List of Hospital-wide/Depsrtmental Policies and Procedures submitted for Approval on September 10, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
Revised Hospital-wide Policies and Procedures				
Revised	LHHPP	20-12	Discharge Cleaning	1. Added "terminal" 2. Added "This process applies to the terminal cleaning of a resident room when the resident will not return the original room." 3. Replaced "perform terminal cleaning and bed making (Refer to D9 2.0 Bedmaking and D9 3.0 Bed Stripping and Terminal Cleaning), including cleaning inside cabinets." with "initiate and post the Room Readiness Checklist on the room resident room door. Nursing team will follow the Room Readiness Standard Work." 4. Replaced "as outlined in the room readiness standard work to begin next step of cleaning process" with "through Epic and requests the room and/or bed cleaning by following the Room Readiness Standard Work." 5. Added "EVS Utility worker/Porters will follow the EVS Permanent Discharge Terminal Cleaning Standard Work." 6. Deleted "Porter begins 7 step cleaning procedure of the room." 7. Deleted "After receiving notification, Nursing Department returns to room to make the bed" 8. Added references "EVS P&P XI Hospital Cleaning Step" and "EVS Standard Work Permanent Discharge Terminal Cleaning"
Revised	LHHPP	22-16	Effective Communications – Resident Who is Deaf	1. Replaced "his/her" with "their" 2. Added "and documented in the resident care plan in the electronic health record " 3. Added "available to LHH through the Department of Public Health (DPH)" 4. Replaced "identified" with "documented" 5. Deleted
Revised	LHHPP	24-11	Notification of Family / Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death	1. Replaced "designated" with "appropriate" 2. Added "which may or may not result in a transfer to acute care or discharge from the facility. 3. Deleted "transfer to acute care or discharge from the facility: and/or" 4. Added "Transfer to acute care or discharge from the facility. Further details of the condition of the resident upon transfer or discharge may be deferred to the physician."
Revised	LHHPP	29-05	Interpreter Services and Language Assistance	1. Added "LHH follows State and Federal civil rights laws. and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation." 2. Replaced "Toishanese" with "Taishanese"
Revised Food and Nutrition Policies and Procedures				
Revised	FNS	1.1	Food from Home or Outside Sources Served Directly to Residents	Changed timeframe from 72 hours to 3 days
Revised Health Information Systems Policies and Procedures				
Revised	HIS	13.06	Patient Access to Health Records	1. Added "or accounting of disclosures"
Revised Medical Services Policies and Procedures				
Revised	MSPP	A00	E-REFERRAL CONSULTATION PROCEDURE FOR OUTPATIENT CLINIC	Minor change- updated with deletion of references to outdated electronic health record
Revised	MSPP	A01	Unsigned Electronic Health Record Notes	Updated policy to reflect workflow in Epic and to better conform with DPH unsigned EHR notes policy
Revised	MSPP	CO1-01	PATIENT EXPIRATION	Minor grammatic change and updated to include new nomenclature of NHA
Deletion Medical Services Policies and Procedures				
Deletion	MSPP	D10-02	Central Line Insertion	This procedure is no longer in use at LHH
Revised Outpatient Clinic Policies and Procedures				

Revised	OPC	A1	Outpatient Clinic Services	1. Updated "Policy" and "Purpose" statements. 2. Deleted "Clinic Staff", "Outpatient Clinic Staff" and "Medical and Surgical Staff" sections 3. Added Appendix A and Appendix B
Revised Rehabilitation Policies and Procedures				
Revised	Rehab	10-04	Patient Vs Resident Terminology	Added “wherever, applicable, updates will be made to add both patient/resident terminology for policies, procedure, but not limited to”.
Revised	Rehab	10-05	Written Policies and Procedures for Rehabilitation Services	Added “but not limited to” throughout the policy.
Revised	Rehab	20-01	Responsibility and Accountability of Rehabilitation Services	Added resident and resident care team throughout the policy. For 1.b): Added “SFHN VP Executive Rehabilitation Services”. For 1.a), b): added “but not limited to”. For 3: added “executive leadership” and “but not limited to”.
Revised	Rehab	20-02	Rehabilitation Center Staff	Updated first paragraph under policy. For procedure introductory paragraph: removed “a sufficient number of qualified, competent therapeutic services, professionals, and support staff are available to meet Rehabilitation Service’s needs, including the following”. Replaced the respective sentence with: “The rehabilitation center/rehabilitation services staff shall consist of the following, but not limited to.” Removed #2 and #3. Removed full time/part time designation under #4. Added for #4: Other personnel experience in rehabilitation shall be provided to meet the needs of the service and shall include but not limited to the following”. Also added “therapy aides and any additional supporting staff”.
Revised	Rehab	20-05	Staff Orientation, In-service training, and continuing education	Minor edits to state, “but not limited to” and “may be updated, as indicated.” Added reference to California Board of Physical Therapy/Occupational Therapy/Speech Language Pathology”; Added all licensed staff members’ active licenses will be maintained per therapist
Revised	Rehab	30-05	Behavioral Health Services	Added “resident” in reference to “patient”; Clinical edit/updates from neuropsych: Policy section addition: “It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to ensure all residents receive necessary behavioral health care and services to assist them in reaching and maintaining their highest level of physical, mental and psychosocial functioning (HWPP 24-28). “ Procedure section - #1 addition of “specialty”, #2 addition of “clinical psychologist”, Reference section addition: “HWPP 24-28 Behavioral Health Care and Services”
Revised	Rehab	30-06	Social Work Services	Added “resident” in reference to “patient”; Clinical updates from Janet Gillen: 2.b. – “including but not limited to Trauma Informed Care Screening”
Revised	Rehab	30-07	Activity Therapy Services	Added “resident” in reference to “patient”
Revised	Rehab	30-08	Vocational Rehabilitation Services	Added “resident” in reference to “patient”; added “RCT” to “PCT”
Revised	Rehab	40-01	Rehabilitation Services for Rehabilitation Unit (Acute Rehab & SNF Rehab)	Added for #4: “and/or caregivers”. Added for #6: moved “including time frames for achievement to before the parenthesis opening.
Revised	Rehab	40-02	Rehabilitation Services for Long Term Care SNF Unit Patients	Removed Patients and replaced with Residents for the title, and all applicable areas of the policy secondary this being a policy for Long Term Care SNF Unit. Removed Hospital and replaced with “facility” as a generic term applicable to Long Term Care SNF. Removed Audiology and Physiatry as these do not fall under the Rehab Department; they must have their own specific policies and/or references in their P&P. Audiology service will need to be within Primary Clinics Physician Department. Physiatry must be included under Physicians’ Department.
Revised	Rehab	40-03	Rehabilitation Center – Goals and Objectives	Added patient and/or resident throughout the policy. Added: Skilled Nursing Rehabilitation Services, Inpatient Rehabilitation Services, and Outpatient Clinic Rehabilitation Services to the first paragraph under “policy”. Added “functional” next to independence within first paragraph for “Policy”. Removed “and maximum level of functional independence” in the first paragraph under “policy”. Added for #3 under “procedure”: “cognition, swallowing”, and “overall well being”.

Revised	Rehab	40-04	Rehabilitation Services and Medical Record	Added throughout the policy: “and/or resident”. Removed for #1: “or admission to the Rehabilitation Unit”. Added for #4: “and/or caregiver”.
Revised	Rehab	40-05	Rehabilitation Case Conference	Added “/resident” throughout the policy. Under “purpose” subheading, for #3: added “and/or caregivers”.
Revised	Rehab	40-06	Evaluation of Services	Added under “purpose”: add “once per month”: “added Nursing Home Administrator Assistant, Quality Management, Director of Nursing”. Added “Additional interdisciplinary team members including, but not limited to, social work, minimum data set and utilization management nursing team, grievance team”. Added under “procedure”: #1 – “Added Nursing Home Administrator Assistant, Director of Nursing, and Quality Management designee”; removed “and the supervisors of each rehabilitation service”; and added, “best practice and quality rehabilitation services”’ removed, “evaluation”, and added, “and procedures”. #2 – “added of interdisciplinary rehabilitation services process and procedures”, and “but not limited to”. Added component a: “Interdisciplinary team leadership identify the key performance indicator (KPI) measures using A3 form and including but not limited to, presenting this at the Performance Improvement Plan (PIP) committee.” For component b, added “KPI quality measures for”, and removed “or unit or”. For component c: added “and/or resident”. For #3: “and/or resident”. For #4: added “presented at the facility wide PIP committee”; remove “as appropriate, may be reported to Hospital Wide Performance Improvement and Patient Safety Committee”. For #5: added “but not limited to, for the interdisciplinary team Rehabilitation Services”; added for within 5.b) “for best practice”; “removed for 5.c) “direction of”; added 5.d) “regulatory requirements and compliance needs.
Revised	Rehab	40-07	Utilization Management	Remove “please refer to the UM plan which is reviewed annually by the members of the UM Committee”.
Revised	Rehab	40-08	Rehabilitation Assessment and Interdisciplinary Care Planning	Added "resident care team (RCT)” throughout the policy. Added “resident” throughout the policy. For Procedure: b) added “For Rehabilitation Services Team members”; removed “individual department heads” and added “rehab leadership”. For Procedure: c) added “include but not limited to, goals that”; and “and as per clinician’s clinical judgement and patient/resident related assessment findings”. Added “resident and/or caregiver/family member”. For #2. a): added “status post completion of evaluation by end of business day (evaluation date of completion”; removed “within 24-48 hours following the evaluation”.
Revised	Rehab	40-09	Treatment Authorization Request	For “purpose”: removed “in this policy the term “patients” also refers to residents in the skilled nursing facility (SNF)”; added “this process may apply for submission of rehabilitation services treatment orders for all patients and/or residents receiving rehabilitation services.” Added “/residents” throughout the policy. Added under “II Specific Sections of Rehabilitation Treatment Order”: “Physician signature required and identified the referring provider for the treatment order”; removed “per protocol – no cosign required” and identifies the referring provider”. For III TAR Processing, added “by the patient access team within the San Francisco Health Network (SFHN))”. For IV TAR EXTENSIONS: added for first bullet point: “with physician signature”; added for second bullet point: “another reassessment with physician signature and rehab treatment order with physician signature including the date extension will be included, and process, accordingly.” Added last bullet point: “All patient and/or resident related TAR needs will be collaborated between rehabilitation services and patient access team to receive support for TAR processing, submission, but not limited to.. “ Added “patient/resident” throughout the policy.

Revised	Rehab	50-01	Admission and Eligibility Criteria for Acute Rehabilitation Services	Under “policy”: removed “any patient” and replaced by “patients”. Added “and would benefit from intensive”. Added “services”; added “due to complex nursing, medical management and rehabilitation needs”; removed “to achieve maximal functional independence”; added “at Laguna Honda Hospital and Rehabilitation Center (LHH)”. For #4: removed “rehabilitation physician”, and replaced it with “physiatry”. For #6: Removed “two ADL impairments that are functional, ADL, safety, or education related, and has”. For #6. A): removed “Psychological or psychiatric therapy and social work services related to the acute rehabilitation treatment plan not to exceed four (4) hours of the 18 hours”. For #6. B): Added “at least”, and “one of which must be physical therapy or occupational therapy”. For #8: added “completed by interdisciplinary team approach including but not limited to: Admissions & Eligibility (A&E), Utilization Management (UM),” and “the Director of Nursing and the Assistant Nursing Home Administrator, support services or designee, and/or designee from the respective departments.” Added “this preadmission screening may involve, but not limited to,” and added “and additional patient related factors”. Removed: “or his/her designee”. For 8.a) added “24”; removed “by licensed or certified clinician”. Removed #9. Replaced with: “Information pertinent to the patient’s admission to Acute Rehabilitation will be forwarded to or made available to the LHH rehabilitation team prior to or at the time of admission”.
Revised	Rehab	50-02	Admission and Eligibility Criteria for SNF-level Rehabilitation Services	Added for #5: “skilled” and “but not limited to”. Added #8: “an interdisciplinary team including but not limited to: A & E, Utilization Management, Director of Nursing, Nursing Home Administrator Assistant (Support Services)”, “of the respective departments”.
Revised	Rehab	50-03	Sources and Forms Used for Referral of Patients	Added “residents” throughout the policy. #2: “Added Outpatient Clinics, and SNF Rehabilitation for LHH Residents.” #3 b): “short term stay/long term care LHH residents”; and added “residents”.
Revised	Rehab	60-01	Outpatient Rehabilitation Services	Remove “audiology, physiatry, and neuropsychological services”. Adding “residents” throughout the policy.
Revised	Rehab	60-02	Procedure for Outpatient Referral, and Treatment	Added “residents” throughout the policy.
Revised	Rehab	70-01	OT Services	Removed pronoun
Revised	Rehab	70-02	OT Staff	Added “resident” in reference to “patient”; revised that the NBCOT is preferred, but not mandated as per state regulations. Stated therapists must have current licensure from CBOT (removed “or to be qualified to take the next licensing exam”)
Revised	Rehab	70-04	Scope of Occupational Therapy Services	Added “resident” to all references to “patient”; deleted line item that refers to group activities which is no longer applicable; added Patient Care Team to Resident Care Team
Revised	Rehab	70-05	Establishment of Treatment Programs and Documentation	Added “resident” to all references to “patient”; Removed line items that referenced other policies
Revised	Rehab	70-09	Occupational Therapy Service Equipment and Supplies	Added “resident” to all references to “patient”
Revised	Rehab	80-01	Physical Therapy Service Definition	Added resident throughout the policy. Added “but not limited to” at the end of the paragraph.
Revised	Rehab	80-02	Physical Therapy Staff	Added resident throughout the policy. Added under policy: “SFHN Executive Rehab Leadership” and removed “director”. Added “integrated”. For Procedure #2: Added “SFHN Executive Rehab Leadership of Integrated Rehabilitation Services”. For #6: Added, “and line of sight as per California Board of Physical Therapy regulations”.
Revised	Rehab	80-03	Clinical Training for Physical Therapy Students or Interns	Added resident throughout the policy.
Revised	Rehab	80-04	Scope of Services	Added resident and resident care team throughout the policy
Revised	Rehab	80-07	Physical Therapy Service Equipment and Supplies	Added “but not limited to” to the first sentence. Added resident throughout the policy.
Revised	Rehab	80-08	Orthotics Clinic	Updated “two times per month” to at least once per month or as needed”. Added resident/patient, resident care team/patient care team throughout the policy. Added for Purpose #2: “and overall quality of life”. Added “but not limited to” wherever applicable throughout the policy.

Revised	Rehab	90-01	Speech Language Pathology Service Definition	Added “resident” to all references to “patient”, REMOVED Audiology Services, REMOVED “Speech Pathology and Audiology Service means evaluation and rehabilitation services for individuals with speech, voice, language, cognitive-linguistic, swallowing, and/or hearing disorders.” ADDED “Speech Pathology Service: evaluation and rehabilitation management of dysphagia, speech-language, cognitive-communicative disorders, and voice disorders.” Updated: Appropriate staff, space, equipment, and supplies are available to meet service needs. Therapy goals include achieving and maintaining the highest functional level of Communication” To “Appropriate staff, space, equipment, and supplies are available to meet service needs. Therapy goals include achieving and maintaining the highest functional level of Cognitive – Communication and safe swallow function.”
Revised	Rehab	90-02	Speech Language Pathology Staff	Removed audiology services, Changed “Speech Pathologist” to “Speech Language Pathologist (SLP), referenced SLP as needed for Speech Language Pathologist, Added “resident” to all references to “patient”, removed “audiologists” and “In addition, audiologists must hold a current California State Hearing Aide Dispenser’s License”
Revised	Rehab	90-03	Speech Pathology Scope of Services	Removed Audiology services, Added “resident” to all references to “patient”, removed Audiology Services, removed “assessment” & “evaluation”) redundant in section: “Diagnostic Evaluation” section, updated clinical language/grammar in Diagnostic Evaluation and Therapy sections. Diagnostic Evaluation section: changed “speech production” to “Speech and Language skills, removed “assessment of language skills,, both comprehension and expression” removed “assessment of cognitive linguistic skills”, added “Cognitive-Communication skills” , removed swallowing added “Swallow function and safety” added “Laryngectomy management, including alaryngeal speech”, removed “testing of hearing acuity for speech reception and discrimination” and “evaluation of patient’s ability to use hearing aids” Therapy section: add “and language skills” to a. “speech”, c. added “speech”, e. removed “provision of”, f. removed “Alaryngeal speech” and updated to “Laryngectomy and alaryngeal speech”, g. removed “swallowing” and updated to “swallow function”, removed “hearing (including aural rehabilitation and hearing aid fitting) 3. Removed “RCT” 4. added “caregiver”
Revised	Rehab	90-04	Establishment of Treatment Programs and Documentation SLP	Added “resident” to all references to “patient”, removed audiology from header, Clinical update to title to “Speech Language and Cognitive-Communication”, updated Policy to “ Patient/residents are seen by a Speech Language Pathologist (SLP) for a Speech-Language or Cognitive-Communication Evaluation upon referral by Laguna Honda Hospital provider, removed “Outpatients may be referred by a licensed physician in the community.” “medical history” updated to “EHR”, changed “physician” to “ordering provider”, changed “Speech Pathologist” to “Speech Language Pathologist (SLP)”, “SLP” replacing references to Speech Pathologist, updated “speech production” to Verbal expression, added “Cognition”, removed “oral expression”
				Added “resident” to all references to “patient”, removed audiology from header, Clinical update to title to “Speech Language and Cognitive-Communication”, “Speech Pathologist” to “Speech Language Pathologist (SLP)”, “SLP” replacing references to Speech Pathologist, changed “physician” to “provider”, changed “medical record” to “Electronic Health Record” or “EHR” Policy: updated “The treatment plan may include swallowing therapy, to be carried out by the speech pathologist, and/or recommendations regarding food texture and strategies to facilitate improved swallowing and reduce the risk of aspiration.” To “Patient/residents are seen by a Speech Language Pathologist for a dysphagia evaluation upon referral by a physician. Following the evaluation, the SLP develops a treatment plan, as indicated. The treatment plan may include swallowing therapy, to be carried out by the SLP, and/or recommendations regarding least restrictive modified texture, aspiration precautions and strategies to facilitate improved swallow function and reduce the risk of aspiration.” Procedure: removed “Upon physician referral, the speech pathologist reviews the medical history and schedules the patient for a dysphagia evaluation. Upon receipt of a physician’s order, the speech pathologist reviews the Electronic Health Record (EHR) and schedules the patient for an evaluation.” Updated to: “Upon receipt of a provider order, the SLP reviews the Electronic Health Record (EHR) and schedules the patient/resident for an evaluation.” Removed “Observation of dentition”, changed

Revised	Rehab	90-05	Establishment of Treatment Programs and Documentation Dysphagia	schedules the patient/resident for an evaluation." Removed "Observation of dentition", changed "voice" to "vocal quality", removed "assessment of speech production", 1. b. v. removed "oral preparatory and" & "depending on readiness and safety", 1. b. vi. Added "symptoms" 1. d. added "instrumental" and "FEES" & updated "in writing" to "via Secure Chat" 1.f. Removed "Upon completion of the evaluation, the speech pathologist documents results and recommendations in the medical record and reviews them with caregivers. The treatment plan is reviewed with the patient, caregivers and family (if available)" updated to: The treatment plan is reviewed with the patient/resident, caregivers and family (if available). Changed "physician" to "ordering provider", 3. h., removed "The speech pathologist enters a progress note once weekly for inpatients and at least once monthly for outpatients. These notes summarize the treatment plan/goals, as needed. Signed progress notes are documented at least once weekly for inpatients, and at least once monthly for outpatients. These notes summarize the patient's performance/improvement over the period covered. Treatment goals are updated as needed." To current practices "Progress notes are documented at least once weekly for inpatients and at least once monthly for outpatients. These notes summarize the patient/resident's progress over the period covered. Treatment goals are updated as needed.", 5. a. updated "Resident care Team" to "Patient/Resident Care Team" and removed "RCT"
Revised	Rehab	90-07	Establishment of Treatment Programs and Documentation -Audiology	Added "resident" to all references to "patient", removed "Speech/Pathology" from header, "medical record" updated to "EHR", Clinical updates: #1 addition of "If there is a concern for sudden hearing loss, the order should be noted as urgent."
Revised	Rehab	90-08	Hearing Aid Evaluation and Dispensing	Added "resident" to all references to "patient", removed "Speech/Pathology" from header, "medical record" updated to "Electronic Health Record" Clinical updates: #1 added "For hearing aides to be obtained, an audiologic evaluation must have been performed within 6 months. If this is not avail, then an audiologic evaluation should be scheduled prior to a hearing aid evaluation" #2 added "and audiologic evaluation." #3 added "programming the hearing aids and" " usage, safety" "discussing realistic expectations of hearing aids, " and "caregiver" #5 added " if adjustments can be made" #6 added "functionally and/or"
Revised	Rehab	90-09	Speech Pathology Service Equipment and Supplies.	Removed "Audiology" from header 1.Added "Language" to Speech Pathology, added "SLP" 2. removed "Department" and replaced with SLP, removed "to a soundproof audiometric test chamber, diagnostic clinical audiometer, tympanometer, hearing aid analyzer and" ADDED "swallowing" "and Cognitive-Communication" 3. removed "the audiology equipment is inspected and calibrated annually by audiometic specialists" 4. added "resident", removed "safety engineers" and replaced wit "Biomed"
Revised	Rehab	90-10	Audiology Service Definition.	Removed "Speech/Pathology" from header, removed SLP services listed Clinical updates: Removal of "of communication" with edit to "hearing and communication"
Revised	Rehab	90-11	Audiology Staff	Removed "Speech/Pathology" from header, title, & policy and procedure. Capitalized "Audiologist" Per UCSF Audiologist – remove CA State Board of Quality Assurance and ASHA
Revised	Rehab	90-12	Audiology Scope of Services	Added "resident" to all references to "patient", removed "Speech/Pathology" from header, title, policy and procedure. Removed SLP scope of practice from "1. Diagnostic Evaluation" and "2. Therapy" 4. added "caregiver" Clinical updates: 1.a. addition "Screening, identifying, assessing, interpreting, diagnosing, preventing , and (re)habilitating peripheral and central auditory system dysfunctions." 1. b. addition of "Testing of hearing acuity for speech reception and discrimination" 2. a. addition of "hearing services" 2. b. addition of " Assessing and providing nonmedical management of tinnitus." 2. c. addition of "Providing related counseling services to individuals with any type of hearing related communication disorder and their family members."
Revised	Rehab	90-16	Audiology Service Equipment and Supplies	Removed "Speech Pathology" from the title and replaced with "Audiology". For #1: Removed "Speech Pathology" throughout the policy. For #2: Removed "and diagnostic tests/materials for the evaluation and treatment of speech language disorders". For #3: Added "this is coordinated via the Biomed Team". Removed #4.
Revised	Rehab	100-01	Electrodiagnostic Studies	Replaced "program" with "center" under subheading of Policy. For #2: removed "will set up the" and added "coordinate the" and "with the outpatient clinic staff".

Revised	Rehab	100-02	Discharge planning and Durable Equipment	Added residents throughout the policy. Added #3: “Coordinate with social work for any discharge related equipment needs, as indicated”. Added #4: “but not limited to”; and “may”.
Revised	Rehab	100-03	Discharge planning and Emergency Preparedness	Added residents throughout the policy. Added for #1: “VP Executive Rehabilitation Services”. For #2: Replaced “manager” with “director”. For Procedure #1: added “and/or VP Executive Rehabilitation Services”.
Revised	Rehab	100-04	Rehab_Community Eval	Added resident/patient throughout the policy. For Procedure, #4: Added “therapists will follow the standard of work for DPH-approved device used for taking images for the home evaluation”. For Procedure #6: added “the following but not limited to”. For Procedure #7: Added “in consideration of patient/resident diet type and diet consistency”.
Revised	Rehab	100-05	Rehab_HomeEval	Added resident throughout the policy. For Procedure #4: added “therapists will follow the standard of work for DPH-approved device used for taking images for the home evaluation”. For Procedure #7: added “but not limited to”.
Revised	Rehab	110-02	Rehabilitation Center Equipment and Supplies	Added resident throughout the policy. For procedure #2: added “tracking process for environment of care rounding”, and added, “followed and maintained”. Added “but not limited to”. For procedure #4: added, “to the appropriate department”. For #8 a) Added “Biomedical team will provide support for maintaining services tag but not limited to, to assure compliance with safety and environment of care rounding”.
Revised	Rehab	110-03	Rehabilitation Center Equipment	Added resident throughout the policy.
Revised	Rehab	Appendix B	Appendix B: JD-Neuropsychologist, Rehabilitation Services	Added #1 Determination of medical necessity for neuropsychological services.
Revised	Rehab	Appendix B	Appendix B: JD-Staff Physiatrist, Rehabilitation Services	Added for “under the direction of the Executive Rehabilitation Leadership”. Added “as follows but not limited to” in the first paragraph. For #1: added “in collaboration with the executive leadership”. For #2: removed “exercise indirect supervision”. Added “2554 therapy aides and additional supporting staff, but not limited to”. For #3 & #4: added “assist with but not limited tp”. For #5, #6, #9: added “in collaboration with the executive leadership”; and “but not limited to”. For #7: added, “assist with but not limited to”, and “providing support with”. Added “but not limited to” again at the end of the sentence. For #8: added “assist with, but not limited to”. For Appendix B: Revised – Rehabilitation Services, JD, Staff Physiatrist, Rehabilitation Services: For first sentence: added “staff”, and replaced “admitting” with “attending”. For #1: replaced physiatirc with “physiatrist”.
Deletion Rehabilitation Policies and Procedures				
Deletion	Rehab	70-06	Custom Wheelchairs	Merged w/c clinic policy (70-07) into this policy to provide improved clarity on process to order and repair wheelchairs;
Deletion	Rehab	70-07	Wheelchair Clinic (this was requested to be removed)	Delete this policy
Deletion	Rehab	70-08	Connectivity Clinic	Delete this policy; program no longer being offered
Deletion	Rehab	80-06	Equipment Maintenance	Delete/Remove (since there is already a policy for the Rehab Department for equipment maintenance)
Deletion	Rehab	90-06	Hearing Screening revised	Delete this policy
Deletion	Rehab	90-14	Establishment of Treatment Programs and Documentation	Delete this policy

Revised Hospital-wide Policies and Procedures

DISCHARGE CLEANING

POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing and Environmental Services (EVS) departments shall clean the entire room upon resident discharge as outlined in the room readiness standard work.

PURPOSE:

To ensure proper terminal cleaning of resident rooms upon discharge, and communication and documentation after completion.

This process applies to the terminal cleaning of a resident room when the resident will not return the original room.

PROCEDURE:

1. Nursing Department shall initiate and post the Room Readiness Checklist on the room resident room door. Nursing team will follow the Room Readiness Standard Work.perform terminal cleaning and bed making (Refer to D9 2.0 Bedmaking and D9 3.0 Bed Stripping and Terminal Cleaning), including cleaning inside cabinets.

2. Nursing Department notifies EVS of room vacancy through Epic as outlined in the room readiness standard work to begin next step of cleaning processand requests the room and/or bed cleaning by following the Room Readiness Standard Work.

3. EVS Utility worker/Porters will follow the EVS Permanent Discharge Terminal Cleaning Standard Work.
4. Porter begins 7 step cleaning procedure of the room.

5.4. Porter notifies Nursing Department of completion of cleaning via standard work.
6. After receiving notification, Nursing Department returns to room to make the bed.

ATTACHMENT:
None.

REFERENCE:
Terminal Cleaning by Nursing (HHA/PCA/CNA)
Room Readiness Guideline (Charge Nurse)
Room Assessment Checklist
EVS P&P XI Hospital Cleaning Step
EVS Standard Work Permanent Discharge Terminal Cleaning

Original adoption: 19/07/09 (Year/Month/Day)
Revised: 23/01/10, 24/06/24 -(Year/Month/Day)

EFFECTIVE COMMUNICATION – RESIDENT WHO IS DEAF

POLICY:

It is the policy of this facility to accommodate needs when communicating with residents who are deaf to promote dignity, understanding, and safety.

DEFINITIONS:

"**Effective communication**" describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information is provided to the resident ~~is provided~~ in a language, form and manner that the resident can access and understand.~~, including in a language that the resident can understand.~~

PROCEDURE:

1. During the pre-screening and admission process, as much information as possible will be obtained regarding the resident's current processes for communication.

2. The resident and ~~his/her~~their representative will discuss plans and goals for communication with facility staff so that care is individualized and documented in the resident care plan in the electronic health record to meet the resident's needs.

3. The resident's likes and dislikes regarding activity pursuits will be identified, and accommodations will be made as possible to allow for social interaction.

4. The Social Service Director will contact ~~local~~ sign language interpreters available to LHH through the Department of Public Health (DPH) to verify availability of services should the need arise. (Examples: need to relay and verify understanding of critical information regarding resident's condition, plan of care, post-discharge plans.)

5. Direct care staff will be educated on effective communication strategies that reflect~~s~~ the needs of the resident population and needs of the ~~staff, and~~staff and corresponds with the Facility Assessment.

6. Staff will communicate with the resident, using techniques ~~identified~~ documented in their plan of care, and in accordance with ~~his/her~~ their established routine for communication.~~, as possible~~

ATTACHMENT:
Appendix A – Adaptive Techniques

REFERENCE:
29-05 Interpreter Services and Language Assistance

Original adoption: 22/12/13 (Year/Month/Day)

Appendix A – Adaptive Techniques

1. Adaptive techniques include, but are not limited to:

    a. Looking at the resident and sitting face to face when speaking to them to promote dignity and to facilitate resident's ability to speech read/lip read (if capable).

    b. Standing or sitting under or near a light source and keeping hands and objects away from mouth when speaking.

    c. Using sign language (i.e. assigning care givers, if available, who know sign language).

    d. Using written captioning of audio communications (i.e. closed captioning on TV, present educational materials on DVD in closed captioning).

    e. Using communication boards or writing materials (i.e. write legibly, in plain terms).

    f. Getting the resident's attention by tapping him/her on the arm, waving your hand, or flickering the lights.

    g. Speaking one at a time in a group.

NOTIFICATION OF FAMILY / SURROGATE DECISION-MAKERS (SDMs) AND / OR CONSERVATORS OF CHANGE IN CONDITION AND / OR DEATH

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to notify appropriate family members, surrogate decision makers (SDMs) and/or conservators in the event of a significant change in resident condition and/or death; and to document such notification in the medical record.

PURPOSE:

To ensure timely notification of appropriate family/surrogate decision-makers and conservators of a significant change in resident condition and/or death.

PROCEDURE:

1. Residents who are capable of making decisions regarding their health care and capable of expressing preferences regarding notifications shall be queried by the Resident Care Team (RCT) regarding notification preferences and these preferences shall be documented in the advance care planning section of the medical record.

    a. The nurse manager/charge nurse shall note in the resident care plan preferences regarding family notification expressed by residents with decision-making capacity. All stated resident preferences shall be honored.

    b. The RCT shall identify the surrogate decision-maker for all residents without decision making capacity and the physician shall document this information in the advanced directive section of the medical record. The nurse manager/charge nurse shall record and update this information in the resident care plan.

2. The physician shall be responsible for notifying ~~designated~~~~appropriate family~~designated family member~~s~~, SDM~~s~~ ~~and/~~or conservators regarding:

    ~~a.~~ significant change in condition or treatment (including but not limited to deterioration of physical, mental, or psychosocial status from life-threatening conditions or clinical complications); which may or may not result in a transfer to acute care or discharge from the facility.

    ~~b.~~a.

    ~~c. transfer to acute care or discharge from the facility; and/or~~

    ~~d.~~b. death (see section 6).

3. The physician shall document these notifications listed under Procedure 2 in the medical record.

4. The nurse manager/charge nurse shall be responsible for notifying appropriate family and/or surrogate decision-maker regarding:

   ~~e.~~a. Transfer to acute care or discharge from the facility. Further details of the condition of the resident upon transfer or discharge may be deferred to the physician.

   ~~f.~~b. an accident involving injury to the resident

   ~~g.~~c. an update concerning a resident's condition (including but not limited to a new pressure ulcer, change in functional status, change in mental status, need for restraints, poor oral intake, weight loss of 5% or greater in 30 days, elopement, and the need for observation precautions)

   ~~h.~~d. a change in room or roommate assignment

   Notification of appropriate individuals shall be documented in the medical record.

~~3.~~5. The social worker shall be responsible for contacting appropriate family and/or surrogate decision-makers when nursing staff and/or physicians are unable to reach family despite repeated attempts. The social worker shall also be responsible for contacting appropriate family and/or surrogate decision makers regarding changes in psychosocial, financial or legal status. Certified letters may be sent by the social workers if necessary. Notification of appropriate individuals shall be documented in the medical record.

~~4.~~6. Notice of Resident's Death

   a. The physician who pronounces the death is responsible for notifying the family/SDM/conservator.

   b. In addition, the primary physician shall contact the family/SDM within 48 hours of resident death when ~~possible~~possible, to express condolences and answer questions.

   c. The attending or covering physician shall complete the death certificate as soon as possible and forward it to HIS.

   d. The physician who pronounces the death shall be responsible for reporting cases that meet criteria to the Medical Examiner. In these ~~cases~~cases, the body shall not be released until first released by the Medical Examiner.

ATTACHMENT:
None.

REFERENCE:
MSPP C01-03 Organ/Tissue Transplant Donation ~~Program~~Request

Revised: 00/04/06, 12/08/29, 15/01/13, 17/09/12, 19/03/12, 20/10/13 (Year/Month/Day)
Original adoption: 98/11/16

INTERPRETER SERVICES AND LANGUAGE ASSISTANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide equal access to services for limited English-proficient (LEP) and hearing impaired/deaf residents through the use of Interpreter Services, designated bilingual hospital employees and contract agencies.

2. Family members shall not be used to interpret information/instructions regarding consents/authorization to treatment or in situations of child or elder abuse, domestic violence, assault, or other sensitive situations.

3. LHH follows State and Federal civil rights laws. and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

PURPOSE:

1. To ensure that LEP residents and surrogate decision-makers are able to understand their medical conditions and treatment options.

2. To ensure that quality resident care is provided to LEP residents by LHH staff.

3. To ensure LHH meets the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care, specifically the principal standard (number 1) and communication and language assistance standards (numbers 5 - 8).

4. To provide standardization of requests for translation of vital hospital documents.

PROCEDURE:

1. **Interpreter Services and Language Assistance**

    a. LHH Human Resources Services (HRS) shall compile, update and distribute a Designated Bilingual Employee Program roster at least twice a year. This list shall include all staff who are fluent in languages other than English and can provide language assistance related to resident care information and translate documents.

    b. Nursing Services shall maintain information on the location and shift of qualified nursing staff who are on the Designated Bilingual Employee Program roster.

    c. The primary language vendor is 911Interpreters and the secondary language vendor is Lionbridge. Call for interpreter services at 628-206-5133 or extensions 65133 or 40999.

~~i.~~ If your call is being routed to an outside language agency, the voice announcement will inform you of the agency's name. Below is the language menu for interpreter services. If you select option '9' on the language menu, you will be asked to say the language of your choice.

1. Spanish
2. Cantonese
3. Mandarin
4. ~~Toishanese~~Taishanese
5. Vietnamese
6. Russian
7. Korean
8. Arabic
9. Other Languages
10. For in-person or other requests

ii. If access is taking longer than expected, or to report any other interpreter service issue, please email: interpreterservices@sfdph.org or call 628-206-5133 and select '0' during Monday-Friday, 8am-5pm.

d. If the resident or surrogate decision maker prefers the use of a friend or family member to provide them with language assistance for routine matters involving activities of daily living, LHH personnel may utilize the authorized friend or family member for language assistance. LHH personnel may additionally retain a healthcare interpreter to participate in the exchange to ensure that it represents an accurate portrayal of the information to hospital staff and resident.

2. Language Competency

a. All Interpreter Service Department interpreters shall pass a language proficiency test provided by the office of Equal Employment Opportunity/Affirmative Action (EEO/AA) and successfully complete an Interpreter Training Program approved by the Department within one year from the hiring date.

b. Language proficiency examinations are offered periodically to all Department of Public Health (DPH) employees and medical residents in a variety of major languages spoken in San Francisco. Testing instruments are used to examine an individual's ability to fluently carry on a conversation within a medical or mental health setting. The ~~oral~~ exams are written specifically for DPH employees by culturally diverse medical and mental health care providers in consultation with the Interpreter Services Department. All employees who use their second language shall be tested for proficiency before providing language services.

3. Requests for Language Assistance

a. Inform the resident and surrogate decision maker of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Inform them the service is at no cost to them.

b. Call the Nursing office for language assistance.

c. The following information is required to secure the appropriate service:

   i. The resident's name.

   ii. The language needed, i.e. Cantonese, Mandarin, Russian, Tagalog, Vietnamese, Spanish, Sign Language for the deaf/hearing impaired, etc. (Please plan ahead and let the Nursing office know when a resident is scheduled who speaks an uncommon language or who needs a sign interpreter. This is important because an ASL interpreter may not be available for a same day request).

   iii. The name and location of the requesting department, contact person in the department, telephone number, and/or pager number.

   iv. The name of the physician, nurse, or other staff member who shall need language assistance.

   v. The approximate amount of time needed for language assistance.

d. Nursing office documents and tracks all requests for language assistance.

4. Documentation of Language Assistance

a. Whenever language assistance is used to communicate with a resident, the provider (physician, nurse, or other clinician who is using the language assistance) shall document the need and how the need was addressed in the resident's medical record.

b. If a family member/friend provides language assistance for a resident, document the relationship of the person providing assistance, and the reason why assistance was provided.

5. Translation of Vital Documents

a. Vital documents are written materials encompassed in section 91.5 of the Language Access Ordinance. Applicable hospital documents included in this criterion is subject to translation and or signage.

b. Department managers shall request for translation and or signage of the vital document. The Assistant Hospital Administrator shall make approval determination of the request.

c. If request is approved, the Assistant Hospital Administrator or designee shall utilize the Designated Bilingual Employee Program roster or third-party vendor services to have the written materials translated in five threshold languages at a minimum.

   i. Spanish

ii. Vietnamese

iii. Chinese (Cantonese/Mandarin)

iv. Tagalog

v. Russian

d. Vital documents that have been translated in the five threshold languages shall be made available electronically to the department by the Assistant Hospital Administrator or designee. Department managers and or designee are responsible for using the electronic versions to produce and post appropriate signage.

e. If a document previously translated needs to be edited, refer to 5b. in this policy.

ATTACHMENT:
Attachment A: Guidelines for the Care of the Hearing Impaired/Deaf Resident.
Attachment B: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
Attachment C: Ordinance 27-15 Administrative Code – Language Access for Departments

REFERENCE:
LHHPP 01-07 Posting Notices, Hanging Artwork, and Caring for the Buildings

Revised: 98/11/16, 02/04/12, 13/01/29, 15/03/10, 16/09/13, 19/07/09, 22/06/17, 22/11/08 (Year/Month/Day)
Original adoption: 89/09/01 Translation Services

ATTACHMENT A

GUIDELINES FOR THE CARE OF THE HARD OF HEARING ~~EARING IMPAIRED~~/DEAF RESIDENT

1. To schedule an appointment with an American Sign Language interpreter please call Interpreter Services at 628-206-5133 between the hours of 8:00 am to 12:00 midnight. After midnight please contact the Nursing office at extension 4-1501.

   - Sign language interpreters are arranged through an agency. When possible, please call to set up an appointment at least 48 hours in advance or sooner. If there is less than 48 hours' notice, there shall be an extra charge to LHH. Cancellations shall also be made 48 hours prior to the appointment or LHH shall be billed for the service. The sign language agency shall also try to assist with immediate or urgent needs.

   - Remember to coordinate the appointment time with all health care providers and do not arrange for the sign language interpreter when the resident shall be off the unit for diagnostic tests.

2. Obtain a packet of resource materials by contacting the Interpreter Services staff at 628-206-5133 and informing them of the resident's name, medical record number. Nursing office shall arrange for the packet of resource materials to be delivered to the unit/location. The packet can also be obtained by picking it up from the Nursing office. The packet of resource materials includes the following:

   a. "Deaf Resident Alert" or "Resident who is Deaf" sign (choose sign ands sticker in section be below based on resident's identity preference) - ~~-~~For hospitalized residents, please place the sign at the head of the bed, not outside the door.

   b. "Deaf Resident Alert" or "Resident who is Deaf" stickers - Please place the stickers on the call light system, as appropriate.

   c. Graphics Communication Sheet, pad of paper, and pencil- For hospitalized residents, please place at the resident's bedside.

3. Sign Language Agency information sheet.

Revised Food and Nutrition Policies and Procedures

1.1 Food from Home or Outside Sources Served Directly to Residents

~~Established and~~ Revised: 7/2024 10/98, 9/06, 12/06, 7/09, 8/18, 2/23

Reviewed: 8/13, 8/14, 8/18, 3/23

Policy: Food intended for resident consumption from outside sources shall be held to the same high levels of food safety and sanitation, storage, handling, and consumption as properly applied in the Food and Nutrition Services Department. Volunteers and Staff shall adhere to all aspects of this policy.

Purpose: To help visitors, friends, and family members understand safe food handling practices which may include holding or transporting foods containing perishable ingredients. This shall be done by assisting in the safe and sanitary storage, handling, reheat, and discard, using safe food handling practices.

Definition: Outside sources are those sources of food from any place not produced within the portals of Laguna Honda Hospital. The resident is a resident, patient, or client receiving care or services from Laguna Honda Hospital.

Procedure: Reasonable attempt shall be made to meet the following:

1. Residents have the right to accept food from a visitor, family, or friend as long as it is identified as non-facility prepared food.
2. Food shall be handled in accordance with applicable food sanitation guidelines.
3. Food brought in by family or visitors shall be stored separately or easily distinguishable from facility food. Perishable food is labeled with the resident's name, date received and expiration date, and kept in the designated resident refrigerator.
4. Food from home is discarded after 3 days~~72 hours~~ or per manufacture recommendation. Any food brought in from outside will be discarded if not properly labeled and dated.
5. Nursing staff is responsible for labeling, dating, and discarding items prior to expiration.
6. Nursing staff is responsible for assisting the resident in accessing and consuming outside ~~food, if~~food if the resident is not able to do so on his or her own.
7. Food from home cannot be accepted, stored, heated, or served by Food and Nutrition department.
8. The staff member who receives, labels, and dates the food is responsible for either alerting FNS or providing education on safe food handling (see references). This may include safe cooling/reheating processes, hot/cold holding temperatures, preventing cross- contamination and hand hygiene.
10. Any volunteer or staff member serving foods shall follow safe food handling procedures.

References:

- Safe Minimum Internal Temperatures <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm> Accessed 3/1/2023.
- Safe Food Handling: What You Need to Know <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm> Accessed 3/1/2023.

Revised Health Information Systems Policies and Procedures

RELEASE OF INFORMATION

PATIENT ACCESS TO HEALTH RECORDS:

POLICY:

The resident or resident's legal representative shall have access to current Protected Health Information, or accounting of disclosures, of the resident, **within five days** after submitting a written request (excluding weekends or holidays) according to the California Health and Safety Code Section 123100 – 123149.5.

PURPOSE:

1. To allow residents the right review their protected health information.
2. To comply with current HIPAA Rules, California and Federal laws.

PROCEDURE:

1. Responding to Requests from In House Residents

Per Health & Safety Code Section 123100: The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided.

Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care. **It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.**

Pursuant to Health & Safety Code Section 123110 :(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available.

A. Monday to Friday, 9:00 a.m. to 4:00 p.m. except holidays: contact Health Information Services.

i. Request that the resident complete the Authorization for Release or Disclosure of Protected Health Information Form; Appendix B-1).

ii. See "Responding to Verbal Requests" section below, if the resident refuses to sign the Authorization Form.

iii. Make contact with Unit and have the Nurse Manager to notify Health Information Services when the resident is available to review their PHI.

A. Responding to Verbal Requests

Explain to resident or their legal representative that a written request is required. Use of the Hospital Form "Authorization for Use or Disclosure of Protected Health Information" is required. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be returned to the sender. Access is given no later than five days of receipt of the request.

a. If a copy or ~~/~~copies are requested, the copies will be charged at the current rate per page.~~ .~~

b. Payment must be made by check or money order only.

c. Complete the required screens in the Release of Information module.~~ of the~~

I. State Personnel

a. Use same procedure as for the Ombudsman.

II. Attorney/Client

a. Arrange a date and time for the attorney/client to examine the record.

b. Only authorized H.I.S. staff must supervise the review.

c. If copies are requested, the charge will be determined by the number of copies at the current rate per page.

d. Payment must be made by check only.

e. Complete the required screens in the Release of Information module

B. Processing Requests for Copies of Protected Health Information

Upon receipt of an Authorization for use or disclosure of PHI:

I. Enter the requestor's information into the Release of Information module of the E.HR Release of Information Module.

~~I.~~ II. Locate record:

1) SCAN a copy of the Authorization for use or disclosure of PHI form in the resident's medical record.

III. When payment is received:

a. Copy the requested pages of PHI.
b. Enter any remaining information into the HIS ROI module.
c. Mail copy by certified mail to requestor.

Revised: 2011/08/24, June 2022
Original adoption: 1986/08

Revised Medical Services Policies and Procedures

E-REFERRAL CONSULTATION PROCEDURE FOR OUTPATIENT CLINIC

POLICY:

Laguna Honda Hospital (LHH) Outpatient Clinic services are provided based on an E-Referral Consultation Request from an Attending or authorized physician to make the request.

PURPOSE:

To provide a process by which LHH Medical Staff can obtain needed specialty care for LHH Residents and Community Clients.

PROCEDURE:
Each LHH Outpatient clinic has a designated consultative clinician reviewer(s) or Clinic Staff who may redirect the referral to a different service, may request additional information or clarification of the consultative question. The consultative clinician may provide co-management guidance via E-Referral. The goal of E-Referral is to allow for communication between the referring provider and the specialist reviewer until both agree that the resident/client either does not need an appointment or the appointment is scheduled. Please note that E-Referral is only intended for initial consultative requests; follow up appointments should be made by contacting the clinic directly.

1. Initial consultative request
   The referring provider (Attending Physician, Nurse Practitioner or LHH Authorized Physician) selects the desired resident/client in the Invision/LCR electronic health record system, then selects the desired clinic. The referring provider should review the clinic's referral guidelines prior to submitting a
   consultative request.

2. E-Referral submission: Complete the following information through the E-Referral program:
   a. reason for referral (consultative question)
   b. relevant details of examinations and laboratory results
   c. pertinent past medical/surgical history
   d. relevant medications
   e. any relevant diagnostic testing that was not performed at LHH/San Francisco General Hospital (SFGH) that cannot be accessed through the invision/LCRelectronic health record system.

3. E-Referral supervision:
   An Attending Physician must be included as part of the referral process. Nurse Practitioners do not require the co-signature of an Attending Physician unless in training or so required by the standardized procedures under which they are practicing.

4. E-Referral Consultant review and response
   a. Each clinic designates a clinician to review all submissions, unless otherwise previously agreed upon by the consultant physician to have the clinic staff review and directly schedule a resident into the specialty clinic.
   b. The consultant reviewer or clinic staff reviews and responds to the consultative request in a timely fashion; referring providers receive an automated email regarding the disposition of their requests within 5 business days.
   c. The consultant reviewer may forward the consultative request to the clinic staff for an appointment; alternatively, the consultant reviewer may redirect the referral to a different

service, may request additional information or clarification of the consultative question, or may provide co-management guidance via E-Referral.

d. When the clinic staff review the ~~submissions~~submissions, this is at the request of the consultant who has given consent for the referral to be directly scheduled into the next available clinic based on the referring provider's request.

5. E-Referral provider review and response
   a. Referring providers receive an automated email when the consultant reviewer responds to the consultative request; the E-Referral page with the consultant's response can be accessed from the resident's/client's ~~Invision/LCR~~ electronic health record or from the referring provider's E-Referral work list.
   b. For residents/clients who are scheduled for an appointment, if referring providers want to provide additional information or request a change in the appointment date, they should do so via the same E-Referral page.
   c. For residents/clients who are not scheduled for an appointment, referring providers should reply to the consultant reviewer's questions or requests for additional information via the same E-Referral page; if an E-Referral is inactive for more than 180 days, it is ~~closed~~closed, and a new E-Referral request needs to be submitted

6. E-Referral adjudication
   In the event that the referring provider and the consultant cannot come to an agreement about the need for an appointment or the timing of the appointment, the following adjudication process should be followed:
   a. Contact the Supervisor of the Department or Chief of ~~Staff .~~Staff.
   b. If there continues to be disagreement, the case should be forwarded to the hospital's Chief Medical Officer (CMO) for adjudication; the CMO may appoint a review panel comprised of primary care and specialty care providers to assist in the adjudication process.

7. E-Referral missed appointments
   In the event that a patient misses a specialty clinic appointment scheduled through E-Referral, the referring provider can resubmit the same E-Referral form up to 180 days after the missed appointment date; after that time a new form needs to be submitted.

Revised: ~~N/A~~24/07/31
Original Adoption: 13/08/08
Approved: 13/08/08

~~UNLOCKED~~ UNSIGNED ELECTRONIC HEALTH RECORD (EHR) NOTES

POLICY:
All Electronic Health Record (EHR) notes should be ~~locked~~ electronically signed within 3 days~~72 hours~~.

PURPOSE:
To provide consistent and timely standards of documentation, in alignment with San Francisco Health Network.

PROCEDURE:
1. After provider documentation and nursing functions have been completed, EHR notes shall be ~~locked~~electronically signed.
2. Notes can be ~~locked~~ signed immediately, but no later than 3 days~~72 hours~~ after the visit.
3. Failure to ~~lock~~ sign notes as delineated by this policy will result in notification to the CMO, COS, VCOS and Clinical Service Chiefs for interventions leading up to and including suspension of clinical privileges.

APPENDIX 1 – Guidelines for clinical suspension related to unlocked EHR notes.

1. A ~~twice weekly~~ monthly ~~re~~port of ~~unlocked~~ unsigned notes will be provided to the Chief Medical Officer, Chief of Staff, Vice Chief of Staff and Clinical Service Chiefs.
2. ~~In accordance with SFDPH policy, a~~~~Any~~Any provider with ~~ten or greater unlocked~~ notes that ~~have been unlocked~~ have remained unsigned for more than ~~72 hour~~3 days~~s~~ from the time of opening the note will result in a written warning. The second such warning in a 12 month period of time will result in ~~be notified and may be subject to~~ an immediate suspension of clinical privileges ~~from clinical duties~~ and potential other administrative remedies until all ~~notes~~delinquent notes are ~~locked~~ signed.

REFERENCE: SFDPH P&P Timely Documentation of Medical Encounters in the Electronic Health Record

REVISIONS: 19/12/05, 24/05/28 (Year/Month/Day)

ORIGINAL ADOPTION: 15/12/24 (Year/Month/Day)

PATIENT EXPIRATION

POLICY:
All patient deaths at Laguna Honda Hospital (LHH) LH shall be documented and reviewed. Next of kin shall be notified promptly. As appropriate, information shall be referred to the Medical Examiner/Coroner's Office (hereafter referred to as Medical Examiner) or other authorities.

PURPOSE:
To assure ensure appropriate and timely handling of patient deaths.

PROCEDURE:

1. The nurse in charge on a unit where a patient expires shall immediately notify the attending or covering physician (hereafter referred to as the attending physician) of the death.

2. A physician shall pronounce the patient dead and document the death with a brief note including information on whether or not the family and/or Medical Examiner have been notified. The physician pronouncing the patient's death shall complete a Patient Expiration Checklist and, in cases where the patient died on an acute care unit, a Tissue Donation Referral form. The Organ Tissue Donor Network must be notified within one hour of any death on acute medicine or acute rehabilitation units. The attending physician shall complete a death certificate and enter a death summary in the patient's medical record which details the hospital course, the time and circumstances of the patient's death, the presumed cause of death, and any other pertinent information about the death such as notification of the family or legal conservator, notification of the Medical Examiner, or request for autopsy.

3. All deaths falling under the jurisdiction of the Medical Examiner's office shall be reported to the Medical Examiner by the physician pronouncing the patient's death Reportable deaths include any possible aspiration event and any history of trauma, even remote trauma.

4. All deaths occurring under circumstances of unnatural causes or other catastrophes shall be reported to the state licensing authorities by the Executive Administrator/NHA or designee.

5. Requests for autopsy shall be made by the attending physician according to Guidelines for Autopsy Requests.

6. All deaths are reviewed by the Medical QI committee which shall assess the quality of care provided to the deceased throughout the hospital stay.

7. The Primary Care Physician shall, when possible, contact the family/surrogate decision maker within 48 hours of the resident's death to offer condolences and answer any questions.

REFERENCES:

- MSPP C01-02 Guidelines for Autopsy Requests
- MSPP C01-03 Organ Tissue Donation RequestHPP 29-03 Organ/Tissue Transplant Donation Program

MS Approved: September 16, 1996
MS Reviewed: September 30, 2010
MS Revised: June 21, 2022, July 31, 2024

Deletion Medical Services
Policies and Procedures

CENTRAL LINE INSERTION

POLICY:
Physicians will comply with the following guidelines when inserting central venous access lines.

PURPOSE:
Improvement of patient care through standardization in techniques of placement and management of central venous catheters.

GENERAL CONSIDERATIONS:
1. PICC placement when possible/available
2. Minimize incidence of catheter related infections
3. Minimize incidence of catheter related mechanical complications

INDICATIONS FOR CENTRAL LINE PLACEMENT:
1. Poor peripheral venous access
2. Rapid fluid resuscitation
3. Infusion of vasoactive substances, chemotherapy or hyperalimentation
4. Access for prolonged course of antibiotics

ABSOLUTE CONTRAINDICATIONS:
1. Infection at insertion site
2. Anatomic obstruction (thrombosis, anatomic variation)
3. Superior vena cava syndrome
4. Lack of on site radiology for post placement x-ray (subclavian, internal jugular lines)

RELATIVE CONTRAINDICATIONS:
1. Coagulopathy
2. Uncooperative patient or inability to tolerate Trendelenberg
3. Morbid obesity

GUIDELINES:
EQUIPMENT AND SET UP
1. Maximal sterile barriers required: sterile mask; sterile gloves, sterile gown, cap, full body sterile drape
2. Monitors (pulse oximeter, blood pressure)
3. Central line kit

PROCEDURE:

1. Obtain written consent from the patient or decision maker, explaining risks and benefit
2. Apply oxygen if sedation is given
3. Place patient in supine position and Trendelenberg (if possible) with head turned 45 degrees away from cannulation site (except for femoral)
4. Open central venous access kit
5. Wash hands
6. Put on sterile mask, cap, gloves and gown
7. Sterile prep of site with chlorhexidine
8. Fully drape the procedure area
9. Use of Seldinger technique

A. INTERNAL JUGULAR VEIN

i. Located between sternal and clavicular heads of the sternalcleidomastoid muscle
ii. Lateral to carotid artery
iii. Lower incidence of pneumothorax compared with subclavian vein catheterization
iv. Right internal jugular vein takes a straight course to the right atrium, easier to position at SVC-RC junction
v. Right internal jugular vein catheterization has lower incidence compared to left due to lower dome of pleura on the right side
vi. Right internal jugular vein catheterization avoids thoracic duct injury on the left
vii. More likely to become contaminated due to respiratory secretions

B. SUBCLAVIAN VEIN

i. Located under clavicle, passes over first rib and apical pleura, parallel to subclavian artery
ii. Lower incidence of infection compared to internal jugular catheterization
iii. Higher comfort level in patients

C. EXTERNAL JUGULAR

i. More difficult to pass wire to subclavian vein due to presence of valve approximately 4 cm above the clavicle

D. FEMORAL

i. Best approach during code situation with CPR

ii. Higher incidence of infection compared to subclavian vein or internal jugular vein catheterization

iii. Avoid in situations of elective catheter placement

iv. Entry point is approximately 1 cm below the inguinal ligament and 0.5 to 1 cm medial to the femoral arterial pulsation. Enter skin at 45 degrees in a cephalic direction

E. SUBCLAVIAN APPROACH

i. Turn head of patient away from side to be cannulated, position arms at the side
ii. Locate midpoint of clavicle (mid-way between sternal notch and AC joint) and insert needle 1 cm lateral to the midpoint and inferior to the clavicle.
iii. Using an angle of 10 to 15 degrees beneath the clavicle, use an 18 or 20 gauge needle and aim for the clavicle then "walk" the needle below the clavicle
iv. Once the clavicle is passed, continue to advance in a plane almost parallel to the skin until venous blood is aspirated into the syringe
v. After blood is freely aspirated into syringe, disconnect the syringe from the needle
vi. Remove needle while leaving catheter in place and pass the guidewire about 6 to 8 inches
vii. Remove catheter while leaving guidewire in place
viii. Using a scalpel, make a small incision at the wire
ix. Advance a dilator to just beyond the skin until there is a loss of resistance (about 2 to 3 cm)
x. Remove dilator, leaving wire in place
xi. Pass catheter over the wire
xii. Remove the wire
xiii. Aspirate air from each port with a sterile syringe and flush with saline
xiv. Secure catheter with sutures at the skin

F. POST-PROCEDURE CARE

i. Order chest x-ray to confirm tip of catheter is at SVC-RA junction and to rule out presence of pneumothorax
ii. If catheter needs to be adjusted, use sterile technique including full gown and gloves and full body drape

iii. For removal – place patient in Trendelenberg position, ask patient to exhale as catheter is removed to prevent air embolism, apply pressure over the site for 1 to 2 minutes until bleeding stops

G. COMPLICATIONS

i. Hematoma
ii. Arterial puncture (3% IJ, 0.5% subclavian, 6.25% femoral)
iii. Infection (8.6% per 1000 catheter days for IJ, 4 for subclavian, 15.3 for femoral)
iv. Arrhythmia
v. Cardiac perforation and tamponade
vi. Thoracic duct injury
vii. Pneumothorax (0.1 to 0.2% for IJ, 1.5 to 3% subclavian)
viii. Hemothorax (0.4 to 0.6% subclavian)
ix. Nerve injury
x. Venous thrombosis, pulmonary emboli

CENTRAL LINE INSERTION PRACTICES (CLIP)

A. Subclavian central line recommended
B. IJ acceptable for <72 hours duration, or if contraindication to subclavian line
C. Guide wire/sheath exchange can be used to replace a malfunctioning central line if there is no evidence of infection
D. Routine change of central line over guide wire to prevent infection no longer recommended
E.A. CLIP surveillance by CDC required due to Senate Bill 739 (September 2006)

Revised Outpatient Clinic Policies and Procedures

OUTPATIENT CLINIC SERVICES

~~**POLICY:**~~

~~All practitioners providing services to residents in the Outpatient Clinics of LHH will be qualified by training, experience and credentialing for the services they perform and shall have been granted privileges by the Governing Body upon recommendation of the Medical Executive Committee in accordance with LHH Medical Staff Bylaws.~~

~~**PURPOSE:**~~

~~The Outpatient Clinics provide on site medical and surgical services to assist the Medical Staff of LHH in the care of residents.~~

~~**CLINIC STAFF:**~~

~~*OUTPATIENT CLINIC STAFF:*~~

~~The Outpatient Clinics is staffed at a minimum by a Clinic Director (aka Chief of Outpatient Services), a Clinic Nursing Director, and a licensed RN. Additional staffing may include LVNs, CNAs, and Medical Evaluation Assistants.~~

~~*MEDICAL AND SURGICAL STAFF:*~~

~~Please refer to LHH Medical Staff Bylaws.~~

~~Most recent review: 09/08, 13/09/24~~

POLICY:

All clinicians and staff providing services at Laguna Honda Hospital & Rehabilitation Center (LHH) Outpatient Clinic (OPC) for residents, who are called patients at OPC, shall be qualified by training, experience, licensure, and credentialing for the services they perform and shall have been granted privileges by the Governing Body in accordance with LHH Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and Interdisciplinary Practice Committee Standardized Procedures.

PURPOSE:

Provide an overview of OPC scope of services with the aim to provide patient-centered care and consultation by partnering with LHH Inpatient Resident Care Teams.

GENERAL STATEMENT:

Outpatient Clinic offers non-emergency health care services to patients with appropriate staffing, space, equipment, and supplies.

All services are delivered in a manner that promotes and aligns with LHH General Administration Policy *LHH 01-00 Vision, Mission and Vision Statements*, and that assures all patients receive the same level of care consistent with community standards.

Outpatient Clinic provides the following medical, surgical, and ancillary services:

- Dental
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Hand
- Infectious Disease
- Nephrology
- Neurology
- Oculary
- Optician
- Optometry
- Orthopedics
- Otolaryngology
- Pain Management
- Physiatry
- Plastic Surgery
- Pulmonary
- Minor Procedure
- Psychiatry/Neuropsychology
- Rheumatology
- Podiatry
- Occupational Health Service

HOURS OF OPERATION:

Outpatient Clinic operates Monday to Friday from 6:30 am – 5 pm, excluding holidays.

See Appendix A – LHH Outpatient Clinic Schedule.

PATIENTS:

Outpatient Clinic serves LHH patients of all ages, race, gender, religious affiliation, and sexual orientation, who are referred by a LHH attending physician.

Average annual number of patient encounters: 6,000 – 7,000.

SUPPORT SERVICES:

Transport support for patients, who need such service, is provided, and coordinated between neighborhood and OPC staff.

Interpreter services are provided to all patients throughout the entire encounter consistent with *LHH 29-05 Interpreter Service and Language Assistance.*

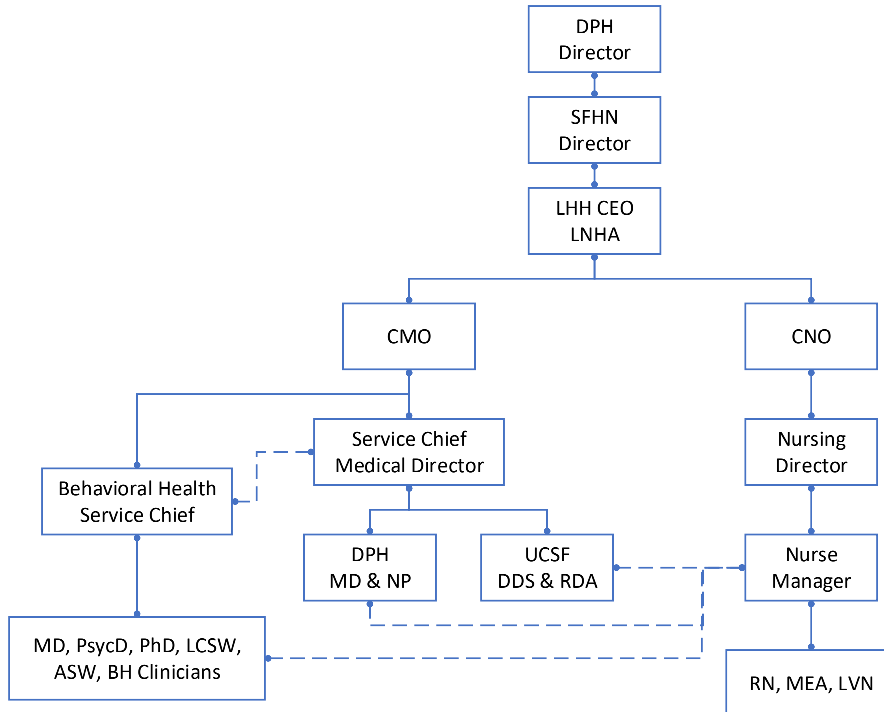
Patients, who need additional consultative, surgical, diagnostic, and/or ancillary services that are not available at OPC, are referred to Zuckerberg San Francisco General Hospital, LHH Post-Acute Services, and local hospital systems with transport support to and from such facilities.

Other support services are provided in partnership with, but are not limited to, Environmental Services, Facilities Services, Food Services, Health Information Management, Security Services, Workplace Safety and Emergency Management, Central Processing and Distribution, Materials Management, Office of Compliance and Privacy Affairs, and Patient Financial Services.

ORGANIZATION, AUTHORITY, RESPONSIBILTY, AND ACCOUNTABILITY:

Organizational Structure

Outpatient Clinic represents one of four clinical services that report up to the LHH Medical Staff. *Policies LHH 01-03 and 01-03A LHH Hospital Organizational and LHH Admin Org Charts*.



Responsibility and Functions

Outpatient Clinic shall meet all State, Federal and City regulatory and legal requirements that govern its services or functions. OPC Service Chief and Nurse Manager shall be responsible for the overall delivery and supervision of the clinical services, teaching, and research within the OPC. Qualifications and responsibilities of the OPC Service Chief are in accordance with LHH Medical Staff Bylaws and Rules and Regulations.

1. Service Chief (Medical Staff Bylaws Article IX – Section 3)
    - Accounts for all professional and administrative activities of the service.
    - Implements actions taken by the Medical Executive Committee.
    - Makes recommendations to the Chief of Staff concerning staff scheduling, privileges, and reappointment.
    - Acts as presiding office at service meetings.
    - Evaluates and monitors the performance of all professional appointees.
    - Conducts peer review with respect to the quality and appropriateness of patient care provided within clinical services.
    - Accounts for all proctoring protocols and quality improvement activities.
    - Develops and ensures compliance with the Medical Staff Bylaws and Rules and Regulations, and LHH policies and procedures within the respective clinical services.
    - Assesses and recommends off-site resources that provide patient care services not available at the hospital.
    - Prepares annual reports, including budgetary planning for respective clinical services.

2. Nurse Manager
   - Accounts for all nursing and administrative activities of the service.
   - Assesses, plans, implements and evaluates nursing care using patient outcomes data.
   - Provides clinical leadership within the institution.
   - Collaborates with the unit-based Interdisciplinary Team to provide patient-centered care.
   - Ensures unit compliance to regulatory standards.
   - Represents OPC in a variety of meetings and committees.
   - Maintains, monitors, and promotes a patient-centered philosophy that supports the autonomy, dignity and rights of residents and others.
   - Attends staff and clinic meetings and LHH leadership meetings as requested.
   - Participates and co-leads quality improvement activities with Service Chief.
   - Ensures adequate staffing coverage for daily operations at Outpatient Clinic.
   - Evaluates and monitors the performance of all nursing and administrative staff.
   - Handles non-professional consultant payroll.
   - Develops smooth collaborative relationship with other LHH clinical and administrative units.

CARE TEAM PROVIDERS and STAFFING:

See Appendix B – OPC Care Team Inventory

Staffing

A. Core Staffing – During hours of operation, at least one RN and 2 nursing support staff will be onsite during business hours of 6:30 am – Noon, and 1 pm – 4 pm.

B. Augmented Staffing – Staff augmentation occurs whenever one of the following conditions are met:
- Staffing falls below core staffing standard.
- Scheduled appointments exceed available staffing.
- Disaster activation requiring OPC to serve as a triage site.

A. Minimum Staffing – During disaster and/or work stoppage

Class	# of Staff	Function	Shift	Hours
RN	1	Triage & Direct Care	Day	7am-7pm
RN	1	Triage & Direct Care	Evening	7pm-7am
LVN	1	Direct Care	Day	7am-7pm
LVN	1	Direct Care	Evening	7pm-7am
MEA	1	Direct Care	Day	7am-7pm
MEA	1	Direct Care	Evening	7pm-7am
MD/NP	1	Consultation & Direct Care	Day	7am-7pm
MD/NP	1	Consultation & Direct Care	Evening	7pm-7am

SPACE, EQUIPMENT & SUPPLIES

- Examination and treatment rooms shall be adequate in relation to the volume and nature of work performed.
- Waiting areas shall be readily accessible to patients and personnel.
- Cleaning, sanitizing, and stocking shall be in accordance with *LHH Administrative, Environment and Equipment Cleaning, and Infection Disease Prevention and Control* policies and procedures.
- Available laboratory and pharmacy services shall be in accordance with *LHH Administrative, Department, and Medication Management* policies and procedures.

STANDARDS & GUIDELINES

Outpatient Clinic shall be in accordance with all relevant *LHH DPH-wide, Administrative, Department, Clinical Record Management, Resident Rights, Safety and Facility Practices, Medical Devices and Equipment, Emergency Management, Fire Safety and Prevention, Infection Control, Occupational Safety and Health, and Student Program policies and procedures and Medical Staff Bylaws* and *DPH Professional Codes of Conduct.* Examples include the following, but are not limited to:

DPH-Wide, Administrative, and Department Procedures and Standards:

1. DHR Vaccination and Booster Policy for City Employees – *DHR 00-00*
2. DPH Privacy Policy – *DPH 1-00*
3. Point of Care Testing – *DPH 16-20*
4. Medication Reconciliation – *DPH 16-35*
5. Order Entry – *DPH 18-04*
6. Timely Documentation of Medical Encounters in the EHR – *DPH 4-08*
7. Timely Reviewing of Diagnostic Results in EHR – *DPH 4-09*
8. Open Notes Policy – *DPH 5-10*
9. HIPAA Compliance Authorization of Use and Disclosure of Protected Health Information – *DPH 8-11*
10. Electronic Health Record (EHR) Downtime – *DPH 9-03*
11. Managing Patient Identification – *DPH 9-06*
12. Medical Record Documentation – *LHH 21-05*
13. Handling of misfiled Electronic Health Records and Chart Correction – *LHH 21-07*
14. Authorization of Use and Disclosure of Protected Health Information – *LHH 21-13*
15. Document Shredding – *LHH 21-17*
16. Interpreter Services and Language Assistance – *LHH 29-05*

Daily Care Management – Category 24

1. Denture Replacement – *LHH 24-27*
2. Behavioral Health Care and Services – *LHH 24-28*

Medical Devices and Equipment – Category 31

1. Wireless Refrigeration and Warming Temperature Monitoring System – *LHH 31-01*
2. Training Staff on Using New Equipment – *LHH 31-04*

Reporting Requirements, Audits, Survey Admin – Category 60

1. Quality Assurance Performance Improvement Program – *LHH 60-01 and Appendix_A*
2. Incidents Reportable to the State of California – *LHH 60-03*
3. Environment of Care Program – *LHH 60-10*
4. Patient Safety Committees and Plans – *LHH 60-13*
5. Monitoring of Third-Party Agreements – *LHH 65-02 and Appendix_A*

Emergency Management – Category 70

Infection Control – Category 72

1. Section A – Program Description and Activities – *LHH 72-01_A01-A11*

2. Daily Practice Standard Precaution – *LHH 72-01_B01*
3. Hand Hygiene – *LHH 72-01_B02*
4. Respiratory Hygiene / Cough Etiquette – *LHH 72-01_B24*
5. Employee Influenza Vaccination – *LHH 72-01_C24*
6. Guidelines for Prevention and Control of Tuberculosis – *LHH 72-01_C26*
7. COVID-19 Immunization – *LHH 72-01_C28*
8. Pre-employment and Annual Screening of Employees – *LHH 72-01_D01*
9. Evaluation of Communicable Illness in Health Care Workers – *LHPP 72-01_D02*
10. Blood Spill Clean Up – *LHH 72-01_F10*
11. Classification of Reusable Medical Devices and Processing Requirements – *LHH 72-01_F11*
12. Cleaning and Disinfecting Non-Critical Resident Care Equipment – *LHH 72-01_F13*
13. Storage of Supplies (Clean/Sterile) – *LHH 72-01_F15*

Occupational Safety and Health – Category 73

Environmental Services – Departmental Policies
1. Waste Management Policy – *LHH_EVS_IX*
2. Hospital Cleaning Steps Standard Cleaning Procedures – *LHH_EVS_XI*
3. Transmission-Based Precautions Cleaning – *LHH_EVS_XII*
4. Ice Machine and Refrigerator Cleaning – *LHH_EVS_XVI*

In addition to LHH Hospital-Wide Policies and Procedures, OPC shall also be in accordance with *applicable* LHH Departmental Policies and Procedures including, but not limited to following LHH Departments – Biomedical Engineering, Central Processing Department, Environmental Services, Facility Services, Health Information Services, Human Resources, Medical Staff, Nursing, and Pharmacy.

Revised: 08/01/2009, 09/24/2013

APPENDIX

- Appendix A – LHH Outpatient Clinic Schedule.
- Appendix B – OPC Care Team Inventory

Appendix A - OUTPATIENT CLINIC WEEKLY SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
Primary Care Minor Procedure **Rheumatology 1x/month** **Dermatology 2x/month** **Dental**	**Primary Care Minor Procedure** **Ocularist call 1-2X/year** **Nephrology 2nd Tuesday** **Physiatry/EMG** **Infectious disease** **Optician 4th Tuesday** **Dental**	**GI** **Primary Care Minor Procedure** **Optometry** **Physiatry PRN** **Dental**	**Primary Care Minor Procedure** **Cardiology clinic 2x/month** **Physiatry EMG clinic** **Pain Clinic** **Dental**	**Primary Care Minor Procedure** **Plastic** **Orthopedic** **Physiatry PRN** **ENT 3rd Friday AM** **Dental**
Podiatry clinic **Dental**	**Primary Care Minor Procedure** **Physiatry/EMG** **Hand** **Q2month – 2nd Tuesday PM in the Odd month** **Dental**	**Primary Care Minor Procedure** **Pain** **Optometry** **Endocrinology 4th Wed** **Neurology** **Dental**	**Primary Care Minor Procedure** **Physiatry/EMG** **Dental**	**Neurology** **Dental**

Appendix B – OPC Care Team Inventory

CDPH Licensed Service	Epic LHH Clinic Department	Last Name	First Name	Discipline	Clinic Schedule
OP Cardiology	LHH Cardiology Clinic	Durstenfeld	Matthew	MD	Tues am 2x/mo
OP Dermatology	LHH Dermatology Clinic	Chang	Aileen	MD	M am, 2x/mo
OP Endocrinology	LHH Endocrinology Clinic	Patzek	Sophie	MD	W pm, 1x/mo (4th)
OP Gastroenterology	LHH Gastroenterology Clinic	Fung	Gregory	MD	W am, wkly except 1st/mo
OP Gastroenterology	LHH Gastroenterology Clinic	Reed	James	MD	W am, 1x/mo (1st)
OP Hand Clinic	LHH Hand Clinic	Lee	Nicholas	MD	T pm, q2 off months
OP Infectious Disease	LHH Infectious Disease Clinic	Jain	Vivek	MD	eConsult
OP Infectious Disease	LHH Infectious Disease Clinic	Winston	Lisa	MD	eConsult
OP Nephrology	LHH Nephrology Clinic	Delphine	Tuot	MD	T am, 1x/mo (2nd) TBD
OP Neurology	LHH Neurology Clinic	William	Corn	MD	W pm, F pm
OP Oculary	LHH Ocularist	Alcorta	Tony		T am, 1-2x/year
OP Optician Services	LHH Optician Services	Jack	Sinow		T am, 1x/mo (4th)
OP Optometry	LHH Optometry Clinic	Lau	Angie	OD	W am/pm, 1x/mo (3rd)
OP Optometry	LHH Optometry Clinic	Tran	Hieu	OD	W am/pm, 1x/mo (4th)
OP Orthopedics	LHH Orthopedic Clinic	Richard	Coughlin	MD	F am
OP Otolaryngology	LHH Ear Nose Throat Clinic	Shauna	Brodie	NP	F am, 1x/mo (3rd)
OP Pain Management	LHH Pain Clinic	Rybold	Daniel	MD	W pm, Th am
OP Pain Management	LHH Pain Clinic	Dammann	Grace	MD	W pm, Th am
OP Physiatry	LHH Physiatry	Pascual	Lisa	MD	T am, T pm, Th am, Th pm
OP Physiatry	LHH Physiatry	Cohn	Jennifer	MD	W am
OP Physiatry	LHH Physiatry	Fung	Nancy	MD	F am
OP Plastic Surgery	LHH Plastic Clinic	Young	David	MD	F am
OP PC & Minor Procedures	LHH Minor Procedure Clinic	Lee	Christine	MD	M am, T, W, Th am/pm, F am
OP OHS	LHH Ocupational Health	Shute	Michelle	MD	M-W am/pm
Podiatry	LHH Podiatry Clinic	Parks	Charles	DPM	M pm
OP Rheumatology	LHH Rheumatology Clinic	Margaretten	Mary	MD	M am, 1x/mo
Dental Service	LHH Dental Clinic	Kim	Kwang	DDS	
Dental Service	LHH Dental Clinic	Cheng	Yi	Dental Supervisor	3 shifts q month
Dental Service	LHH Dental Clinic	Josue	Hidalgo	Denta assistant	M-F
Dental Service	LHH Dental Clinic	Kammy	Ninh	Dental assistant	M-F
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Qian	Yifang	MD, PhD	Tu-Th am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Olson	Daniel	MD	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Lin	Katrina	DO	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Wheeler	Tyler	MD	Tu am/pm; F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Lenrow	Laurie	LCSW	M-F, am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Gysens	Sabine	PhD	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Murphy	Michelle	PsyD	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Martinez	Elizabeth	PhD	M-W am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Scherdell	Traci	PsyD	M am/pm as needed
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Philipp	Julian	LMFT	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Keans	Sovin	AMFT	M-F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Mello	Lazzuly	LCSW	M-W am/pm; F am/pm
OP Psychiatry/Neuropsychology/Behavioral Health	LHH Psychiatry	Rosales-Escobar	Tamara	CDAC-II	M-F am/pm
	Other LHH Outpatient Care Team Members:				
	Medical Director	Chen	Helen	MD	M-F 8-5
	Nurse Manager	TBD	TBD		
	Charge Nurse	Huang	Bi	RN	M,T, W, Th, F am/pm
		San Jose	Julian	RN	M,T, W, Th, F am/pm
		Phu	Nhu	LVN	M,T, W, Th, F am/pm
		Gomez Cruz	Oscar	MEA	M,T, W, Th, F am/pm
		Saiz	Christian	LVN	M,T, W, Th, F am/pm

Revised Rehabilitation Policies and Procedures

PATIENT VS. RESIDENT TERMINOLOGY

Because these policies and procedures refer to both Acute- and SNF-level units, the word “patient,” is used to refer to both “patients” on the Acute Rehabilitation Unit and “residents” on the SNF Rehabilitation Unit. Wherever, applicable, updates will be made to add both patient/resident terminology for policies, procedures, but not limited to.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 23/05/16, 22/04/19, 17/08/14, 16/08/05, 18/08/24, 20/04/22, 21/07/13
Revised: 06/09/22, 14/08/21, 16/08/05, 20-07-21, 24/04/24
Original Adoption: 99/08/23

WRITTEN POLICIES AND PROCEDURES FOR REHABILITATION SERVICES

POLICY:

Written policies and procedures describe mechanisms for effective organizational management, interdepartmental relationships and communications, and adherence to federal, state and local regulations. -Policies and procedures are developed and maintained by the person responsible for the service in consultation with other appropriate healthcare professionals, Administration, and medical staff, where appropriate.

PROCEDURE:

1. Qualified individuals provide administrative direction of each rehabilitation service. -Written procedures are developed by the person responsible (or their representative) for the service, in consultation with other appropriate healthcare professionals and Administration and in accordance with federal, state and local regulations, but not limited to.

2. The Executive Rehabilitation Leadership Director, or designee, develops, reviews, and approves the Rehabilitation Services' policies and procedures, in consultation with the Department Heads and the Chief of Rehabilitation Services (see P&P # 40-06, Evaluation of Services), but not limited to.

3. Staff orientation, in-service training, and appropriate continuing education are provided, and these activities are documented, but not limited to.

4. When clinical facilities are provided for education and training of students, the roles and responsibilities of Rehabilitation Services staff members, and features of the educational program, are defined in writing, but not limited to.

ATTACHMENT:
None

REFERENCE:
1. HWP&P: 01-01 Approval Format and Format Approval of Hospital-wide and of Departmental Policies and Procedures
2. Barclays California Code of Regulations, Title 22 § 72405 Physical Therapy Service Unit–Policies and Procedures, § 72415 Occupational Therapy Service Unit–Policies and Procedures, § 72425 Speech Pathology and/or Audiology–Policies and Procedures
3. Barclays California Code of Regulations, Title 22 § 70597 (a) (Rehabilitation Center General Requirements)

Most Recent Review: 23/05/16, 22/04/19, 16/08/05 , 17/7/31, 18/08/24, 20/04/22, 21/07/13
Revised: 06/09/22, 14/08/21, 24/04/24
Original Adoption: 99/08/23

RESPONSIBILITY AND ACCOUNTABILITY OF THE REHABILITATION SERVICES

POLICY:

The responsibility and accountability of the Rehabilitation Services to the medical staff and administration is outlined below.

PROCEDURE:

1. Under the direction of the Medical Director of the Hospital, the overall responsibility for Physical Medicine Services at the Rehabilitation Services lies with the Chief of Rehabilitation Services.

    a. The Chief of Rehabilitation Services provides medical oversight of Rehabilitation Services and supervision of physiatrists or physicians practicing in the field of rehabilitation medicine. The Chief of Rehabilitation Services facilitates integration of the service with other services within the hospital, but not limited to.

    b. The Department of Public Health (DPH)/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services, in consultation with the Chief of Rehabilitation Services and under the direction of the SFHN VP Executive Rehabilitation Services, ,and/or SFHN Chief Operating Officer, provides administrative management of the Rehabilitation Services, including monitoring the budget; chairing monthly department meetings; oversight of the continuing education program; assuring adherence to federal, state and local regulations; and identification and planning for future program needs, but not limited to.

2. The delivery of medical rehabilitation services is provided by qualified physicians on the Medical Staff who have training and experience in the field of rehabilitation medicine (e.g. physiatrists).

    a. On the Rehabilitation Unit(s), the physiatrist, in consultation with other members of the Rehabilitation Unit's Patient Care Team (PCT)/ Resident Care Team (RCT), determines rehabilitation goals and prescribes a comprehensive interdisciplinary rehabilitation treatment plan for each patient/resident, which includes a detailed diagnosis and a projected length of treatment time.

    b. On the Acute Rehabilitation Unit, physiatrists will provide patients with close medical supervision and ongoing assessment of their changing medical and rehabilitation needs. Face to face visits will be made by physiatrists at least three times/week and documented in the electronic medical record.

    b. On general skilled nursing facility units, the Unit Physician is responsible for the general medical care of the patient/resident and ancillary services, as needed. When consulted, Rehabilitation Services and physiatrists interact closely with the

Unit's PCT/RCT, patient/resident and the patient's/resident's family/caregivers towards achieving realistic rehabilitation goals.

3. Under the direction of the DPH/San Francisco Health Network (SFHN) Executive Leadership Director of Integrated Rehabilitation Services, the Senior Physical Therapist, Supervising Speech/Language Pathologist, and Senior Occupational Therapist arrange scheduling of patients, supervise all staff activities, bear responsibility for carrying out prescribed treatment programs, and assure proper documentation in patient's/resident's charts, but not limited to.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: A05-01 Rehabilitation Services
2. Barclays California Code of Regulations, Title 22 § 70597 (a)

Most Recent Review: 18/08/24, 16/08/05, 20/04/22, 21/07/13, 22/-04/29, 23/05/16
Revised: 18/08/24, 06/09/22, 14/08/21, 17/07/31, 20/07/17, 24/04/24
Original Adoption: 99/08/23

REHABILITATION CENTER & REHABILITATION SERVICES STAFF

POLICY:

Qualified professionals and support staff are available either as part of the Rehabilitation Center or Rehabilitation Services Staff ~~or~~ by consultation or referral when deemed appropriate per Title 22 § 70599. ~~Each individual who provides rehabilitation services has been determined to be competent to provide such services by reason of education, training, experience, and demonstrated adherence to current standards of care.~~

PROCEDURE:

~~A sufficient number of qualified, competent therapeutic services, professionals, and support staff are available to meet Rehabilitation Service's needs, including the following:~~ The Rehabilitation Center/Rehabilitation Services staff shall consist of the following, but not limited to:

~~1.~~ A physiatrist or physician experienced in rehabilitation medicine, in the role of Chief of Rehabilitation, has overall responsibility for Rehabilitation Services. [Title 22 § 70599(a)]

~~2. A physiatrist(s) experienced in rehabilitation medicine to provide assessment and ongoing evaluation of the patient's rehabilitation needs.~~

~~3.~~1. ~~Qualified physicians, who perform inpatient services, general medical management, and acute medical care, with specialty consultation and management, as required, by the patient's condition.~~

~~4.~~2. A registered nurse, in the role of Nurse Manager, with training in, and at least one year of experience with, rehabilitation nursing, who is responsible for nursing care and nursing management of rehabilitation services on the Rehabilitation Unit. [Title 22 § 70599(b)]

~~5.~~3. Registered Nurses

4. Other personnel experienced in rehabilitation shall be provided to meet the needs of the service and shall include but not be limited to the following:

   a). ~~Full-time~~ Physical Therapists and Physical Therapy Assistants

   b). ~~Full-time~~ Occupational Therapists

   c). ~~Full-time, part-time or referral-based Speech/Language~~Speech Language Pathologists

d) Therapy Aides and any additional supporting staff

6. Physical Therapists

Occupational Therapists

7. Speech/Language Pathologists

8.5. Audiologist

9.6. Dietitian

10.7. Neuropsychologist consultant

11.8. Psychiatrist, neurologists, ENT, and other medical consultants

12.9. Social Workers

13.10. Activity Therapists

14.11. Clinical Dietitians

15.12. Orthotists and prosthetists,Orthotists and prosthetists are available on a consultation or referral basis.

16.13. Vocational Rehabilitation Services

ATTACHMENT:
None

REFERENCE:

1. Nutrition Services Department Policies and Procedures Manual
2. Activity Therapy Department Policies and Procedures Manual
3. Barclays California Code of Regulations, Title 22 § 70597(c); 70599(a–d, § 70519 (a-d), § 70559 (a-c), § 70643 (a-d)
4. Barclays California Code of Regulations, Title 22 § 72407 Physical Therapy Service Unit–Staff, § 72417 Occupational Therapy Service Unit–Staff, § 72427 Speech Pathology and/or Audiology–Staff

Most Recent Review: 23/05/16, 22/04/19, 18/08/24, 17/08/14, 16/08/05, 20/04/22, 21/07/13
Revised: 06/09/22, 10/12/07, 13/08/22, 14/08/21, 16/08/05, 20/07/17, 24/04/24
Original Adoption: 99/08/23

STAFF ORIENTATION, IN-SERVICE TRAINING, AND CONTINUING EDUCATION

POLICY:

Staff orientation, in-service training, and appropriate continuing education are provided, but not limited to. -These activities ~~are~~ may be documented, as indicated.

PROCEDURE:

1. New staff members are oriented to their respective Department when first employed in Rehabilitation Services. An Orientation Manual is maintained by the department, and may be updated, as indicated.
2. State-mandated in-services for licensing and certification are provided by Laguna Honda Hospital's Department of Education and Training and documented accordingly.
3. Educational leave days for continuing education credit hours are provided for staff members according to individual Memoranda of Understanding with recognized employee organizations.
4. Staff will complete minimum requirements for licensure renewal as per California Board of Physical Therapy/Occupational Therapy/Speech Language Pathology. A list of activities and courses completed by Rehabilitation Services employees will be maintained by each therapist and, all licensed staff members' active licenses will be maintained per therapist and/or in the~~ir~~ departmental file.

REFERENCES:

1. Barclays California Code of Regulations, Title 22 § 70055, Personnel (405.1031d); 70597(a)(5)
2. Barclays California Code of Regulations, Title 22 § 72075, Occupational Therapist; § 72083, Physical Therapist; and § 72107, Speech Pathologist
3. Business and Professions Code 1399.160-1 and 1399.160-2 (Speech-Language Pathologists only)

Most Recent Review: 22/04/19, 14/08/21, 17/8/15, 18/08/15, 20/04/20
Revised: 06/09/22, 10/12/07, 11/08/30, 14/08/22, 21/07/13, 24/04/22
Original Adoption: 99/08/23

BEHAVIORAL HEALTH SERVICES

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to ensure all residents receive necessary behavioral health care and services to assist them in reaching and maintaining their highest level of physical, mental and psychosocial functioning (HWPP 24-28). Specialty ~~B~~behavioral health services, including neuropsychological services, shall be available for consultation for patients undergoing a comprehensive rehabilitation program.

PROCEDURE:

1. Request for specialty behavioral health services may be submitted via the electronic health record.

2. Based on the service needs, the request will be triaged to appropriate LHH Psychiatry provider(s), including psychiatrist, neuropsychologist, clinical psychologist, behavioral health clinician~~s~~, and counselor~~s~~.

3. Services include (MSPP D08-02):

   a. Neuropsychological and Psychological Testing services (MSPP D08-08), which include neuropsychological assessment of patients with cognitive dysfunction after central nervous system injury.

   b. Behavioral Management services (MSPP-D08-10), which include

      i. Assistance in the development of behavior management programs appropriate to patients in need of cognitive, psychosocial, or behavior therapy.

      ii. Coordination of the implementation of such behavior management programs with all Medical, Nursing, Rehabilitation Services, psychiatry and psychology, and other therapy staff responsible for the care of the patient.

      iii. Ongoing reassessment of the patient's status and function, and revision of the behavioral ~~management~~ plan, as indicated.

   c. Mental Health Services (MSPP D08-09), which include psychotherapy.

   d. Psychotropic Medication Management services (MSPP D01-05)

   e. Substance Treatment and Recovery Services (MSPP-D08-07)

5. LHH Psychiatry providers may participate in *Rehabilitation Patient Care Case Conferences* and discharge planning as needed.

6. The Chief of Psychiatry/designee shall assist the Chief of Rehabilitation Services in long-term program planning for the optimal therapeutic milieu for identified patients with psychological needs, with input from LHH Psychiatry providers.

ATTACHMENT:
None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70599(d)(4)(g)
HWPP 24-28 Behavioral Health Care and Services
MSPP D08-02 LHH Psychiatry Scope of Service and Organization
MSPP D08-03 Access to LHH Psychiatry Services
MSPP D01-05 Psychotropic Medication Management
MSPP D08-07 Substance Treatment and Recovery Services
MSPP D08-08 Neuropsychological and Psychological Testing Services
MSPP D08-09 Mental Health Services
MSPP D08-10 Behavioral Management Services

Most Recent Review: 14/08/21, 23/06/03
Revised: 06/09/22, 17/08/14, 22/04/20, 23/06/03, 03/04/24
Original Adoption: 99/08/23

SOCIAL WORK SERVICES

POLICY:

In the rehabilitation setting, social work services shall provide assessments and interventions relative to psychosocial factors and the social context in which the physically-disabledphysically disabled patient/resident patient lives.

PROCEDURE:

1. The scope of rehabilitation social work services includes, but need not be limited to, the following:

   a. Assessment of the patient/resident patient's personal coping history and current psychosocial adaptation to their disability.

   b. Assessment of immediate and extended family members, caregivers and other support persons relative to support networks.

   c. Assessment of housing, living arrangements, and stability and source of income relative to facilitating discharge plans.

2. Intervention strategies designed to increase the effectiveness of coping, strengthen informal support systems, and facilitate continuity of care include, but need not be limited to, the following:

   a. Discharge planning activities

   b. Casework counseling and therapy, including but not limited to Trauma Informed Care screening.

   c. Group work focused on education and therapy

   d. Community service linkage/referrals

3. Social Work Services staff monitor the achievement of goals relative to discharge planning activities designed to meet the basic sustenance, shelter, transportation, and quality-of-life needs of patient/resident patients and their families.

ATTACHMENT:
None.

REFERENCE:

Social Work Services P&P

Most Recent Review: 22/04/20, 17/08/11, 18/08/23, 20/04/27, 21/07/16
Revised: 06/09/22, 23/05/23, 12/04/24
Original Adoption: 99/08/23

ACTIVITY THERAPY SERVICES

POLICY:

In the rehabilitation setting, recreational and other leisure time activity therapy services provide for development, maintenance, and expression of an appropriate leisure/social lifestyle for individuals with physical or cognitive impairments.

PROCEDURE:

1. Activity Therapy staff monitor the patient/resident's participation in their chosen activities, and the extent to which goals are explored relative to the use of leisure time and the acquisition of socialization skills.

2. Activity therapy services provide, but need not be limited to, the following:

   a. Assessment of the patient/resident's ~~patient's~~ preferred leisure, social, and recreational abilities, as well as identifies deficiencies, interests, barriers, life experiences, needs, and potential.

   b. Activities are designed and offered to improve social, emotional, and cognitive well-being to prepare for future, leisure/social involvement.

   c. Leisure education designed to help the patient/resident~~patient~~ acquire the knowledge, skills, and attitudes needed for independent leisure/social involvement, adjustment in the community, decision-making ability, and appropriate use of free time.

ATTACHMENT:
None

REFERENCES:

Activity Therapy Services P&P

Most Recent Review:	23/05/16, 17/08/11, 20/04/27, 21/07/16, 22/04/20
Revised:	06/09/22, 14/08/21, 16/08/11, 18/08/23, 21/07/16, 12/04/24
Original Adoption:	99/08/23

VOCATIONAL REHABILITATION SERVICES

POLICY:

In the rehabilitation setting, referral for in-house and/or community-level vocational rehabilitation services shall be considered for patient/residents who may benefit from services aimed at returning them to productive work through evaluation and linkage to local and state Department of (Vocational) Rehabilitation, and other related activities.

PROCEDURE:

Patient/residents Patients deemed ready to participate in in-house or community-level vocational activities will be considered for referral by the Patient Care Team (PCT)/ Resident Care Team (RCT)PCT/RCT to the Laguna Honda Hospital and Rehabilitation Services (LHH) Vocational Rehabilitation program and/or other vocationally related programs, as indicated.

ATTACHMENT:
None

REFERENCES:
Vocational Rehabilitation P and P, VR 2.0 Scope of Services

Most Recent Review: 23/05/16, 17/08/11, 18/08/23, 20/04/27, 21/07/16, 22/04/20
Revised: 06/09/22, 13/08/22, 21/07/16, 12/04/24
Original Adoption: 99/08/23

REHABILITATION SERVICES FOR REHABILITATION UNIT (ACUTE REHABILITATION AND SNF REHABILITATION) PATIENTS

POLICY:

The following minimum requirements are included in the process of providing rehabilitation services to patients.

PROCEDURE:

1. Consistent with applicable law and Laguna Honda Hospital and Rehabilitation Services (LHH) policies, rehabilitation services are initiated by a referral from a physiatrist, physician, or other qualified individual.

2. Such referrals must be dated, signed, and include a detailed diagnosis or problem for which treatment is anticipated.

3. A rehabilitation treatment plan for patients admitted to the Rehabilitation Unit is developed by the physician, in conjunction with the patient care team based on the functional assessment and evaluation of the patient.

4. Patient and family and/or caregivers participate ~~, as appropriate,~~ in the development and implementation of the rehabilitation treatment plan.

6. The rehabilitation treatment plan includes measurable goals and objectives, including time frames for achievement (described in functional or behavioral terms) tailored to the patient~~, and include time frames for achievement.~~.

7. The patient's progress and results of treatment are assessed on a timely basis, which is weekly for acute-level rehabilitation inpatients and periodically as defined by CMS guidelines for SNF-level rehabilitation inpatients. Rehabilitation treatment goals are revised, as appropriate.

8. The patient's progress and response to rehabilitation treatment are documented in the medical record.

9. Continued rehabilitation care is justified either by evidence of observed or expected improvement in functional ability.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 22/04/19,18/08/24,16/08/14, 17/07/28, 20/04/27, 21/07/13
Revised: 18/08/24, 06/09/22, 07/08/24, 14/08/21, 17/07/28, 2023/05/19, 24/04/04
Original Adoption: 99/08/23

REHABILITATION SERVICES FOR GENERAL SNF UNIT ~~PATIENTS~~ RESIDENTS

POLICY:

In addition to rehabilitation services provided to patients on the Rehabilitation Unit, rehabilitation services are provided to meet the rehabilitation needs of residents ~~patients~~ on the general SNF units throughout the facility ~~Hospital~~. Rehabilitation services include Physical Therapy, Occupational Therapy, Speech Pathology. ~~, Audiology, and Physiatry.~~

PROCEDURE:

1. Rehabilitation services are provided only by electronic orders of an attending physician.
2. Qualified rehabilitation professionals are responsible for the following:
    a. Evaluating each resident ~~patient~~ referred for care.
    b. Recommending a rehabilitative treatment regimen for residents ~~patients~~ who have an anticipated positive outcome as a result of therapeutic intervention.
    c. Participating in resident ~~patient~~ care in conjunction with the Resident ~~Patient~~ Care Team.
    d. Reevaluating the ~~patient's~~resident's continuing need for rehabilitation care.
    e. Supervising the provision of care to assure an acceptable level of performance from rehabilitation assistants and other qualified support personnel.
    f. Providing in-service training for staff, as needed.
    g. Monitoring and evaluating, on a regular basis, the quality and appropriateness of care provided.

ATTACHMENT:
None

REFERENCE:
Medical Staff P&P: A05 Rehabilitation Services

Most Recent Review: 23/05/16,22/04/19,18/08/24, 16/08/05, 17/07/31, 19/01/07, 20/04/27, 21/07/13
Revised: 18/08/24, 06/09/22, 07/08/24, 24/04/04
Original Adoption: 99/08/23

GOALS AND OBJECTIVES

POLICY:

Comprehensive rehabilitation services will be provided for each patient and/or resident referred for~~ inpatient rehabilitation~~, Skilled Nursing Rehabilitation Services (Short term rehab and skilled nursing facility resident), Inpatient Rehabilitation Services, and Outpatient Clinic ~~Rehabilitaiton~~Rehabilitation Services, ~~-~~with the goal of maximizing functional independence, ~~and~~ return to ~~in~~ the community ~~-~~and restoring that individual to the highest level of self-sufficiency~~ and maximum level of functional independence~~.
[Title 22 § 70597(a)(1)]

PROCEDURE:

The goals and objectives of the Rehabilitation Center will be achieved by providing the following for each patient and/or resident:

1. Implementing a comprehensive rehabilitation plan through an interdisciplinary team approach.

2. Increasing endurance and work tolerance via rehabilitation to as near community level as possible.

3. Maximizing physical independence, cognition, swallowing~~ and~~, communication ~~needs~~, and psychological well-being to increase social and vocational opportunities and overall ~~well being~~well-being. ~~for all functional tasks including but not limited to, activities of daily living, mobility, transfers.~~

4. Preparing the patient for living in the community with the provision of assistive devices and/or through patient and caregiver training.

5. Laying groundwork for vocational or additional training post-discharge.

ATTACHMENT:
None

REFERENCE:
1. HWP&P: 23-01, Resident Care Plan, Resident Care Team, Resident Care Conference
2. Barclays California Code of Regulations, Title 22 § 70597

Most Recent Review: 23/05/16, 22/04/19, 18/08/24, 16/08/05, 17/07/31, 20/04/27, 21/07/13
Revised: 06/09/22, 13/08/22, 04/04/24
Original Adoption: 99/08/23

REHABILITATION SERVICES AND MEDICAL RECORD

POLICY:

The medical record of a patient and/or resident receiving rehabilitation services includes, at a minimum, the following information.

PROCEDURE:

1. The reason for referral to Rehabilitation Services., or admission to the Rehabilitation Unit.
2. A summary of the patient and/or resident's clinical condition, functional strengths and limitations, indications for rehabilitation services, and prognosis.
3. The goals of treatment and treatment plan, including any problem that may affect the outcome of rehabilitation services.
4. Treatment or progress records, with appropriate ongoing assessments as required by the patient and/or resident 's condition that includes a description of the patient and/or resident, and family and/or caregiver in goal setting.
5. Assessment of rehabilitation progress and estimates of further rehabilitation potential entered on a timely basis.
6. Discharge summary that includes recommendations for further Rehabilitation Services if such services are needed.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 23/05/16, 22/04/19,18/08/24, 6/08/05, 17/07/28, 20/04/27, 21/07/13
Revised: 18/08/24, 06/09/22, 02/04/24
Original Adoption: 99/08/23

REHABILITATION PATIENT/RESIDENT CARE TEAM CONFERENCE

POLICY:

Rehabilitation Patient/Resident Care Team Conferences are held regularly to determine continued need for treatment or modification of a patient's rehabilitation program. [Title 22 § 70597(h)]

PURPOSE:

1. To affect integration of all rehabilitation and ancillary services for the benefit of each patient, including descriptions of the patient's capacities, strengths, impairments, and weaknesses.

2. To identify the patient's rehabilitation goals, stated in functional and performance measures.

3. To facilitate participation of the ~~patient, and family~~patient, family and/or caregivers, as appropriate, in the Rehabilitation Patient/Resident Care Team Conference and care planning.

4. To assess the need for ongoing rehabilitation based on evidence of observed or expected improvement, or evidence of functional response to treatment.

PROCEDURE:

1. The patient/resident ~~'s~~ progress toward the achievement of rehabilitation goals, including the results of planned therapeutic interventions and responses to such interventions, as discussed in the case conference, should be documented in the medical record.

2. All patients and/or residents shall be discussed at *Rehabilitation Patient/Resident Care Team Conferences* according to assigned conference schedules.

ATTACHMENT:

None

REFERENCE:

1. HWP&P: 23-01, Resident Care Plan, Resident Care Team, Resident Care Conference
2. Medical Staff P&P: D11-~~03 Resident~~03 Resident Participation in Care Planning
3. Barclays California Code of Regulations, Title 22 § 70597(h~~)~~() (1–2)

Most Recent Review: 23/05/16, 22/04/19, 18/08/24, 16/08/05, 17/07/31, 20/04/27, 20/07/17, 21/07/13
Revised: 06/09/22, 10/12/07,13/08/22, 19/03/15, 04/04/24
Original Adoption: 99/08/23

EVALUATION OF SERVICES

POLICY:

As part of Laguna Honda Hospital and Rehabilitation Services' Quality Improvement program, the quality and appropriateness of patient care provided by any rehabilitation service — whether provided provided individuallysingly, in combination, or as part of a comprehensive rehabilitation program or unit — is monitored and evaluated, and identified problems are resolved.

PURPOSE:

Rehabilitation Leadership Meetings are held at least once per month quarterly under the direction of the Nursing Home Administrator Assistant, Quality Management (QM), Director of Nursing, Chief of Rehabilitation Services and/or Department of Public Health (DPH)/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services. These meetings include the supervisors and/or designee of Physical Therapy, Occupational Therapy, and Speech- Language Pathology, QM, Nursing,. Staff Physiatrists, and ,the DPH/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services. and, the Nurse Manager of the Rehabilitation Unit, and the supervising Neuropsychologist assigned to the Rehabilitation Unit Additional interdisciplinary team members including, but not limited to, social work, minimum data set and utilization management nursing team, grievance team may participate in the meeting for the purpose of developing processes for monitoring and evaluating the quality and appropriateness of patient care, and for the resolution of identified problems.

PROCEDURE:

1. The Chief of Rehabilitation Services, in conjunction with the DPH/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services, Nursing Home Administrator Assistant, Director of Nursing, and Quality Management designee and the supervisors of each rehabilitation service, is responsible for assuring that best practice and quality rehabilitation services evaluation processes and procedures are implemented.

2. Such monitoring and evaluation of interdisciplinary rehabilitation services process and procedures are accomplished through the following means, but not limited to:

   a. Interdisciplinary team leadership identify the key performance indicator (KPI) measures using A3 form and including but not limited to, presenting this at the Performance Improvement Plan (PIP) committee.

~~a.~~b. Routine collection of information relating to the KPI quality measures for comprehensive rehabilitation program ~~or unit or~~ rehabilitation service(s).

~~b.~~c. Periodic assessment of the information collected in order to identify important issues related to patient and/or ~~resident care~~resident care and to identify opportunities to improve care.

~~c.~~d. Objective criteria that ~~reflects~~reflect current knowledge and clinical experience, is used in the collection and assessment of the information gathered.

3. When important issues related to patient and/or resident care or opportunities to improve care, are identified:

   a. A plan of action is determined and implemented.

   b. The effectiveness of the action taken is evaluated.

4. The findings from, and conclusions of monitoring, evaluation, and problem-solving activities are documented and presented at the facility wide PIP committee. ~~, as appropriate, may be reported to Hospital Wide Performance Improvement and Patient Safety Committee.~~

5. As part of the Quality Improvement program, the following are also discussed, but not limited to, for the Interdisciplinary team Rehabilitation Services:

   a. Staffing and budgetary needs.

   b. Departmental rehabilitation goals for best practice.

   c. ~~Direction of I~~in-service programs.

   d. Regulatory requirements and compliance needs.

6. A record of the attendance and minutes of these meetings shall be kept.

ATTACHMENT:
None

REFERENCES:

1. HWP&P: 60-01 Quality Assurance Performance Improvement Program
2. Medical Staff P&P: A05 Rehabilitation Services
3. Barclays California Code of Regulations, Title 22 § 70597(h)(2)(i)

Most Recent Review: 16/08/14, 17/07/28, 18/08/14, 20/04/27, 22/04/28, 23/05/16
Revised: 06/09/22, 10/12/07, 14/08/22, 17/08/01, 03/04/24
Original Adoption: 99/08/2312/7/10

UTILIZATION MANAGEMENT (UM)

Please refer to the UM plan which is reviewed annually by the members of the UM Committee.

OUTCOME STANDARD:

I. PURPOSE, OBJECTIVES AND SCOPE

As medical necessity and cost-effectiveness are considered to be essential components of the definition of quality in health care delivery, and as the Health Commission (The Governing Body) of Laguna Honda Hospital and Rehabilitation Center (LHH) is responsible for establishing policy and maintaining quality patient care, The Health Commission, through the Joint Council Committee (JCC), the Administration and Medical Staff has established a comprehensive Utilization Management (UM) process. The goal of the process is appropriate allocation of resources through identification and elimination of over-utilization, under-utilization, and the inefficient delivery of health care services.

Through implementation of an effective UM process, LHH will further its commitment to the community to provide high quality health care in a cost-effective manner. Implementation of this process will achieve the following objectives:

- Facilitate the delivery of health care services in the setting most appropriate to the patient's needs.
- Facilitate timely discharge and use of community resources through early identification and referral of patients.
- Promote efficiency and effectiveness in the delivery of health care services.
- Minimize patient, physician, and facility financial liability through consistent screening for required authorizations by insurance companies for admissions and/or continued stay.

This process will be integrated into the facility's utilization management program and will be composed of the following components:

Admission planning
Continuing care planning
Admission/continued stay review
Level of care appropriateness and necessity
Monitoring of denial of payments and implementation of appeals procedures
Analysis and interpretation of utilization data
Ongoing process effectiveness assessment

The program scope, through some or all of its components, extends to inpatients and outpatients regardless of payment source. Program scope may be modified as the need is demonstrated, upon recommendation of the Utilization Management Committee and approval of the Medical Executive Committee.

II. AUTHORITY AND RESPONSIBILITY

A. Health Commission
The Health Commission has delegated authority to the Hospital Administration to establish and maintain a comprehensive UM process. The Health Commission monitors the process through reports from the Hospital Administration.

B. Administration
The Health Commission has assigned accountability and delegated authority to the Hospital Administration for providing the Utilization Management Department with administrative and technical support for all components of the UM process. Administration supports the ongoing education of UM personnel to facilitate a thorough knowledge of applicable regulations and requirements and optimal coordination of this process.

C. Medical Staff
The Health Commission has assigned accountability and delegated authority to the Medical Staff for the appropriate allocation of the hospital's resources. The Medical Staff fulfills this accountability through internal assignment of functions to the Medical Staff, Utilization Management Committee, and physicians selected to provide medical direction for the utilization process. The Medical Staff monitors the utilization process through the Utilization Management Committee and the Medical Executive Committee.

D. Utilization Management Committee
The Medical Staff has assigned accountability and delegated authority to the Utilization Management Committee for maintaining an ongoing UM process in compliance with all applicable regulations and special agreements. This committee has been delegated authority to discharge all duties and functions as defined in Section III of this plan. At least two physicians must serve on this committee.

E. Medical Direction for the Utilization Process
Physicians appointed to the positions of Utilization Management Committee Chairperson and physician advisors are delegated authority by the Medical Staff for discharge of duties and responsibilities as defined in Article IV of this plan.

F. Hospital Staff
Authority is delegated by administration to Hospital staff members for the discharge of utilization process-related duties as defined in this plan, in departmental policies and procedures, and in respective position descriptions.

III. UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Department and Medical Staff maintains a Utilization Management Committee to which it assigns accountability for the oversight of the Utilization Process. Membership on this committee will include at least two physicians. This committee acts to facilitate, monitor, and promote the effectiveness of the UM process by reviewing:

-The medical necessity of resource utilization
-The cost-effectiveness of care
-Compliance with state and federal requirements for participation in Medicare and Medicaid programs
- Hospital and medical staff UM obligations for:
  - UM Activities delegated to the hospital by external review groups
  - UM aspects of hospital- based on MediCal and Medicare - UM aspects of non-hospital-based other contract care arrangements

A. Committee Functions

The Utilization Management components of the Utilization Management Committee include the following:

- Maintain an ongoing Utilization Management Program in compliance with applicable regulations and special UM or contract care arrangements.
- Establish and maintain a criteria-based system for the concurrent monitoring of appropriateness of level of care and the use of hospital resources and services.
- Select and train a Physician Advisor (PA) and establish a PA coverage plan which promotes adequate coverage for referrals as well as necessary medical and surgical specialty referral backup.
- Evaluate data generated by the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.
- Monitor the effectiveness of actions taken to improve efficiency or resolve problems.
- Review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital. Some portions of denial review will be delegated to the Revenue Cycle Committee - findings of which will be shared with the Utilization Management Committee.
- Review the results of Peer Review Organization (PRO) and other external review group monitoring, including any Recovery Audit Contractor activities, and recommend action as determined necessary.
- Make recommendations as determined appropriate for focused review activity in admission planning, concurrent review, discharge planning and outpatient service utilization monitoring.
- Recommend medical and hospital staff educational programs as determined appropriate based on external factors impacting health care utilization and based on problems identified within the Utilization Management program or the medical staff.
- Participate in treatment protocol development through establishing expected service utilization levels for select patient classifications.
- Coordinate the Utilization Management Program with the Hospital's Quality Management Program.
- Provide input into Hospital Administration on components of the Hospital's Strategic

Business Plan which relate to resource utilization and case mix strategy.
♦ Develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost-effective health care.
♦ Provide input into Administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis.
♦ Perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

B. Meetings and Committee Records

The Utilization Management Committee will meet at least quarterly, more frequently at the direction of the Chairperson. Minutes of all meetings will be recorded, maintained, and will include meeting attendance, committee findings, conclusions and recommendations. The utilization management component will focus on:

- Resource utilization profiles and trending reports
- Claims denial data
- External review group monitoring results
- Program review and referral activity
- Select problematic cases
- Reports of special studies
- New regulation updates
- Focused DRG reviews as indicated

C. Conflict of Interest

Any individual who holds financial interest in the hospital is not eligible for appointment to the Committee. No individual may participate in review of any case in which he/she has been professionally involved.

D. Administrative Support

Hospital Administration will provide direct assistance to the Utilization Management Committee through participation in Committee activities and indirect assistance by: providing support for data analysis; assembly and display of information; providing forms, clerical support and meeting space; and through serving as liaison with all hospital departments.

Hospital Administration will also be responsible for providing access to Medical Records and for considering/acting upon decisions and recommendations of various committees with respect to hospital policy, procedures, and resources.

E. Committee Reporting

Reporting on Utilization Management occurs at the Utilization Management Committee and the PIPS. The Chairperson of the Utilization Management Committee reports findings to the Medical Staff and, as appropriate, to other hospital departments and/or administration. The Revenue Cycle Committee coordinates the evaluation of all hospital claimhospital claim denials, and this information is also shared with the Utilization Management Committee and/or the pertinent providers directly.

Through the above channels the issues are reported at least quarterly to the Medical Executive Committee. Reports concerning Utilization Management activities will also be made to the entire Medical Staff on an ad hoc basis.

IV. MEDICAL DIRECTION FOR THE UTILIZATION MANAGEMENT PROGRAM

A. Medical Direction for the UM program will be the responsibility of the Utilization Management Committee Chairperson and the Physician advisor(s).

1. Responsibilities and functions will include the following:

a. Act as liaison between Utilization Management Committee, Medical Staff, and hospital departments on UM issues, including criteria development, definition, and revision

b. Establish effective physician advisor coverage - when deemed appropriate through the medical staff structure, members of the medical staff who are not members of the Utilization Management Committee will serve as physician advisors. This ad hoc expansion of physician advisor role recognizes the limited number of medical staff members and the need at times for use of a specialty "peer," who may not be a member of the Utilization Management Committee.

c. Provide information and training to the Medical Staff at large regarding Utilization Management issues

d. Meet as necessary with representatives of other external review organizations, employers, and/or insurers to discuss issues relating to resource utilization

e. To participate in the third partythird-party denial monitoring and reconsideration process as outlined in those procedures

f. In referral cases to render medical determinations or designate physicians to do so, when physician advisors and attending physicians cannot reach agreement

g. Assist in analyzing cost and utilization data for problem identification, provide objective assessment, provide input into prioritization of problems for evaluation and action as necessary and recommend actions for correction of problems

h. Communicate UM concurrent review activities as appropriate to the Chief of Staff and/or members of the Medical Staff

i. Review and comply with changes in federal, state, and third party regulations and policies affecting the utilization management process

j. Assist in designing, implementing, and monitoring the strategy for reducing inappropriate utilization of services or lengths of stay

k. Provide individual physician education and consulting on appropriate health care service utilization as necessary

l. Keep Medical Staff members current on internal and external utilization management issues

m. Assist in developing hospital policies relating to medical issues

B. PHYSICIAN ADVISORS

This group of physicians is assigned responsibility for acting as advisors to the review staff and the Utilization Management Program, and handling referral cases as described in the

admission planning, concurrent review, ancillary service, and focused review procedures. Physician advisors may be members of the Utilization Management Committee or, when deemed appropriate, may not be members of the Committee but will be credentialed members of the medical staff with responsibilities as follows:

a. Review of records and related information on those patients whose cases are referred by review personnel to assure that the admission, continued stay, and ancillary services are medically necessary, provided at the appropriate level and provided in accordance with professionally recognized standards of quality.

b. Contact the attending physician to obtain additional information as necessary to establish the medical necessity and appropriateness of admission, continued stay, ancillary service utilization or efficiency of the proposed treatment plan.

c. Refers the case to a second physician advisor for a decision when agreement with the patient's physician cannot be reached.

d. Denies approval of admission, continued stay or ancillary service utilization when medical necessity does not exist and notifies the patient's physician of the decision and the right to reconsider.

e. Treats all information obtained while completing the review process or carrying out other aspects of the UM program with strict confidentiality.

C. PREPARATION FOR UM PHYSICIAN ADVISOR ROLES

The physician advisors and Utilization Management Committee Chair shall be prepared for their respective roles through hospital-provided education in the following:
- Concurrent review and referral procedures
- Various program and contract coverage guidelines
- DRG system structure
- Recovery Audit Contractor review strategies
- Inter-relationships among UM, Risk Management and Quality Management programs

V. HOSPITAL UTILIZATION MANAGEMENT STAFF

The Chief Executive Officer is responsible for assuring the UM Department is provided with administrative and technical support for all components of the UM program. This responsibility includes identification and assignment of qualified personnel to perform the following roles, or combinations of the following roles:
- UM Care Coordinator
- Social Worker/ Discharge Planners

A. UM Care Coordinator

The Care Coordinator performs daily review and analysis of medical records of inpatients. This review may include: utilization monitoring, quality assurance monitoring, deficiency analysis and screening for continuing care planning needs. The UM Care Coordinator refers cases to the physician advisors, and as necessary to appropriate hospital staff members.

B. Social Worker/ Discharge Planners

The social workers will assist in assessing the referred patient's needs and assist with developing, coordinating, and implementing discharge and continuing care plans. The social

workers may serve as the case manager and/or discharge planner.

VI. PROGRAM NORMS, CRITERIA AND STANDARDS

A. All review components of LHH UM program utilize criteria sets and/or review protocols approved through the UM Committee. These criteria sets and protocols may include those for:
- Admission and continued stay necessity or level of care criteria (e.g., Interqual criteria, Milliman criteria)
- Surgical or major diagnostic procedures designated for performance on an outpatient basis
- Observation status admission criteria
- Surgical procedure and major diagnostic procedure clinical indications
- Protocols for efficient scheduling of diagnostic and therapeutic services
- Screening criteria for identification of patients at risk for continuing care planning needs
- LOS norms for use in admission planning and concurrent review
-

B. Upon approval of the Utilization Management Committee, criteria sets utilized in screening may be specific to respective external review groups, payment plans, or review agreements maintained by LHH.

VII. CONCURRENT REVIEW

A. Admission Review:

1. Scope
Scope of admission review of medical necessity and the appropriateness of level of care extends to patients in all payment categories and service categories.

2. Responsibilities
Admission review activities are performed by UM care coordinators, physician advisors, the attending physician including psychiatrists ,psychiatrists, by intake coordinators (psychiatric counselor), social workers, and nursing, and as indicated by the Chief Medical Officer (CMO). As appropriate and based upon payer or contract care plan, review may also be performed with external review groups.

3. Procedures
a. Utilizing the Daily Census Report, the Patient Flow Program and UM Department in discussion with other care providers will screen each admission within one working day of admission to determine whether skilled medical and acute level of care screens havehas been met and to identify and refer patients at risk for requiring Continuing Care Planning (discharge planning) intervention. Care coordinators will review the record and compare documentation with approved criteria for lowest appropriate level of care. All cases will be reviewed and discussed at the daily interdisciplinary meeting.
b. If screening criteria for admission to the skilled medical or acute care level are not met, the Care Coordinator will question the attending physician. If this clarification

provides no additional information, then the case will be referred to the physician advisor (PA).

c. If the PA feels skilled medical or acute inpatient level is indicated, the admission is approved and documented.

d. If the PA feels acute inpatient level is not indicated or if there is a question of treatment plan efficiency, he/she will confer with the attending physician and afford them an opportunity to present their views. If the attending physician concurs, the patient will be dischargeddischarged, or the treatment plan modified. If the screening criteria does not meet skilled medical level of care, the PA will inform the care coordinator who will initiate the notification for discharge planning or custodial plan of care. The care coordinator will collaborate with the social worker assigned.

e. If the attending physician does not concur with the physician advisor, the case will be referred to the Chief Medical Officer or his/her designee.

f. If review by the Chief of Staff or designee determines that continued inpatient acute level of care is not medically necessary, the UM Department will initiate a written denial notice. Procedures to follow are outlined in Article IX of this plan.

g. In all cases, only a physician may make an adverse determination and deny admission or continued stay status.

h. All review findings, decisions, and actions taken during admission review will be documented in the UM Module.

B. Subsequent Review - Continued Stay Review

1. Scope

Scope of subsequent review of the continued appropriateness of the level of care and appropriateness of continued stay service utilization extends to patients in all payment categories. Time between reviews shall in no instance exceed seven (7) days for acute level of care and thirty (30) days for skilled medical level of care; most cases will be reviewed on a daily basis by UM care coordinators and documented in the UM module.

2. Responsibilities

Subsequent review activities are performed by UM care coordinators and, when needed, physician advisors. As appropriate, based upon payer or contract care plan, review may also be performed in consultation with external review groups.

3. Procedures

Utilizing the Daily Census Report, the UM Department identifies cases warranting subsequent review based on review cycle established, or other system alerts. The UM Care Coordinator will screen each patient record against level of care criteria to determine whether the current level of care criteria continues to be indicated based upon the approved criteria.

a. If the case continues to meet skilled medical and acute level criteria, this is noted on the electronic medical record utilized by the UM Department.

b. If screening criteria for continued stay at the skilled nursing and acute level of care are not met or there is a question of plan of careefficiencycare efficiency, the UM Care Coordinator will refer the case to a physician advisor. For acute level of care, if progress (clinical

improvement) is not occurring, the treatment plan is reevaluated and amended in a timely and medically appropriate manner. The treatment being delivered is likely to stabilize the symptoms and behaviors that required admission. There is a reasonable expectation that the patient's illness, condition, or level of functioning that required admission is likely to stabilize so that that treatment can be continued at a lower level of care.

c. If the physician advisor feels skilled medical or acute inpatient level is indicated, the continued stay is approved. This is noted on the electronic medical record and the next review date is assigned. The Care Coordinator has the option of assigning a specific review date, which in no instance shall ever exceed seven days for acute level or care and thirty (30) days for skilled medical level of care.

d. If the physician advisor feels that skilled medical or acute inpatient level is not indicated, orindicated or feels there is a question of plan of care efficiency, he/she will confer with the Attending physician and afford them an opportunity to present their views. If the attending physician concurs, the patient will be discharged back to the skilled nursing unit or if custodial level of care, the plan of care will be modifiedmodified, and discharge planning initiated.

e. If the attending physician does not concur with the physician advisor, the case will be referred to the Chief Medical Officer (CMO) or his/her designee. If this additional review indicated justification for continued stay, this will be noted in the electronic medical record.

f. If review by the CMO or his/her designee determines that continued skilled medical or inpatient acute level of care is not medically necessary, the UM staff will initiate a written denial notice. Procedures as outlined in Article IX of this plan will be followed.

g. In all cases, only a physician may make an adverse determination and deny continued stay.

h. All review findings, decisions and actions taken during subsequent review will be documented in appropriate portions of electronic medical record.

C. Outpatient or Ancillary Service Utilization

The hospital's Utilization Management Program includes both concurrent and retrospective assessment of the necessity and appropriateness of hospital outpatient or ancillary service utilization related to Treatment Authorization Requests (TAR).

XIII. INTENSIFICATION

A. Scope and Definitions

Review and analysis activities within the UM program may be intensified with select groups and subgroups as determined appropriate by the UM Committee.

Intensification will be accomplished through increasing ongoing admission and concurrent review and/or analysis activities, up to 100% in select categories. Review and analysis activities which may be intensified include: admission planning; admission and continued stay reviews; ancillary service use review; and analysis of utilization pattern data.

B. Identification of categories for Intensification

Some groups may warrant intensification based on the nature of payment, e.g., prospectively set rates, or based on hospital contractual arrangements with employers and other organizations.

Groups for intensification may also be identified based upon utilization patterns identified as inefficient, ineffective, inappropriate or outside acceptable ranges. Such patterns may be identified within the following hospital or program functions:

- concurrent review and referral functions
- monitoring of third partythird-party payment denials
- Utilization pattern analysis
- findings reported from Medical Staff Committees or services

IX. ADMISSION, CONTINUED STAY AND SERVICE DENIALS

A. Hospital-Initiated Denials – Discontinuation of Benefits

1. Medicare

The hospital may issue a denial notice prior to or during a stay if the Physician Advisor and the UM Care Coordinator (through the Chief Medical Officer or designee) determine that the patient does not require inpatient skilled medical or acute admission, continued stay, or services and:

a. The attending physician concurs with the decision, OR

b. The UM Medical Director reviews the case and concurs with the level of care

After the receipt of the concurrence of either the attending physician,thephysician, the hospital must notify the patient in writing and include a copy of the notification in the patient's medical record. This termination of benefits notification will be provideprovided within two working days of identification and states that:

“It is the hospital's determination with the concurrence of the attending physicianthatphysician that the patient does not require inpatient hospital care or continued care;”

a. The patient will be liable for the hospital's customary charges for admission, if the patient is notified prior to or at the time of admission that the stay is not medically necessary. In the case of continued stay denial, the patient will be liable for the hospital's customary charges beginning with the third day after receipt of notice;

b. If the patient is admitted or remains in the hospital after he/she becomes liable, the UM Medical Director will make a formal determination of the medical necessity and appropriateness of hospitalization.

This formal determination is subject to a reconsideration at the request of the patient, hospital, or attending physician.

2. Other Hospital-Initiated Denials

The hospital will fulfill the hospital-initiated denial obligations as defined in contract care agreements and special UR agreements.

B. Denial Review and Reconsideration

All cases in which the UM Medical Director/Fiscal Intermediary/other external review group denies payment, or approval of service, will be reviewed by the Utilization Management ~~Committeefor~~Committee for appropriateness of request for reconsideration/appeal.

X. DISCHARGE PLANNING

A. Definition and Policy Statement

Discharge Planning is an interdisciplinary hospital-wide support function which exists to aid the Resident Care Teams, patients, and their families in developing and implementing an ~~optimal plan~~optimal plan of care and in facilitating discharge planning as soon as ~~an~~a skilled medical level of care is no longer required. This process ~~consist~~consists of necessary arrangements for discharge needs. LHH will maintain an effective Discharge Planning function in order to ensure the continuity of ~~high quality~~high-quality patient care, the availability of the hospital's resources for other patients requiring admission, and the appropriate utilization of resources.

B. Program Scope and Responsibilities

1. Identification and Referral – the Social Services Department along with the resident care ~~teamwill~~team will screen for early identification and referral of patients requiring discharge planning services required for a successful transition back to the community. Patients are screened using pre-established criteria, during admission planning, during nursing assessment processes and during concurrent utilization reviews. In addition to this screening, verbal and written referrals are received and acted upon.

2. Needs Assessment and counseling - Patient needs assessments are performed by the Social Worker to determine the full range of needs upon discharge, to prepare patients and affected persons for the ~~transitionof~~transition of care. This includes evaluation of the patients' and families' strengths and weaknesses; the patients' physical condition, illness and treatment; the patients' and families' capacities to adapt to changes, and the ability of the patient to manage their continued care.

3. Plan Development - Development of the plan for continuity of care is coordinated by the social worker and includes the results of the assessment and information from the resident care team, patient, and the family or ~~representative. .~~representative. The Discharge Plan is documented in the patient's medical record and is readily accessible to the resident care team, utilization management personnel and other health care personnel involved. Continuing care plans are adapted as needs change.

4. Patient and Family Education - Appropriate and timely education of the patient and family in self-care and aftercare needs is critical to accomplishing a smooth and timely transition

to the appropriate aftercare setting. Effective coordination of needs identification and service provision between disciplines as appropriate, is accomplished through well-defined departmental accountabilities and through individual case coordination by the Social Worker.

5. Plan Coordination and Implementation - Responsibility for the coordination and implementation of the continuing care plan is assigned to the respective Social Worker though the responsibilities for provision of specialized services which are components of the continuing care plan remain with respective disciplines providing those services. Regular periodic meetings are held to facilitate and encourage communication among health care professionals and to facilitate coordination and implementation of the patient's continuing care plan. These Resident Care Conference meetings may include staff members from the following areas – Physician, Social Worker, UM Care Coordinator, NursingCoordinator, Nursing, Nutritional Services, Pharmacy, Rehab Services, and or other support services as appropriate.

XI. CONFIDENTIALITY STATEMENT

All activities of the Utilization Management Committee, including findings and recommendations, are confidential. These records will be maintained securely and will be accessible only to those responsible for surveying the hospital to determine the existence of an ongoing, effective program. The confidentiality requirements under HIPAA and reporting requirements of the Peer Review Organization shall be observed at all times. Findings of the Utilization Management Program shall be considered peer review activities and, as such, will be protected under the provisions of state and federal laws.

ATTACHMENT:
UM plan

REFERENCE:

1. Medical Staff By-Laws, Article XI, Section 3b
2. Barclays California Code of Regulations, Title 22 § 70597(f)(1)

Most Recent Review: 24/04/02, 23/05/16, 22/04/19, 17/08/09. 18/08/09, 20/04/27, 21/07/14
Revised: 17/08/09, 04/04/24
Original Adoption: 99/08/23

REHABILITATION ASSESSMENT AND INTERDISCIPLINARY CARE PLANNING

POLICY:

1. Rehabilitation staff members of the Patient Care Team (PCTPCT/RCT)Patient Care Team (PCT/RCT)/Resident Care Team (RCT) assist with developing patient care plans.

2. Patient/Resident care is managed in a coordinated, systematic, comprehensive manner through assessments, evaluations, and interventions to promote and maintain the individual patient's highest practicable level of functioning.

PROCEDURE:

1. Attendance at PCTPCT/RCT meetings

a. Rehabilitation Unit Patient Care Team (PCTPCT/RCT)Patient Care Team (PCT/RCT)/Resident Care Team (RCT) members are responsible for attending Patient Care Team interdisciplinary team meetings for patients/residents who have active orders for rehabilitation.

a.b. For Rehabilitation Services Team members: In instances where the primary therapist is unavailable to attend the scheduled PCTPCT/RCT meeting, a suitable representative or written information is provided. Therapists may attend PCTPCT/RCT meetings for patients/residents- who do not have current and active orders on an as-needed basis, but must be notified ahead of time by the PCTPCT/RCT. Therapists may also be available on an ongoing basis for attendance at specific Unit PCTPCT/RCT meetings, at the discretion of the rehabthe rehab leadershipindividual department heads.

b.c. Attendance at PCTPCT/RCT meetings assumes that the therapist will:

I. Check for scheduling of meeting times.

II. Arrange patient/resident care schedules to accommodate PCTPCT/RCT meetings.

III. If unavailable, notify a representative or the head of the PCTPCT/RCT team of the current plan of care.

IV. Contribute to interdisciplinary care planning by:

- Developing rehabilitation goals based on the patient/resident assessment that include but are not limited to, goals that are realistic, measurable, time limited, and consistent with the therapy prescribed by the patient's physician and as per clinician's clinical judgement and patient/resident related assessment findings.
    - Whenever possible, goals are determined in collaboration with the patient/resident and/or caregiver/family member.
- Updating interventions as needed.
- Documenting in the "Team Conference" section with continuation and barriers to progress and treatment plan to achieve goals listed from evaluation.

2. Documentation of Care Plans

a. The assigned therapist has the responsibility for initiating a rehabilitation care plan status post completion of evaluation by end of business day (evaluation date of completion). within 24-48 hours following the evaluation.

b. The treating therapist should monitor the accuracy of the care plan and modify it as needed.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 23/05/16, 22/04/19, 18/08/24, 16/08/05, 17/08/01, 2001, 20/04/27, 20/07/21, 21/07/13
Revised: 18/08/24, 06/09/22, 20/07/21, 03/04/24
Original Adoption: 99/08/23

TREATMENT AUTHORIZATION REQUEST (TAR)

PURPOSE: To ensure that therapists provide accurate and timely information for Medi-~~cal~~Cal Treatment Authorization Requests (TAR's) for submission to the Medi-Cal office. ~~In this policy the term "patients" also refers to residents in the Skilled Nursing Facility (SNF).~~This process may apply for submission of rehabilitation services treatment orders for all patients and/or residents receiving rehabilitation services.

PROCEDURE:

IV. ~~I.~~ TAR COMPLETION

TARs must be completed for patients/residents who have Medi-Cal or Medi-Cal pending at the time Occupational Therapy, Physical Therapy, or Speech-Language Pathology evaluations are performed. Each individual discipline must request authorization for treatments based on their plan of care within the rehabilitation treatment order. This order is submitted when requested via secure chat in the electronic medical record.

II. SPECIFIC SECTIONS of Rehabilitation Treatment Order

A. The therapist completes a rehab treatment order including:

- The ICD 10 code with description.
- Start of care date/ evaluation date to expected end date.
- The specific procedure codes within the comment section.
- Number of treatments requested.
- Frequency and duration.
- Location of services.
- The therapist signs the rehab treatment order by "signing the visit".
- The therapist selects- ~~per protocol – "no cosign required" and identifies the referring provider.~~ Physician signature required and identifies the referring provider for the treatment order.

III. TAR PROCESSING

- An electronic TAR is submitted after receipt of the rehabilitation treatment order by the patient access team within the San Francisco Health Network (SFHN).

IV. TAR EXTENSIONS

- If the patient/resident requires additional therapy beyond what was originally recommended, a re-assessment with physician signature and rehab treatment order with physician signature, shall be submitted.
- If the patient/resident has additional visits left on the TAR but the date has expired, another reassessment with physician signature and rehab treatment order with physician signature including the date extension will be included, and processed, accordingly.

- If a patient/resident is discharged from the facility and readmitted, a new TAR shall be submitted. This is the case regardless of remaining visits on the original TAR. Notation that the patient was discharged and readmitted shall be made in the comments section of the TAR.
- All patient and/or resident related TAR needs will be collaborated between rehabilitation services and patient access team to receive support for TAR processing, submission, but not limited to.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 22/04/19, 2020/5/18 20/04/24, 21/07/13
Revised: 20/04/24, 03/04/24
Original Adoption: 20/04/24

ADMISSION AND ELIGIBILITY CRITERIA FOR ACUTE REHABILITATION SERVICES

POLICY:

~~Any patient~~Patients over the age of 16 who require and would benefit from~~s~~ intensive inpatient ~~intensive~~ rehabilitation services ~~requiring~~ utilizing an interdisciplinary team approach due to complex nursing, medical management and rehabilitation needs ~~to achieve maximal functional independence~~ may be eligible for acute-level rehabilitation services at Laguna Hoda Hospital and Rehabilitation Center (LHH).

PROCEDURE:

The patient must meet the following criteria for admission:

1. Presence of one or more major physical impairments that significantly interfere with the ability to function requiring an intensive interdisciplinary approach to effectively improve functional status.

   These impairments may be a result of recent onset of progressive and chronic disease such as, but not limited to: stroke, traumatic brain injury, severe musculoskeletal injury resulting from trauma, neuromuscular disease, disorders of the central nervous system, severe arthritis, and lower-extremity amputation.

2. Rehabilitation needs will include at least two of the following: impairment in activities of daily living, impairment in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or medical problems best addressed on the Acute Rehabilitation Unit.

3. Patient must be medically stable.

4. Patient requires regular ~~rehabilitation physician~~ physiatry management.

5. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:

   a. Training in ~~self care~~self-care
   b. Training in bowel and bladder management
   c. Training or instruction in safety precautions
   d. Cognitive function training

e. Behavioral modification and management

f. Training in communication

6. Patient has ~~two ADL impairments that are functional, ADL, safety, or education-related, and has~~ the ability to engage in:

   a. At least fifteen hours (15) of therapy in a seven-day period.

   ~~Psychological or psychiatric therapy and social work services related to the acute rehabilitation treatment plan not to exceed four (4) hours of the 18 hours.~~

   b. At least ~~T~~two of the following therapies (one of which must be physical therapy or occupational therapy): physical therapy, occupational therapy, and/or speech therapy.

7. Patients must have a reasonable plan for discharge into the community.

8. Pre-admission screening completed by an interdisciplinary team approach including but not limited to: Admissions & Eligibility (A-&-E), Utilization Management (UM), the Chief of Rehabilitation Services, the Director of Nursing, and the Assistant Nursing Home Administrator, support services or designee ~~Assistant, or his/her designee~~, and/or designee from the respective departments.~~W or his/her designee.,~~ This pre-admission screening may involve, but not limited to, ~~with~~ assessment reflecting the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services, and additional patient related factors.

   a. Pre-admission screening (PAS) must be conducted ~~by licensed or certified clinician~~ within 24-48 hours immediately preceding acute rehabilitation admission. The PAS must be documented in the medical record.

      i. If the preadmission screening is conducted more than 48 hours prior to admission it will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within 48 hours preceding the IRF admission.

   b. Required elements:

      i. prior level of function,

      ii. expected level of improvement,

      iii. expected length of time necessary to achieve level of improvement,

      iv. evaluation of risk for clinical complications,

v. conditions that caused the need for rehab,

vi. treatments needed including expected frequency and duration of treatment,

vii. anticipated discharge destination and any anticipated post-discharge treatments and other relevant information.

c. The physiatrist must document that he/she has reviewed and concurs with the results of the preadmission screening prior to the admission.

d. The preadmission screening documentation must be retained in the patient's medical record at LHH.

9. Post-Admission Physician Evaluation:

a. Must be completed within first 24 hours of admission to acute rehabilitation by a physiatrist and includes

i. documentation of patient's status on admission,

ii. documentation of any differences between the preadmission screening and post-admission physician evaluation.

9. Information pertinent to the patient's admission to Acute Rehabilitation will be forwarded to or made available to the LHH rehabilitation team prior to or at the time of admission.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: B01 Admission01 Admission Screening
2. Barclays California Code of Regulations, Title 22 § 70597(a7)(d)
3. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A
4. Medical Record Form MA 182, Acute Rehabilitation Pre-Admission Screen
4.5. LHPP 27-06 Guidelines Inpatient Rehabilitation Facility Documentation

Most Recent Review: 18/08/24, 16/08/14, 20/04/27, 20/07/21
Revised: 18/08/24, 06/09/22, 11/08/30,14/08/22, 17/08/01, 19/03/15, 20/07/21, 22/04/29, 23/05/19, 03/04/24
Original Adoption: 99/08/23

ADMISSION AND ELIGIBILITY CRITERIA FOR SNF-LEVEL REHABILITATION SERVICES

POLICY:

Any patient over the age of 16 who requires SNF-level rehabilitation requiring an interdisciplinary team approach to achieve maximal functional independence may be eligible for SNF-level rehabilitation services.

PROCEDURE:

The patient must meet the following criteria for admission:

1. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.

   These impairments may be a result of injury, recent onset of progressive and chronic disease, such as, but not limited to: stroke, traumatic brain injury, severe musculoskeletal injury resulting from trauma, neuromuscular disease, disorders of the central nervous system, severe arthritis, and lower-extremity amputation.

2. Rehabilitation needs will include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or medical problems best addressed on the SNF-level Rehabilitation Unit.

3. Patient must be medically stable.

4. Patient requires rehabilitation physician management.

5. Patient requires the availability or supervision of rehabilitation skilled nursing 24 hours daily in one or more of the following, but not limited to:

   a. Training in self--care
   b. Training in bowel and bladder management
   c. Training or instruction in safety precautions
   d. Cognitive function training
   e. Behavioral modification and management
   f. Training in communication

6. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

7. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a general SNF unit requiring a lower level of care..

8. Pre-admission screening must be performed by an interdisciplinary team including but not limited to: A & E, Utilization Management, Director of Nursing, the Chief of Rehabilitation Services, and Nursing Home Administrator Assistant (Support Services), and/ or his/her designee of the respective departments, with assessment reflecting the patient's ability to achieve significant improvement in a reasonable period of time with SNF rehabilitation services.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: B01 Admission01 Admission Screening
2. Barclays California Code of Regulations, Title 22 § 70597(a7)(d)

Most Recent Review: 18/08/24, 16/08/14, 20/04/27, 20/07/21, 22/04/29, 23/05/19
Revised: 18/08/24, 06/09/22, 17/07/31, 03/04/24
Original Adoption: 99/08/23

SOURCES AND FORMS USED FOR REFERRAL OF PATIENTS

POLICY:

The sources and forms used to refer patients/residents to Rehabilitation Services will be designated. [Title 22 § 70597(a)(7)]

PROCEDURE:

1. Sources**:** Rehabilitation Services at Laguna Honda Hospital and Rehabilitation Center (LHH), a facility of the Department of Public Health of the City and County of San Francisco (DPH), accepts referrals for any San Francisco resident. The sources of referrals are broad and include, but are not limited to, inpatients at Laguna Honda Hospital, patients at home or in other hospitals, and patient from other healthcare referring agencies, and residents at LHH. [Title 22 § 70597(a)(6)]

2. Referrals may be made to physiatrists, therapists and/or to one of the inpatient rehabilitation programs (e.g. Acute Rehabilitation [AKA Inpatient Rehabilitation Facility] or SNF Rehabilitation), Outpatient Clinics, and SNF Rehabilitation for LHH Residents.

3. To make a referral to:

   a. Physiatry for LHH inpatients: Physicians must complete an electronic referral for LHH Physiatry.

   b. Acute Rehabilitation (IRF) or SNF Rehabilitation (short term stay/long term care LHH residents): Patients/Residents may be referred for these programs as per the procedure noted in Hospital Wide Policy and Procedure 20-01.

   c. Rehabilitation Services (e.g. Physical Therapy, Occupational Therapy, Speech Language Pathology): Providers must complete an electronic referral for the appropriate discipline.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: A05 In-House Requests for Rehabilitation Consultations and Services
2. Barclays California Code of Regulations, Title 22 § 70597(a)(6) and (a)(7)
3. Hospital Wide Policy and Procedure: 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units

Most Recent Review: 23/05/13,18/08/24, 13/08/22, 17/08/14, 19/01/07, 20/04/27, 20/07/17
Revised: 18/08/24, 06/09/22, 13/08/22, 22/04/29, 03/04/24
Original Adoption: 99/08/23

OUTPATIENT REHABILITATION SERVICES

POLICY:

The Rehabilitation Services at LHH will maintain an outpatient program providing physical therapy, occupational therapy, and speech/language pathology, audiology, physiatry, and neuropsychological services. [Title 22 § 70597(e)]

The outpatient program has a two-fold purpose:

1. To provide continuity of care to patients/residents who have completed inpatient rehabilitation care, and
2. To provide comprehensive, integrated care for outpatients not requiring prior hospitalization.

PROCEDURE:

1. A coordinated system of outpatient scheduling and appointments is maintained [Title 22 § 70597(e)(1)].

2. The outpatient evaluation and treatment information will be maintained in the medical record. Medical records are maintained as required under the provisions of Title 22, §70597(e)(2).

ATTACHMENT:

None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70597(e)(1–2)

Most Recent Review: 16/08/05, 18/08/14, 19/01/07, 20/04/27, 21/07/13, 22/04/29, 23/05/16
Revised: 06/09/22, 13/08/22, 17/08/14, 24/04/24
Original Adoption: 99/08/23

PROCEDURE FOR OUTPATIENT REFERRAL, REGISTRATION, AND TREATMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Services (LH) has an established method for the referral, registration, and treatment of outpatients.

PURPOSE:

1. To ensure that this facility provides continuity of care for patients's/residents discharged to the community following inpatient treatment as well as rehabilitation services to outpatients from the community.

PROCEDURE:

1. Outside Referrals

Referrals for outpatient rehabilitation services are made by the patient's/resident's provider. Outpatient referrals are accommodated as staffing permits, with priority given to those patients/residents requiring outpatient rehabilitation services immediately following discharge from LHH. Outpatients who cannot be accommodated at LHH are referred to the Department of Rehabilitation Services at Zuckerberg San Francisco General Hospital and Trauma Program for outpatient services.

2. Referrals for Outpatient Therapy for Patients being discharged from LHH

a. Follow-up Physiatry appointments for patients being discharged from LHH are scheduled by the treating physiatrist through the LHH outpatient clinic.

b. The referring provider will order outpatient PT, OT, and/or ST via the electronic health record (EHR).

3. Referrals for Outpatient for Outpatient Aquatic PT, PT (non-aquatic), OT and/or Speech Therapy:

Referring provider will order outpatient therapy via the electronic health record. All therapy referrals are triaged by the appropriate therapy disciplines for scheduling. The referrals are then routed to the appropriate scheduler (at ZSFG or LHH) via the EHR.

4. Pre-appointment Process and Scheduling:

At LHH, evaluations are scheduled by Admitting and Eligibility Department (A&E) staff. A&E must determine eligibility for outpatient services prior to initiation of care. Please refer to Admissions and Eligibility Policy and Procedure 3.01 Outpatient Rehabilitation Services for procedure related to eligibility and outpatient scheduling.

5. **Outpatient Appointments**

   a. All outpatients shall check-in with the Department of Admissions and Eligibility (A and E) prior to their appointment, per A and E Policy and Procedure 3.01.

   b. Appropriate billing and documentation are completed by the treating therapist in the EHR.

   c. Subsequent treatment times are scheduled at the end of the appointment per plan of care.

ATTACHMENT:
None

REFERENCES:

Admissions and Eligibility Department Policies and Procedures: Section Number 3.01. Outpatient Rehab Services

Most Recent Review: 16/08/05, 17/08/01, 20/04/27, 22/04/29, 23/05/16
Original Adoption: 99/08/23

Revised: 06/09/22, 10/12/07, 11/08/30, 13/08/22, 14/08/22, 16/08/05, 18/08/14, 19/03/15, 19/06/22, 2020/01/16, 2020/01/27, 24/04/24

OCCUPATIONAL THERAPY SERVICE DEFINITION

Occupational therapy means those services ordered by the licensed healthcare practitioner acting within the scope of the his/her/their professional licensure in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or mental disability.

ATTACHMENT:
None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 72413(a)

Most recent review: 016/08/05, 17/07/28, 18/08/14, 20/04/27, 21/07/21, 22/04/21, 23/05/16, 24/04/02
Revised: 00/06/12, 10/10/21, 16/08/05
Original Adoption: 99/08/23

OCCUPATIONAL THERAPY STAFF

POLICY:

1. Under the direction of the Director of Rehabilitation Services, the Senior Occupational Therapist ensures that the occupational therapy service complies with all regulatory hospital, state, and federal regulations.

2. The Occupational Therapy Department Senior is responsible for the coordination of a therapeutic program in the Rehabilitation Program (Pavilion Building, Mezzanine Floor), and consultative/SNF services on the long-term, short-term care units, and out-patient services.

3. There is sufficient staff to meet the needs of the patients/residents and scope of the services offered. The staff consists of Occupational Therapists, and additionally may consist of therapy aides, ~~healthworkers~~health workers, and other supportive personnel.

4. An Occupational Therapist must supervise occupational therapy treatments rendered by therapy aides. When therapy aides are providing treatment, an occupational therapist must provide direct line of sight supervision of treatment rendered.

5. An Occupational Therapist will provide supervision to a health worker II, as described below:

   "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during functional mobility, ADL care, or transfer training, housekeeping duties, clerical duties, and similar functions.

PROCEDURE:

1. The Occupational Therapy Department is under the direct supervision of the Occupational Therapy Department Senior (or designee), who is under the immediate supervision of the Rehabilitation Manager and/or Rehabilitation Director (or designee).

2. The Occupational Therapy Department Head is responsible for the coordination of therapies on all Units, which includes the Rehabilitation Services (Pavilion Building, Mezzanine Floor), and consultative services and treatment on all long-term, short-term care units, and out-patient services.

3. Sufficient occupational therapy staff are employed to meet the needs of the patients/residents and provide all occupational therapy services. Staff members work under the direct supervision of the Occupational Therapy Department Senior.

4. Occupational therapy students work under the direct supervision of assigned supervising Occupational Therapists. There is an assigned Fieldwork Educator.

5. Occupational therapy aides or therapy aides work directly under occupational therapist supervision.

6. Restorative therapy aides work directly under the Nursing department but may receive practice area guidance from treating therapists.

7. Occupational Therapy Department staff work the hours necessary to accomplish those tasks listed above.

8. The Occupational Therapists employed at LH have evidence of possessing the proper qualifications ~~(i.e., must be registered by the National Board for Certification in Occupational Therapy, Inc.,), and~~ Must have current licensure from the California Board of Occupational Therapy.~~ or be qualified to take the next licensing exam~~. Preferred but not mandated to be registered by the National Board for Certification in Occupational Therapy, Inc.

9. The Occupational Therapists should provide evidence of possessing an active Basic Life Safety CPT certification.

ATTACHMENT:
None

REFERENCE:¶

Barclays California Code of Regulations, Title 22 § 72417

Most recent review: 16/08/05, 17/07/28, 20/04/27, 21/07/22, 23/05/16, 24/04/02
Revised: 00/06/12, 09/11/12, 10/10/21, 16/08/05, 18/08/14, 22/04/21
Original Adoption: 99/08/23

SCOPE OF OCCUPATIONAL THERAPY SERVICES

POLICY:

The Occupational Therapy Department provides a wide range of services to enhance and facilitate the rehabilitation process.

PROCEDURES:

Occupational therapy is an integral part of the rehabilitation services. Occupational therapy services include, but are not limited to:

1. Assisting the physician in the evaluation of the patient's/resident's level of function by performing diagnostic and prognostic tests.
2. Conducting and preparing written initial and continuing assessments of the patient's/resident's condition and modifying treatment goals under the order of a physician, consistent with identified needs of the patient/resident.
3. Decreasing or eliminating disability during the patient's/resident's recovery following injury or illness by neuromuscular and sensory-motor exercises, training, and purposeful activities.
4. Increasing the patient's/resident's capabilities for independence, self –care and life management.
5. Enhancing the patient's/resident's well-being through tasks modified to the patient's/~~resident's ability~~resident's ability to adapt to their physical and social environments.
6. Developing patient's/resident's functional abilities to a maximum level.
7. Assessing the need for slings, splints, and other assistive devices as determined by clinical expertise and patient/resident need or as prescribed by the physician to prevent or correct deformity, and/or to promote function.
8. Evaluating, treating and coordinating with patient/resident and patient/resident care team members to plan for discharge into the community. This process may include home evaluation, community re-entry skills (including but not limited to medication management, home management, financial management, use of public transport, etc.).

9. Evaluating the patient's/resident's psychosocial and cognitive functioning, in the following performance skills: concentration, attention span, visual perception, organization, problem solving, mental flexibility, and insight into his or her deficits.

~~10. Providing groups for cognitively impaired patients to provide routine, and enhance social and emotional functioning within this setting.~~

~~11.~~10. Providing patient/resident/family education and counseling as needed.

~~12.~~11. Participating as ancillary or consultative members of the Resident Care Team (RCT)/Patient Care Team (PCT) to assist with developing the Resident Care Plan/Patient Care Plan.

~~13.~~12. Evaluating and assessing patients/residents for a manual or power wheelchair as prescribed by the physician, either for positioning purposes and/or to improve functional mobility independence.

ATTACHMENT:
None

REFERENCE:

1. Barclays California Code of Regulations, Title 22 § 70597(a)(4)
2. Rehabilitation Program P&P # 40-08, Rehabilitation Assessment and Interdisciplinary Care Planning

Most recent review: 16/08/05, 17/07/28, 18/08/14, 20/04/27, 21/07/22, 22/04/21

Revised: 00/06/12, 10/10/21, 11/08/30, 14/08/22, 16/08/05, 24/04/22
Original Adoption: 99/08/23

ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION

POLICY:

1. When occupational therapy is ordered, the patient/resident is evaluated by an occupational therapist and a treatment program is established to include modalities, frequency, and duration of treatments.

2. Signed treatment notes are entered into the patient's/resident's medical record each time an occupational therapy service has been performed.

3. Patient/resident care plans are completed on each patient/resident receiving occupational therapy, except those seen for assessment only.

4. Progress notes and/or weekly summaries are completed by the occupational therapist. A signed discharge summary is written by the occupational therapist upon completion of the occupational therapy treatment program.

5. Occupational therapists participate as ancillary, or consultative, members of Unit RCT's/PCT's and participate in the Rehabilitation Services Case Conferences to assist with developing the patient/resident care plan.

PROCEDURE:

1. Evaluation of a patient/resident is initiated by the occupational therapist upon referral by the physician.

2. Evaluation may include self-care, visual perception, neuromuscular, sensory-integrative, cognitive, and community re-entry skills, and/or formal testing.

3. With evaluation results, the occupational therapist formulates a treatment plan, including treatment/training to be utilized, frequency and duration of treatment, and measurable goals.

4. The treatment plan is approved in writing by the referring physician. The treatment plan is discussed with the patient/resident and/or their family.

5. After each OT treatment session is completed, a signed treatment note is entered into the patient's/resident's medical record indicating the procedure performed and the reaction of the patient/resident to the procedure.

6. A signed written progress note is written at least weekly by the occupational therapist to summarize patient's/resident's performance over the period covered. Notes are entered in the patient's/resident's medical record.

7. A signed discharge summary is written by the occupational therapist upon completion of the occupational therapy treatment program. All notes are entered in the patient's/resident's medical record.

8. Patient/resident care plans are integrated and documented under appropriate problem, goals are measurable and realistic, and specific interventions are stated.

9. The occupational therapist communicates with other Resident Care Team, (RCT)/Patient Care Team (PCT) members throughout the treatment program; and if indicated, modifications to the resident's/patient's treatment plan are made and approved by the referring physician.

10. ~~See Rehabilitation Services P&P #40-04, Summary of Responsibilities, "PT, OT, ST, Audiology, and Physiatry," paragraph 4, Treatment Modification regarding changes to treatment plans.~~

11. ~~Refer to the Rehabilitation Services Policy and Procedures #40-05 and #40-08 for PCT meetings and Rehabilitation Services Case Conferences.~~

ATTACHMENT:
None

REFERENCE:

1. Barclays California Code of Regulations, Title 22 § 70597(a)(1)
2. ~~Rehabilitation Program P&P # 40-05, Rehabilitation Interdisciplinary Case Conferences~~
3. ~~Rehabilitation Program P&P # 40-08, Rehabilitation Assessment and Interdisciplinary Care Planning~~

Most recent review: 17/07/28, 18/08/14, 20/04/27, 21/07/22, 22/04/21, 24/04/22

Revised: 00/06/12, 08/08/26, 10/10/21
Original Adoption: 99/08/23

OCCUPATIONAL THERAPY SERVICE EQUIPMENT

POLICY:

There is sufficient equipment and supplies appropriate to the needs of the services offered.

PROCEDURE:

Equipment and supplies necessary to enable patients/residents to increase their functional capacity or capability are provided. This includes, but is not limited to:

1. Supportive slings, supporting and assistive hand splints, and the materials from which to fabricate these and other assistive devices.
2. Adaptive devices to aid in the performance of daily living skills, such as eating, dressing, grooming, and writing, with instructions for their use.
3. Equipment and supplies for the development of creative skills.
4. Means and supplies for adapting equipment for re-education in activities of daily living.

ATTACHMENT:
None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 72419

Most recent review: 15/08/26, 16/08/05, 17/07/31, 18/08/14, 20/04/27, 21/07/22, 22/04/21, 24/04/22
Revised: 00/06/12, 10/10/21
Original Adoption: 99/08/23

PHYSICAL THERAPY SERVICE DEFINITION

Physical therapy services are those provided to a patient/resident by, or under the supervision of, a physical therapist to achieve and maintain the patient's/resident's highest functional level. Physical therapy services are provided with appropriate staff, space, equipment, and supplies, but not limited to.

ATTACHMENT:
None

REFERENCE:
HWP&P: 01-00 Mission Statement and Goals Statement

Most recent review: 16/08/16, 17/07/27, 18/08/14, 20/04/27, 21/07/13, 22/04/20, 23/05/16
Revised: 00/06/14, 10/10/21, 24/04/24
Original Adoption: 99/08/23

PHYSICAL THERAPY STAFF

POLICY:

~~1.~~ Under the direction of the SFHN Executive Rehab Leadership ~~Director~~ of Integrated Rehabilitation Services, the Senior Physical Therapist ensures that the physical therapy service complies with all regulatory hospital, state, and federal regulations, but not limited to.

1.

2. ~~2.~~ There are sufficient staff to meet the needs of the patients/residents and scope of the services offered. The staff consists of physical therapists, and may additionally consist of physical therapy assistants, ~~physical~~ therapy aides, health worker II, and other supportive personnel, but not limited to.

3. A physical therapist supervises treatment rendered by assistants and aides.

PROCEDURE:

1. Sufficient physical therapy staff will be employed to meet the needs of the patients/residents and the scope of the services offered.

2. The Physical Therapy Department is under the direct supervision of the Physical Therapy Department Senior (or designee), who is under the immediate supervision of the ~~Rehabilitation Manager (or designee) and/or~~ SFHN Executive Rehab Leadership of Integrated Rehabilitation Services.~~Director (or designee).~~

3. The physical therapists and physical therapy assistants employed at LHH must be licensed by the State of California.~~, or be qualified to take the next licensing exam.~~

4. The Physical Therapists and physical therapy assistants should provide evidence of possessing an active Basic Life Safety CPR certification.

5. A physical therapist will provide supervision to health worker II, as described below:

   “Non-patient/resident-related task” means a task related to observation of the patient/resident, transport of the patient/resident, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions.

6. A physical therapist will provide direct supervision and line of sight as per California Board of Physical Therapy regulations, as described below, when physical therapy aides are providing treatment:

   a. A physical therapist may utilize the services of one aide engaged in patient/resident-related tasks to assist the physical therapist in the ~~his or her~~ practice of physical therapy. "Patient/Resident-related task" means a physical therapy service rendered directly to the patient/resident by an aide, excluding non-patient/resident-related tasks. "Non-patient/resident-related task" means a task related to observation of the patient/resident, transport of the patient/resident, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions, but not limited to. The aide will at all times be under the orders, direction, and immediate supervision and line of sight of the physical therapist. Nothing in this section will authorize an aide to independently perform physical therapy or any physical therapy procedure. The physical therapist shall assign only those patient/resident related tasks that can be safely and effectively performed by the aide. The physical therapist will provide continuous and immediate supervision and line of sight for ~~of~~ the aide. The physical therapist will be in the same facility as, and in proximity to within line of sight, the location where the aide is performing patient/resident-related tasks, and will be readily available at all times to provide advice or instruction to the aide. When patient/resident-related tasks are provided to a patient/resident by an aide, the supervising physical therapist will, at some point during the treatment day, provide direct service to the patient/resident as treatment for the patient's/resident's condition, or to further evaluate and monitor the patient's/resident's progress, and will correspondingly document the patient's/resident's record.

   b. The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment will not be prohibited by this section.

7. A physical therapist provides supervision for physical therapy assistants, as described below, but not limited to:

   a. A licensed physical therapist is at all times responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient/resident, provide direct care to the patient/resident, and to assure that the physical therapist assistant does not function autonomously. The supervising physical therapist will be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients/residents. The supervising physical therapist provides periodic on-site supervision and observation of the assigned patient/resident care rendered by the physical therapist assistant.

   b. Evaluations

- Following an initial evaluation, the supervising physical therapist will indicate when the patient/resident is to be re-evaluated and determine which elements of the treatment plan may be assigned to the physical therapy assistant. This information will be communicated, either verbally or in writing, to the physical therapy assistant.

- The supervising physical therapist will reevaluate the patient/resident as previously determined, or more often if necessary, and modify the treatment, goals, and plan as needed. The reevaluation will include treatment to the patient/resident by the supervising physical therapist. The reevaluation will be documented and signed by the supervising physical therapist in the patient's/resident's record and will reflect the patient's/resident's progress toward the treatment goals and when the next reevaluation will be performed.

8. Documentation

- The physical therapist assistant will document each treatment in the patient/resident record, along with the physical therapist's his or her signature. The physical therapist assistant will document in the patient/resident record and notify the supervising physical therapist of any change in the patient's/resident's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

- The physical therapist assistant will document weekly notes. The supervising physical therapist will discuss the weekly notes in a care conference with the physical therapist assistant and co-sign the weekly note.

ATTACHMENT:
None

REFERENCE:

1. California Code of Regulations, Title 16, Division 13.2, Physical Therapy Regulations
2. Barclays California Code of Regulations, Title 22 § 70559(a-c);§ 70597(c); 70599(d); § 72407 (a-d);
3. § 70597(g)

Most recent review: 16/08/16, 17/07/27, 18/08/14, 20/04/27, 21/07/14, 22/04/20
Revised: 00/06/14, 07/08/24, 10/10/21, 11/08/30, 16/08/16, 23/05/16, 24/04/24
Original Adoption: 99/08/23

CLINICAL TRAINING FOR PHYSICAL THERAPY ST

POLICY:

Clinical facilities are provided for the education and training of physical therapy students/interns and physical therapist assistant students/interns.

PROCEDURE:

1. The roles and responsibilities of the Physical Therapy Department's educational program are defined in writing and kept in the Clinical Education Manual in the department.

2. When rendering physical therapy services as part of academic training, a physical therapy student will only be identified as a "physical therapist student." A person who has completed the required academic course work may be identified as a "physical therapist intern" when rendering physical therapy services.

3. When rendering physical therapy services as part of academic training, a physical therapy assistant student will only be identified as a "physical therapist assistant student." A person who has completed the required academic course work may be identified as a "physical therapist assistant intern" when rendering physical therapy services.

4. The "clinical instructor" or the "supervisor" will be the physical therapist supervising the physical therapist student or intern while practicing physical therapy. The "clinical instructor" or the "supervising assistant" will be the physical therapist assistant supervising the physical therapist assistant student, while practicing physical therapy.

5. The supervising physical therapist will provide on-site supervision of the assigned patient/resident care rendered by the physical therapist student or intern. The supervising physical therapist assistant will provide on-site supervision of the assigned patient/resident care rendered by the physical therapist assistant student.

6. The physical therapist student or physical therapist assistant student will document each treatment in the patient/resident record, along with his or her signature. The clinical instructor, supervising physical therapist, supervising physical therapist assistant will countersign with his or her first initial and last name all entries in the patient's/resident's record on the same day as patient/resident-related tasks were provided by the physical therapist student, or physical therapist assistant student, respectively.

ATTACHMENT:
None

REFERENCES:

California Code of Regulations, Title 16, Division 13.2, Physical Therapy Regulations – 1398.37

Most recent review: 16/08/16, 17/07/27, 18/08/14, 20/04/27, 21/07/14, 22/04/20, 23/05/16
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Original Adoption: 99/08/23

PHYSICAL THERAPY SCOPE OF SERVICES

POLICY:

The Physical Therapy Department provides a wide range of services to enhance and facilitate the rehabilitation process.

PROCEDURE:

Physical therapy services include, but are not limited to:

1. Providing the physician with an initial written evaluation of the patient's/resident's rehabilitation potential.

2. Applying muscle, nerve, joint, and functional ability tests.

3. Treating patients/residents to relieve pain, and to develop or restore function.

4. Assisting patients/residents to achieve and maintain maximum performance using physical means such as exercise, massage, heat, sound, water, ice, and electricity.

5. Providing therapeutic interventions that focus on posture, locomotion, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain, and functional abilities in daily living skills.

6. Providing physical therapy within the aquatic setting which medium allows patients/residents to capitalize on hydrodynamic and thermal properties, including, but not limited to, buoyancy for unweighting and to increase ease of limb movement, viscosity for graded progression of strength training and sensory input, hydrostatic pressure for edema reduction, and thermal shifts for pain control.

7. Providing assessment and training in locomotion, including, as, appropriate, use of orthotic, prosthetic, and assistive devices

8. Providing patient/resident and family education, as appropriate, and providing training to family or care giver(s) on patient's/resident's needs and abilities before discharge.

9. Participating as ancillary or consultative members of the Patient Care Team (PCT)/Resident Care Team (RCT)/Interdisciplinary team (IDT) to assist with developing the Patient/Resident Care Plan.

10. Participating in community evaluations and treatments as appropriate for safe discharge back to the community. Community evaluations may include but are not limited to home evaluations and mobility evaluations/treatment over community surfaces and obstacles.

ATTACHMENT:
None

References:

Barclays California Code of Regulations, Title 22 § 70555(a)(4), § 72403

Most recent review: 16/08/16, 17/07/27, 18/08/14, 20/04/29, 21/07/14, 22/04/20, 23/05/16
Revised: 06/09/20, 10/10/21, 16/08/16, 17/07/27, 24/04/24
Original Adoption: 99/08/23

PHYSICAL THERAPY SERVICE EQUIPMENT AND SUPPLIES

POLICY:

There is sufficient equipment and supplies appropriate to the needs and the services offered. In addition there is, but not limited to:

1. A telephone.
2. A hand-washing sink in the treatment area.
3. Equipment accessible to patients/residents in wheelchairs, on crutches, or when using other adaptive equipment, including, but not limited to:
   a. Adequate width of door openings.
   b. Toilet with grab bars on both sides of the commode.
   c. Over-sink mirrors.
   d. Drinking fountains and/or cup of water.
   e. Adjustable tables.

PROCEDURE:

The LHH Physical Therapy Department, located within the Rehabilitation Department, on Pavilion Ground is fully equipped with all types of fixed and mobile equipment, and necessary supplies to enable the department to provide the services offered.

Most recent review: 16/08/16, 17/07/28, 18/08/14, 20/04/29, 21/07/14, 22/04/20, 23/05/16
Revised: 00/06/14, 04/08/18, 10/10/21, 14/08/22, 24/04/24
Original Adoption: 99/08/23

ORTHOTICS & PROSTHETICS CLINIC

POLICY:

The Rehabilitation Department and approved contractor will conduct orthotics and prosthetics clinic at least once per month or as needed two times per month (frequency may change depending on need and availability) for provision of orthotic and prosthetic services to LHH.

PURPOSE:

1. To ensure patients/residents at LHH have access to high quality orthotic and prosthetic care in a timely manner.

2. To provide orthopedic devices fit to the patient/resident to protect, maintain and aid in achieving set rehabilitation and skilled nursing goals, but not limited to.
1.3. Goals may include achieving or maintaining the patient's/resident's highest functional level of mobility or optimally positioning the patient/resident to prevent loss of joint ROM, and overall quality of life.

PROCEDURE:

1. Referral to the orthotics and prosthetics clinic:
   a. Submit an electronic referral through the EHR by entering an order to "Ambulatory Referral to Orthotics and Prosthetics".
   b. **Do NOT** submit an inpatient consult as all O&P appointments are considered to be outpatient.
2. The UCSF-ZSFG Orthotics and Prosthetics scheduler receives the referral and routes the referral to the responsible certified prosthetist/orthotist (CPO) and billing specialist.
3. The billing specialist then adds the patient to the Laguna Honda Hospital Orthotics and Prosthetics Work in Progress List and performs a chart review to identify the following:
   i. Item requested and accuracy of order
   ii. Insurance and eligibility for coverage through the patient's insurance
   iii. Physician notes with supporting medical justification for the requested device
2.4. The responsible CPO creates a list of patients to be scheduled at the next orthotics and prosthetics clinic referencing the Laguna Honda Hospital Orthotics

and Prosthetics Work in Progress List. The list of patients to be scheduled will include how long each appointment should be and if PT or OT support is needed.

3.5. The list of patients/residents to be scheduled is then sent to the Rehabilitation Department at least 72 hours prior to the next scheduled clinic.

4.6. The Rehabilitation Department then creates a schedule that is cohesive with the PT and OT availability and sends the created schedule to the UCSF-ZSFG Orthotics and Prosthetics team.

i. The CPO may request a therapist attend the appointment.
ii. If an appointment would benefit from therapist support, the therapist's schedules are blocked on EHR snapboard.
iii. If a therapist attends the appointment with the CPO, the therapist will also write a progress note in the EHR.
iv. Patients'/Residents' schedule and specific needs are considered during scheduling.

5.7. The UCSF-ZSFG Orthotics and Prosthetics scheduler then inputs the appointments for each patient into the EHR.

i. Clinic appointments will be held at bedside by default. The patient/resident is required to be in their room at the time of the appointment or the appointment may be cancelled.
ii. If there is additional equipment required, the patient/resident may need to be transported (by nursing staff) to the Rehabilitation Gym. This will only happen on an as needed basis and will be indicated in their appointment notes.
iii. The Charge RN, PCA and CNAs are to be present at bedside to provide patient/resident history and receive instructions on any devices that are provided such as wear schedule, donning/doffing, skin checks and precautions, but not limited to.
iv. If nursing staff are not present at bedside when devices are to be delivered to the patient/resident, the appointment may be cancelled.
v. Nursing staff is responsible to ensure the instructions provided during the appointment are followed, passed along to the next shift and communicated to the physician if nursing orders are required.
vi. If a new device is delivered to the patient/resident, nursing staff is to label device with patient/resident details (including name, MRN, and unit).
vii. The responsible CPO will write an outpatient progress note in the EHR for each patient/resident appointment. Documentation will include all subjective and objective information obtained during the appointment as well as the assessment of the orthotic and/or prosthetic needs with the recommended treatment plan, but not limited to.
viii. The responsible CPO will document anticipated or lack of funding source and anticipated timeframe for fitting/delivery of devices if coverage is established or authorization has been received.

- If insurance eligibility is identified, the UCSF-ZSFG Orthotics and Prosthetics team will process the appropriate documentation provided by the primary provider and/or patient/resident and submit appropriate documentation to the patient's/resident's insurance.
- If the patient/resident is not eligible for coverage through their insurance, the CPO will inform the referring provider and the Resident Care team/Patient Care team. The referring provider and Resident Care team/Patient Care team are then responsible to identify additional funding resources. If funding cannot be established, the referring provider is to cancel the order.

j. Once a device is provided, the responsible CPO will include the recommended wear schedule, frequency of skin checks, and any additional precautions in the outpatient progress note, but not limited to.

k. The UCSF-ZSFG Orthotics and Prosthetics team are available via EHR or phone at (628) 206-4387.

   i. Contact UCSF-ZSFG Orthotics and Prosthetics team directly for concerns or questions regarding Orthotic and Prosthetic devices.

ATTACHMENT:
None

R EFERENCE:
None

Most recent review: 7/09/21, 23/05/16
Revised:24/04/24

Original Adoption: 21/09/07

SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY SERVICE DEFINITION

Speech Pathology and Audiology Service means evaluation and rehabilitation services for individuals with speech, voice, language, cognitive-linguistic, swallowing, and/or hearing disorders.

Speech Pathology Service: evaluation and rehabilitation management of dysphagia, speech-language, cognitive-communicative disorders, and voice disorders.

Speech Pathology Service: evaluation and rehabilitation management of dysphagia, speech-language, cognitive-communicative disorders, and voice disorders

Appropriate staff, space, equipment, and supplies are available to meet service needs. Therapy goals include achieving and maintaining the highest functional level of Cognitive – Cognitive- – Communication and safe swallow function.and safe swallow function.

ATTACHMENT:
None

REFERENCE:

LHPP: 01-00 Mission Statement and Goals Statement

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21

Revised: 04/08/18, 23/05/16, 10/04/24
Original Adoption: 99/08/23

SPEECH LANGUAGE PATHOLOGY ~~AND AUDIOLOGY~~ STAFF

POLICY:

A licensed ~~S~~ Speech ~~Pathologist~~ Language Pathologist (SLP) ~~or audiologist~~ has overall responsibility for the services rendered in the Department. Staffing is sufficient to meet the needs of the patients/residents and the scope of the services provided.

PROCEDURE:

The SLP ~~Speech Pathologists and audiologists~~ working at Laguna Honda Hospital must show evidence of being fully qualified and licensed by the California State Board of Quality Assurance, as well as certified by the American Speech, Language, and Hearing Association. ~~In addition, audiologists must hold a current California State Hearing Aide Dispenser's License.~~

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(b)

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21, 23/05/17

Revised: 04/08/18, 23/05/19, 24/04/24
Original Adoption: 99/08/2

SPEECH/LANGUAGE PATHOLOGY SCOPE OF SERVICES

POLICY:

The Speech Pathology ~~and Audiology~~ Department provides a wide range of services to enhance and facilitate the rehabilitation process.

PROCEDURE:

Speech Pathology ~~and Audiology~~ services include, but are not limited to, the following:

1. Diagnostic Evaluation

   a. ~~Examination of oral~~ Oral motor function

   b. ~~Assessment of voice~~ Voice production

   ~~c. Assessment of speech production~~ Speech and language skills

   ~~d. Assessment of language skills, both comprehension and expression~~

   ~~Assessment of cognitive-linguistic skills~~ Cognitive-Communication skills

   ~~e.~~c.

   ~~f.~~d. ~~Evaluation of swallowing swallow function~~ Swallow function and safety

   e. ~~Assessment for augmentative~~ Augmentative communication systems

   f. Laryngectomy management, including alaryngeal speech therapy

~~g.~~ ~~2.~~ Treatment

~~h. Assessment of alyarngeal speech~~

~~i. Testing of hearing acuity for speech reception and discrimination~~

~~j. Evaluation of patient's ability to use hearing aids~~

2. ~~Therapy~~

   ~~a.~~ Speech and language skills

   a.

   ~~b.~~ Voice production

   b.

   ~~c.~~ ~~Language~~ Speech and language comprehension and expression

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c.

d. Language -related cognitive skills

e. Provision of augmentative Augmentative communication systems

e.f. Laryngectomy and alaryngeal speech

3. Alaryngeal speech

4. Swallowing swallow functionSwallow function

5. Hearing (including aural rehabilitation and hearing aid fitting)

6. Consultation with other members of the Patient/-Resident Care Team (RCT) regarding strategies to facilitate improved function on the care Unit.

7.3.

8.4. Provision of patient/resident/family/caregiver education and training, as needed.

9.5. Development of Restorative Care Programs — Level II, when indicated.

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(a)(4)

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21

Revised: 04/08/18, 23/05/19, 11/01/24
Original Adoption: 99/08/2

ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: ~~SPEECH-LANGUAGE PATHOLOGY~~ SPEECH LANGUAGE AND COGNITIVE-COMMUNICATION

POLICY:

Patient/residents~~s~~ are seen by a Speech Language Pathologist (SLP) for a ~~speech-language evaluation~~ Speech-Language or Cognitive-Communication Evaluation upon referral by a Laguna Honda Hospita~~ll~~ provider ~~physician~~. ~~Outpatients may be referred by a licensed physician in the community.~~

PROCEDURE:

1. Upon receipt of a physician's order, the ~~speech pathologist~~ SLP reviews the ~~medical history~~ Electronic Health Record (EHR) and schedules the patient/resident for an evaluation.

2. The initial evaluation includes, but need not be limited to, the following assessment of:

   a. Oral motor function

   ~~b. Speech production~~ ~~Verbal expression~~ Verbal expression

   ~~b.~~c. Cognition

   ~~c.~~d. Voice production

   ~~d.~~e. Auditory comprehension

   ~~e. Oral expression~~

3. When indicated, evaluation also includes assessment of reading comprehension, written expression, and language-related cognitive skills.

4. When clinically indicated, patients/residents are evaluated for and provided with, augmentative communication devices (e.g., picture/word boards, electronic communication aids).

5. Once the patient/resident has been evaluated, an initial evaluation and treatment plan is entered in the ~~medical record~~ ~~EHR~~ EHR and electronically signed by the SLP ~~speech pathologist~~ and the ordering provider~~physician~~. The treatment plan includes goals and the frequency/duration of treatment. If treatment is not indicated, the reason is documented.

6. The treatment plan is reviewed with the patient/resident, caregivers and family (if available).

7. The speech pathologist and the physician electronically sign the treatment plan.

8.7. The treatment plan is documented in the Resident Care Plan (RCT). All Rehabilitation Services RCT meetings are attended by the patient/resident's primary therapist or a representative. RCT meetings on other Units are attended on an as-needed basis on the request of any RCT member.

9.8. The SLP speech pathologist works with Unit staff and other caregivers to ensure carryover of skills, as needed.

10.9. The SLP Speech Pathologist may develop a formal Restorative Care Program – Level I or II to be carried out by trained staff, when indicated.

11.10. Following each treatment session, the treatment and the patient's/resident's performance is documented in the EHR medical record and electronically signed.

12.11. Signed progress notes are documented at least once weekly for in-patients, and at least once monthly for outpatients. These notes summarize the patient's performance/improvement over the period covered. Treatment goals are updated as needed.

13.12. A signed discharge summary is documented in the EHR medical record upon completion of the treatment program.

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(a)(4)
Most recent review: 16/08/05, 17/08/01, 20/04/27, 21/07/22, 22/04/21
Revised: : 04/08/18, 10/12/07, 14/08/22, 19/02/7, 23/05/16, 10/04/24
Original Adoption: 99/08/2

SPEECH LANGUAGE PATHOLOGY ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: DYSPHAGIA

POLICY:

Patient~~s~~/resident~~s~~s are seen by a Speech Language Pathologist for a dysphagia evaluation upon referral by a physician. Following the evaluation, the ~~speech pathologist~~ SLP develops a treatment plan, as indicated. The treatment plan may include swallowing therapy, to be carried out by the SLP ~~Speech Pathologist,~~ and/or recommendations regarding ~~food texture least restrictive modified texture~~ least restrictive modified texture, aspiration precautions and strategies to facilitate improved ~~swallowing swallow function~~ swallow function and reduce the risk of aspiration.

PROCEDURE:

1. **Evaluation**

~~Upon physician referral, the speech pathologist reviews the medical history and schedules the patient for a dysphagia evaluation. Upon receipt of a physician's order, the speech pathologist reviews the Electronic Health Record (EHR) and schedules the patient for an evaluation.~~

a. Upon receipt of a provider order, the SLP reviews the Electronic Health Record (EHR) and schedules the patient/resident for an evaluation.

b. Dysphagia evaluation includes, but need not be limited to, the following:

i. Thorough review of the patient/resident's swallowing history, as possible, including review of any episodes of choking, silent aspiration, or ~~silent aspiration, or~~ pneumonia, current diet and dietary restrictions, and consultation with Nursing and/or a provider ~~physician~~ regarding observations/reason for referral.

ii. Assessment of oral motor function

~~iii. Observation of dentition.~~

~~iv.~~iii. Assessment of ~~voice vocal~~ vocal quality.

~~v. Assessment of speech production.~~

~~vi.~~iv. Observation of level of alertness, responsiveness and general cognitive status, including ability to follow directions.

~~vii.~~v. Assessment of ~~oral preparatory and~~ oral phase of swallowing with different food/liquid consistencies, as indicated.~~, depending on readiness and safety.~~

~~viii.~~vi. Observation for signs/symptoms of pharyngeal phase impairment and aspiration.

c. When a dysphagia evaluation involves upgraded food or liquid consistencies ***not*** currently included in the patient/resident's diet order, tray precautions will be followed~~. per LHPP 260~~ p~~2:p~~er LHPP 26-02.

d. The SLP ~~speech pathologist~~ recommends further instrumental ~~instrumental~~ assessment of ~~swallow function~~ swallow function via ~~Modified~~ Modified Barium Swallow Study ~~Barium Swallow Study~~ (MBSS) or Fiberoptic Endoscopic Evaluation of Swallowing (FEES), ~~Fiberoptic Endoscopic Evaluation of Swallowing (FEES),~~ when indicated.

i. This recommendation is discussed with the provider ~~physician~~, who makes an electronic outpatient referral for the MBSS or FEES. ~~or FEES.~~ The ~~Speech Pathologist~~ SLP confirms the scheduled appointment with Nursing via Secure Chat ~~in writing~~ regarding the date, time, and place for the MBSS/FEES. Nursing arranges transportation and completes necessary documentation.

~~d.~~e. Once the patient/resident has been evaluated, an initial evaluation and treatment plan is entered in the EHR, is electronically signed by the SLP ~~speech pathologist~~ and co-signed by the ordering provider ~~physician~~. The treatment plan includes goals and the frequency/duration of treatment. If treatment is not indicated, the reason is documented

~~e.~~f. ~~Upon completion of the evaluation, the speech pathologist documents results and recommendations in the medical record and reviews them with caregivers. The treatment plan is reviewed with the patient, caregivers and family (if available).~~ The treatment plan is reviewed with the patient/resident, caregivers and family (if available).

2. **Aspiration Precautions** Refer to LHPP 26-02.

3. **Treatment**

a. When swallowing therapy is recommended, the ~~Speech Pathologist~~ SLP will document a treatment plan to be signed by both the SLP ~~Speech Pathologist~~ and the ordering provider ~~physician~~ in the ~~EHR~~ EHR ~~medical record~~.

b. When treatment involves upgraded food/liquid consistencies/textures not currently included in the patient/residents's diet order, refer to tray precautions in LHPP 26-02.

c. The SLP ~~Speech Pathologist~~ reviews the treatment plan with the patient, caregivers and family (when available).

d. The treatment plan includes goals, frequency, and duration of treatment.

e. The SLP ~~Speech Pathologist~~ incorporates the treatment plan into the Patient/Resident Care Plan.

f. The SLP ~~Speech Pathologist~~ works with staff, caregivers, and ~~and~~ family, as indicated, to ensure carryover of skills.

~~g.~~ Following each treatment session, the SLP ~~speech pathologist~~ documents the patient/~~resdients's~~resident's performance in the EHR. ~~EHR medical record..~~

g. ~~The speech pathologist enters a progress note once weekly for inpatients and at least once monthly for outpatients. These notes summarize the patient's performance/improvement over the period covered and update treatment plan/goals, as needed. Signed progress notes are documented at least once weekly for in-patients, and at least once monthly for outpatients. These notes summarize the patient's performance/improvement over the period covered. Treatment goals are updated as needed.~~

h. Progress notes are documented at least once weekly for inpatients, and at least once monthly for outpatients. These notes summarize the patient/residents progress over the period covered. Treatment goals are updated as needed.

i. Upon completion of treatment, the SLP ~~Speech Pathologist~~ enters a discharge summary the EHR ~~medical record.~~

4. Treatment Modifications

See Rehabilitation Services P&P #50-04, Summary of Responsibilities, PT, OT, SLP ~~ST~~, Audiology, and Physiatry, paragraph 4, Treatment Modification regarding changes to treatment plans.

5. Follow-Up

a. The SLP ~~Speech Pathology~~ Department is available to monitor any patient/resident during a meal who has been seen for a dysphagia evaluation. The request may be made by any member of the Patient/Resident Care Team. ~~RCT.~~ No provider ~~physician's~~ order is required for monitoring of a patient on his/her current diet. The Department should be contacted directly by phone.

b. Request for re-evaluation may be made if indicated (provider ~~physician's~~ order required); refer to guidelines for referral for dysphagia evaluation as outlined in LHPP 26.02, Management of Dysphagia and Aspiration Risk.

ATTACHMENT:
None

REFERENCE:
LHPPP 26-02~~,~~ Management of Dysphagia and Aspiration Risk

Most recent review: 16/08/05, 17/08/01, 20/04/29, 22/04/22
Revised: 04/08/18, 10/12/07, 14/08/22, 21/07/22, 23/05/16, 10/4/24
Original Adoption: 99/08/2

ESTABLISHMENT OF TREATMENT PROGRAMS A
DOCUMENTATION: AUDIOLOGY

POLICY:

Patient/residents are seen by an ~~A~~ Audiologist for an ~~A~~ Audiological ~~E~~ Evaluation upon referral by a physician.

PROCEDURE: ~~Duplicant~~Duplicate with P&P 90-14 (changes only made to 90-07)

1. When a physician's order for a hearing evaluation is received, the Audiologist schedules the patient/resident. If there is a concern for a sudden hearing loss, the order should be noted as urgent
2. Once the patient/resident has been evaluated, the ~~A~~ Audiologist enters the audiogram and a signed note, which includes test results and recommendations, in the patient's/resident's ~~medical record~~. Electronic Health Record (EHR).
3. After each session with the ~~A~~ Audiologist, a signed note is entered into the patient's/resident's ~~medical record.~~ EHR. ~~Electronic Health Record (EHR).~~
4. If a hearing aid is indicated, ENT or primary care physician will provide the Audiologist with a medical clearance. If a pathology is suspected, the patient/resident will be referred to ENT prior to assessment for a hearing aid. If impacted cerumen is noted, removal prior to the assessment for a hearing aid will be recommended.

ATTACHMENT:
None

REFERENCE:
None

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/14, 22/04/27
Revised: 04/08/18, 14/08/22, 23/05/19, 11/4/24
Original Adoption: 99/08/2

HEARING AID EVALUATION AND DISPENSING

POLICY:

Hearing aid evaluation, selection, orientation, and counseling are provided.

PROCEDURE:

1. Upon referral by the primary care physician or the ENT physician, patient/residents are seen for a hearing aid evaluation. For hearing aids to be obtained, an audiologic evaluation must have been performed within 6 months. If this is not available, then an audiologic evaluation should be scheduled prior to a hearing aid evaluation.

   ~~1.~~

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2. A hearing aid is ordered if indicated by results of the hearing aid evaluation and audiologic evaluation.

3. Upon receipt of hearing aid, the patient/resident is scheduled for fitting and orientation. The orientation includes programming the hearing aids and familiarizing patient/resident with parts of the hearing aid; instructing them on insertion, adjustment, usage, safety, and care; training to use hearing aid to improve listening; discussing realistic expectations of hearing aids; covering selective listening skills; and utilization of visual cues. This information is also reviewed with Nursing staff and/or family/caregiver, as appropriate.

4. The primary care and/or ENT physician is notified that the patient/resident's hearing aid trial has begun.

5. The patient/resident is given hearing aid for an approximate one-month trial. At or near the end of the trial period, the patient is seen for a hearing aid check. Patient/resident's objective and subjective benefits are evaluated and it is determined if adjustments can be made whether or not patient/resident should continue using the hearing aid.

6. If a hearing aid is reportedly malfunctioning, it is checked functionally and/or electro-acoustically and appropriate steps are taken for repair.

7. Other listening aids/training may be provided when a hearing aid is not indicated.

8. Following each session, the treatment and patient/resident's performance is documented in the Electronic Health Record medical record and electronically signed.

ATTACHMENT:
None

REFERENCES:
Barclays California Code of Regulations, Title 22 § 70597(h)(1–2)

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/14, 22/04/27, 23/05/19

Revised: 04/08/18, 19/02/08, 11/04/24
Original Adoption: 99/08/2

SPEECH LANGUAGE PATHOLOGY SERVICE EQUIPMENT AND SUPPLIES

POLICY:

Sufficient and clinically appropriate equipment is provided.

PROCEDURE:

1. The Speech Language Pathology (SLP) ~~and Audiology~~ Department located in the Pavilion Building, Room PG 172, is fully equipped with all necessary equipment and supplies to enable the ~~Department~~ SLP to provide the services offered.

2. Equipment includes, but is not limited ~~to a soundproof audiometric test chamber, diagnostic clinical audiometer, tympanometer, hearing aid analyzer and~~ diagnostic tests/materials for the evaluation and treatment of swallowing, speech-language, and cognitive-communication disorders.~~The audiology equipment is inspected and calibrated annually by audiometric specialists.~~

3. Equipment used in patient/resident care is monitored annually for safety by Biomed. ~~safety engineers~~

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 72419
Most recent review: 16/08/05, 17/8/01, 20/04/29
Revised: 04/08/18, 10/12/07, 21/07/22, 22/04/22, 23/05/19, 30/04/24
Original Adoption: 99/08/2

SPEECH PATHOLOGY AND AUDIOLOGY SERVICE DEFINITION

Speech Pathology and Audiology Service means evaluation and rehabilitation services for individuals with speech, voice, language, cognitive-linguistic, swallowing, and/or hearing disorders. Appropriate staff, space, equipment, and supplies are available to meet service needs. Therapy goals include achieving and maintaining the highest functional level hearing and communication. of communication.

ATTACHMENT:
None

REFERENCE:

LHPP: 01-00 Mission Statement and Goals Statement

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21

Revised: 04/08/18, 23/05/19, 11/4/24
Original Adoption: 99/08/23

SPEECH PATHOLOGY AND AUDIOLOGY STAFF

POLICY:

A licensed speech pathologist or AAudiologist has overall responsibility for the services rendered in the Department. Staffing is sufficient to meet the needs of the patient/residents and the scope of the services provided.

PROCEDURE:

The Speech Pathologists and Audiologists working at Laguna Honda Hospital must show evidence of being fully qualified and licensed by the California Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board. California State Board of Quality Assurance, as well as certified by the American Speech, Language, and Hearing Association. In addition, Audiologists audiologists must also also hold a current California State Hearing Aide Dispenser's License.

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(b)

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21, 23/05/17

Revised: 04/08/18, 23/05/19, 11/04/24
Original Adoption: 99/08/2

SCOPE OF SERVICES

POLICY:

The Speech Pathology and Audiology Department provides a wide range of services to enhance and facilitate the rehabilitation process.

PROCEDURE:

Speech Pathology and Audiology services include, but are not limited to, the following:

1. Diagnostic Evaluation
   a. Examination of oral motor function
   b. Assessment of voice production
   c. Assessment of speech production
   d. Assessment of language skills, both comprehension and expression
   e. Assessment of cognitive-linguistic skills
   f. Evaluation of swallowing
   g. Assessment for augmentative communication systems
   h. Testing of hearing acuity for speech reception and discrimination
   a. Screening, identifying, assessing, interpreting, diagnosing, preventing, and (re)habilitating peripheral and central auditory system dysfunctions.
   b. Testing of hearing acuity for speech reception and discrimination
   i. c. Evaluation of patient/resident's ability to use hearing aids
2. Therapy
   a. Speech
   b. Voice production
   c. Language comprehension and expression
   d. Language-related cognitive skills
   e. Provision of augmentative communication systems
   f. Swallowing
   a. Hearing (including aural rehabilitation and hearing aid fitting/hearing services)
   b. Assessing and providing nonmedical management of tinnitus.

Providing related counseling services to individuals with any type of hearing related communication disorder and their family members.

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3. Consultation with other members of the Patient/Resident Care Team (RCT) regarding strategies to facilitate improved function on the care Unit.

4.3.

5.4. Provision of patient/resident/family/caregiver education and training, as needed.

6.5. Development of Restorative Care Programs — Level II, when indicated

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(a)(4)

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21

Revised: 04/08/18, 23/05/19, 11/04/24
Original Adoption: 99/08/2

SPEECH PATHOLOGY AUDIOLOGY SERVICE EQU SUPPLIEES

POLICY:

Sufficient and appropriate equipment is provided.

PROCEDURE:

1. The Speech Pathology and Audiology Department located in the Pavilion Building, Room PG 172, is fully equipped with all necessary equipment and supplies to enable the Department to provide the services offered.

2. Equipment includes, but is not limited to a soundproof audiometric test chamber, diagnostic clinical audiometer, tympanometer, and hearing aid analyzer. and diagnostic tests/ materials for the evaluation and treatment of speech-language disorders.

3. The audiology equipment is inspected and calibrated annually by audiometric specialists. This is coordinated via the Biomed Team.

3.

4. Equipment used in patient care is monitored annually for safety by safety engineers.

5.4.

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 72419
Most recent review: 16/08/05, 17/8/01, 20/04/29
Revised: 04/08/18, 10/12/07, 21/07/22, 22/04/22, 23/05/19
Original Adoption: 99/08/2

ELECTRODIAGNOSTIC STUDIES

POLICY:

Laguna Honda Hospital and Rehabilitation ~~Program~~ Center provides electrodiagnostic services. These may include performance of electromyography, nerve conduction studies, electroencephalography, somatosensory evoked potential studies, and visual evoked potentials.

PURPOSE:

To assist in the diagnosis of neurologic and/or muscular disorders.

PROCEDURE:

1. Requests for electrodiagnostic evaluation may be made via the electronic medical record.

2. Depending on the service requested, referrals will then be routed to the physiatrist or neurologist. The physiatrist or neurologist ~~will set up the~~coordinate the appointment date with the outpatient clinic staff.

3. No written consent is required for electrodiagnostic procedures, but the procedure must be explained to the patient by the examining physiatrist/neurologist.

4. The electrodiagnostic evaluation shall be performed with sterile needle technique according to accepted standards.

5. A detailed report of each electrodiagnostic study will be generated and scanned to the electronic medical record.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 18/08/27, 16/08/14, 20/04/29
Revised: 06/09/22, 10/12/07, 20/07/21, 21/08/20, 22/04/29, 23/05/19, 17/04/24
Original Adoption: 99/08/23

DISCHARGE PLANNING AND DURABLE MEDICAL

POLICY:

Patients'/Residents' -discharges are discussed and planned during patient/resident care conferences. —Appropriate durable medical equipment is ordered and provided for patients/residents on discharge.

PROCEDURE:

Community Skills Evaluations and Home Evaluations for Equipment:

1. Community skills evaluation and/or home evaluations for appropriate durable medical equipment may include members of the interdisciplinary staff. The attending physician shall refer to the appropriate discipline via the electronic medical record.

2. The home assessment for durable medical equipment will determine specific equipment needs for the patient/resident. Appropriate ordering forms will be completed by an Occupational Therapist or Physical Therapist, signed by the referring physician, and submitted to the supplier, who will process the forms to the funding source. Equipment will be delivered to the patient's/resident's home or to the hospital, as indicated.

2.3. Coordinate with social work for any discharge related equipment needs, as indicated.

3.4. Funding sources may include, but not limited to, Medicare, Medi-Cal FFS or Managed Care, private insurance, private pay, San Francisco Health Plan, Community Living Fund, or other sources.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 16/08/05, 17/08/05, 18/08/1, 19/01/07, 20/04/29, 21/07/14, 22/04/20, 23/08/23
Revised: 06/09/22, 19/04/24
Original Adoption: 99/08/23

DISASTER PLANNING AND EMERGENCY PREPAREDNESS

POLICY:

To maintain a state of preparedness for emergency or disaster.

DEFINITIONS:

1. **In Charge:**
   Chief of Rehabilitation Services and/or VP Executive Rehabilitation Services, Rehabilitation Director, or Designee.

2. **Automatic Immediate Return without Callback:**
   Rehabilitation DirectorManager, Senior Physical Therapist, Senior Occupational Therapist, and Speech Therapy Supervisor.

3. **Return with Callback for Regular Shift:**
   All employees other than the above named positions.

PROCEDURE:

When activated by the Hospital Incident Command Center (HICS), the disaster plan for Physical Therapy, Occupational Therapy, and Speech Therapy includes:

1. Emergency Call Roster:

a. The Chief of Rehabilitation Services and/or VP Executive Rehabilitation Services, and the Rehabilitation Director will be notified of emergencies or disasters through activation of the Medical Services Emergency Call Roster.

b. The Rehabilitation Director will call the two people below him/her on the roster list, following department guidelines to contact all employees in Rehabilitation Services.

2. Staffing Plan:

a. The In-charge will designate sufficient staff to remain with patients/residents who may be in the department.

b. The In-charge will instruct all remaining staff to report to the designated staff staging area for appropriate assignment.

c. All employees called back will report directly to the designated staff staging area for appropriate assignment.

3. Department Plan of Operation for the First 72 Hours:

a. Staff will return to their respective departments and check-in with their supervisor (or acting supervisor).

b. Staff will secure the PT/OT/ST departments (close windows, turn off equipment and lights) and prepare patients in the department for return to their respective units.

c. The In-charge will designate sufficient staff to remain with patients/residents in therapy at time of occurrence.

d. All remaining available staff will report to the designated staff staging area for appropriate assignment.

4. Evening, Night, Weekend, Holiday

a. All employees called back will report directly to the designated staffing area for appropriate assignment.

ATTACHMENT:
None

REFERENCE:
HWP&P # 70-04 Committees – Other: Safety and Emergency Preparedness Committee

Most Recent Review: 16/08/05, 18/08/15, 20/04/29, 21/07/14, 22/04/20
Revised: 06/09/22. 17/08/14, 23/08/23, 19/0424
Original Adoption: 99/08/23

Rehabilitation Services Community Evaluation

POLICY:
~~The~~ Rehabilitation Center may provide a community evaluation for each patient/resident before discharge from the facility to assess community level skills. This includes but not limited to: use of public transportation, mobility or ambulation in the community, ability for street crossing and able to problem solve pathfinding.

PROCEDURE:

1. Consideration for a community evaluation will be discussed with patient/resident care team to determine necessity and goals.

2. Obtain referral and/or appropriate plan of care to include needs.

3. Notify nursing and unit staff at least one day before community evaluation date.

4. Therapists can check out a cellphone from a Senior and obtain an emergency kit (located in office PG153) in preparation for home evaluation. Therapists will follow the standard of work for DPH-approved device used for taking images for the home evaluation.

5. Therapists confirm stable vital signs OR receive acceptance of stability from charge nurse.

6. Therapist will accompany patient/resident on evaluation and can address the following but not limited to: abilities to effectively use public transportation, mobility or ambulation for community distances/surfaces/obstacles, safety for street crossing, ability to problem solve and path find appropriately.

7. In accordance to the Sugar Sweetened Beverage (SSB) Ordinance (effective 9/1/15), Therapist will notify patients/residents not to purchase SSB drinks during community evaluation to comply. The following are acceptable choices in consideration of patient/resident diet type and diet consistency:
   - 100% fruit and vegetable juice without added caloric sweeteners
   - Only beverages containing 25 calories or less per 12 ounces of beverage
   - Milk
   - Flavored mild containing no more than 40 grams of total sugar per 12 ounces
   - Unsweetened tea
   - Coffee
   - Water / sparkling water
   - Diet carbonated beverages

8. Expenditure of DPH funds for food is allowed if food is served for a business purpose.

a. Allowable Expenditures: 1. Food provided to clients for a legitimate client benefit or purpose (e.g. vouchers for groceries, food provided to clients, client incentives, etc.)..

9. Healthy Food: DPH employees that order, authorize, or purchase refreshments for any purpose must use their best efforts that ensure that all foods and beverages served at City Meetings or City-Sponsored Events and purchased using City funds meet the nutritional standards outlined in Ordinance 91-16.

10. Written evaluation and recommendations from OT, PT, or ST will be documented in the medical record and will be discussed with team and patient.

11. Follow up on any treatment plans and recommendations resulting from community evaluation.

ATTACHMENT:
None

REFERENCE:

Most Recent Review: 10/19/17, 18/08/15, 20/04/29, 21/07/14, 22/04/20, 23/08/23
Revised: 19/04/24
Original Adoption:

Rehabilitation Services Home Evaluation

POLICY:
The Rehabilitation Center may provide a home evaluation for each patient/resident before discharge from facility to assess the patient's/resident's skills within their home environment. This includes- but not limited to: car/van transfers, entry to home assessment, accessibility to bedroom, kitchen and living spaces as well as bathrooms and showering facilities with regards to safety. Caregiver assessment and training may also be included.

PROCEDURE:

1. Consideration for a home evaluation will be discussed with patient/resident care team and determine necessity.

2. Obtain referral and/or appropriate plan of care to include needs.

3. Members of the PCT/RCT (social work, nurse and/or physician) will set potential date and alert team members of scheduled evaluation.

   Therapists can check out a cellphone from a Senior and obtain an emergency kit (located in office PG153) in preparation for home evaluation. Therapists will follow the standard of work for DPH-approved device used for taking images for the home evaluation.

4.

5. Therapists confirm stable vital signs OR receive acceptance of stability from charge nurse.

6. Formal home evaluation will be performed and can address but not limited to: transfers including car, functional mobility, stairs, toileting, bathing, home environment safety, patient and caregiver training.

7. Home evaluation may be conducted without patient/resident being present. Assessment of the environment (bedroom and bathroom), stairs, walking path inside and outside of home and caregiver training will be addressed.

8. Written evaluation and recommendations from PT and OT will be documented in the medical record and will discussed with team and patient.

9. Follow up on any treatment plans and recommendations resulting from home evaluation.

ATTACHMENT:
None

REFERENCE:

Most Recent Review: 10/19/17, 18/08/15, 20/04/29, 21/07/14, 22/04/20, 23/08/23
Revised: 19/04/24
Original Adoption:

REHABILITATION SERVICES EQUIPMENT AND SUPPLIES

POLICY:

Laguna Honda Hospital and Rehabilitation Services provides sufficient equipment and supplies to fulfill the need of the services provided by the Rehabilitation Services. Equipment is of sufficient quality and ~~quantity, and~~quantity and is therapeutically sound to provide safe and effective patient care. In accordance with all federal, state, and local requirements, annual testing and maintenance of equipment is required.

PROCEDURE:

1. On a daily basis, all spaces, supplies, and electrically and manually powered equipment used in the diagnosis, treatment, and monitoring of patients will ~~be inspected~~be inspected and surveyed no less than Monday – Friday, excluding ~~for~~ City-designated holidays.

2. A tracking process for environment of care rounding ~~log~~ will be followed and maintained ~~kept~~ in the department to track the completion of departmental duties, which entails but not limited to, daily monitoring of equipment functionality, supply inventory, spatial organization, and regular cleaning schedules.

3. Prior to the use of any equipment, rehabilitation staff inspect and observe each piece of equipment for any malfunctions, alerts, or safety concerns.

4. For any safety issues, including performance requirements and quality controls for all equipment used in the provision of patient/resident care services, a work order will be placed to the appropriate department in accordance with the preventative maintenance assignments per Hospital Wide Policy and Procedure 31-05 *Preventative Maintenance Plan*.

~~5.~~ Use of therapeutic equipment requires that each staff member has been introduced to the equipment and demonstrates basic competency in equipment use.

5.

6. On an annual basis, to ensure patient/resident care equipment functions properly, annual preventive maintenance of all electrically- and non-~~electrically-powered~~electrically powered equipment used in diagnosis, treatment, or monitoring of patients will be handled in accordance with Hospital Wide Policy and Procedure 31-05 *Preventative Maintenance Plan*.

7. Safety issues, including performance requirements and quality controls for all equipment used in the provision of patient care services, are addressed by the appropriate department.

   a. For Bio-Medically maintained equipment, the rehabilitation department will contact Central Processing Department to schedule biomedical technician support. Biomedical team will provide support for maintaining service tag but not limited to, to assure compliance with safety and environment of care rounding.

   b. For Information Technologically maintained equipment, the rehabilitation department will submit an IT help desk ticket.

   c. For Facility maintained equipment, a Facilities work request will be placed by the Rehabilitation Department.

   c.

   d. d. For Vendor supported equipment, the rehabilitation department will contact the manufacturer.

8. Equipment user manuals will be kept on the premises in either hard copy or electronic format.

ATTACHMENT:
None

REFERENCE:

1. HWP&P: 60-08 Risk Management Program (Medical Devices and Equipment)
2. HWP&P: 31-05 *Preventative Maintenance Plan (*Medical Devices and Equipment)
3. Barclays California Code of Regulations, Title 22 § 72409 Physical Therapy Service Unit–Equipment, § 72419 Occupational Therapy Service Unit–Equipment, § 72429 Speech Pathology and/or Audiology Service Unit–Equipment
4. Plant Services Department P&P # EM-1 Equipment Maintenance Program (Testing and Maintenance of Patient Care Equipment)
5. Title 22 § 70601(a–b))

Most Recent Review: 16/08/05, 17/07/28, 18/08/15, 20/04/29, 21/07/14
Revised: 06/09/22, 10/12/07, 17/07/28, 22/06/08, 19/04/24
Original Adoption: 99/08/23

REHABILITATION SERVICES EQUIPMENT AND SPACE

POLICY:

Laguna Honda Hospital and Rehabilitation Services provides sufficient equipment and space to fulfill the need of the services provided by the Rehabilitation Services. Equipment is of sufficient quality and quantity and is therapeutically selected to provide safe and effective patient care.

PROCEDURE:

1. To help assure that patient/resident care equipment functions properly and in accordance with all federal, state, and local requirements, all electrically and manually powered equipment used in the diagnosis, treatment, and monitoring of patients/residents will be checked off no less than Monday – Friday and excluding for City-designated holidays.

2. A log will track the departmental duties checklist to include daily monitoring of functionality and regular cleaning.

3. Before use of any equipment, rehabilitation staff shall inspect each piece of equipment for an malfunctions or safety concerns.

4. For any safety issues, including performance requirements and quality controls for all equipment used in the provision of patient care services, a work order will be placed in accordance with preventative maintenance assignments per Rehabilitation Policy and Procedure 110-02 *Rehabilitation Services Equipment and Supplies* as well as Hospital Wide Policy and Procedure 31-05 *Preventative Maintenance Plan*.

ATTACHMENT:
None

REFERENCE:
1. HWP&P: 60-08 Risk Management Program (Medical Devices and Equipment)
2. Barclays California Code of Regulations, Title 22 § 72409 Physical Therapy Service Unit–Equipment, § 72419 Occupational Therapy Service Unit–Equipment, § 72429 Speech Pathology and/or Audiology Service Unit–Equipment
3. Plant Services Department P&P # EM-1 Equipment Maintenance Program (Testing and Maintenance of Patient Care Equipment)
4. Title 22 § 70601(a–b))

Most Recent Review:
Revised: 24/04/24
Original Adoption: 22/06/08

NEUROPSYCHOLOGIST, REHABILITATION SERVICES

The neuropsychologist will serve as a consultant on the Rehabilitation Unit. Specific duties will include:

1. Determination of medical necessity for neuropsychological services.

~~1.~~2. Cognitive evaluations for ~~all~~ patients admitted with neurologic diagnoses that meet medical necessity for an evaluation.

~~2.~~3. Development of behavior management programs, including staff in-services of such programs.

~~3.~~4. Attendance at *Rehabilitation Patient Care Team Conferences* for all appropriate patients.

~~4.~~5. Attendance at Rehabilitation Unit Meetings and Rehabilitation Leadership Meetings, as appropriate.

~~5.~~6. Neuropsychologic testing.

7. Supportive psychotherapy.

Most Recent Review: 18/08/24, 17/08/14, 20/04/29, 20/07/21, 21/08/06, 22/04/27, 23/06/03
Revised: 23/06/03, 24/04/24
Original Adoption: 17/08/14

STAFF PHYSIATRIST, REHABILITATION SERVICES

The staff physiatrist will serve as ~~admitting~~ attending physician for patients admitted to the Rehabilitation Unit. Specific duties will include:

1. Performing a ~~physiatric~~physiatrist evaluation of all referred patients with subsequent development and implementation of a rehabilitation treatment plan.

2. Participating in Rehabilitation Patient Care Team Conferences.

3. Attending Rehabilitation Services Unit meetings and Rehabilitation Leadership Meetings (as needed).

4. Assisting in the admission screening process as needed.

5. Participating in Performance Improvement activities.

6. Other duties, as required.

Most Recent Review: 18/08/24, 17/07/31, 20/04/29, 20/07/17

Revised: 18/08/24, 22/04/29, 23/05/19, 24/04/24

Original Adoption: 14/08/31

Deletion Rehabilitation Policies and Procedures

CUSTOM WHEELCHAIRS

POLICY:

Custom wheelchairs may be ordered for residents/patients with specialized positioning and seating needs who cannot be safely and adequately positioned in a facility wheelchair, provided a funding source is identified. The funding source must be able to pay for ongoing maintenance and repairs.

DEFINITION:

Custom Wheelchairs: A custom wheelchair is defined as one that has been constructed to address a particular resident's/patient's individual medical needs for positioning, support, and mobility.

GOAL:

- Resident/patient will be able to maintain highest functional level of mobility skills and overall Quality of Life (QOL).
- Resident/patient will be optimally positioned when up in a wheelchair to participate in functional tasks for QOL.

INCLUSION CRITERIA:

Residents/patients may be considered for custom wheelchairs based on medical necessity and upon the recommendation of the Occupational Therapist/Physical Therapist. The resident/patient must also meet one of the following criteria:

- A physician's order for a wheelchair evaluation, and a subsequent Occupational Therapy/Physical Therapy evaluation or assessment confirms that proper seating and mobility cannot be achieved with available equipment. For power wheelchairs, the resident/patient must demonstrate the ability to drive and operate the power wheelchair independently.

- A resident/patient cannot be easily transported to activities in a facility provided wheelchair due to positioning needs.

- A custom wheelchair is needed for discharge to the community to enable mobility, completion of activities of daily living, or vocational activities and overall QOL.

- When specific components are needed to position residents to reduce current contractures.

- A resident/patient has a history of positioning problems. The Occupational/Physical Therapist is unable to position resident safely and adequately in available wheelchairs. Criteria may include, but is not limited to:
    - Supporting midline orientation.
    - Providing normal visual access to the environment.
    - Enabling adequate respiration.
    - Enhancing ability to swallow or improving ability to perform self-feeding.
    - Protecting a resident from injury (e.g., due to movement disorders).
    - Reducing risk of falls to floor due to lateral, posterior, or anterior flexion.
    - Reducing slides from chair due to posterior tilt or trunk extension.

PROCEDURE:

- If a resident/patient meets any of the criteria for a custom wheelchair, a physician may request for an Occupational Therapy/Physical Therapy evaluation for a functional mobility evaluation through the electronic health record (EHR).
- On receipt of the physician's order, the Occupational/Physical Therapy Department will conduct an evaluation or assessment of the resident's/patient's custom wheelchair needs.
- Adjustments or modifications may be made to a personal wheelchair, or a facility owned custom wheelchair, pending wheelchair parts and/or insurance to meet the resident's needs.
- If a wheelchair cannot be modified, a trial with an appropriate custom wheelchair (if available from a vendor or from the Rehabilitation Department) will be conducted to see if it will benefit the resident's/patient's condition.
- If a facility wheelchair and positioning devices are unable to meet a resident's highest functional independence and/or are unable to meet their positioning needs, and a trial of a custom wheelchair has demonstrated medical benefit, the Occupational/Physical Therapist will:
    - Communicate the assessment or evaluation with the Resident Care Team/Patient Care Team and/or document in the resident's/patient's medical record, the outcome of any trial of the equipment.
    - Consult with vendor(s) for evaluation of an appropriate custom wheelchair for the resident/patient.
    - The Occupational/Physical Therapist will facilitate the procurement process and assist with completing and/or obtaining the required forms regulated by specific insurance requirements (i.e. Medi-Cal or Medicare) from the prescribing physician, as needed.

- Identifying an appropriate funding source and submit the required documentation to the vendor.
- Consider the following when completing the medical record documentation for skilled seating evaluations:
  i. Intervention(s) that were tried by Nursing staff and/or rehabilitation department;
  ii. Functional deficits due to poor seating or positioning;
  iii. Most recent prior functional level;
  iv. Postural deficits the resident/patient is unable to self-correct;
  v. Recent event(s) that prompted a seating evaluation;
  vi. Specific wheelchair, specialty items, dimensions and/or specific cushions that were evaluated and/or recommended;
  vii. A clear explanation of how the proposed custom wheelchair or seating device will make a significant improvement in functional abilities versus current wheelchair or seating device;
  viii. Transition to caregiver follow-up.

- If the resident's/patient's insurance denies a custom wheelchair while the resident/patient is residing at LHH, the resident/patient will remain in the facility provided wheelchair.

- If the resident/patient receives a custom wheelchair, the licensed nurse shall document the make, model, and serial number in the designated unit records per resident/patient inventory.

- For repairs of custom wheelchair on loan from Laguna Honda Hospital Rehabilitation Department, a quote for the repair will be obtained from a vendor and submitted to the supervisor for approval. If the cost of repair is approved, the therapist will contact the vendor to have the parts ordered and schedule for a follow up visit to complete the repair.

- **Nursing/Unit staff will**:
  - Monitor residents'/patients' needs and relay this to physicians for a Rehab referral for a wheelchair evaluation if needed.
  - Refer to the vendor: The most recent custom wheelchair issued to resident by insurance requiring repairs are referred to the vendor who supplied the wheelchair or vendor of resident's choice. Vendors will be contacted by nursing/unit staff to repair personal custom wheelchairs. This may be dependent on insurance approved vendors. Vendor availability is subject to each company and not related to LHH staffing.
  - Address resident's/patient's needs and submit work order to Facilities department to obtain a facility wheelchair and/or facility chair repairs (Refer to LHH EM -b0: Manual Wheelchair Maintenance and Repair).

- Submit a work order to LHH Facilities for custom wheelchair repairs that do not affect the integrity or warranty of the wheelchair. This is subject to LHH facility discretion (i.e inflating air into tires, tightening a screw).

- Place work order for maintenance or repair of resident's/patient's own or loaned w/c not provided by insurance or LHH. A work order can be placed to LHH facilities. If LHH facilities is not able to repair the w/c, resident/patient or nursing/unit staff can contact an outside vendor if the resident/patient would like to self-pay for the repairs/maintenance.

ATTACHMENT:
None

REFERENCE:

1. Barclays California Code of Regulations, Title 22 § 51303(a – i).
2. Barclays California Code of Regulations, Title 22 § 51321
3. Physical Therapy, Occupational Therapy and Speech-Language Pathology Outpatient Services Educational Update, United Government Services (fiscal intermediary), 2nd Revision, November 2003.
4. LHH EM -b0: Manual Wheelchair Maintenance and Repair.
5. California Advocates for Nursing Home Reform: Access to Durable Medical Equipment in Nursing Homes. Retrieved on 7/18/2023 from http://www.canhr.org/publications/newsletters/Advocate/FrontArticle/adv_2001_4.htm

Most recent review: 17/07/31, 20/04/27, 21/07/22, 22/04/21, 23/05/16
Revised: 04/03/29, 04/08/18, 10/10/21,16/08/05, 18/08/14, 20/05/21, 23/07/20, 24/04/22
Original Adoption: 99/08/23

WHEELCHAIR CLINIC

POLICY:

The Rehabilitation Department and approved vendors will provide wheelchair clinic one time per month (frequency may change depending on need and availability) for repairs on facility owned custom wheelchairs.

PURPOSE:

1. Maintain and repair resident's custom wheelchair on loan from Laguna Honda Hospital Rehabilitation Department.
2. Resident will be able to maintain highest functional level of mobility skills.
3. Resident will be optimally positioned when up in a wheelchair.

PROCEDURE:

1. Referral to the wheelchair clinic:
   a. Submit an electronic referral through EPIC to the Occupational Therapy Department
   b. Verbal order from MD
   c. Verbal recommendation or written chart notes by LHH Occupational Therapist
   d. Request of resident
   e. Request of member from the resident care team.

2. Evaluation of equipment needed, and/or recommendations for repairs or modifications, are performed by any one or more of the following:
   a. Occupational Therapist
   b. Physical Therapist
   c. Assistive Technology Professional
   d. Technician from an approved wheelchair vendor.

3. Reasons for wheelchair clinic for residents custom wheelchair on loan from Laguna Honda Hospital Rehabilitation Department include:
   a. Repairs
   b. Retro-fit

4. A wheelchair clinic schedule is developed by the Rehabilitation Department and vendor one week prior to the next scheduled clinic.
   a. Residents' appointment for the wheelchair clinic will be on the snap board in EPIC.
   b. Units are notified by telephone by Rehabilitation Department to informed staff about the scheduled appointment. Residents schedule and specific needs are considered during scheduling.
   c. Rehabilitation Department will write a progress note in the electronic health records on EPIC for each resident that attends wheelchair clinic. Documentation includes issues with the wheelchair, work planned and/or performed, and/or if wheelchair cannot be repaired due to the cost of the repair exceeding the value of the wheelchair.
   d. Rehabilitation Department will obtain a quote for the repair and/or modification from vendor and submit to supervisor for approval.
      1. If the cost of repair and/or modification are approved, the therapist will contact the vendor to have the parts ordered. Once parts are received by vendor, patient will be scheduled for a follow up wheelchair clinic visit to complete the repair/modification.
      2. If the repairs and/or modifications are denied, OT will see if there is a facility wheelchair to meet resident's mobility and/or positioning needs. If a facility wheelchair is not available and therapist feels that a custom wheelchair is needed, they will obtain a referral for a functional mobility evaluation and contact a vendor to schedule an appointment for a new custom wheelchair evaluation.

ATTACHMENT:
None

R EFERENCE:
None

Most recent review: 15/08/26, 16/08/05, 17/07/31, 18/08/14, 20/04/27, 22/04/21
Revised: 06/09/22, 08/08/26, 10/10/21, 13/08/22, 20/05/21, 21/07/22
Original Adoption: 99/08/23

CONNECTIVITY CLINIC

POLICY:

The Psychosocial Occupational Therapy groups are treatment programs facilitated by a psychosocial occupational therapist or a trained occupational therapist. The program provides patients with Alzheimer's Disease, and other dementias, with a unique opportunity to engage in stimulating tasks. The structured treatment groups meet weekly in a campus community space.

GOALS:

1. Patients will increase their functional capacity: i.e. increase endurance for time out of bed, and increase their participation in functional activities.

2. Patients will increase their tolerance for group participation; i.e. increased attention span, ability to follow directions, mental flexibility, and engage with peers.

3. Patients will have opportunities for increased group diversity, peer support, and developing ongoing relationships with patients from other units in mixed gender groups.

4. Patients will optimally, demonstrate improved mood, decreased use of psychotropic medications for the treatment of agitation, and decreased use of sleep medications with improved sleep.

PROCEDURE:

1. Referral to Psychosocial Occupational Therapy groups offered may be made at the request of a member of the patient's RCT or at the request of the patient to the RCT.

    a. The physician submits a Rehabilitation Services electronic referral through EPIC, indicating Occupational Therapy Eval and Treat and Psychosocial Group Treatment.

2. Psychosocial OT will complete an assessment and determine if patient is appropriate for group and recommend group assignment.

3. Patient and the patient's unit are notified of group schedule and the unit staff are informed that they will escort patient to and from the Psychosocial OT group according to group schedule.

4. Psychosocial OT completes evaluation documentation for each patient assessed. The Psychosocial OT evaluation is recorded in the electronic medical record used by the LHH Rehabilitation Department.

ATTACHMENT:
None

R EFERENCE:
None

Most recent review: 15/08/26, 16/08/05, 17/07/31 , 20/04/27, 21/07/22, 22/04/21
Revised: 07/08/24, 09/11/12, 10/10/21, 14/08/22, 18/08/23
Original Adoption: 11/08/30

EQUIPMENT MAINTENANCE

POLICY:

To assure that patient care equipment functions properly and in accordance with all federal, state, and local requirements, all electrically and non-electrically powered equipment used in the diagnosis, treatment, or monitoring of patients.

PROCEDURE:

1. Annual equipment monitoring for proper functioning and safety is carried out by staff designated as per HWPP 31.05.
2. The Rehabilitation Department will place a Facilities Work Order to notify and request the annual maintenance.
3. Documentation of the tests is kept by the Rehabilitation Services Department.
4. When equipment is non-functional, standard procedures will be followed to repair or remove equipment, as appropriate.
5. User/operator instructions and manuals are available for every item identified in the patient care equipment list. Individuals may receive additional instruction, as needed, to operate equipment they use in the performance of their prescribed duties.

ATTACHMENT:
None

REFERENCE:

1. HWP&P: 60-08 Risk Management Program (Medical Devices and Equipment)
2. Facility Services Department P&P # EM-1 Equipment Maintenance Program (Testing and Maintenance of Patient Care Equipment)

Most recent review: 16/08/16, 17/07/28, 18/08/14, 20/04/29, 21/07/14
Revised: 00/06/14, 06/09/20, 10/10/21, 11/08/30, 14/08/22, 17/07/28
Original Adoption: 99/08/23

HEARING SCREENING

POLICY:

A pure tone audiometric screening shall be part of every initial Speech-Language Evaluation (SLP) Speech Language Evaluation (SLP) speech/language evaluation for new admissions, as deemed appropriate by the Speech Language Pathologist, and with the exception of those patient/residents unable to participate in the procedure.

PROCEDURE:

1. The audiometric screen is provided by a licensed audiologist
2. If the loss of hearing sensitivity is documented by this screening, the patient/resident receives a complete audiologic evaluation upon a provider physician's order.
3. The Audiologist documents findings of the screen in the patient/resident's Electronic Health Record. medical record.

ATTACHMENT:

None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70597(a)(1)

Most recent review: 16/08/05, 17/08/01, 20/04/29

Revised: 04/08/18, 21/07/14, 22/04/21, 23/05/17, 24/04/11
Original Adoption: 99/08/2

DELETE POLICY (Duplicate for 90-07):

ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: AUDIOLOGY

POLICY:

Patients are seen by an Audiologist for an Audiological Evaluation upon referral by a physician.

PROCEDURE:

1. When a physician's order for a hearing evaluation is received, the Audiologist schedules the patient.
2. Once the patient has been evaluated, the Audiologist enters the audiogram and a signed note, which includes test results and recommendations, in the patient's medical record.
3. After each session with the Audiologist, a signed note is entered into the patient's medical record. Electronic Health Record (EHR).
4. If a hearing aid is indicated, ENT or primary care physician will provide the Audiologist with a medical clearance. If a pathology is suspected, the patient will be referred to ENT prior to assessment for a hearing aid. If impacted cerumen is noted, removal prior to the assessment for a hearing aid will be recommended.

ATTACHMENT:
None

REFERENCE:
None

Most recent review: 16/08/05, 17/08/01, 20/04/29, 21/07/14, 22/04/27
Revised: 04/08/18, 14/08/22, 23/05/19
Original Adoption: 99/08/2