin Per-Pharmacy Dosing Protocol

~~File: 25-XX~~ Laguna Honda Hospital~~HH~~ ~~(&ZSFG Joint)~~ Adult Intravenous Vancomycin ~~——~~ ~~New Policy June 2019~~ Per-Pharmacy Dosing Protocol

~~The Pharmacy Practice Act allows pharmacists to practice under a Collaborative Practice Agreement with individual physicians. Pharmacists may participate in the practice of managing and modifying drug therapy according to a written protocol between the specific pharmacist and the individual physician(s) who is/are responsible for the patient's care and authorized to prescribe drugs.~~

~~By signing this document, the named physicians agree that the named pharmacist may enter into a Collaborative Practice with them for the management of IV vancomycin in patients receiving this drug according to the attached protocol for IV Vancomycin Service. By signing this document, the physician agrees with the management outlined in the attached protocol.~~**~~IV VANCOMYCIN SERVICE PROTOCOL AND COLLABORATIVE AGREEMENT APPROVED BY:~~**

~~PHARMACIST CLINICIANS:~~

~~_____~~
~~[INSERT PHARMACIST NAME] R.Ph., Pharm.D.~~

~~_____~~
~~[INSERT PHARMACIST NAME] R.Ph., Pharm.D.~~

~~_____~~
~~[INSERT PHARMACIST NAME] R.Ph., Pharm.D.~~

~~_____~~
~~[INSERT PHARMACIST NAME] R.Ph., Pharm.D.~~

~~PHYSICIANS:~~

~~_____~~
~~[INSERT PHYSICIAN NAME, M.D.] [INSERT PHYSICIAN NAME, M.D.]~~

~~_____~~
~~[INSERT PHYSICIAN NAME, M.D.] [INSERT PHYSICIAN NAME, M.D.]~~

~~_____~~
~~[INSERT PHYSICIAN NAME, M.D.] [INSERT PHYSICIAN NAME, M.D.]~~

PURPOSE:

~~The purpose of this protocol is t~~To establish a framework for pharmacist-directed management of IV vancomycin therapy in adult patients~~; this will include~~ which includes initial dosing, monitoring of pertinent laboratory values and vancomycin levels, and dose modification. Other institutions with similar pharmacist-led dosing protocols have shown optimized outcomes, such as higher proportions of vancomycin trough levels ~~time~~ within therapeutic range.

POLICY:

To establish a standardized protocol for vancomycin dosing and monitoring in adult patients intended to optimize efficacy and reduce the potential for adverse events. Based on ~~the following~~this protocol, pharmacists will be able to write orders for vancomycin dose, trough levels, and related laboratory studies as specified. See below for inclusion and exclusion criteria.

ORGANIZATION:

The clinical pharmacist will coordinate the vancomycin service and will determine patient-specific intervals for lab draws, evaluate patient's vancomycin therapy, and make dosage adjustments per protocol if necessary. The pharmacist will be available to evaluate all vancomycin levels ~~with~~ and related monitoring labs returning between the hours of 8am-4:30pm on Monday-Friday. All other lab results which return outside this designated window must be evaluated and acted upon by the primary or covering physician. The physician will provide information regarding interventions and blood draw intervals to the clinical pharmacist when they are next available.

When outlined by the protocol, or at any time an unusual or unexpected situation arises, the clinical pharmacist will consult the primary or covering provider for medical guidance. If the patient has a critically high lab value related to vancomycin monitoring as indicated by the protocol, then appropriate interventions will be initiated after discussion with the physician~~a provider~~. If adverse reaction is noted, the primary ~~physician~~ or covering physician and the clinical pharmacist will be notified and the corresponding physician will evaluate the patient for appropriate management.

DEFINITIONS:

Setting/Patient Population

1. Inclusion Criteria:

All adult patients admitted to ~~ZSFG or~~ LHH receiving IV vancomycin therapy. Note: ~~providers~~ Physicians ~~will be~~are able to opt out of the pharmacist-driven protocol and order vancomycin doses and levels independently.

2. Exclusion Criteria:

This protocol is not intended for the scenarios below:

a. Patients whose physician has opted out of the pharmacist-driven protocol.
~~a. a.~~ Patients initiated on IV vancomycin for anticipated duration < 24 hours ~~-~~including single dose~~doses~~ or for peri-operative prophylaxis use.
~~b.~~
~~c. including single doses or peri-operative prophylaxis~~
~~d. b. Pediatric patients (< 18 years old)~~
b.
~~a. c. Patients whose provider has opted out of the pharmacist-driven protocol~~

PROCEDURES:

1. **Pharmacist-managed IV vancomycin management protocol:**
   a. **Initiation and Discontinuation of the protocol**
      i. ~~Provider~~ Physician orders IV vancomycin per pharmacy and specifies the indication, duration and goal trough levels.
         1. ~~ZSFG Providers~~ Physicians ~~will have the option of ordering~~will leave ~~a specified loading dose followed by maintenance dose per pharmacy consult or leave~~ all dosing decisions to pharmacist discretion ~~by ordering "vancomycin IV - consult pharmacy to dose"~~ by ordering the ~~protocol placeholder~~consult order, "Pharmacy consult – dose vancomycin". The pharmacist may adjust any loading and maintenance doses placed by the physician, if appropriate.
         2. ~~LHH- Provider will order a specified loading dose, followed by ordering "vancomycin IV – consult pharmacy to dose".~~
         ~~3.~~2. ~~Providers~~Physicians may opt-out and manage all doses and levels, as described above.

      ii. Pharmacists will be responsible for initiating, evaluating, and/~~-~~or modifying ~~a~~ vancomycin dosing regimen and laboratory values ~~as below~~ for any patients with the ~~protocol~~pharmacy ~~placeholder~~consult order.

      iii. ~~Providers~~ Physicians who order vancomycin per pharmacy consult may discontinue and/or reinitiate the protocol at any time. ~~When the IV vancomycin order is discontinued by the physician, the protocol will be considered discontinued.~~Whenwillconsults

      ~~iii.~~iv. Upon receiving orders to discontinue therapy, pharmacists ~~should~~will ensure all related orders are discontinued (e.g. labs, trough level, med order, and ~~placeholder~~consult order). If there is any uncertainty about whether the per pharmacy protocol should be discontinued, the pharmacist will contact the physician for clarification.

   b. **IV Vancomycin Regimen Management**
      i. Upon receipt of a vancomycin per pharmacy consult order, pharmacists will order the initial IV vancomycin regimen if not done by ~~provider~~ physician or assess the appropriateness of the initial IV vancomycin regimen ordered by the ~~provider~~ physician based on patient-specific parameters (e.g., height, weight, renal function, indication, pharmacokinetic goal ~~trough~~).

ii. Pharmacists may adjust ~~the~~an ~~initial~~ existing vancomycin order, as clinically appropriate, once the protocol is active.

iii. The pharmacist will be responsible for ordering and timing vancomycin trough and/or random level(s) and adjusting regimens, as appropriate.

iv. Dose and/or frequency adjustments by pharmacists will be based on the UCSF Antimicrobial Dosing Guidelines, the vancomycin dosing nomogram, and pharmacokinetic analysis. (See Appendix A for details).

v. Modifications to IV Vancomycin therapy by the pharmacist will be documented in the notes section of the electronic ~~health~~ medical record (EM~~H~~R).

c. **IV Vancomycin Level Monitoring**

i. After initiation of the protocol, ~~P~~pharmacists will order or adjust the timing of vancomycin levels according to protocol. In addition to vancomycin ~~trough~~ levels, pharmacists ~~will be~~are authorized to order laboratory values necessary to evaluate the safety and efficacy of IV vancomycin, including, but not limited to:

1. Serum creatinine (SCr)
   a. If no baseline SCr is available, pharmacists should order one "STAT". When treating serious infections, it is reasonable to proceed with an initial dose prior to the SCr result.
   b. SCr should be ordered daily for acute care patients receiving IV vancomycin; pharmacists can place orders if not otherwise followed by physicians.
   ~~a.~~ Long term care patients will have SCr checked weekly or as appropriate
   c.
2. Blood urea nitrogen (BUN)
   ~~b.~~ BUN can be followed weekly; pharmacists can place orders if not otherwise followed by physicians.
   a.
3. CBC with differential
   a. CBC can be followed weekly; pharmacists can place orders if not otherwise followed by physicians.
   ~~c.~~b. CBC with differential should be ordered daily for acute care patients

~~ii.~~ Pharmacists will be available to review or provide guidance on vancomycin dosing based on levels and renal function regardless of protocol status. If a~~no~~ per pharmacy ~~protocol placeholder~~consult order has not been placed, this indicates the physician will manage vancomycin dosing and monitoring. In these cases, pharmacists will communicate recommendations to physicians rather than make changes independently.

ii.

iii. Goal trough level (Table 1)

If monitoring AUCs, the goal will generally be 400 – 600 mg*hr/L. If monitoring trough levels, the goal will be as follows:

Table 1. Goal Trough Level by Indication

Indication	Goal Trough (mg/L)

Skin/Soft tissue infections, UTI	10-15
Bacteremia, Endocarditis, Meningitis, Pneumonia, Severe Sepsis, Osteomyelitis, Hardware Infections, Febrile neutropenia or other serious infections not listed above	15-20

~~iii.~~ If the vancomycin trough is above goal or if there are any concerns while on IV vancomycin, the pharmacist will check in with the nurse for potential side effects. The physicians will be notified of any of the following:

iv.

1. Any new onset of rash (e.g. maculopapular rash vs. vancomycin ~~infusion reaction~~flushing syndrome~~red man syndrome~~)
2. Ototoxicity (e.g. hearing loss, tinnitus)
3. Infusion site reactions (e.g. phlebitis, pruritus, irritation, pain)
4. Hypersensitivity reactions or anaphylaxis during and after the infusion (e.g. fever, dyspnea, wheezing, chest pain, hypotension)

~~**Table 1. Goal Trough Level by Indication**~~

~~**Indication**~~	~~**Goal Trough (mg/L)**~~
~~Skin/Soft tissue infections, UTI~~	~~10-15~~
~~Bacteremia, Endocarditis, Meningitis, Pneumonia, Severe Sepsis, Osteomyelitis, Hardware Infections, Febrile neutropenia~~	~~15-20~~

d. Regimen adjustments for Vancomycin

i. The pharmacist will use the vancomycin dosing nomogram, the guidance for dose modification, and pharmacokinetic calculations (Appendix A) to determine the optimal dose of IV vancomycin for the patient. ~~This nomogram does~~These references do not replace clinical judgment.

ii. The pharmacist may consult with the ID ~~pharmacist or~~ physician if necessary.

iii. Pharmacists may temporarily discontinue IV vancomycin for ~~elevated~~ supratherapeutic vancomycin levels ~~based on goal troughs~~ and re-order vancomycin therapy regimen when levels have returned to goal range, as clinically appropriate.

e. Vancomycin Duration

i. The ~~provider~~ physician is responsible for determining duration of IV vancomycin therapy. The pharmacist will evaluate need for ongoing IV vancomycin therapy and may recommend discontinuation of vancomycin therapy or request review by antimicrobial stewardship team member.

ii. When a ~~provider~~ physician discontinues the IV vancomycin order, pharmacists are authorized to discontinue the protocol and associated lab orders.

2. DOCUMENTATION

a. Pharmacists will place an order in the ~~EHR~~ electronic medical record (EMR) for initial IV vancomycin doses, dose or frequency modifications, or laboratory values.

b. Pharmacists will document rationale for all vancomycin regimens (initial or modifications) and pharmacokinetic assessments in a note in the ~~EHR~~ EMR.

3. TRAINING

a. Pharmacists will undergo clinical training and must ~~pass an initial and annual competency exam to~~be credentialed by medical staff every 2 years in order to provide services under the protocol.

b. The ~~competency exam will be developed and managed by the ID Pharmacist, clinical pharmacists, and ID physicians~~ credentialing process will be managed by the medical executive committee.

4. QUALITY ASSURANCE

a. The Pharmacy Department at ~~of ZSFG/~~LHH will have oversight of the pharmacist managed IV vancomycin protocol.

b. The ~~ID Pharmacist and cli~~Clinical p~~P~~harmacist ~~groups~~team will ensure regular review of the protocol, working in collaboration with ~~Pharmacy Department~~the Interdisciplinary Practices Committee, the Antimicrobial Stewardship Program and Laboratory Medicine.

c. Data describing program outcomes will be presented to the Pharmacy & Therapeutics Subcommittee (~~ZSFG/~~LHH), Antimicrobial Stewardship Program (~~ZSFG/~~LHH), and Antibiotic Subcommittee (ZSFG) periodically.

ATTACHMENT:

Appendix A: **Clinical Guidance for Adult IV Vancomycin Per-Pharmacy Dosing Protocol**

REFERENCES:

1. Adapted from ZSFG Adult Intravenous Vancomycin Per-Pharmacy Dosing Protocol.
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~~Original adoption: (YY/MM/DD) 19/xx/xx~~

Appendix A:

Clinical Guidance for Adult IV Vancomycin Per-Pharmacy Dosing Protocol

1. Gather pertinent info
    a. Patient Specific
        i. Age
        ii. ~~Gender~~Sex
        iii. Height
        iv. Weight
        v. Serum creatinine (most recent and trend)
        vi. Renal replacement therapy (hemodialysis, CRRT, peritoneal dialysis)
        vii. Allergies
        viii. Pregnancy status
        ~~viii.~~ix. Hemodynamic status (BP, HR, RR, temp)
    b. Infection Specific
        i. Indication, Goal Trough Level

Table 1: Goal Trough Levels

Indication	Goal Trough (mg/L)
Skin/Soft tissue infections, UTI	10-15
Bacteremia, Endocarditis, Meningitis, Pneumonia, Severe Sepsis, Osteomyelitis, Hardware Infections, Febrile neutropenia, or other serious infections not listed above	15-20

Note: if monitoring AUCs, the goal will generally be 400 – 600 mg*hr/L.

~~i.~~ii. Determine whether this is a new start or dose modification.
    1. Review current/ historic med list for prior vancomycin dose.
    2. Review patient chart for prior vancomycin levels, SCr

~~ii.~~iii. If applicable, review appropriateness of prior vancomycin levels
    1. Drawn at steady state?
        a. Usually defined as a level drawn just prior to the 4th or 5th dose.
    2. Drawn at the appropriate time?
        a. E.g. a true trough is drawn approximately 8 hours *after* prior dose when scheduled Q8h or 12 hours *after* prior dose when scheduled Q12h, etc.

2. Calculate estimated creatinine clearance (CrCL)
    a. Use Cockcroft-Gault equation.

$$\frac{(140 - \text{age}) * \text{weight}}{\quad} \quad (*0.85 \text{ if female})$$

72 * SCr

i. Use IBW- to calculate estimated CrCL for most patients.

IBW (male) = 50 kg + 0.91 * (cm > 152 cm)

IBW (female) = 45.5 kg + 0.91 * (cm >152 cm)

ii. Use ~~Corrected~~ Adjusted BW (if TBW >120% of IBW)

~~Corrected~~ Adjusted BW = IBW + 0.4 * (actual BW – IBW)

iii. Use TBW if TBW < IBW

iv. Consider ~~rounding~~ round up SCr to 0.7 mg/dL if < 0.7 mg/dL

v. Keep in mind this equation may underestimate CrCl if SCr is improving or overestimate CrCl if SCr is worsening; SCr trends must be considered when evaluating appropriate doses.

3. Calculate Initial Loading Dose
   a. Appropriate for most patients with a complicated infection (e.g. goal 15-20 mg/L)
      i. Critical illness requiring vasopressors.
      ~~i.~~ii. Bacteremia
      ~~ii.~~iii. Endocarditis
      ~~iii.~~iv. CNS infections (e.g. m~~M~~eningitis)
      ~~iv.~~v. Pneumonia
      ~~v.~~vi. Severe sepsis or septic shock
      ~~vi.~~vii. Osteomyelitis
   b. Vancomycin 20-25 mg/kg IV x1
      i. ~~(~~Bb~~b~~asede~~d~~ on **total BW**
      ii. ~~;~~ R~~r~~ounde~~d~~ to nearest 250 mg
      ~~vii.~~iii. ~~;~~ M~~m~~aximum 2 g dose~~)~~

4. Calculate Initial Maintenance Dose
   a. Recommend using UCSF vancomycin dosing nomogram.
      i. Based on total or adjusted body weight, CrCl as in ~~**tables**~~ **Table 2** below
      ii. Consider deviating from nomogram if appropriate based on prior doses and levels when applicable.

Table 2: Vancomycin Dosing Nomogram

~~ZSFG and~~ LHH IV Vancomycin Dosing Nomogram *~~For use in any patients at ZSFG and for patients ≤ 65 years old at LHH~~*				
	Use total body weight (kg) unless total BW > 120% IBW, then use adjusted BW			
CrCl (mL/min)	< 60	60-80	81-100	>100
>90 (complicated & age <65)	750 mg IV q8h	1000 mg IV q8h	1250 mg IV q8h	1500 mg IV q8h
>90 (complicated & age ≥65 or uncomplicated & age <65)	1000 mg IV q12h	1250 mg IV q12h	1500 mg IV q12h	1750 mg IV q12h
50-90	750 mg IV q12h	1000 mg IV q12h	1250 mg IV q12h	1500 mg IV q~~12~~8h Complicated & age <65 1000 mg IV q8h
15-49	750 mg IV q24h	1000 mg IV q24h	1250 mg IV q24h	1500 mg IV q24h
<15	10-15 mg/kg IV x1, then redose according to levels			
CRRT	10-15 mg/kg IV q24h			
HD	5-10 mg/kg (typically 500 mg) IV post-HD (after 15-25 mg/kg loading dose, as described above)			
PD	Maintenance dose based on random levels; typically re-dosed Q 5-7 days			

Recommendations assume stable CrCl.
CRRT = continuous renal replacement therapy, e.g. CVVH, CVVHD; HD = hemodialysis; PD = peritoneal dialysis
Complicated infection (e.g. goal trough requiring 15-20 mg/L)

~~b. May consider using a calculator tool~~
~~i. Epic Pharmacokinetic Navigator~~
~~ii. IDMP website: idmp.ucsf.edu → UCSFMC Adult Vancomycin Dosing and Monitoring Recommendations for guidance & downloadable PK calculator (excel)~~

~~https://idmp.ucsf.edu/vancomycin-dosing-and-monitoring-recommendations~~

~~LHH IV Vancomycin Dosing Nomogram > 65 years old~~	
	~~Use total body weight (kg) unless total BW > 120% IBW, then use adjusted BW~~

CrCl (mL/min)	35-50 kg	51 - 60 kg	61-80 kg	81-100 kg	> 100 kg
> 90	500-750 mg q12h	750 mg q12h	1000 mg q12h	1,250mg q12h	1,500 mg q12h
50-90	250-500 mg q12h	500 mg q12h	750 mg q12h	1,000 mg q12h	1,250 mg q12h
15-49	500-750 mg q24h	750 mg q24h	1,000 mg q24h	1,250 mg q24h	1,500 mg q24h
<15	10-15mg/kg x1 then redose according to levels				
CRRT	10-15 mg/kg q24h				
HD	5-10 mg/kg (typically 500mg) IV post-HD (after 15-25 mg/kg loading dose, as described above)				
PD	Maintenance dose based on random levels; typically re-dosed Q 5-7 days				

This table may be most relevant for older, more frail patients at LHH

Recommendations assume stable CrCl. CRRT = continuous renal replacement therapy, e.g. CVVH, CVVHD; HD = hemodialysis; PD = peritoneal dialysis

5. Consider calculating predicted trough if unsure of initial dose calculation
    a. Use ~~above~~ below calculator tools (section 9) or perform calculations by hand, below:
    b. Population estimate of V_d, k_e, CL_{vanc}

$CL = k_e V_d$ Vd = 0.7L/kg $CL_{vanc} = 0.75 * CrCL$ (L/hr) $t_{1/2} = 0.693/k_e$

$$Cpeak = \frac{Dose/t'}{Vd * K_e} * \frac{(1-e^{-kt'})}{(1-e^{-k\tau})} \qquad Ctrough = Cpeak * e^{-k(\tau-t')}$$

k, k_e = elimination rate constant Vd = Volume of Distribution

CL_{vanc} = vancomycin clearance Cpeak = predicted peak concentration

Ctrough = predicted trough concentration T' = infusion time

τ = dosing interval

6. ~~Determine appropriate time for level and order vancomycin trough (approximately 30 min prior to scheduled dose)~~Order Vancomycin level
    a. Typically prior to 4th dose, but there are numerous exceptions
        i. ~~Consider convenience~~ Specify date and time (approximately 30 minutes prior to scheduled dose)
        ii. ~~Prefer results~~Recommend ordering level during day shift when more pharmacists available to review during that time

Table 3: Guidance on Timing of Vancomycin Levels

Vancomycin Frequency	Typical Level Time
Q8h or Q12h	Trough level prior to 4th or 5th dose (prefer day shift)
Q24h (non dialysis and CRRT)	Trough level prior to 3rd or 4th dose
Intermittent Dosing by Level	Random level within 24 hours of dose (often with AM labs the following day)
Post HD	Random level prior to 2nd or 3rd dose (often with AM labs; should be drawn pre-HD)
Intermittent Dosing in Peritoneal Dialysis	Random level drawn 2 to 4 days after loading dose

~~b. Q8h or Q12h regimen: before 4th or 5th dose~~
~~c. Q24h regimen: before 3rd or 4th dose~~
~~d. Dose by level: within 24 hours of dose or with AM labs following day~~
~~e. Hemodialysis:~~
~~f. Intermittent HD: prior to 2nd or 3rd dose~~
~~g. Continuous HD (CRRT): prior to 3rd or 4th dose~~
~~h. Peritoneal dialysis: random level ~2 to 4 days after loading dose~~

~~i.~~b. When to draw early (e.g. prior to 2nd or 3rd dose)
   i. Severe AKI
      1. SCr > 2-fold increase from baseline
   ii. Fluctuating renal function
      1. SCr increased by ≥ 0.3 mg/dL from baseline or ≥ 2 or 3-fold increase from baseline
   iii. Other concern for toxicity
      1. Decreased urine output
      2. Increased BUN
   iv. Concomitant nephrotoxic agents; may include, but are not limited to the following:
      1. Aminoglycosides
      2. Amphotericin
      3. IV Contrast
   v. Consider asking RN to hold next vancomycin dose until level returns if high concern for supratherapeutic level

7. Order~~ing~~ SCr
   a. Baseline (~~&~~ within 24 hours of vancomycin initiation)
   b. Same day as any vancomycin level (unless on renal replacement therapy)

8. Evaluate level ~~as described in 1d~~
   a. Drawn at steady state?
      i. Usually defined as a level drawn prior to the 4th or 5th dose
   b. Drawn at the appropriate time?

i. For example, a true trough is drawn ~8 hours after the prior dose when on vancomycin Q8h or ~12h after prior dose when on vancomycin Q12h, etc.

c. Level within therapeutic range?

i. Adjust as necessary (see tables below for guidance)

Table 4: Guidance on Vancomycin Level Interpretation

For Patients not on ~~without~~ Dialysis or ~~on~~ Continuous Renal Replacement Therapy

Measured vancomycin trough (mg/L)	Goal vancomycin trough (mg/L)	Action*
< 5	10-15 and 15-20	Change interval and increase dose
5-10	10-15 and 15-20	Change interval or increase dose
10-15	10-15 15-20	No change Increase dose or change interval
15-20	10-15 15-20	Consider changing interval or decreasing dose No change
20-25	10-15 and 15-20	Change interval or decrease dose
> 25-34	10-15 and 15-20	Change interval and/or decrease dose; consider holding vancomycin until level < 20 mg/L
≥ 35	10-15 and 15-20	Hold vancomycin, order random level and Scr within 12 to 24 hours. Change interval and decrease dose. Resume vancomycin when level < 20 mg/L

*Assumes level is drawn at steady-state and at appropriate time relative to prior dose. Interpret other levels with caution. Typical maximum single dose is 2 grams. This is a general guidance. There may be circumstances when it would be appropriate to continue the current dose and recheck a level, particularly if the level is only slightly out of the therapeutic range.

Table 5: Guidance on Vancomycin Level Interpretation in Patients on iHD

For patients on

Intermittent Hemodialysis (iHD)

Vancomycin level (mg/L) measured BEFORE HD	Maintenance Dose to be Administered POST-HD
< 10	1000 mg
10-15	500 – 750 mg
16-25	500 mg
> 25	Hold vancomycin x1, check level prior to next HD session and decrease post-HD dose

9. Calculate Dose Modification

   Suggested mMethods ~~to Calculate Dose Modification~~are listed below

   a. PK Calculator

      i. Vancopk.com

      ~~i.~~ii. UCSF Adult Vancomycin Dosing (excel)

      ~~ii. Epic kinetics Navigator~~

   b. Linear proportion

      i. Most appropriate when modifying dose but keeping same interval

      ii. $\frac{\text{Ctrough observed}}{\text{Ctrough desired}} = \frac{\text{Current TDD}}{\text{New TDD}}$

   c. Calculate based on patient specific k (see equations on following page)

      i. Using measured trough level

      ii. Population estimate of Vd

      iii. Predicted peak level

Equations to calculate patient specific PK parameters:

$k = \frac{\ln(C_{peak}/C_{trough})}{\Delta t}$ $\quad C_{peak\ (predicted)} = C_{trough\ (measured)} + \Delta C$ $\quad \Delta C = \frac{Dose}{V_d}$

      iv. Calculate half-life: $t_{1/2} = 0.693/k$

      v. Determine appropriate interval taking into account patient age, calculated half-life

Estimated Half-life (hours)	Dosing Interval
< 6	Q6h
≥ 6 and ≤ 10	Q8h
> 10 and ≤ 18	Q12h
> 18 and ≤ 24	Q24h
> 24	Consider dosing by level

      vi. Note: most adult patients will accumulate to supratherapeutic levels when using Q6h dosing intervals; exceptions may include very young, pregnant, or critically ill patients. Most elderly patients will accumulate to supratherapeutic levels when using Q8h dosing intervals; proceed with caution. Repeat ~~step #5 to~~ predicted trough ~~level~~ calculation if uncertain of modified dose recommendation.

10. Repeat Vancomycin trough level

   I. Every 2-3 days in patients with unstable renal function or on concomitant nephrotoxic drugs or if initial trough is at the higher end of the range.

   II. Every 5-7 days in patients with stable renal function and therapeutic levels at steady state on a stable dose

a. More frequently as needed if signs of fluctuating renal function, such as a SCr that has consistently trended up on consecutive days or has increased or decreased by > 0.3 mg/dL in 24 hours.

Created: 1/2019
Reviewed: 12/2023
Approved: X/2024

Deletion Medical Services Policies and Procedures

BILLING FOR PHYSICIAN SERVICES: ACUTE HOSPITAL VISITS

ACUTE CARE UNITS: Medical and Rehabilitation

INITIAL HOSPITAL CARE CODES

99221 Initial hospital care or observation care, per day, for the evaluation and management of a patient, which requires these 3 components. a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded:

- A detailed or comprehensive history
  40 minutes met or exceeded on the day of encounter (midnight to midnight); or
- A detailed or comprehensive examination; and • Medical decision making that is straightforward or of low complexity

Low severity
30 minutes at the bedside and on the patient's hospital floor or unit

99222 Initial hospital or observation care, per day, for the evaluation and management of a patient, which requires these 3 components. a medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded:

  55 minutes met or exceeded on the day of encounter (midnight to midnight); or
- A comprehensive history
- A comprehensive examination; and
- Medical decision making of moderate complexity

Moderate severity
50 minutes at the bedside and on the patient's hospital floor or unit

99223 Initial hospital or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for the code selection, 75 minutes must be met or exceeded:

patient, which requires these 3 components.

- 75 minutes met or exceeded on the day of encounter (midnight to midnight); or
- A comprehensive history
- A comprehensive examination; and
- Medical decision making of high complexity

High severity
70 minutes at the bedside and on the patient's hospital floor or unit

SUBSEQUENT HOSPITAL CARE CODES

99231 Subsequent hospital or observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 componentsa medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded:

- A problem focused interval history
- A problem focused examination25 minutes met or exceeded on the day of encounter (midnight to midnight); or
- Medical decision making that is straightforward or of low complexity

Patient is stable, recovering or improving
15 minutes at the bedside and on the patient's hospital floor or unit

99232 Subsequent hospital or observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 componentsa medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded:.

- An expanded problem focused interval history
- An expanded problem focused examination 35 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- Medical decision making of moderate complexity

Patient is responding inadequately to therapy or has developed a minor complication.

25 minutes at the bedside and on the patient's hospital floor or unit

99233 Subsequent hospital or observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components.a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded:

- A detailed interval history
- A detailed examination 50 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- Medical decision making of high complexity

Patient is unstable or has developed a significant complication or significant new problem.
35 minutes at the bedside and on the patient's hospital floor or unit

OBSERVATION OR INPATIENTHOSPITAL CARE CODES, ADMISSION/DISCHARGE SAME DATE

99234 Observation or inpatient hHospital or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 componentsa medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded:

- A detailed comprehensive history
- A detailed or comprehensive examination; and 45 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- Medical decision making that is straightforward or of low complexity
- Admission and Discharge on the same date

Low severity

99235 Observation or inpatient hHospital or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 componentsa medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded:

- A comprehensive history
  - A comprehensive examination; and70 minutes met or exceeded on the day of the encounter (midnight to midnight); or
  - Medical decision making of moderate complexity
  - Admission and Discharge on the same date

Moderate severity

99236 Observation or inpatient hHospital or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 componentsa medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter of code selection, 85 minutes must be met or exceeded:

- A comprehensive history
  - A comprehensive examination; and 85 minutes met or exceeded on the day of the encounter (midnight to midnight); or
  - Medical decision making of high complexity
  - Admission and Discharge on the same date

High severity

HOSPITAL DISCHARGE SERVICES

99238 Hospital discharge day management, 30 minutes or less

99239 Hospital discharge day management, more than 30 minutes

NURSING FACILITY CARE:

NF CARE UNITS (formerly SNF)

Nursing facility service involves active, definitive professional care of a patient.

NURSING FACILITY SERVICES CODES

Annual Health and Physical

99318 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 components.

- **A detailed interval history**
- **A comprehensive examination; and**
- **Medical decision making that is of low to moderate complexity**

Patient is stable, recovering or improving
30 minutes at the bedside and on the patient's hospital floor or unit

This code cannot be used on the same date of service as NF service Codes 99304-99316. 99318 (Annual History and Physical) is deleted: To report see codes 99307-99310

Monthly and Other Visits

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 components.a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded:

- A problem focused interval history 10 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- A problem focused examination
- Straightforward medical decision making

Patient is stable, recovering or improving
10 minutes at the bedside and on the patient's hospital floor or unit

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 components.a medically appropriate history

and/or examination and low level medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded:

- An expanded problem focused interval history 15 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- An expanded problem focused examination
- Medical decision making of low complexity

Patient is responding inadequately to therapy or has developed a minor complication. 15 minutes at the bedside and on the patient's hospital floor or unit

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 components.a medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded:

- A detailed interval history 30 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- A detailed examination
- Medical decision making of moderate complexity

Patient has developed a significant complication or a significant new problem 25 minutes at the bedside and on the patient's hospital floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 components.a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded:

- A comprehensive interval history 45 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- A comprehensive examination
- Medical decision making of high complexity

Patient has developed a significant new problem requiring immediate physician attention 35 minutes at the bedside and on the patient's hospital floor or unit

Admission Health History and Physical

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 components.a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total

time on the date of the encounter for code selection, 25 minutes must be met or exceeded:

- A detailed or comprehensive history 25 minutes met or exceeded on the day of encounter (midnight to midnight); or
- A detailed comprehensive examination; and
- Medical decision making that is straightforward or of low complexity

Low severity
25 minutes at the bedside and on the patient's hospital floor or unit

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 components.a medically appropriate history and/or examination and moderate level medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded

- A comprehensive history 35 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- A comprehensive examination; and
- Medical decision making of moderate complexity

Moderate severity
35 minutes at the bedside and on the patient's hospital floor or unit

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 components.a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded:

- A comprehensive history 45 minutes met or exceeded on the day of the encounter (midnight to midnight); or
- A comprehensive examination and
- Medical decision making of high complexity

High severity
45 minutes at the bedside and on the patient's hospital floor or unit

RCT Meetings

99367 Medical team conference with resident care team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician. USE THIS CODE FOR RCT MEETINGS.

(This service may be documented for productivity purposepurpose, but service is not billable to a payer.)

Discharges

99315 Nursing facility discharge day management; 30 minutes or less.

99316 Nursing facility discharge day management; more than 30 minutes.

BILLING FOR PHYSICIAN SERVICES: CONSULTATION

A Consultation is considered here to include those services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation and/or treatment of a patient's illness or problem. Consultations may be given in the acute hospital, nursing facility, or clinic setting.

CONSULTATION:

Effective January 1, 2021 the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for **Medicare Part B** payment.

Effective for Outpatient Consultation services (99241-99245) furnished on or after January 1, 2021, providers should code an office/outpatient patient evaluation and management visit (99202-99215) for all new and established patients seen in the office setting using either time or medical decision making (MDM) to decide the level of the office/outpatient E/M visit.

Old **Outpatient Consultation Codes** Effective Jan 1, 2021 Office visits include both face: face and non-face: face time spent by the provider on the encounter date	
New Patient	Established Patient
99201 Do Not Use- Invalid as of 1/1/21	99211
99202	99212
99203	99213
99204	99214
99205	99215

EVALUATION AND MANAGEMENT

Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient clinic or other ambulatory facility.
As of Jan 1, 2021, the E/M level is determined by the MDM or the total time.
The level of HPI or physical exam is no longer used toward the E/M level.

NEW PATIENT

99201 – DO NOT USE. NO LONGER VALID AS OF JAN 1, 2021

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and:

- Straightforward medical decision making; or

- When using total time on the date of the encounter for code selection, 15 -29 minutes of total time is spent on the encounter date. must be met or exceeded

- **99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and:

  A low level of medical decision making; or

- A low level of medical decision making
  - When using total time on the date of the encounter for code selection, 30 -44 minutes of total time is spent on the encounter date.must be met or exceeded

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and:

- A moderate level of medical decision making; or
- When using time for code selection, 45-59 minutes of total time is spent on the encounter date.
  When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and:

- A high level of medical decision making; or
- When using total time on the date of the encounter for code selection, 60 -74 minutes of total time is spent on the encounter date.must be met or exceeded.

ESTABLISHED PATIENT

Received prior professional services from physician or qualified health care professional or another physician or qualified health care professional in the same practice in the exact same specialty or subspecialty in the previous 3 years.

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.

- Presenting problems are minimal
- No time descriptor or reference (Nurse visits)

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and:

- Straightforward medical decision making; or
- When using total time on the date of the encounter for code selection, 10-19 minutes of total time is spent on the encounter datemust be met or exceeded

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and:

- A low level of medical decision making; or
- When using total time on the date of the encounter for code selection, 20-29 minutes of total time is spent on the encounter datemust be met or exceeded

- **99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and:

A moderate level of medical decision making; or
When using total time on the date of the encounter for code selection, 30-39 minutes of total time is spent on the encounter
- A moderate level of medical decision making
- When using time for code selection, 30-39 minutes of total time is spent on the encounter datemust be met or exceeded

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and:

- A high level of medical decision making; or
- When using total time on the date of the encounter for code selection, 40-54 minutes of total time is spent on the encounter datemust be met or exceeded

Old Inpatient Consultation Codes	Crosswalk Codes, effective January 1, 2010
99251	99221 or 99304
99252	99221 or 99222 or 99304 or 99305
99253	99222 or 99.05
99254	99222 or 99223 or 99305 or 99306
99255	99223 or 99306

Hospital Inpatient Services

The following codes are used to report evaluation and management services provided to hospital inpatients.

Initial Hospital Care

99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 components.

- A detailed or comprehensive history
- A detailed or comprehensive examination: and
- Medical decision making that is straightforward or of low complexity ○ Low severity ○ 30 minutes at the bedside and on the patient's hospital floor or unit

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 components.

- A comprehensive history
- A comprehensive examination: and
- Medical decision making of moderate complexity ○ Moderate severity ○ 50 minutes at the bedside and on the patient's hospital floor or unit

BILLING FOR PHYSICIAN SERVICES: CONSULTATION

Laguna Honda Hospital Medical Services Policies & Procedures

~~File: MSPP 003-06 **BILLING FOR PHYSICIAN SERVICES: CONSULTATION**~~ ~~Revised March 10, 2021~~

~~**99223** Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 components.~~

- ~~A comprehensive history~~
- ~~A comprehensive examination: and~~
- ~~Medical decision making of high complexity o High severity~~

~~o 70 minutes at the bedside and on the patient's hospital floor or unit~~

Office or Other Outpatient Consultations – Medi-Cal billing only

Effective January 1, 2010, the following codes are no longer recognized by Medicare, valid for Medi-Cal only.

99241 – Deleted, no longer valid effective 1/1/2023 Office consultation for a new established patient, which requires these 3 components.

- A problem focused history
- A problem focused examination: and
- Straightforward medical decision making. ○ Self limited or minor

○ 15 minutes face-to-face with patient and/or family

- **99242** Office or other outpatient consultation for a new or established patient, which requires these 3 componentsa medically appropriate history and /or examination and: .
  - An expanded problem focused history • An expanded problem focused examination: and •Straightforward medical decision making; or
  - When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded:

Straightforward medical decision making. ○ Low severity

○ 30 minutes face-to-face with patient and/or family

99243 Office or other outpatient consultation for a new or established patient, which requires these 3 components.a medically appropriate history and/or examination and :

- Medical decision making of low complexity; or
- A detailed history When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- A detailed examination: and

Medical decision making of low complexity ○ Moderate severity

○ 40 minutes face-to-face with patient and/or family

99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and: these 3 components.

- Medical decision making of moderate complexity; or
- A comprehensive history When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
- A comprehensive examination: and
- Medical decision making of moderate complexity ○ Moderate to high severity

○ 60 minutes face-to-face with patient and/or family

99245 Office or other outpatient consultation for a new or established patient, which requires requires these 3 components. a medically appropriate history and/or examination and:

- Medical decision making of high complexity; or
- A comprehensive history When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded
- A comprehensive examination: and
- Medical decision making of high complexity ○ Moderate to high severity

○ 80 minutes face-to-face with patient and/or family

- Medical decision making of high complexity ○ Moderate to high severity

○ 80 minutes face-to-face with patient and/or family

Inpatient Consultations – Medi-Cal billing only

Effective January 1, 2010, the following codes are no longer recognize by Medicare, valid for Medi-Cal only.

99251 -Deleted, no longer valid effective 1/1/23 Inpatient consultation for a new or established patient, which requires these 3 components.

- A problem focused history
- A problem focused examination: and
- Straightforward medical decision making. ○ Self limited or minor

○ 20 minutes at the bedside and on the patient's hospital floor or unit

99252 Inpatient consultation for a new or established patient, which requires these 3 components.a medically appropriate history and/or examination and:

- Straightforward medical decision making; or
- An expanded problem focused history • When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded
- An expanded problem focused examination: and •
  Straightforward medical decision making. ○ Low severity

○ 40 minutes at the bedside and on the patient's hospital floor or unit

99253 Inpatient consultation for a new or established patient, which requires these 3 components.a medically appropriate history and/or examination and:

- A detailed history
- A detailed examination: and
- Medical decision making of low complexity o Moderate se; orverity
- When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded

○ 55 minutes at the bedside and on the patient's hospital floor or unit

99254 Inpatient consultation for a new or established patient, which requires these 3 components.a medically appropriate history and/or examination and:

- Medical decision making of moderate complexity; or
- When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

- A comprehensive history
- A comprehensive examination: and
- Medical decision making of moderate complexity ○ Moderate to high severity

○ 80 minutes at the bedside and on the patient's hospital floor or unit

99255 Inpatient consultation for a new or established patient, which requires these 3 components.a medically appropriate history and/or examination and:

- Medical decision making of high complexity; or
- When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded

- A comprehensive history
- A comprehensive examination: and
- Medical decision making of high complexity ○ Moderate to high severity
  - ○ 110 minutes at the bedside and on the patient's hospital floor or unit

Revised: 11/04/14, 20/09/03, 24/06/27 (year/month/day)

Revised Nursing Policies and Procedures

DISCHARGE PROCEDURE TO ACUTE

POLICY:

1. A resident who is sent to any acute facilities including Psychiatric Emergency Services are considered discharged if resident has not returned to Laguna Honda Hospital within 24 hours from the time of transfer.

2. A resident who is transferred to Pavilion Mezzanine Acute (PMA) ~~, except for transfusion of blood products, are~~ is considered discharged. (Refer to NPP ACUTE 2.0 Documentation of Care – Acute Unit)

3. A resident who is sent to acute is considered Leave of Absence (LOA) and not "discharge" in EPIC.

4. Licensed nurse (LN) will verify acute admission for those residents that are sent out to emergency room for evaluation. Bedhold clock begins as soon as LOA is entered in EPIC.

~~3.~~5. A bed hold status will remain in effect for 7 days. The resident will be processed as a final discharge on the 8th day from the date of transfer. (Refer to HWPP 20-14 Leave of Absence and Bed Hold)

~~4. License Nurse will verify acute admission for those residents that are sent out to emergency room for evaluation. Only when acute admission is confirmed, that resident is discharge from LHH and bed hold starts.~~

PURPOSE:

To describe procedure when a resident is transferred to an acute facility.

PROCEDURE:

Discharge: movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) To a bed in an acute care facility, including but not limited to the licensed general acute care portion of LHH; or (2) To the community, which may include the resident's home or a facility that provides a lower level of care.

NOTE: A resident who is sent to acute is considered LOA and not "Discharge" on EPIC

A. Process

~~1. The physician, LN, or any member of the Resident Care Team (RCT) will inform the resident, family member, or his/her representative of any acute medical problem and the reason for transfer to the acute facility.~~

~~2.~~1. The LN will request physician to complete the discharge order, which includes the reason for transfer to acute facility.

~~3.~~2. The Inter-Facility Transfer Records, printout of resident profile, copy of Advanced Directives, and Physicians Order for Life Sustaining Treatment (POLST) (if available) and transfer documents from the electronic health record (EHR) (which includes interfacility transfer records, resident's profile and diagnosis, hospital course, medications, treatments, dietary requirements, allergies, treatment plan and advance directive documents) will be sent with the resident upon transfer.

3. The LN will arrange transportation -/- ambulance based on medical urgency. For life-threatening situations requiring immediate response of a paramedic team, LN may ~~activate a~~call 911 ~~call~~ per physician's order.
~~4.~~
4. For Psychiatric Emergency Services discharges, refer to Psychiatric Emergency Policy

~~5. The LN will document in the Notes section the condition of the resident at the time of discharge and notification of the responsible party.~~

5. Notifications:
   a. Team Physician notifies the family or legal representative, or delegates this responsibility to the attending physician, and shall document this notification/delegation in the medical record.
   b. Licensed nurse notifies nursing operations, food services and social services.
   c. Licensed nurse notifies clinic or other departments for cancelling any future appointment(s) when indicated.
   ~~6. The LN is responsible for informing the Food Services and other departments such as clinics for cancelling any future appointment/s when indicated.~~

~~7. The LN is also responsible for notifying the Nursing Operations and Social Services when a resident is discharge to acute facility.~~

6. All medications in the resident~~"~~'s cassette will be sent back to pharmacy.

B. Documentation
~~8.~~
7. The LN will document the condition of the resident at the time of discharge, and notification of the responsible party, in the nurses' notes.

Nursing will complete an
~~9.~~8. ~~i~~inventory of ~~r~~Resident~~"~~'s ~~P~~property and ~~V~~valuables on the Inventory Property Sheet (Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss):

~~a. Itemize all property and valuables sent with the resident.~~

~~b. Label and secure the remaining valuables and resident's belongings.~~

~~10.~~9. ~~Enter the discharge to acute facility or PMA on the electronic health record~~Discharge resident from the unit in the EHR.

~~11.~~10. Complete the RAI/MDS Discharge within 24 hours.

~~12. Close the medical record:~~

~~13. For Psychiatric Emergency Services discharges, refer to Psychiatric Emergency Policy~~

~~14. If resident requires bed hold, refer to LHHPP File # 20-02 Bed Hold.~~

CROSS REFERENCES

Hospitalwide Policy and Procedure

LHHPP File #20-14 Leave of Absence and Bed Hold ~~LHHPP File #20-02 Bed Hold~~
LHHPP File #22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP File #~~-~~50-02 Resident Trust Fund

Nursing Policy and Procedure

NPP ACUTE 2.0 Documentation of Care – Acute Unit
~~NPP C 5.0 Maintaining Accurate Neighborhood Census~~

Revised: 2002/08, 2008/10, 2015/03/10; 2019/07/09; 2024/02/28

Reviewed: 2019/07/09

Approved: 2019/07/09

EMERGENCY INTERVENTION FOR CHOKING

POLICY:

1. Nursing staff must follow facility's procedures (e.g., urgent speech referrals) to safely manage residents who are identified to be at risk of aspiration.

2. The Code Blue process shall be utilized for choking events, unless specific directive has been expressed in the resident's/patient's Advanced Directive, stating otherwise.~~Residents, regardless of code status, who are observed to manifest signs of choking must promptly be attended to with rescue interventions and activate code blue.~~

3. All nursing staff ~~wi~~shall be trained in conscious emergency identification and intervention for choking during orientation, annually, and as needed.

4. All licensed nurses and patient care assistants (PCA) ~~must be proficient in emergency intervention for all individuals who are choking as evidenced by current CPR certification~~shall be trained and remain current in Basic Life Support (BLS).

PURPOSE:

To ensure that residents who are choking receive prompt, effective interventions.

DEFINITION:

Choking is obstruction or constriction of the airway passage due to a foreign body such as inadequately chewed food which can result into respiratory blockage or even death. ~~The universal sign of choking is clutching of the neck with hands; other choking signs include ineffective cough or no cough at all, inability to speak, possible cyanosis, high-pitched noise while inhaling or no noise at all, or poor or weak air exchange. Choking is considered a medical emergency and prompt intervention is needed.~~

~~Heimlich~~ Abdominal thrust maneuver is a technique intended to remove foreign body from the airway passage to relieve resident from choking. This maneuver consists of repeated abdominal thrusts by wrapping your arms around the resident's waist from behind and making a fist with one hand and placing it against the resident's abdomen.

SIGNS:

The universal sign of choking is clutching of the neck with hands; other choking signs include ineffective cough or no cough at all, inability- to speak, possible cyanosis, high-pitched noise while inhaling or no noise at all, or poor or weak air exchange. Choking is considered a medical emergency and prompt intervention is needed.

While anyone experience an episode of choking, specific residents who are at risk for aspiration are identified with a pink sticker.in the following locations:

- Bed card (above bed)
- Hallway
- Mobility devices (wheelchairs, geri-chairs, canes, front wheel walkers, etc.)

The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual resident needs and risks.

PROCEDURE:

~~**A. Responding to resident who manifests signs of possible choking**~~

~~1. If resident remains alert and responsive but exhibits signs of choking such as inability to breathe, cough, or speak, assess resident's mouth for any foreign bodies, perform Heimlich maneuver, and have a fellow employee activate Code Blue.~~Refer to: https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco

~~2.~~○ If resident is able to expel or nursing staff is able to retrieve the object that caused the blockage, the licensed nurse will retain the object until further instructions from the physician and nursing supervisor.

~~3.~~○ After a choking incident, the registered nurse will perform a thorough assessment, inform the physician of assessment data and request for additional interventions (e.g., urgent speech referral, update in advanced directive, or downgrading diet). (Refer to HWPP 26-02: Management of Dysphagia and Aspiration Risk)

~~**B. Refer to Attachment for Choking Interventions for a Conscious and Unconscious Resident**~~

~~C.~~**A. Documentation**

1. Licensed Nurse is to document the procedures and the condition of the resident, pre and post choking incident, in the electronic health record (EHR) and update resident care plan.

REFERENCES:

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

American Heart Association, BLS for Healthcare Providers 202011~~1~~

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-16 Code Blue
26-02 Management of Dysphagia and Aspiration Risk
B5.0 Resident Identification and Color Codes

Revised: 2000/08, 2005/01, 2010/03, 2013/11/01, 2014/03/25, 2019/03/12; 2024/01/02

Reviewed: 2019/03/12

Approved: 2019/03/12

ATTACHMENT:

~~**A. Choking Intervention for a Conscious Resident**~~

~~1. Stand or kneel behind the resident and wrap your arms around the resident's waist.~~

~~2. Make a fist with one hand.~~

~~3. Place the thumb side of your fist against the resident's abdomen, in the midline, slightly above the navel and well below the breastbone.~~

~~4. Grasp your fist with your other hand and press your fist into the victim's abdomen with a quick, forceful upward thrust.~~

~~5. Repeat thrusts until the object is expelled from the airway.~~

~~6. Give each new thrust with a separate, distinct movement to relieve the obstruction.~~

~~**B. Choking Intervention for an Unconscious Resident**~~

~~1. Resident who manifest signs of choking may be initially responsive; however if airway passage continues to be obstructed, resident may become unresponsive.~~

~~2. If resident became unresponsive or if found responsive, activate Code Blue.~~

~~3. Lower the resident to the ground and begin CPR, starting with compressions.~~

~~4. Every time you give a breath, open mouth and check for objects blocking the airway passage. Remove objects from mouth if visible.~~

~~5. If unable to see objects, continue to perform CPR. Do not do a blind sweep.~~

Deletion Nursing
Policies and Procedures

UTILIZATION AND MONITORING OF INTERNAL AND EXTERNAL PER DIEM / P103 NURSING PERSONNEL

POLICY:

1. The Nurse Manager or the Nursing Supervisor will monitor the Per Diem Nurse performance and adherence to the Per Diem policy and contract.

2. The Per Diem nurse working at Laguna Honda Hospital and Rehabilitation Center (LHH) is clinically responsible to the Nurse Manager/Charge Nurse of the assigned unit and is administratively responsible to Nursing Operations.

3. Minimum work commitment for each External Per Diem nurse is four (eight hours) shifts per month. The External Per Diem nurses, who work 64 hours or less a month, must commit to work one full weekend (Saturday and Sunday) per month. The External Per Diem nurses, who work more than 64 hours per month, must commit to work 2 full weekends per month.

4. The Nursing Operations Supervisor will monitor the frequency of self cancellations.

5. Per Diem nurses are expected to comply with all Policies and Procedures of the Nursing Department.

6. The Nursing Operations Supervisor is responsible for monitoring the work time of DPH clinic/unit/department Per Diem staff.

PURPOSE:

The need for Per Diem / P103 licensed staff is evaluated critically because of the fiscal impact to the operation and will be used to address unplanned staffing needs that impact resident care.

BACKGROUND:

The Per Diem Nurse / P103 is a civil service non-benefited Registered Nurse (RN) or Licensed Vocational Nurse (LVN) / Licensed Psychiatry Technician (LPT) who is hired to augment staffing on the nursing units.

Internal Per Diem / P103: A RN who also holds a permanent Civil Service classification anywhere in the (Department of Public Health (DPH).

External Per Diem / P103: A RN who does not hold a permanent Civil Service classification anywhere in the DPH.

PROCEDURE:

A. Hiring Procedure

1. The RN (External P103) and LVN interested in working Per Diem will contact and interview with the Nurse Recruiter. The interview will include completion of the application form, validation of current California Registered or Vocational Nurse license and current CPR certificate and obtaining a signed release for employment verification.

2. The Nurse Recruiter in collaboration with the Nursing Directors for Clinical Program and Nursing Director of Operations will determine area(s) for which the external per diem nurse is qualified and interested in working, and will review available positions and shifts.

3. The Nurse Manager, Nurse Recruiter, or Nurse Educator will administer a written test of nursing knowledge and drug calculation for the appropriate clinical areas (i.e., Medical-Surgical, Psychosocial, Geriatrics, etc). The Nurse Manager will forward exam material and successful results to the Nurse Recruiter who will contact the candidate to schedule appointment for employment processing with the Human Resource Service.

4. The Nurse recruiter will coordinate employment processing which will include review of Per Diem Policy and Procedure, initiation of Per Diem Nurse Contract, and completion of Department of Human Resource employment packet. The Nurse Recruiter sends the candidate to the Human Resource Service office to complete the required personnel forms and be scheduled for physical examination with the Center for Municipal & Occupational Safety & Health (CMOSH) and for finger printing.

5. The Nurse Recruiter will forward the candidate's file containing copy of application, and license, current CPR card, SS card, Request to Hire, exam results and Per Diem Contract to Nursing Operations Supervisor to complete processing (One-Staff, etc).

B. Orientation Procedure

1. The Unit Nurse Manager will arrange for the External Per Diem nurse's orientation to the assigned nursing unit. The orientation period is for a total of 40 hours. The unit Preceptor or Nurse Manager will review the Per Diem nurse's team leading skills and incorporate team leading into the orientation where appropriate.

2. The Nursing Education Department will schedule the newly hired External Per Diem nurse to attend the earliest Hospital Orientation. This program will include orientation to OBRA/Title 22 and Hospital required classes.

3. Once oriented to a unit or area, the External Per Diem nurse's contract will then include that unit or area.

4. The External Per Diem Nurse must attend all required mandatory classes as specified by the Nursing Department. Failure to comply with this requirement will lead to termination of per diem status.

C. Work Commitment

1. Self-cancellation calls must be preceded as follows:

AM Shift	by 2030 hour	(8:30 PM)
DAY Shift	by 0430 hour	(4:30 AM)
PM Shift	by 1230 hour	(12:30 PM)

Self-cancellations with a greater frequency than:

a. three weekday shifts or 2 weekend shifts in a three month period;
b. three weekend shifts in a six-month period will lead to automatic termination of employment

2. The Nursing Operations Supervisor will re-evaluate employment status and take necessary action if the External Per Diem nurse has not submitted any scheduled shifts as stipulated in the contract.

D. Supervising Per Diem Practice

1. The External Per Diem Nurse will receive a written evaluation by the Preceptor/ Nurse Manager/Nursing Operations Supervisor at the end of orientation. If this evaluation is unsatisfactory, the External Per Diem nurse will meet with the Nursing Operations Supervisor, Nurse Manager and Preceptor to determine the next course of action.

2. The External Per Diem Nurse will be evaluated within 90 calendar days and one year from the date of hire and annually thereafter. The Nursing Operations Supervisor will coordinate the Performance Appraisal conference with input for the clinical performance portion provided by the Nurse Managers/Charge Nurses.

3. The Nursing Operations Supervisor will be responsible for monitoring the External Per Diem nurse's attendance, punctuality, and adherence to work commitment contract, license renewal, policies & standards; and for initiating disciplinary action when appropriate.

4. The Nursing Operations Supervisor will be responsible for monitoring the External Per Diem Nurse's clinical performance. In the event of inadequate performance, the Unit Nurse Manager will conference with the Nursing Operations Supervisor. Conference documents will be maintained in the External Per Diem Nurse's personnel file.

E. Additional Responsibilities of Per Diem Staff

1. Per Diem nurses are responsible for reading all new and revised Policies and Procedures available in the Nursing Office or on line in assigned units.

2. Per Diem nurses are responsible for immediately communicating changes in address/telephone to the Nursing Office and Human Resource Department.

F. Floating

1. In the event that it is necessary for a staff nurse to float, consideration will be given to both the External Per Diem staff (based on her/his contract) and regular staff on duty. Management shall select the appropriate personnel to float depending on specific circumstances.

2. Float assignments are based on competency.

3. A Per Diem Nurse is expected to float to any area to which he/she has been oriented or in which she has competency.

4. Refusal to float within the above guidelines constitutes "refusal of assignment" and appropriate disciplinary action will be taken.

G. Scheduling of Internal and External Per Diem / P103 Nurse

1. **Six-Week Advance Schedule**

a. Internal Per Diem P103 RN can be scheduled up to 24 hours per week, but no more than 40 hours per pay period based on the seniority in the following order:
   i. Within the unit.
   ii. Internal P103's who have a regular RN appointment at DPH.
   iii. External P103s

b. If Inside Per Diem P103s are not available or have been awarded their 24 hours in a week, then an External Per Diem P103s can be scheduled, not to exceed 40 hours per week.

2. Two-Week Advance Schedule

If unfilled staffing needs exist after close of posted bidding period, all P103s (Internal and External) will be considered for scheduling on a first-come, first-serve basis.

3. Unanticipated Staffing Needs (Short Call List)

Those nurses who indicated availability for short call, i.e. in a timeframe proximal to the shift, will be called in order of seniority. Management retains the right of assigning mandatory overtime to the regular Civil Service staff, after seeking volunteers to work as P103. Overtime maybe offered to P103 nurses to prevent the need to require mandatory overtime of a permanent staff nurse.

Original: 10/2008

Revised: 03/25/2014

Reviewed: 03/25/2014

Approved: 03/25/2014

UTILIZATION OF OVERTIME STAFF

POLICY:

1. Per the collective bargaining agreement, overtime will be awarded based on seniority on a rotational basis.

2. Those employees who are not reached due to lower seniority and who want to continue to be considered for overtime will roll over to the next month to allow a fair distribution of overtime.

3. Overtime is not guaranteed to anyone; this has been discussed and agreed upon by the union.

4. Based on clinical needs, the department can impose mandatory overtime.

5. Due to resident safety and well-being of the staff, only 24 hours of overtime work is permitted per week (Saturday to Friday), maximum of 40 hours per pay period, and a total of 1040 hours per Fiscal Year (July 1- June 30).

PURPOSE:

The need for overtime is to address unplanned staffing needs that impact resident care.

PROCEDURE:

An employee who volunteers to sign-up for overtime agrees to the following guidelines and principles:

A. All overtime assignments are made to support resident care. Nursing Office staff will not pre-designate unit assignment. Staff agrees to work in whichever unit there is a need.

B. Staff needs to have at least 6 months of seniority before becoming eligible to sign up for overtime.

C. Staff are allowed up to 16 hours of sick time usage in the 30 days prior to an overtime assignment. If the sick time usage exceeds 16 hours within this 30 days, any overtime scheduled will be cancelled in the next 30- day period.

D. Employee will observe the call-in for self cancellation of OT deadline as follows:

AM Shift	by 2030 hour	(8:30 PM)
DAY Shift	by 0430 hour	(4:30 AM)
PM Shift	by 1230 hour	(12:30 PM)

E. It is the employee's responsibility to provide the nursing department a contact number (cell preferred) where staff can easily be contacted for scheduling or cancellation (no answering machines that screen calls, etc). When overtime is being scheduled, if the staff is not available, the next person on the list will be contacted.

F. If staff is contacted to work overtime and he/she declines, cancels, or refuses because he/she does not like the assignment, the staff member will be placed at the end of the list

regardless of seniority. Staff will also go to the end of the list if he/she is unavailable more than twice in a 60-day period.

G. Staff hired to work OT maybe given an initial unit assignment however, the department reserves the right to reassign the staff based on the operational needs of the department. If the employee refuses to accept the new unit assignment, he/she could be charged with refusal of assignment, abandonment of post, resident endangerment, up to and including dismissal.

REFERENCE:

Collective Bargaining Agreement, March 2007.

Original: 10/2008

Revised: 03/25/2014

Reviewed: 03/25/2014

Approved: 03/25/2014

Laguna Honda Hospital and Rehabilitation Center
Interdisciplinary Practices Committee

STANDARDIZED PROCEDURE – ADVANCED PRACTICE NURSE (NP/CNS) PREAMBLE

Title: Wound Management

I. Policy Statement

A. It is the policy of Laguna Honda Hospital (LH) that all standardized procedures are developed collaboratively and approved by the Interdisciplinary Practices Committee whose membership consists of Advanced Practice Nurses, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All approved standardized procedures will be filed in a Standardized Procedure section of the Nursing policy and procedure. A copy of these signed procedures will be kept in an operational manual in the Medical Directors office and on file in the credentialing liaison Medical Staff Office.

II. Functions To Be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the CNS in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical setting or inpatient care on a unit-based hospital setting.

An Advanced Practice Nurse is a Nurse Practitioner (NP) or a Clinical Nurse Specialist (CNS) who is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. NPs and CNSs provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the NP or CNS to seek physician consultation.

The CNS conducts focused physical exams, assesses wound healing, orders relevant tests, and makes treatment recommendations consistent with specific protocol and as established by state law.

III. Circumstances Under Which APNs May Perform Function

A. Setting
1. Location of practice is Laguna Honda Hospital and Rehabilitation Center.
2. Role in each setting may include inpatient and outpatient clinic.

B. Overall Accountability:
The APN is responsible and accountable to Laguna Honda Medical Director, or a designated Physician consultant.

C. A consulting physician, who may include the Medical Director or designated Physician consultant will be available to the CNS, by phone, in person, or by other electronic means at all times.

D. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
1. Acute patient decompensation.
2. Problem that is not resolved after reasonable trial of therapies.
3. Unexplained historical, physical, or laboratory findings.
4. Upon request of patient, CNS, or physician.
5. Initiation or change of treatment other than those in the formulary.

IV. Scope of Practice

Protocol 1. Wound Assessment and Management
Protocol 2. Wound Debridement
Protocol 3. Negative Pressure Wound Therapy (NPWT)

V. Requirements for the Clinical Nurse Specialist

A. Basic Training and Education
1. Active California Registered Nurse.
2. Successful completion of a program, which conforms to Board of Registered Nurses (BRN).
3. Maintenance of Board Certification.
4. Maintenance of certification of Basic Life Support (BLS).
5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application. (NPI number).
6. Copies of licensure and certificates must be on file at the Medical Staff Office.

B. Specialty Training
1. Specialty requirements: Master's degree in a clinical field of nursing and Clinical Nurse Specialist Certification.
2. At least 6 months of previous experience in specialty area is expected for this position.

C. Evaluation of CNS: Competence in performance of standardized procedures
1. Initial: at the conclusion of the standardized procedure training, the Medical Director or physician designee will assess the CNS's ability to practice relative to standardized procedure.
   a. Clinical Practice
      - Length of proctoring period will be at least 3 months or length of time needed to consult and review 10 cases.
      - The evaluator will be the Plastic Surgeon, Medical Director or physician designee.
      - The method of evaluation in clinical practice will be ten medical record reviews.

D. Annual: Medical Director or physician designee will evaluate the CNS competence through an appropriate competency validation for the setting, including the review of 5 medical records and feedback from colleagues.

E. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director or physician designee at appropriate intervals until acceptable skill level is achieved.

F. Documentation will be maintained in the credentialing file, which is kept in the Medical Staff office.

VI. Development and Approval of Standardized Procedure

A. Method of Development

1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Clinical Nurse Specialists, PharmD, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval

1. The Interdisciplinary Practices, Credentials, Medical Executive Committees and Governing Body approve all standardized procedures prior to their implementation.

C. Review Schedule

1. The standardized procedure will be reviewed every three years by the affiliated staff and the Medical Director and as practice changes.

D. Revisions

1. All changes or additions to the standardized procedures are to be approved by the Interdisciplinary Practices Committee accompanied by the dated and signed approval sheet.

Protocol 1: Wound Assessment and Management

A. DEFINITION

This protocol covers the procedure for the assessment and management of wounds. Scope of care includes standard wound assessment and management and will include recognition of possible complicating factors as well as recognition of complex wounds requiring specialty evaluation.

B. DATA BASE

1. Subjective Data

a. Initial screening with symptoms and history relevant to wound risk factors for poor wound healing including:

- infected wounds
- dirty and contaminated wounds
- malnutrition
- diabetes mellitus
- sepsis
- chemotherapy
- immunosuppression
- peripheral vascular disease
- obesity
- radiation therapy
- edema
- foreign body
- tension on wound edge
- pressure over a bony prominence

b. Ongoing/Continuity: review of symptoms, new medical problems relevant to wound healing, and treatment relevant to the wound.

2. Objective Data

Physical exam with clinical assessment of wound characteristics, including appearance and color, location, size/depth/tunneling, presence of exudates or odors, and appearance of surrounding skin.

C. DIAGNOSIS

Assessment of subjective and objective findings to determine optimal management of wounds. May include risk versus benefit of treatment.

D. PLAN

1. Therapeutic Treatment Plan

a. Reduce or eliminate underlying contributing factors.
b. Provide appropriate support surface to aid in wound healing.
c. Local wound care using standard treatments available at Laguna Honda Hospital based on wound characteristics.
d. Consider/evaluate adjunctive treatments, including negative wound pressure therapy.
e. Establish plan for monitoring and wound documentation by licensed nurses.
f. If no improvement in wound healing in 2 weeks, reassess treatment plan.
g. Referral to specialty clinics and supportive services as needed.

2. Patient conditions requiring Attending Consultation

a. Wound, which is not resolved after reasonable trial of therapies.
b. Initiation or change of treatment other than those in the formulary.
c. Evidence of wound or systemic infection.
d. Upon request of patient, CNS, or physician.

3. Follow-up

As indicated by patient health status, wound healing, or deterioration.

E. RECORD KEEPING

All information relevant to wound care will be recorded in the medical record in writing, or as transcribed, or as electronically recorded. Completes and submits an accurate record of services provided, for billing purposes, as appropriate.

Protocol 2: Wound Debridement

A. DEFINITION

Debridement is the process of removing irreversibly damaged and necrotic/nonviable tissue using surgical instruments (sharp debridement), enzymatic, mechanical, or autolytic in order to promote wound healing and decrease bioburden.

1. Indications
   - Patients who present with necrotic/nonviable tissue in and around the wound
2. Precautions: patients with the following conditions:
   - Coagulopathies or who are on anticoagulant medications
   - When debridement may expose viable tendon, bone, or fascia
3. Contraindications: patients with the following conditions:
   - Wounds located on areas with inadequate arterial perfusion
   - Anesthesia is required
   - Other clinical conditions

Evaluation of CNS Competence in performance of minor procedure (sharp debridement) of superficial necrotic /nonviable wounds with little risk of bleeding or trauma:

- Proctoring and direct supervision by the Plastic Surgeon, Medical Director or physician designee of the first ten procedures prior to independent practice.
- Ongoing competency will be determined by a review of 10 charts, direct observation, and feedback from colleagues.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms focused on the procedure to be performed.
   b. Pertinent past medical history, current medications, and allergies.

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging studies as indicated and relevant to history and exam.

C. DIAGNOSIS

Assessment of subjective and objective data to identify need for wound debridement and to determine appropriate type of debridement.

D. PLAN

1. Therapeutic Treatment Plan
   a. Documented patient consent when minor debridement is performed.
   b. Diagnostic tests for purposes of wound healing.
   c. Initiation or adjustment of wound treatment available at LH wound care formulary.
   d. Referral to physician, specialty clinics, and supportive services as needed.

2. Patient conditions requiring Attending Consultation

a. Acute decompensation of patient situation.
b. Unexplained historical, physical, or laboratory findings.
c. Upon request of patient, CNS, or physician.
d. Initiation or adjustment of treatment other than those in the formulary.

3. Education
Appropriate and relevant patient and family education/counseling in written or verbal format.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING
All information relevant to wound debridement will be recorded in the medical record in writing, or as transcribed, or as electronically recorded. Completes and submits an accurate record of services provided, for billing purposes, as appropriate.

Protocol 3: Negative Pressure Wound Therapy (NPWT)

A. DEFINITION

NPWT is the application of continuous or intermittent suction to the wound bed. It is intended to create an environment that promotes wound healing by secondary or tertiary intention by preparing the wound bed for closure, reducing edema, promoting granulation tissue formation and perfusion. The pressure range for suction is 80 to125 mmHg, depending upon several factors including the device, patient tolerance, and wound bed. Dressing changes are recommended every 48 to 72 hours, or as needed if the seal is broken.

1. Indications

- NPWT is indicated for patients with chronic, acute, traumatic, subacute and dehisced wounds, partial thickness burns, ulcers (diabetic, pressure, or venous insufficiency), flaps and grafts.
- LH Plastic surgery consultant will initiate NPWT.
- LH Physician may order NPWT for newly admitted patients on NPWT pending Plastic Surgery consultant's evaluation.

2. Precautions: patients who present with the following conditions:

- Patients at high risk for bleeding and hemorrhage
- Patients on anticoagulants or platelet aggregation inhibitors
- Patients with:
  - Friable vessels and infected blood vessels
  - Vascular anastomosis
  - Infected wounds
  - Osteomyelitis
  - Exposed organs, vessels, nerves, tendons, and ligaments
  - Sharps edges in the wound (i.e. bone fragments)
  - Spinal cord injury (stimulation of sympathetic nervous system)
  - Enteric fistulas
  - Bradycardia
  - Patients requiring MRI, hyperbaric chamber, and defibrillation
  - Patient size and weight

3. Contraindications: NPWT is contraindicated for these wound types/conditions:

- Necrotic tissue with eschar present
- Untreated osteomyelitis
- Non-enteric and unexplored fistulas
- Exposed vasculature
- Exposed nerves
- Exposed anastomotic site
- Exposed organs

B. DATA BASE

1. Subjective Data

a. History and review of symptoms relevant to NPWT.
b. Pertinent past medical and surgical history, current medications, and allergies.

2. Objective Data

a. Physical exam appropriate to NPWT.
b. Laboratory and imaging studies as indicated and relevant to NPWT.

C. DIAGNOSIS

Assessment of subjective and objective data to determine possible benefit of NPWT.

D. PLAN

1. Therapeutic Treatment Plan

a. If patient is receiving NPWT, assessment of subjective and objective data to determine its effectiveness and/or complications.
b. Assess the NPWT treatment plan if the wound deteriorated or no improvement in the wound is observed within two weeks.
c. Initiation or change of wound treatment available at LH wound care formulary if NPWT is not effective.
d. Recommend discontinuance of NPWT if the wound deteriorated or show no improvement within four weeks.

2. Patient conditions requiring Attending Consultation

a. Acute decompensation of patient situation.
b. Wound, which is not resolved after reasonable trial of NPWT or alternate treatment.
c. Initiation or change of treatment other than those in the formulary.
d. Evidence of wound or systemic infection.
e. Upon request of patient, CNS, or physician.

3. Education

Appropriate and relevant patient, family, and staff education/counseling in written or verbal format.

4. Follow-up

If no response or improvement in the wound is observed after two weeks of NPWT, reassess the treatment plan.

E. RECORD KEEPING

All information relevant to NPWT will be recorded in the medical record in writing, as transcribed, or as electronically recorded. Completes and submits an accurate record of services provided, for billing purposes, as appropriate.

Revised Social Services Policies and Procedures

7.5 Social Services Department: Discharges to the Acute Care Unit (PMA)

Policy: The Social Services Department shall chart within 1 business day of Admission Report when a resident has been admitted to the Acute Care Unit for acute care treatment so that a final disposition note will be part of the permanent medical record.

Purpose:

1. To ensure continuity of care for the resident and to apprise the physician and interdisciplinary team of social service contact with the family and families' concerns.

Procedure:

A. Admission and Discharge Note

1. The social worker will receive a face sheet in their mailbox with the resident's name that requires a note in the EHR. As a way of checks and balances, MSW will also check the Acute Medical folder in the EHR for any admissions that require a note.

2. The social worker will chart a consult note under the Notes section in the EHR within 1 business day of being notified on all residents who are transferred from SNF to Laguna Honda's Acute Care Unit.

3. The note should document date and reason for transfer and any assistance provided by the social worker.

4. The social worker will include a discharge disposition and any psychosocial changes that have occurred due to the acute episode under the Expected Discharge section under the Social Work tab in the EHR.

5. A Resident Social History Initial Assessment will be completed in the EHR Acute Medical record.

6. A Care Plan will be completed in the EHR Acute Medical record within 48 hours of admission.

7. A resident who tests positive for MRSA (Methicillin-resistant Staphylococcus aureus) infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

~~7.~~

7.6 Social Services Department: Documentation of Care Plans

Policy: All residents with problems requiring social service intervention will have appropriate documentation of the problem, action, goal and review date in the EHR resident care plan.

Purpose: To assure that all members of the resident care team are aware of the need for social service intervention and the nature of that intervention so that other team members can support the work of the social worker.

Procedure:

1. Problems requiring social service intervention will be identified at the time of initial assessment, annual assessment, Resident Care Conferences or through routine contact with the resident.

2. Specific problems identified will be listed on the resident care plan. The proposed intervention of the social worker will be described. The goal of the intervention will be described in resident centered terminology. A review date will be listed of not more than three months following the date of problem identification.

3. All interventions will be reviewed by the social worker with respect to goal achievement on or before the review date. If the goal has been achieved, the intervention will be discontinued as of the date of achievement or review, whichever occurs first. If the goal has not been achieved, but the intervention is moving the resident toward goal attainment, then the problem will be restated with a new review date. If the intervention is not being effective and not resulting in goal attainment, then an alternate intervention will be written with a new review date. If the goal is determined to be unattainable due to the resident's physical or mental status, then a more appropriate goal may be developed or the problem may be redefined.

4. Social workers ~~are not required to write in the~~ will create a resident care plan ~~if there are no~~ with clearly defined social service needs for that resident ~~other than a discharge care plan~~.

5. Resident care plans will be reviewed by Social Services leadership and the department manager as part of the quality assurance activities of the department and as part of the employee evaluation process.

7.7 Social Services Department: Discharge Planning and Implementation

Policy: The Social Services Department is responsible for coordinating discharge planning. Discharge Planning is a process that includes collaboration of the Resident Care Team, residents, families and residents' legal decision makers.

Purpose: To ensure continuity of care, sustain the optimal level of health gained through hospitalization, and provide care in the least restrictive setting.

Procedure:

1. All residents on admission will be assessed by Social Services for discharge potential. This will be documented in the Resident Social History Initial Assessment within five (5) working days of admission. If resident is coded as a short stay resident, the assessment must be in the record within two (2) working days of admission. If there is discharge potential, ~~1) a care plan will be completed under the Care Plan tab in the EHR, 2)~~ the Discharge Milestones and Delays, Discharge Planning and Expected Discharge sections under the Social Work tab must be completed within 48 hours of admission. A care plan under the Care Plan tab in the EHR will be updated accordingly. The Resident Care Team will further assess for discharge potential and identify residents appropriate for discharge to the community. Social Workers will actively coordinate discharge plans at the request of the Attending Physician.

2. After assessment process is completed, MSW will coordinate an interdisciplinary determination of a discharge care plan to assist the resident in the transition to the community and in identifying discharge considerations and interventions that impact the discharge plan.

3. Pertaining to Hudman v Kizer calls, if UM informs Social Service Department of an available Medi-cal bed at another skilled nursing facility, Social Services will identify the resident to refer to the vacant nursing facility Medi-cal bed. Social Worker will discuss with RCT, resident, SDM/DPOA/Conservator the option of referral to other nursing facility. Social Worker will document discussion with RCT and resident in the EHR and send application in if agreed upon.

4. A Resident Discharge Information sheet including projected discharge date and equipment needed will be placed in resident's room with resident's permission and updated as needed.

5. If the resident is conserved, the permission of the Conservator must be obtained prior to discharge. Conservators will be invited to team meetings to participate in the discharge planning process.

6. Counsel resident, family, and caregivers regarding resident's needs and options for services. This includes psychosocial support to deal with issues of loss and transition and education about the resident's diagnosis and what services will need to be implemented for a safe discharge to a lower level of care.

7. Coordinate with hospital staff and community care providers to enable the resident to return to the community with the necessary supportive shelter, health, medical, and other services. Referrals include housing, substance abuse treatment programs, outpatient counseling, In-Home Support Service and home care services, case management, durable medical equipment, Adult day health programs and meal and transportation programs. Coordinate home evaluation with resident/caregiver, OT and PT. Email the Rehab team and A&E via "DPH-LHH Discharge Address" list when discharge date and location is established to start DME ordering process. Hospital beds and hoyer lifts require a minimum one month notification. A Discharge Checklist will be reviewed by all team members to review to ensure resident is ready to go.

8. When a discharge date is finalized, the MSW will initiate and provide the resident or legal representative with a 30-day notice (Notice of Proposed Transfer/Discharge) at least 72 hours prior to discharge date. The signed notice will be uploaded into the EHR. If a resident should refuse to sign, the MSW will so note this and furnish the resident with one copy. A copy will be faxed to the Ombudsman program at 415-751-9789 and if any changes are made to the notice, all recipients will be updated.

9. An After Visit Summary (AVS) is given to resident at discharge delineating all community services arranged to facilitate their transition to community living.

7.9 Social Services Department: Readmission Assessments

Policy: Residents readmitted following either an acute medical or acute surgical transfer to another facility or to Laguna Honda's Acute Care Unit will be reassessed for change in psychosocial status and discharge planning status requiring social service intervention.

Purpose: To record any changes due to acute episode, analyze psychosocial, discharge or other needs that have arisen and provide more comprehensive social service interventions.

Procedure:

I. Readmission from acute care to SNF *WITHIN* 7 days:

1. The case will be assigned to the previous social worker, if possible, who provided coverage to allow for continuity of care. An initial assessment will be completed addressing any significant psychosocial changes in the EHR.

2. A brief readmission consult note is to be completed within five (5) days of readmission and address any significant psychosocial changes.

3. A Trauma Care Screening (TICS) will be completed. A Consults note will be entered in the EHR noting that a TICS was completed.

4. A Care Plan will be completed for all residents ~~on the discharge track~~ within 48 hours~~-~~ of readmission ~~for short stay codes and 5 business days for General SNF codes~~.

5. For Readmissions from acute care to SNF *AFTER* 7 days:
   - Complete Procedure I, 1-4 as well as the Expected Discharge and Discharge Planning sections in the Social Work tab in the EHR.

6. Readmission notes will be reviewed by a social service supervisor and/or the Social Service Director as part of the quality improvement activities of the department and as part of the employee evaluation process.

II. Readmission from the community to SNF:

1. Upon readmission, the Resident Social History Initial Assessment will be updated in the EHR under Notes section by copying a previous note and addressing any

significant psychosocial changes. A readmission note outlining any significant psychosocial changes will be recorded in a consult note.

2. Complete Procedure I; 1-5 as pertinent.

3. Readmission assessment will be reviewed by a social service supervisor and/or the Social Service Director as part of the quality improvement activities of the department and as part of the employee evaluation process.