List of Hospital-wide/Depsrtmental Policies and Procedures submitted for Approval on October 8, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
JCC Follow-up					
Revised	LHHPP	20-04	Discharge Planning	**Z. Brucell**	1. Deleted "Certain residents may be expected to leave LHH and return, perhaps repeatedly. " 2. Deleted "Resident's right to request a seven-day bed hold." 3. Updated refeences to policies.
Revised	LHHPP	55-03	Pre-Admission Screening and Resident Review (PASRR)	**Z. Brucell**	1. Added "Level II PASRR's will be reviewed on a case-by-case basis to determine if admission to LHH is appropriate." 2. Changed MOS to MDS throughout the document 3. Added "LHH is required to initiate a Resident Review (RR) by completing a Level I Screening when there is a significant change in condition relating to the individual's SMI and/or ID/DD/RC or when the Minimum Data Set (MDS) does not match the Level I Screening from the hospital. LHH must initiate the RR as a Level I Screening within 72 hours of identification of a significant change in condition or identification of variance between the MDS and Level I Screening." 4. Added "When a resident is returning from a hospital stay (readmission), there may be a clear change in condition. In instances where the significant change is evident, the individual is subject to a RR within 72 hours upon their return to the SNF. In other cases, it may take time before changes to the resident's condition become apparent. In these situations, LHH should use the MDS Significant Change in Status Assessment to evaluate whether a RR is required." 5. Replaced "Neighborhood" with "unit" 6. Added ", if and only if LHH can implement the recommendation(s). If the recommendation(s) cannot be followed, the RCT must document why the recommendation(s) was not used, what interventions were used instead, and/or substitutions based on availability of the services that LHH provides" 7. Added "LHH will initiate completion of the PASRR when admission is from the community setting. "
Revised Hospital-wide Policies and Procedures					
Revised	LHHPP	20-01	Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units	**A. Lam**	2. Replaced "Physician" with "LHH physician " 3. Added "SNF" 4. Added "Nursing Home Administrator" and "NHA" 5. Deleted "Applicants who will not sign the Laguna Honda House Rules and Responsibilities" 6. Deleted "when we begin to evaluate new admission requests " 7. Deleted "Admissions Coordinator" 8. Added "Utilization Management " 9. Replaced "accepted" with "reviewed" 10. Replaced "dictated" with "complete" 11. Deleted "As a condition of admission, the resident or resident's surrogate decision-maker must agree to these conditions by signing these agreements prior to admission. " 12. Replaced "the Admissions Coordinator" with "Patient Flow" 13. Added "Come and go" procedures or infusions for" 14. Deleted "SNF" 15. Deleted "who require blood transfusions, but who are" and "provided care on the Acute Medical Unit as "come and go" cases." 16. Deleted "SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for" 17. Added "only if licensed as an infusion clinic" 18. Deleted "as a "come and go" case, after approval by the CMO." 19. Changed "Residents being evaluated for admission to LHHs Acute Medical unit with suspicion of COVID-19 will have a minimum of one negative antigen test within 24 hours of transfer. If resident acuity is unstable and a testing delay would impact care, the resident will be transferred to a facility outside LHH, if within goals of care. Residents with a positive COVID-19 test will be transferred to a facility outside LHH unless they have an advance directive requesting that care be provided only at LHH. Decisions to admit/transfer will be a joint discussion between the resident, their family, and the attending physician." to " Residents being evaluated for admission to the Acute Medical Unit with known or suspected Covid-19 may be admitted to PMA if specific criteria are met:" 20. Added "There is an available Airborne infection isolation room (AIIR) or an AIIR capable room can be made available within 5 hours. If there are no available AIIRs, or the acuity of the resident precludes waiting 5 hours, then the resident should be transferred to another acute care facility if within their goals of care. " 21. Added "The resident does not have comorbidities or coexisting acute conditions that might require urgent access to a level of care not available at the PMA (for example but not limited to: advanced cardiac care or impending ventilatory support). These residents would require transfer to an outside acute care facility. " 22. Added "Decisions to admit/transfer Covid-19 positive or suspected residents should remain a joint discussion between the attending physicians, the resident, and their decisionmaker(s)." 23. Added "If the transferred resident is ruled out for Covid-19 and still meets PMA LOC, they should be moved to a non-AIIR room as soon as feasible." 24. Added "on leave of absence" 25. Deleted " (and resident's medical record is closed)" 26. Added ", after the 7 days bed hold" 27. Deleted " Admissions Coordinator and " 28. Replaced "Sunday" with " Weekend " in multiple locations. 29. Added "For readmissions" 30. Deleted "knowledge of" 31. Added "Relocations shall not be proposed for the sole purpose of staff convenience, and solely for the purpose of medical/care needs."

Revised	LHHPP	22-09	Psychiatric Emergencies	**Y. Qian**	This policy is revised to reflect the new state law SB43 (changed definition of gravely disability), to clarify 5150 designated providers, and clarify procedures. Main edits are: 1) Clarified definition for psychiatric emergencies, added definitions for 5150, indications for 5150, and 5150 designated providers, 2) deleted 5150 protocol attachment (The protocol is converted to a standard work for 5150), and 3) rearranged/clarified Procedure steps.
Revised	LHHPP	24-10	Coach Use for Close Observation	**T. Brown** **T. Grados**	1. Deleted "LVn or RN" 2. Added "either as a nursing note or on the " 3. Added "LN" 4. Added "LN will verify coach presence and documentation through LN documentation in the EHR flowsheet or in a nursing note in the EHR."
Revised	LHHPP	27-02	Referrals for Rehabilitation Services	**D. Swiger**	1. Added "and/or patients" 2. Deleted "during business days, excluding holidays." 3. Added "4.In the event, when staffing volume is unable to meet all in-house referrals, physical therapy, occupational therapy, speech pathology, will follow rehabilitation services prioritization guidelines (see Appendix A). " 4. Added Appendix A
Revised	LHHPP	27-03	Natural Dye Swallowing Assessment for Patients with Tracheostomy	**D. Swiger**	1. Added "resident" throughout the document 2. Added "swallowing assessments facilitate detection of aspiration in patients/residents who have a tracheotomy. Natural dye " 3. Deleted "This is to augment a traditional bedside swallow evaluation and " 4. Deleted "The physician shall order a swallow evaluation. 5. Deleted "speech language pathologist (SLP) shall conduct a thorough chart review." 6. Added "Speech Language Pathologist (SLP) reviews the Electronic Health Record (EHR) and schedules the " 7. Deleted "a Passy-Muir Speaking Valve prior to the swallow evaluation (per LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir)." 8. Deleted"If the tracheostomy has" and "inflated cuff, a physician's order to deflate the cuff is obtained. If the patient cannot tolerate cuff deflation, the procedure is deferred or modified" 9.Added"In cases where the patient/resident's tracheostomy tube is cuffed and inflated, a provider order is obtained to conduct the procedure with the cuff deflated." 10. Added "If the patient/resident cannot tolerate cuff deflation, the procedure is deferred or modified as
Revised	LHHPP	27-06	Guidelines for Inpatient Rehabilitation Facility Documentation	**D. Swiger**	1. Replaced "RCT" with "IDT" throughout the document 2. Replaced "Medical necessity" with "Need" 3. Added "that may include" 4. Replaced "inpatient" with "intensive" 5. Replaced "Inpatient Rehabilitation Services" with "Intensive Therapy Program" 6. Added "i.The ARD is defined as the 3rd calendar day of the rehabilitation stay, which represents the last day of the 2-day admission assessment time period. If the stay is less than 3 calendar days, the admission ARD is the last day of the stay. If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days." 7. Deleted "Within 24 hours after admission of a patient, UM shall notify the RCT and Patient Billing if the patient is Medicare A eligible and the ARD. " 8. Replaced "Appendix C" with "Attachment A" 9. Replaced "IRF registered nurse" with "MDS RN" 10. Replaced "the IDT assessments" with "Medicare A assessments of the IDT" 11. Added reference to "LHHPP 55-01 Payor Eligibility Certification and Coverage"
Revised	LHHPP	60-12	Review of Sentinel Events (Applicable to Acute Care Units Only)	**N. Zahir**	1. Replaced "acute care" with "Pavilion Mezzanine Acute" 2. Replaced "resident" with "patient" 3. Replaced "adverse" with "sentinel 4. Deleted "Deputy City Attorney" 5. Added "the Assistant Nursing Home Administrator (ANHA)"
Revised Medical Services Policies and Procedures					
Revised	MSPP	C01-02	Guidelines for Autopsy Requests	**L. Hoo**	Grammatic and wording changes. Clarified abbreviation for ZSFG and updated departmental names for HIM and A&E
Revised	MSPP	MSPP D13	Consultant Responsibilities	**L. Hoo**	1. Changed title and content to include In-patient consultation 2. Updated timeframe for completion of electronic health record notes to reflect current DPH policy for signing/completion of electronic health record notes 3. Clarify responsibility for diagnostic testing follow-up 4. Removed process no longer necessary with current electronic health record/EPIC 5. Minor wording changes
Deletion Medical Services Policies and Procedures					
Deletion	MSPP	D14-01	HIV Testing and Prevention for Residents	**L. Hoo**	Policy is outdated and continuously updated information is available in clinical resources accessible to all providers.
Revised Nursing Policies and Procedures					
Revised	NPP	Acute 01.0	Nursing Staff Education – Acute Unit	**J. Selerio**	1. Corrected spelling of scope 2. Replaced "XX.XX" with "Acute-02.0"

Revised	NPP	Acute 02.0	Documentation of Care – Acute Unit	**J. Selerio**	Removed the following from notifications section: "For any patients admitted from SNF, request SNF Unit send multi dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials bottles, eye drops, fridge items) with the patient to the Acute Unit. Refer to policy Pharmacy 02.0100b Skilled Nursing Distribution of Medications and Order Processing."
Revised	NPP	A 8.0	Decentralized Staffing	**J. Selerio**	No changes to policy • References updated • Reviewed with no changes needed. Ensured that Appendix A matches the grid in HWPP 20-15 PCS • 20-15.pdf
Revised	NPP	C 1.3	Discharge Procedure to Acute	**J. Selerio**	Reviewed with no changes since last revision that is currently in the policy approval process
Revised Rehabilitation Policies and Procedures					
Revised	Rehab	40-01	Rehabilitation Services Rehabilitation Services for Rehabilitation Unit (Acute Rehabilitation and SNF Rehabilitation) Patients	**D. Swiger**	1. Added "at LHH", "All" and "will" 2. Replaced "dated, signed" with "submitted via the HER" 3. Replaced "diagnosis" with "diagnoses" 4. Added "and their specific needs" 5. Added "For" 6. Deleted ", which is weekly for" 7. Added "this is completed weekly" 8. Replaced "medical" with "electronic health" 9. Replaced "justified" with "determined"

JCC Follow-up

DISCHARGE AND TRANSFER PROCESS

PHILOSOPHY:

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

POLICY:

1. LHH strives to assist every client/resident (hereafter “resident”) to achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the Resident Care Team (RCT) shall continue to support maximal social integration. In addition, LHH may also transfer patients to another skilled nursing facility to continue the current level of care of skilled nursing needs if appropriate based on hospital operation.

2. LHH provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences.

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

4. Intensive discharge planning support and skills training shall be provided to the resident to assist them to transition from an institutional setting to community living.

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

6. Residents with decision making capacity who repeatedly decline discharge/transfer options, or refuse to participate in discharge/transfer planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT. The notice requires that a discharge/transfer address and discharge/transfer date be obtained prior to issuance.

7. This policy does not apply to residents who are being relocated to another SNF as a “Facility Closure Transfer,” only when LHH is subject to a facility closure plan, as described in LHHPP 01-16 Facility Closure Plan. Facility Closure Transfers are subject to the requirements and procedures described in LHHPP 01-16 Facility

Closure Plan. Residents who are discharged to the community, including their home or a lower level of care facility, when LHH is subject to a facility closure plan will be discharged according to the procedures outlined in this policy, LHHPP 20-04 Discharge and Transfer Process

8. For residents who qualify for Medicare hospice care services, LHH will either arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices or, if such an agreement(s) has not been arranged, then LHH will assist the qualifying resident to transfer or discharge to a facility that will arrange for the provision of hospice care services when the resident requests a transfer or discharge.

PURPOSE:

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

DEFINITION:

"**Facility-initiated Transfer or Discharge**": A Transfer or Discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

"**Resident-initiated Transfer or Discharge**": Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

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

"Transfer": Includes movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) to a bed in an emergency department; or (2) to another certified skilled nursing facility. Transfer does not refer to movement of a resident to a bed within LHH's skilled nursing facility.

"Anticipated Discharge": A discharge that is planned and not due to unforeseen circumstances, including, for example, the resident's death or an emergency.

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

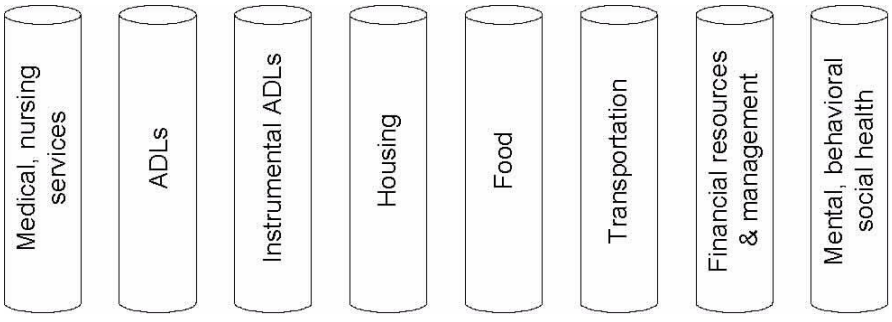
"Recapitulation of Stay": a concise summary of the resident's stay and course of treatment in the facility.

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

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

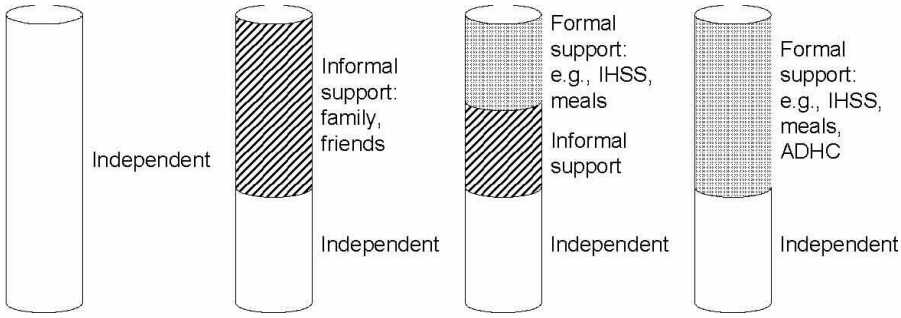
ADLs	IADLs
Dressing	Shopping
Eating	Housework
Ambulating	Accounting/finances
Toileting	Food preparation
Hygiene	Transportation

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



Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially

independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).



PROCESS GUIDELINE:

1. Discharge assessment process considers:

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

b. The resident's values and preferences.
   i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.

   ii. The resident's self-assessment of needs and priorities may legitimately differ from that of the RCT[1].

2. Discharge planning:

a. Begins during the resident's admission assessment.

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

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

[1] Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single 'appropriate' setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers." (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).

ii. ~~Certain residents may be expected to leave LHH and return, perhaps repeatedly.~~

iii. ~~The experience of residents who have been at a lower level of care for one or more limited periods can lead to valuable refinements of the discharge plan.~~

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

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

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

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

3. Utilization Resources:

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

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

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

4. Conservatorship and decisional capacity:

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

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

~~i. A resident may have only partial or varying capacity to make informed decisions.~~

~~ii. Capacity determination for residents with mild-moderate impairments is a clinical art about which good clinicians may responsibly disagree.~~

~~iii. The conservatorship process may be helpful in resolving disputes and protecting residents.~~

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

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

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

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

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

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

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

PROCEDURE:

Discharge to the Community

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner; or when the resident's condition improves, and ~~s/he~~they no longer require SNF services. The RCT assessment and discharge

planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. Upon admission and periodically during admission, designated members of the RCT shall educate the resident and/or their SDM that when their health condition sufficiently improves, or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be prepared and finalized to transition the resident back to the community.

3. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Director of Social Services or designee, the Utilization Management Nurse Manager or designee, the Chief Medical Officer or designee, and Chief Nursing Officer or designee, shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

4. RCT Roles and Responsibilities
   The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

   a. RCT Responsibilities[2]

      The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, or speech therapist with others as needed:

      i. Perform the discharge assessment process as described and negotiate the discharge plan.

      ii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.

      iii. Encourage the resident to sustain healthy relationships and interests in the community.

      iv. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.

[2] The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.

v. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.

vi. Identify need for evaluation of resident's baseline function in regard to ADLs, IADL, or mobility that require rehabilitative services to assess readiness for discharge.

vii. Document the resident's (and/or SDM's) understanding of the discharge plan.

viii. Complete the appropriate sections of the AVS (After Visit Summary) and related discharge sections on the Social Work Activity Tab in Epic.

b. Physician

i. Addresses the resident’s preliminary rehabilitation and discharge potential in the admission History & Physical.

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

iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.

iv. Attempts to simplify the resident’s medication regimen, preferably months or weeks prior to discharge.

v. Ensures that appropriate post-discharge medical follow-up is arranged.

vi. Writes discharge order.

c. Social Worker

i. Coordinates the discharge assessment process and plan.

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

iii. Attempts to secure the resident’s housing if discharge is appropriate.

iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.

v. Enters into the electronic health record (EHR) any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.

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

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

viii. Identifies differences of opinion among RCT members in regard to the resident's discharge and encourages open discussions based upon professional assessments.

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

x. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.

xi. Makes additional referrals as needed prior to discharge.

xii. Discusses the discharge plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

xiii. Prepares and provides the resident and Ombudsman with a preliminary copy of a Notice of Proposed Transfer/Discharge. If the date changes, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

xiv. After nursing signs and prints the AVS, reviews the AVS with resident.

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

d. Nurse

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

ii. Provides resident and family education to support self-care and independence, based on the care plan. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.

iii. Arranges for discharge supplies as needed.

iv. Arranges pre-discharge pharmacy consultation for medication education.

v. Completes and prints out the AVS on day of discharge for resident.

e. Activity Therapist

i. Assesses and documents the resident's pre-admission interests.

ii. Promotes maintenance/enhancement of IADLs through activities.

iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.

iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.

f. Rehabilitation Specialist (occupational, physical, speech therapy) upon receipt of referral from physician: Performs evaluation of resident's overall functioning including basic activities of daily living, instrumental activities of daily living, community re-integration, recommendations and training for use of Durable Medical Equipment, recommendations for continued therapy and support services at the appropriate level of care post-discharge.

g. Other Disciplines/Services

In addition to the RCT responsibilities noted above:

i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the EHR Post-Discharge Plan of Medication Instruction.

ii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborates with the social worker on enteral feeding supplies.

iii. Utilization management staff provides focused studies of the quality of discharge/transfer planning and documentation based on level of care.

iv. Vocational Rehabilitation, the People Realizing Employment Potential (PREP) Coordinator meets with interested residents about pre-vocational options, training, and community resources.

v. Peer Mentors provide education and practical support about In-Home Support Services (IHSS) to residents transitioning into the community.

5. Notification of Resident Regarding Discharge/Transfer from Facility

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

   i. Improvement in medical condition requiring a lower level of care.

   ii. The health or safety of individuals in the facility is endangered.

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

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

   i. Medical emergency.

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

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

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

   i. Name of resident

   ii. Date resident notified

   iii. Reasons for discharge/transfer.

   iv. Date the discharge/transfer will occur.

   v. Discharge/transfer destination.

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

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

   viii. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill

individuals established under the Protection and Advocacy for Mentally Ill Individuals Act

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

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

~~xi. Resident's right to request a seven-day bed hold.~~

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

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

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

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

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

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

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

vi. The resident shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge. If the resident falls into the five categories listed above in section 5a and 5b, the notice may be less than 30 days. Otherwise, the 30-day period may be waived only in cases of resident-initiated transfer or discharge.

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

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

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

ix. The UM leadership or designee shall gather pertinent resident information and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.

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

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

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

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

- The UM leadership shall coordinate a meeting to discuss the safety risk with the LHH Executive team and, if necessary, the City Attorney's Office.

- The facility's Administrator or designee is required to provide DHCS Office of Administrative Hearings and Appeals written notification as soon as possible if the resident is transferred or discharged prior to the hearing under this exception.

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

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

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

6. After Visit Summary (AVS) and Discharge Summary

   a. For Anticipated Discharges, the physician shall develop a discharge summary for the resident and shall include:

      i. An overview of the resident's stay including, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results;

      ii. A final summary of the resident's status including items from the resident's most recent comprehensive assessment (Refer to LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), Procedure 1(c)(ii).) that may be available to authorized persons and agencies upon consent of the resident or resident's representative;

      iii. A reconciliation of the resident's pre-discharge medications with his/her/their post-discharge medication, both prescribed and over the counter; and,

      iv. A post-discharge plan of care that is developed with consideration to the resident's and/or the resident's representative preferences, which shall include where the resident shall live, information on the resident's follow-up care, any necessary medical and non-medical services, and information on how and when to contact the continuing care provider(s).

   b. The discharge summary shall be complete and conveyed, with the resident's permission, to the receiving provider at the time the resident leaves the facility.

7. Transfer to an Emergency Department (ED)

   a. Physician
      i. The physician will assess the need for higher level of care. If appropriate, the physician will order the LOA order for transfer to the ED.

      ii. The physician will conduct a hand-off with the receiving ED.

iii. Document in the EHR of the medical assessment and need for higher level of care.

iv. Complete the Interfacility Transfer Record.

b. Nursing

i. Document that Change of Condition in the EHR.

ii. Place the resident on LOA in the EHR.

iii. Print out necessary transfer documents from the EHR to send with the resident.

8. Discharge to an Acute Care Facility

a. Bed Hold (refer to LHHPP 20-~~06~~ 14 Leave of Absence~~, Out on Pass~~ and Bed Hold Policy)

b. Nursing

i. Contacts the acute facility to determine if the resident was admitted.

c. Physician

i. Writes a discharge summary in the EHR.

9. Involuntary Discharges

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

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

10. Transfer to Another Skilled Nursing Facility

a. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, and/or speech therapist with others as needed~~. Each member~~ will work in ~~colperform~~ collaboration to complete the t~~T~~ransfer assessment process according to the transfer plan.

b. Physician

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

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

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

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

v. Writes transfer order.

c. Social Worker

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

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

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

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

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

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

vii. Makes referrals to other skilled nursing facilities.

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

ix. Prepares and provides the resident and Ombudsman with a preliminary copy of a Notice of Proposed Transfer/Discharge. If the date changes, a revised

Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

~~x. After nursing signs and prints the AVS, reviews the AVS with resident.~~

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

d. Nurse

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

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

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

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

11. Residents Leaving Against Medical Advice (AMA)

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

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

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

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

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

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

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

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

12. Residents Qualifying for Hospice Care Services

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

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

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

REFERENCE:
LHHPP 20-06 ~~Leave of Absence (~~Out on Pass~~)~~
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
NPP C1.0 Resident Admission and~~,~~ ~~Relocation and Discharge Procedures~~Readmission for SNF

Revised: 08/04/29, 09/10/27, 13/05/28, 13/09/24, 13/11/21, 15/05/12, 17/09/12, 19/03/12, 19/07/09, 20/10/13, 22/07/12, 23/06/13 (Year/Month/Day)
Original adoption: 03/07/15

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~M~~LHH) must ensure the PASRR process is completed before admitting individuals to Laguna Honda Hospital and Rehabilitation Center (LHH). When a patient is being admitted to LHH from a Hospital, LHH must not submit a new Level I Screening and must instead confirm that the PASRR process was completed by the Hospital. This is done by accepting and reviewing the PASRR documentation submitted by the Hospital via the file exchange feature in the PASRR Online System for serious mental illness (SMI) cases, and by mail, email, or fax for intellectual disability, developmental disability, and/or related condition(s) (ID/DD/RC) cases. However, the only scenario where LHH must initiate and complete the PASRR process before admitting the patient is when an individual is seeking admission from a community-level setting. Patients who are currently at LHH and has had a significant change of condition related to mental illness and/or intellectual or developmental disability or related conditions will be referred for a PASRR Level II assessment.

PURPOSE:

1. To screen and identify patients who may have a diagnosis of mental illness (MI) and/or Intellectual or Developmental Disability (ID/DD), and to refer these residents to the Department of Mental Health (DMH), and/or Department of Developmental Services (DDS).

2. To partner and coordinate the assessment review process with State programs and ensure that individuals with mental illness and ID/DD receive the care and services they need in the most appropriate setting.

BACKGROUND:

Per Title 42 of the Code of Federal Regulations (C.F.R.) sections 483.100 through 483.138, all individuals, regardless of payer source, seeking admission to a Medicaid-certified SNF are subject to a PASRR for screening and evaluation of suspected SMI or ID/DD/RC. All individuals must have a preliminary screening (Level I Screening). If the Level I Screening indicates suspected SMI and/or ID/DD/RC, the individual must be referred for further evaluation (Level II Evaluation). The goal of the Level II Evaluation and subsequent Determination process is to ensure appropriate placement of individuals in the least restrictive setting that best meets their needs and identify the need for specialized services (PASRR Determination).

The Level II Evaluation is performed by a Level II Evaluation Contractor (Level II Contractor). The screening and evaluation information is used by DHCS (the State Mental Health Authority) and/or by the Department of Developmental Services (DDS) to issue the PASRR Determination. FFP is available for services provided to a Medicaid eligible

individual determined to need NF care or specialized services after the PASRR process has been completed (42 C.F.R. 483.122). Therefore, the PASRR process must be completed prior to a SNF accepting admission.

PROCEDURE:

1. New admission

i. Prior to admitting individuals from a Hospital, Utilization Management (UM) Department must ensure that the Hospital completed the PASRR by accepting and reviewing PASRR documentation~~1~~ submitted by the Hospital via the file exchange feature in the PASRR Online System for SMI cases, and by mail, email, or fax for ID/DD/RC cases. If the UM determines that the Hospital did not initiate the file exchange in the PASRR Online System, UM must contact the Hospital and request that they initiate the file exchange prior to discharging the individual. UM must not submit a new Level I Screening as a preadmission screening (PAS) for individuals being admitted from a ~~Hospital~~hospital.

ii. For patients being admitted from a community-level setting, UM Department must submit a Level I Screening as a PAS to initiate the PASRR process. UM may enter a future tentative admission date on the Level I Screening in the PASRR system to start and complete the process prior to the admission date. In instances of positive Level I Screenings, the Level II Contractor will call the UM Department to confirm the information on the Level I Screening and determine if a Level II Evaluation is needed (Initial Assessment).

iii. Level II PASRR's will be reviewed on a case-by-case basis to determine if admission to ~~Laguna Honda Hospital~~LHH is appropriate.

2. Readmissions

a. A patient is a readmission if they were readmitted to LHH from a Hospital to which they were transferred for the purpose of receiving care. If a patient already has a PASRR on file and is readmitted to LHH, neither the Hospital nor LHH does not need to complete a new PASRR. In this instance, the existing PASRR for the patient is still valid. If the patient is going from LHH to a Hospital and then goes to a different Medicaid-certified SNF, the admitting SNF must obtain the PASRR documentation from LHH. ~~Resident Review~~

b. LHH is required to initiate a Resident Review (RR) by completing a Level I Screening when there is a significant change in condition relating to the individual's SMI and/or ID/DD/RC or when the Minimum Data Set (MD~~O~~S) does not match the Level I Screening from the hospital. UM Department must initiate the RR as a Level I Screening within 72 hours of identification of a significant change in condition or identification of variance between the MD~~O~~S and Level I Screening.

c. The MD~~O~~S Coordinator includes information from PASRR letter/report in the Minimum Data Set (MD~~O~~S) Section A.

~~c.~~d. LHH is required to initiate a Resident Review (RR) by completing a Level I Screening when there is a significant change in condition relating to the individual's SMI and/or ID/DD/RC or when the Minimum Data Set (MDS) does not match the Level I Screening from the hospital. LHH must initiate the RR as a Level I Screening within 72 hours of identification of a significant change in condition or identification of variance between the MDS and Level I Screening.

~~d.~~e. When a resident is returning from a hospital stay (readmission), there may be a clear change in condition. In instances where the significant change is evident, the individual is subject to a RR within 72 hours upon their return to the SNF. In other cases, it may take time before changes to the resident's condition become apparent. In these situations, LHH should use the MDS Significant Change in Status Assessment to evaluate whether a RR is required within 14 calendar days.

~~e.~~f. The UM Nurse notifies the RCT via EHR if a Resident Review/Status Change PASRR was submitted.

g. The UM Nurse sends notification via EHR to the RCT if a PASRR Level II will be conducted and most likely a PASRR Level II Determination Letter will be received.

~~f.~~h. All PASRR outcome letters shall be emailed by UM LN to Health Information System (HIS) for uploading in Epic.

3. Determination of Level II **referral to DMH**

The DHCS PASRR web-based system determines if DMH referral is required and automatically sends the referral to DMH.

a. DMH Contractor shall contact the UM Department to confirm that the resident is still in-house prior to assigning a DHCS psychologist or psychiatrist to conduct the DMH Level II Evaluation.

i. Note: For an evaluation scheduled on Monday-Thursday, the assigned DHCS psychologist or psychiatrist shall inform the neighborhood before the psychologist/psychiatrist comes on-site to conduct the evaluation. For an evaluation scheduled on Friday-Sunday or holidays, the UM Nurse/designee shall inform the neighborhood RCT via EHR of the planned evaluation. The Evaluator is to call the Nursing Office on the day of evaluation to inform the ~~Neighborhood~~ unit and to check if resident is still in-house.

4. Determination of Level II **referral to DDS**

a. DHCS PASRR web-based system determines if DDS referral is required and automatically sends the referral to DDS.

b. The Golden Gate Regional Center (GGRC) representative obtains resident information from the UM Department prior to conducting Level II evaluation.

c. The GGRC representative conducts Level II evaluation and sends the Level 2 PASRR Summary Report to the UM Department.

5. PASRR Notice Review by the Resident Care Team (RCT)

a. Upon receipt of a PASRR notification from the UM Department, the RCT will conduct a meeting to review the letter/report.

i. The physician and nurse shall review the report in the RCT meeting.

ii. MSW shall revises the discharge plan as needed or otherwise addresses recommendations that are not implemented in the medical record.

iii. The RCT shall incorporate the PASRR Level II recommendations into the resident's care plan, if and only if LHH can implement the recommendation(s). If the recommendation(s) cannot be followed, the RCT must document why the recommendation(s) was not used, what interventions were used instead, and/or substitutions based on availability of the services that LHH provides.

iv. The RCT will document the PASRR discussion on the RCT Conference Note via EHR.

b. If the RCT determines a patient has a significant change of condition (SCOC), the medical social worker will notify the UM Department via EHR.

c. The UM Nurse completes status change PASRR Level I via DHCS' PASRR web-based system for SCOC.

d. MOS will provide a list of SCOC to the UM Department for validation of PASRR submission.

6. DMH Report

a. The UM Department will monitor the status of the Level II determination on the DHCS web-based system twice a month from the initial submission.

b. Upon availability of Level II Report from the web-based system, the UM Nurse shall:

i. Document-specific PASRR information in the EHR.

ii. Forward the electronic copy of the PASRR notices/reports to Health Information System (HIS) to be uploaded in the EHR.

iii. Notify the RCT that a PASRR notice/report is available for review via EHR.

c. If the Level II Determination Letter is not available in the ~~web-based~~web-based system in a month following evaluation, the UM Nurse or designee shall follow-up

and contact DMH.

7. DDS Report

a. Upon receiving the GGRC report, the UM Nurse shall:

i. Document specific information from the GGRC report in the EHR.

ii. Log the referral information in the DDS Referral Log.

iii. File a copy in the UM eTAR folder.

iv. Forward the electronic copy of the DDS report to HIS to upload in the EHR.

v. Sends notification via EHR to the RCT of the availability of the report for review.

b. If the Level II Report is not received in 30 days following evaluation, the UM Nurse Manager or designee shall follow-up and contact GGRC.

8. Prior Authorization Requests

As of May 1, 2023, Medi-Cal Managed Care Health Plans (MCPs) are approving prior authorization requests for SNF placement after the PASRR process is completed. LHH must follow the MCPs' established policies and procedures for submitting prior authorization requests with supporting documentation. For additional information on the Hospital and SNF PASRR responsibilities for MCP prior authorization requests, please refer to PASRR IN 23-001.

9. Treatment Authorization Requests

As of January 1, 2023, DHCS is adjudicating Treatment Authorization Requests (TARs) for SNF services when the PASRR process is completed. The TAR's 'from' date is the date the Determination Letter was issued by DHCS. Therefore, SNFs must ensure that the 'from' date requested on the TAR is on or after the Determination Letter date or the TAR may be modified. Additionally, if the individual has not had a significant change in condition, the SNF does not need to initiate a RR by completing a new Level I Screening. In this instance, the SNF must submit the existing PASRR documentation with the TAR. Note: SNFs are to use the PASRR completed by the Hospital(s) for their TAR submissions. The SNFs are not to submit a new Level I Screening just to submit a TAR. LHH will initiate completion of the PASRR when admission is from the community setting.

ATTACHMENT:
None.

REFERENCE:

https://www.dhcs.ca.gov/services/MHfPages/PASRR.aspx

Revised: 15/07/14, 16/08/18, 16/11/08, 17/09/12, 19/07/09, 19/09/10, 22/07/12, 23/11/21, 24/04/09 (Year/Month/Day);
Original adoption: 11/11/29

Revised Hospital-wide Policies and Procedures

ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (LHH) regardless of race, color, creed, religion, national origin, ancestry, gender, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age over 16. LHH shall comply with California and federal laws pertaining to non-discrimination.

1. LHH shall accept and care for those San Francisco residents:

    a. Who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation inpatient rehabilitation facility (IRF) care ~~criteria;~~criteria.

    b. For whom it can provide safe and adequate care; and/or

    c. Who are at least 16 years of age.

2. Applicants for admission to LHH shall be screened prior to any admission.

3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether Laguna Honda Hospital's care environment is best able to meet these needs.

4. LHH shall accept pre-scheduled admissions of new and returning patients Monday through Friday.

5. LHH shall accept residents to the first available SNF bed appropriate to meet their clinical care needs when they have lost their bed hold.

6. New and returning patients may be admitted on Saturdays and Sundays if pre-arranged on Friday.

7. LHH shall centrally coordinate resident relocations to:

    a. Optimize utilization of ~~resources;~~resources;

    b. Optimize bed availability for new admissions; and

    c. Minimize the potential for adverse impact on the resident.

8. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

~~8.~~9. In case of emergency and/or medical surge conditions:

a. LHH physician~~Physician~~ may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.

b. The patient's stay shall be documented according to established procedures (i.e.: Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or SNF rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.

2. To allocate services in coordination with available hospital resources.

3. To provide a standard procedure for relocation of residents within the facility.

DEFINITIONS:

1. A&E means Admissions and Eligibility Department.

2. Bed hold means a bed shall be held for a specific resident discharged to an acute unit or facility. A bed may be held up to seven (7) days, with the date of discharge being day 1. A bed hold may not be placed on LHH acute unit beds.

3. PFC means Patient Flow Coordinator.

4. RCT means Resident Care Team.

PROCEDURE:

1. Admissibility and Screening Procedures

a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Nursing Home Administrator/Chief Executive Officer (NHA/CEO~~)~~), or designee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.

b. The LHH Chief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH CMO is the ultimate authority over admissions. The following sequential priority [(d) i-v] will be followed unless the LHH CMO or designee in his/her professional judgement,

based on risk assessment and the totality of circumstances consistent with the patient~~''~~s best interest determines otherwise.

c. LHH cannot adequately care for prospective residents with the following:

   i. Communicable diseases for which isolation rooms are unavailable~~.~~

   ii. In police custody unless approved by CMO, NHA/CEO, Chief Nursing Officer (CNO) or designees.

   iii. Ventilator

   iv. Medical problem requiring Intensive Care Unit care~~.~~

   v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care~~.~~

   vi. Highly restrictive restraints

   vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:

      - Actively suicidal~~–~~, residents with +SI (low, med, high) that require 1:1 observation cannot be admitted
      - Violent or assaultive behavior
      - Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia
      - Sexual predation
      - Elopement or wandering not confinable with available elopement protections~~.~~
      - ~~Applicants who will not sign the Laguna Honda House Rules and Responsibilities~~

d. People are accepted to LHH who are confirmed residents of San Francisco and in need of skilled nursing and/or rehabilitation services based on the following priority guidelines:

   i. 1st Priority:

Residents who were involuntarily transferred and meet the criteria for care at LHH will be considered new admissions and given first priority ~~when we begin to evaluate new admission requests~~ based on LHH's admission criteria~~.~~

ii. 2nd Priority:
Persons not in a medical facility (e.g. home) who are currently receiving skilled nursing and/or rehabilitation services (e.g. home care for wounds) and are now in need of skilled nursing / rehabilitation care in a facility~~.~~

iii. 3rd Priority:
Patients at a San Francisco Health Network (SFHN) facility who need skilled nursing and/or rehabilitation services and are ready for discharge to SNF level of care.

iv. 4th Priority:
Persons not in a medical facility who are receiving skilled nursing and/or rehabilitation services and are adequately cared for~~adequate care~~ in their present circumstances but might be better served in a facility~~.~~

v. 5th Priority:
Patients at non-~~San Francisco Health Network~~SFHN medical facilities who require skilled nursing and/or rehabilitation services.

e. Screening of applicants:

i. The Screening Committee which includes the following: CMO or designee, CNO or designee, ad~~Admissions Coordinator,~~ Patient Flow Coordinator, ~~Admissions and Eligibility~~A&E, Utilization Management and other members as designated by the CEO, is responsible for screening referrals to LHH and accepting residents for admission.

ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Palliative Care) will be screened and ~~accepted~~ reviewed by the unit screening physician or screener.

iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the CMO or designee, and the CNO or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have behavioral or psychiatric problems and/or history of substance misuse.

f. Admission of applicants:

i. LHH shall admit a patient only on a LHH Admitting Physician's order.

ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.

iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident's individual needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. [1]Residents lacking capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.

iv. In all cases of admission from another facility, a ~~physician to physician~~ physician-to-physician clinical hand off and a complete~~dictated~~ discharge summary is required.

g. Resolution of problem screening and admissions:

i. Problems shall be brought to the LHH CMO and LHH NHA/CEO for resolution.

ii. The LHH NHA/CEO shall have the final authority over admissions to LHH.

h. The LHH NHA/CEO shall serve as the LHH's review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices shall be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

a. Pre-Admission Procedures

i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.

ii. Residents (or their representatives) shall receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement shall be reviewed and signed by the resident or the resident's surrogate decision-maker.

[1] If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each residents' individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences." CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).

iii. Residents (or their representatives) shall receive a copy of the Laguna Honda House Rules and Responsibilities. ~~As a condition of admission, the resident or resident's surrogate decision-maker must agree to these conditions by signing these agreements prior to admission.~~

iv. The Screening Committee shall make placement decisions based on the identified physical, mental, social and emotional needs of the resident; family connection with staff, if any; and bed availability. The Screening Committee shall communicate with the nursing unit and the RCT, including the primary physician and nurse manager admitting the new resident.

v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until ~~the~~ Patient Flow~~Admissions Coordinator~~ has evaluated the referral packet.

vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit Neighborhood

i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.

ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.

~~iii.~~ "Come and go" procedures or infusions for ~~SNF~~ residents and patients~~who require blood transfusions, but who are~~ not acutely ill will~~, shall~~ be allowed~~provided care on the Acute Medical Unit as "come and go" cases.~~

~~iv.~~iii. ~~SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for~~ in the Acute Medical Unit only if licensed as an infusion clinic~~as a "come and go" case, after approval by the CMO~~.

Procedures Specific to the Acute Medical Unit

i. All residents admitted to the Acute Medical Unit, ~~except those residents admitted on a "come and go" basis,~~ shall have a separate complete medical record covering the period of their acute hospitalization~~.~~

ii. ~~Residents being evaluated for admission to LHHs Acute Medical unit with suspicion of COVID-19 will have a minimum of one negative antigen test within 24 hours of transfer. If resident acuity is unstable and a testing delay would impact care, the resident will be transferred to a facility outside LHH, if within goals of care. Residents with a positive COVID-19 test will be transferred to a facility outside LHH unless they have an advance directive requesting that care be provided only at LHH. Decisions to admit/transfer will be a joint discussion between the resident, their family, and the attending physician.~~ Residents being evaluated for admission to the Acute Medical Unit with known or suspected Covid-19 ~~-~~may be admitted to PMA if specific criteria are met:

- There is an available Airborne infection isolation room (AIIR)~~-~~ or an AIIR capable room can be made available within 5 hours. If there are no available AIIRs, or the acuity of the resident precludes waiting 5 hours, then the resident should be transferred to another acute care facility if within their goals of care.

- The resident does not have comorbidities or coexisting acute conditions that might require urgent access to a level of care not available at the PMA (for example but not limited to~~:~~ advanced cardiac care or impending ventilatory support). These residents would require transfer to an outside acute care facility.

- Decisions to admit/transfer Covid-19 positive or suspected residents should remain a joint discussion between the attending physicians, the resident, and their decisionmaker(s).

~~ii.~~ If the transferred resident is ruled out for Covid-19 and still meets PMA LOC,~~-~~ they should be moved to a non-AIIR room as soon as feasible.

~~iii.~~

~~iv.~~ Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, ~~she/he is~~they are (discharged) on leave of absence from the previous care unit ~~(and resident's medical record is closed), except in those cases where residents "come and go" for transfusion.~~

~~v.~~

~~vi.~~iii. A new SNF resident record shall be started upon the resident's re-admission to a SNF care unit, after the 7 days bed hold.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units

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

ii. Patient must be medically stable.

iii. Patient requires rehabilitation physician management.

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

- Training in bowel and bladder management
- Training in self-care
- Training or instruction in safety precautions
- Cognitive function training
- Behavioral modification and management
- Training in communication

Admission Criteria Specific to Acute Rehabilitation Unit

i. The LHH Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF).

ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

- Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.
- 24 hour availability of nurses skilled in rehabilitation.
- Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.

iii. The medical and/or surgical stability and comorbidities of patients admitted to the unit must be:

- Manageable in the rehabilitation program
- Permit participation in the rehabilitation program

iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:

- Ability to respond to verbal, visual and/or tactile stimuli and to follow commands.
- Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week).

v. Patients must demonstrate the ability to progress towards objective and measurable functional goals that:

- Will offer practical and beneficial improvements.
- Are expected to be achieved within a reasonable period of time.

vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.

vii. Patients in most circumstances, ha~~s~~ve a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

Admission Criteria Specific to SNF Rehabilitation Unit

i. The rehabilitation needs of the patient must include one of the following impairments or complex issues:~~Rehabilitation needs shall 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 other medical problems best addressed on the SNF-level Rehabilitation Unit.

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

iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a ~~long-term~~long term care unit.

Admission Procedures Specific to Acute Rehabilitation Unit

i. A physiatrist or designee shall perform pre-admission screening (PAS) to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.

ii. A new SNF record shall be started if the patient is discharged to a LHH SNF Care Unit.

iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation LHHPP 27- 06.

Admission Procedures specific to SNF Rehabilitation Unit

i. The Chief of Rehabilitation Services or designee shall perform PAS to assess the patient's ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

d. Positive Care Unit

Admission Criteria Specific to the Positive Care Unit

i. Patients who have HIV infection and require SNF level or palliative care and prefer an HIV / AIDS focused unit.

e. Palliative Care Unit

Admission Criteria Specific to Palliative Care Unit

i. Patients who have a terminal disease or would benefit from a palliative approach.

f. Secure Memory Care Unit

Policies Specific to Secure Memory Care Unit

i. The goals of the Secure Memory Care Unit are:

- To promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and

- To meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming. ~~while minimizing the use of individual restraints~~.

Admission Criteria Specific to Secure Memory Care Unit

i. Residents who are ~~mobile;~~mobile.

ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for ~~him/herself;~~themselves.~~.~~

iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and

iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

v. The requirements above do not preclude LHH from placing a resident in the memory care unit on an emergency basis to ensure the resident's safety~~,~~ but the placement must be authorized by the CMO.

Exclusion Criteria Specific to Secure Memory Care Unit

i. Residents whose aggressive behavior cannot be safely managed in this setting.

ii. Residents without surrogate or conservator.

Procedures Specific to Secure Memory Care Unit

i. The ~~Admissions Coordinator and~~ Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Neighborhood RCT.

ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

iii. The RCT shall reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT shall explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT shall document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.

iv. A resident of the LHH Secure Memory Care Unit shall be relocated as soon as practicably feasible to other LHH units or transferred to another facility or the

community if the resident's status changes such that the resident is no longer mobile, the resident's cognitive status improves such that secured placement no longer is needed; or the resident's cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.

v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts shall be made to adapt such a resident to another unit.

3. ~~Sunday~~ Weekend Admissions

a. From ZSFG

i. For readmissions, LHH primary physician shall refer the ZSFG team to LHH A&E once the patient is accepted.

ii. Pre-scheduled admissions shall be accepted for Palliative Care, Positive Care, ~~General SNF,~~ SNF and Acute Rehab (IRF) patients on ~~Sundays~~the weekend.

iii. ~~Sunday~~ Weekend admissions from ZSFG must be approved by the LHH admissions Screening Committee, and ~~accepted~~ reviewed by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.

iv. LHH A&E shall inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for ~~Sunday~~the weekend. LHH A&E shall inform ZSFG MSW of LHH primary physician's pager number.

v. Approval by LHH weekend admitting physician is not required for admission.

vi. LHH A&E shall complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.

vii. LHH primary physician shall receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a discharge summary must be available at the time of admission.

viii. LHH nursing shall receive report from ZSFG nursing on the day of transfer.

ix. LHH A&E shall remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.

x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.

4. Procedures Related to Coming and Going from the Hospital

a. Return of current residents after come-and-go procedures at other acute facilities.

i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes:

- Procedures done
- Complications, if any, both intra- and postoperative
- New orders recommended for the first 24 hours at LHH
- Recommendations for special studies and follow-up care

ii. A checklist reminding the responsible physician of the need for this information shall be sent with the resident from LHH to the other facility. The physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.

iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.

5. Relocation of Current Resident Fromfrom One SNF Unit to Another SNF Unit

a. Relocation Guidelines

i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager shall be responsible for explaining to the resident or surrogate decision maker (SDM) the process by which the RCT assesses the resident for the purpose of appropriate placement.

ii. Decision criteria. Criteria for determining the appropriate unit shall be based on an assessment of the resident's needs, and knowledge of services available in the facility, including knowledge of available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units

shall be made by the PFC in collaboration with the CMO or designee and CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.

iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT shall be evaluated by the PFC who facilitates the decision-making process.

iv. Relocation. In the event that a resident is to be relocated involuntarily in order to better match the resident's needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. This shall be documented by completing the Transfer of Room Notification form, which includes:

- Reasons for the relocation;
- Date the relocation will occur; and
- The care unit to which the resident will be relocated.~~; and~~

The RCT shall take into consideration the resident's response in deciding whether to continue with the relocation. This discussion must be documented in the medical record. In a contested relocation the medical social worker (MSW) shall notify the ombudsman. Relocations shall not be proposed for the sole purpose of staff convenience, and solely for the purpose of medical/care needs.

v. Problem resolution. Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT shall utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.

vi. Re-evaluation of problematic relocations. RCTs shall re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.

vii. Appeal route for conflict intervention. Conflicts about relocation process shall be referred to the CNO and CMO for joint resolution.

viii. Neighborhood moves. When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when residents and families shall be informed, must be worked out in advance by the RCT.

b. Relocation Procedures

i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, shall be routed through the designated PFC. For relocations to specialty units, the PFC shall communicate with the unit RCT and A&E.

ii. The resident and appropriate family/surrogate decision maker(s) shall be notified in writing when the relocation is being planned and be informed of the reason and the estimated waiting period, if known. They shall be offered an opportunity to visit the new location and ask any questions that may arise.~~, if possible.~~

iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician shall communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.

iv. Once an appropriate bed becomes available, the PFC shall confirm relocation plans and confirm that the sending and receiving care units are notified.

v. A physician's order is required for the relocation.

vi. To promote continuity in care, the sending physician shall document in the medical record, a relocation note.

vii. The receiving RCT shall review the existing treatment plans initiated by the previous ~~team, and~~team and review the plan and all changes with the resident.

viii. Each discipline shall take appropriate measures to assure continuity of care.

ix. Ancillary Service departments, who receive the Daily Census report, shall make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

ATTACHMENT:
Appendix A: Relocation Checklist for Individual Resident
Appendix B: Behavioral Screening
Appendix C: LHH Palliative Care Program

REFERENCE:
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-03 Resident Rights
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
LHHPP 24-06 Resident and Visitor Complaints/Grievances
Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual

Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual
LHHPP 70-01 C04 Laguna Honda Hospital Medical Surge Plan for Nursing Home Incident Command Activation Due to Public Health Emergency / Mass Casualty Event

Revised: 00/07/13, 04/02/06, 04/03/02, 04/12/16, 09/08/24, 10/11/09, 11/01/25, 11/09/27, 12/01/31, 12/07/31, 13/11/21, 14/07/29, 14/11/25, 16/09/13, 17/11/14, 18/01/09, 18/11/13, 19/03/12, 20/12/08, 23/10/10 (Year/Month/Day)

Original adoption: This is a consolidation of 12 previous policies

PSYCHIATRIC EMERGENCIES

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) residents who require acute psychiatric attention shall be attended to in a timely manner.

PURPOSE:

To assure that acute psychiatric issues or crisis situations are addressed appropriately in a timely manner.

DEFINITIONS

1. **A ~~P~~psychiatric eEmergency~~crisis~~:** ~~is a~~An acute disturbance of ~~emergency condition in which~~ thought~~s~~, mood, behavior, or social relationship that ~~feelings, or actions are seriously disturbed and~~ require~~s~~ immediate therapeutic intervention(s) to prevent imminent danger to the individual and/or others. ~~injury, deterioration of health, or loss of life.~~ Crises may include violent or destructive behavior, or serious threats of such behavior, aimed at self or others; crises may also include nonviolent behaviors that place an individual in imminent danger. ~~(e.g., insistence on leaving "against medical advice" even though an individual has no means to provide food, clothing, or shelter).~~

2. **5150:** Short for Section 5150, et seq. or Section 5585, et seq. of the California Welfare and Institutions Code, which specifies when " … a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. …"

3. **Indications for 5150:**
   a. 5150 may be initiated when there is probable cause to believe that a resident is a
      i. Danger to Self (DTS) as a result of a mental health disorder,
      ii. Danger to Others (DTO) as a result of a mental health disorder,
   Gravely disabled adult as a result of a mental health disorder, severe substance use disorder, or co-occurring mental health disorder and severe substance use disorder (as defined in W&I Code section 5008(n)~~)~~,

iii. and is unable or unwilling to accept treatment voluntarily.

4. 5150 Designated Providers:

a. At LHH, the following professional staff who has completed the required 5150 certification training by Behavioral Health Services (BHS) and has successfully passed the examination (as evidenced by possessing a valid 5150 certification issued by DPH 5150 Training Team), has the authority to initiate the 5150 process and sign an Application for up to 72-Hour Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment (Form DHCS 1801):

i. qualified LHH Psychiatry staff certified by BHS

ii. qualified LHH Medicine physicians certified by BHS

PROCEDURE:

1. LHH Psychiatry providers shall be contacted by a physician when there is a psychiatric emergency~~crisis~~. See policy MSPP-D08-03, Access to LHH Psychiatry Services. During regular business hours, LHH Psychiatry Urgent Pager (415-327-5130) may be contacted. During afterhours/weekends/holidays, the on-call psychiatrist may be contacted per the ~~standard work~~process for Psychiatrist Afterhours On Call Services.

2. If a psychiatric emergency occurs or is developing, and the resident (who is NOT LPS conserved) is assessed by a LHH 5150 designated provider, as meeting criteria for 5150, the involved provider(s) and Resident Care Team (RCT) shall follow the LHH ~~standard work~~process for 5150. Note: Persons who are not certified by BHS in the 5150 process may provide history, regulatory/legal information, and recommendations to persons who are certified in the 5150 process. However, the non-certified person(s) may not direct or mandate a 5150-certified provider to place or not place a 5150 hold.

W-

3. ~~W~~hen a resident experiences acute behavioral distress, and if it is clearly due to a medical condition (e.g., delirium~~,~~, neurocognitive disorder), the RCT must follow the procedures for medical emergencies. ~~, not 5150.~~ If it is unclear whether the distress is due to a medical versus psychiatric condition, the physician may consult a Psychiatry provider (urgent pager provider or on-call psychiatrist) to determine if 5150 is warranted.

4. If a 5150 and transfer to Psychiatric Emergency Service (PES) is warranted, the designated provider shall contact the Zuckerberg San Francisco General Hospital (ZSFG) PES triaging clinician/psychiatrist of the day to discuss the case and arrange for an emergency evaluation. Should ZSFG be on diversion status, a local 5150-accepting emergency room via paramedic knowledge of diversion status shall be

utilized per the ~~standard work~~process for 5150.

~~as a danger to others, or to themselves, or gravely disabled, as a result of a mental disorder, and is in need of a psychiatric evaluation, the LHH 5150 Guideline (Attachment 1) should be followed.~~

5. If there are ~~disagreements that~~disagreements that cannot be resolved at the provider/team ~~level, the~~level, the case shall~~will~~ be referred to the Chief of Psychiatry/designee or Chief Medical Officer/designee ~~-~~ for immediate consideration.

6. Temporary close observation measures are ~~not~~ intended for residents who are actively suicidal or in imminent danger of harm to themselves or others, ~~except~~ while awaiting urgent evaluation and/or transfer to a higher level of care setting. (Also see LHHPP 24-10 Close Observation.)

~~1.~~7. If a resident is transferred to Psychiatric Emergency Services (or any medical or psychiatric acute care setting due to a behavioral crisis), a LHH Psychiatry licensed provider must evaluate the resident (either by phone report with PES clinician/psychiatrist, or by in-person assessment when necessary and feasible) to assess ~~for~~ behavioral risks, appropriateness for return, and behavioral plan recommendations. The evaluation result shall be communicated to the primary physician and RCT prior to the resident returning to LHH. Both the LHH Psychiatry provider and the attending physician must agree to the return. The attending physician makes the ultimate decision as to taking the resident back or not. Disputed cases shall be referred to the Chief of Psychiatry/designee or Chief Medical Officer/designee.

~~**ATTACHMENT:**~~

~~LHH 5150 Guideline~~

REFERENCE:

American Psychiatric Association Task Force on Psychiatric Emergency Services: Report and Recommendations Regarding Psychiatric Emergency and Crisis Services
California Senate Bill SB43, 2023-2024
LHHPP 24-10 Close Observation
LHHPP 22-10 Management of Resident Aggression
~~LHH standard Work: Psychiatrist After Hours On Call Services~~
~~LHH Standard Work: 5150 of a Resident~~

Original adoption: 09/16/10 (Year/Month/Day)
Revised: 09/24/13, 01/28/14, 5/14/19, 03/05/20; 08/04/22, 22/12/13

COACH USE FOR CLOSE OBSERVATION

POLICY:

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

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

    a. High risk for falls

    b. Impulsive behavior

    c. Risk for aggression

    d. Elopement risk

    e. Intrusive behavior

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

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

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

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

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

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

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

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

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

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

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

    b. Using personal cell phone,

    c. Reading,

    d. Sleeping

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

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

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

PURPOSE:

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

PROCEDURE:

1. **Role of the RCT**

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

i. Assess needs.

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

ii. RCT must develop an observation and intervention plan as follows:

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

- Increasing/decreasing the frequency of observation time periods

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

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

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

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

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

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

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

iii. Evaluate the plan.

- While close observation is implemented, the RCT shall meet regularly, every two weeks and quarterly to:
- Review any changes in resident's condition.
- Assess effectiveness of current interventions.
- Evaluate resident goals and the need for ongoing close observation.
- The RCT shall summarize each meeting via EHR.
- If resident is not progressing with support of a one-to-one coach, the Resident Care Team will evaluate and may refer to the Department of Care Coordination for potential transfer or discharge to another appropriate facility.

2. **Role/Expectations of the Coach Providing Close Observation**

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

i. Why they are assigned to the resident.

ii. What goals are identified for this resident.

iii. What interventions can be employed with the resident.

b. All staff that are assigned to be coaches are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:

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

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

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

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

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

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

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

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

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

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

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

i. Feeding residents on a Specialized Feeding Plan

ii. Showering/bathing

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

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

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

b. LHH PCA/CNA who are assigned as coaches are expected to complete documentation hourly. LN will verify coach presence and documentation through LN documentation ~~on epic~~in the EHR flowsheet or in a nursing note in the EHR.

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

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

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

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

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

REFERENCE:
None.

Revised: 21/07/29, 00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10, 21/10/12, 22/12/13, 23/06/13, 23/10/10, 24/05/14 (Year/Month/Day)

Original adoption: 98/11/16

Attachment A: Coach Use for Close Observation
Roles and Responsibilities

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

IN-HOUSE REFERRALS FOR REHABILITATION SERVICES

POLICY:

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

PURPOSE:

To assure that each referral is processed and addressed in a timely and efficient manner.

PROCEDURE:

1. Requests for rehabilitation services or evaluations shall be made by the referring physician via the electronic health record (EHR).

2. The evaluation, recommendations and/or subsequent treatments shall be documented in the EHR.

3. Physical therapy, occupational therapy, ~~and~~ speech pathology, will respond to referrals within 24 – 48 hours. ~~during business days, excluding holidays.~~

4. In the event ~~ent, when~~ that staffing volume is unable to meet all in-house referrals, physical therapy, occupational therapy, speech pathology, will follow rehabilitation services prioritization guidelines (see Appendix A).

ATTACHMENT:

Appendix A
~~None.~~

REFERENCE:

None.

Reviewed: 22/04/21
Revised: 08/8/22, 09/01/13, 19/07/09, 23/11/14~~23/11/14~~ (Year/Month/Day)

Original adoption: 92/05/20 (MSPP); 01/01/11 (LHHPP)

Appendix A:

PRIORITIZATION GUIDELINES:

To optimize resource management for Laguna Honda Hospital and Rehabilitation Center (LHH) Rehabilitation Services, and to provide guidelines for staff to determine clinical prioritization in the event of high census or low staffing circumstances for all disciplines including Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP).

PROCEDURE

A. Staffing Levels

Rehab staffing levels are set to ensure that services can be provided to as many patients as possible. Staffing will be adjusted at any time to provide appropriate patient or resident coverage, at the discretion of Rehab Department leadership.

B. Communication

When the patient or resident census exceeds the staffing volume to provide evaluations, re-evaluations, and treatment for all therapy orders within 24-48 hours, the following communication will be relayed to appropriate departments and executive leadership team, but not limited to:

- Rehab Seniors and Leads will communicate this situation with the Executive Rehab Leadership.
- Rehab Seniors and Leads will report out these details during Rehab Department daily Huddle and Interdisciplinary Department Team (IDT) LHH Huddle, and any other related resident care team (RCT) meetings and/or discussions.

C. Contingency Staffing plan

When staffing volume is unable to meet all patients and/or residents' needs within 24-48 hours, guiding factors (refer to D) will be considered for clinical decision making and prioritization of patient and/or resident care (refer to E).

D. Guiding Factors for Clinical Decision Making for Prioritization

When staffing volume is unable to meet all patients and/or residents' needs, the following factors will be taken into consideration, but not limited to, as per clinical judgement to determine the prioritization of patient or resident evaluations, reevaluations, treatments, and discharges:

- Medical Necessity

- Expedite Discharges
- Resident/Patient Admission Status – Inpatient (Acute Rehab and Skilled Nursing Short-Term Stay Rehab); Outpatient; Long Term Care Resident.
- Scheduled Appointments
- Disease Specific Protocols
- Rehab Program Specific Protocols
- Insurance Authorization requires Rehab notes for continued rehabilitation services insurance coverage
- Family and/or Patient or Resident requests and/or grievances
- Rehab Program Centers for Medicare and Medicaid Services (CMS) Certification Requirements
- Speech Language Pathology Appropriateness (i.e., Obtunded, Nothing by Mouth (NPO))
- Missed Patients or Residents > 24-48 hours
- Plan of Care (i.e., Frequency, Discharge plan, Caregiver Training needs, etc.)
- Acute change in functional status and/or medical condition

E. Prioritization Guidelines

When staffing volume is unable to meet all patients and/or residents' needs, the following prioritization guidelines will be followed, but not limited to, for patient and/or or resident evaluations, reevaluations, treatments, and discharges. Highest priority (level I) to lowest priority (Level III) will be followed, but not limited to.

Level 1:

- Acute Rehab Patients (Inpatient Rehabilitation Facility IRF)
- Skilled Nursing Short Term Stay Rehab Patients
- Long term Care Facility Residents acute functional and/or medical needs
- Part A insurance (may include but not limited to: readmission, admission from the community, etc.)

Level II:

- Long term Care Facility Residents quality of life care needs
- Outpatient referrals

Level III:

- All other patients and/or residents' referrals

- Quarterly rehabilitation services screens

REFERENCES:

Agency for Healthcare Research and Quality (AHRQ):

American Occupational Therapy Association (AOTA):

American Physical Therapy Association (APTA):

American Speech-Language-Hearing Association (ASHA):

California Code of Regulations (CCR), Title 22:

California Board of Physical Therapy:

California Board of Occupational Therapy:

California Board of Speech Language Pathology:

Centers for Medicare and Medicaid Services (CMS):

Institute for Healthcare Improvement (IHI):

Medi-Cal:

Society of Critical Care Medicine:

The Joint Commission (JC):

NATURAL DYE SWALLOWING ASSESSMENT FOR PATIENTS/RESIDENTS WITH TRACHEOSTOMY

POLICY:

At Laguna Honda Hospital and Rehabilitation Center (LHH), natural dye swallowing assessments facilitate detection of aspiration in patients/residents who have a tracheostomy. Natural dye testing is appropriate as partone aspect of a comprehensive swallowing evaluation when the residentpatient has a tracheostomy, and is alert, awake, and able to tolerate the procedure. It This is to augment a traditional bedside swallow evaluation and does not replace Modified Barium Swallow Studymodified barium swallow study (MBSS) or Fiberoptic Endoscopic Evaluation of Swallowingfiber-optic endoscopic evaluation (FEES) for instrumental assessment of swallow function. a differential diagnosis of dysphagia.

PURPOSE:

Natural dye swallowingswallow assessments facilitate detection of aspiration in resident/patients who have a tracheostomy. NOTE: Natural dye testing is one component of a comprehensive swallowing evaluation but does not definitively rule-out aspiration.

PROCEDURE:

1. The physician shall order a swallow evaluation.

2. The Upon receipt of speech language pathologist (SLP) shall conduct a thorough chart review.

3. If appropriate and with a physician's order, the Speech Language Pathologist (SLP) reviews the Electronic Health Record (EHR) and schedules the patient shall be evaluated for a Passy-Muir Speaking Valve prior to the swallow evaluation (per LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir).

4.1. If the tracheostomy has an evaluationinflated cuff, a physician's order to deflate the cuff is obtained. If the patient cannot tolerate cuff deflation, the procedure is deferred or modified as clinically indicated.

   a. The SLP shall coordinate the evaluation schedule with the Respiratory Care Practitioner (RCP).

2. In cases where the patient/resident's tracheostomy tube is cuffed and inflated, a provider order is obtained to conduct the procedure with the cuff deflated.

a. If the patient/resident cannot tolerate cuff deflation, the procedure is deferred or modified as clinically indicated.

~~5. The speech pathologist shall conduct an oral motor and laryngeal function examination.~~

~~6. Colored food/liquid (no red so as not to be mistaken for blood if suctioned) is selected for PO trials: grape juice if available, orange juice, grape/orange juice with thickener, chocolate pudding, banana slices coated with chocolate pudding, graham crackers coated with chocolate pudding.~~

~~7. The RCP shall suction the trachea prior to introduction of PO trials, clearing any secretions.~~

~~8.~~3. If appropriate, the assessment is conducted using the~~with a~~ Passy-Muir ~~Speaking~~ Valve to improve~~(PMSV) for improved~~ subglottic pressure for swallowing (see LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir).~~.~~

4. The SLP will conduct an oral-motor and laryngeal function examination.

~~9. The shall give the patient/resident will be suctioned by RCP via tracheostomy 3 tsp trials of water to determine presence of a swallow prior to continuing with the evaluation.~~

~~10.~~

~~The SLP presenting PO trialsshall select.~~

~~11.~~5. The SLP selects the appropriate PO texture~~textures~~ to be tested. One ~~-~~to ~~-~~two consistencies are tested daily ~~per clinical judgement of the SLP.~~

a. Food/liquid selected for PO trials are mixed with Phage-in Blue Dye

~~12.~~6. The swallow assessment shall include the procedure defined in Rehabilitation Services Policies and Procedures 90-05: Establishment of Therapy Programs and Documentation: Dysphagia.

~~13.~~7. Residents/patients are~~The trachea is~~ suctioned by ~~the~~ RCP via tracheostomy~~immediately~~ after PO trials to observe, ~~examining tracheal secretions~~ for the presence~~evidence~~ of colored food/liquid in the tracheal secretions. The nurse, RCP and/or SLP continue to monitor for delayed natural dye in tracheal secretions. These findings are documented in the EHR~~.~~

~~14.~~8. Nursing shall be notified to monitor for delayed natural dye in the tracheal secretions for the next 24 hours. If, as determined by the SLP, suctioning should be

scheduled at specific intervals, the SLP shall request an order for suctioning, including frequency and duration. The SLP shall post a sign re: times of suctioning. These findings are documented in the EHR.

~~15.~~ Once the patient/resident has been evaluated, an initial evaluation and treatment plan is entered in the EHR, is electronically signed by the SLP and co-signed by the physician. The treatment plan includes goals and the frequency/duration of treatment. If treatment is not indicated, the reason is documented. ~~Findings, including recording suctioning of colored secretions, are documented in the electronic health record (EHR).~~

~~16. SLP documents results and recommendations on the dysphagia evaluation in the EHR, including recommendation for MBSS if indicated.~~

~~17. The physician is notified of results and recommendations.~~

9.

10. The treatment plan is reviewed with the patient/resident, caregivers/ ~~and~~ family ~~surrogote~~surrogate decision maker (if available).

11. 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.

12. SLP works with Unit staff and other caregivers to ensure carryover of skills, as needed.

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

14. Following each treatment session, the treatment and the patient/resident's progress is documented in the EHR and electronically signed.

15. 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.

16. A signed discharge summary is documented in the EHR upon completion of the treatment program.

ATTACHMENT:

None.

REFERENCE:

Fornatoaro-Clerici, Lisa and Roop, Thomas A.: Clinical Management of Adults Requiring Tracheostomy Tubes and Ventilators, A Reference Guide for Healthcare Practitioners Northern Speech Services, 1997.
Logemann, J.A.: Evaluation and Treatment of Swallowing Disorders. Austin Texas: Pro-ed, Inc., 1998.
LHHPP 26-02: Management of Dysphagia and Aspiration Risk
LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir Valve
LHHPP 27-05: Tracheostomy Management
Nursing I3-0: Tracheostomy Care
Rehabilitation Services 90-05: Establishment of Therapy Programs and Documentation: Dysphagia

Original adoption: 20/05/19 (Year/Month/Day)

GUIDELINES FOR INPATIENT REHABILITATION FACILITY DOCUMENTATION

POLICY:

1. Patients who are admitted to the Pavilion Mezzanine Acute Rehabilitation unit (PMR), which is designated as an Inpatient Rehabilitation Facility (IRF), shall have required assessment and documentation completed in a timely manner.

2. Interdisciplinary Team (IDT) members are responsible for the timely completion of patient assessment, evaluation and progress note documentation for their respective disciplines at admission, discharge and throughout the acute rehabilitation patient's stay.

3. The medical records of all patients admitted to the IRF must contain documentation that reflects the patient's need for admission and ongoing need for intensive rehabilitation delivered by the IDT.

4. All patients admitted to the IRF shall have an Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) completed electronically at admission and discharge.

5. The Utilization Management (UM) nurse shall notify the IDT~~RCT~~ and Patient Billing of Medicare A eligible patients who are admitted to the IRF and their respective Assessment Reference Day (ARD) dates within 24 hours of admission.

6. A Minimum Data Set~~minimum data set~~ (MDS) Registered Nurse~~registered nurse~~ (RN) is responsible for completing the IRF-PAI by reviewing the medical records and the assessment of the IDT.

PURPOSE:

1. To guide the IRF IDT in the completion of required documentation, including assessments and outcomes reflecting each patient's need for intensive rehabilitation and to promote continuity and quality care for Laguna Honda acute rehabilitation patients.

BACKGROUND

An IRF is a hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients who:

1. Are sufficiently medically stable and can reasonably be expected to actively participate,

2. Will significantly benefit from an inpatient, intensive interdisciplinary team

approac~~t~~oh rehabilitation care

~~3.~~ Ha~~s~~ve complex medical ~~problems~~needs that require~~s~~ the services of a physician, and

~~4.~~3. ~~Can benefit from an interdisciplinary team approach in the delivery of rehabilitation care.~~

~~5.~~4. Have a discharge disposition.

The IRF-PAI is a comprehensive tool to collect standardized patient assessment data to conform to the Centers for Medicare and Medicaid Services (CMS) Regulations which identifies and develops an individualized plan of care for Medicare A eligible patients admitted to the IRF unit.

PROCEDURE

1. Preadmission Screening (PAS)

   a. Is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment.

   b. Must be performed by a licensed or certified clinician (i.e., Physiatrist or Licensed Therapist). If not performed by the physiatrist, the physiatrist must document or co-sign-s /~~he~~they ha~~s~~-ve reviewed and concur~~s~~ with the finding and results prior to the IRF admission.

   c. Must be completed within 48 hours immediately preceding the IRF admission.

   d. Must be reassessed if the PAS is completed more than 48 hours prior to the admission. Any changes from the previous assessment must be documented.

   e. May be performed in person and/or via review of medical records.

   f. Include documentation of the following:

      i. Specific reasons that the IRF admission is reasonable and necessary.

      ii. Patient's prior level of function.

      iii. Expected length of time necessary to achieve the expected level of improvement.

      iv. An evaluation of the patient's risk for clinical complications.

      v. Need~~Medical necessity~~ for rehabilitation treatments that may include:

(Occupational Therapy (OT), Physical Therapy (PT)), Speech Language Pathology (SLP) and/or Orthotics/Prosthetics (O&P).

vi. Expected frequency and duration of treatment in the IRF.

vii. Anticipated discharge destination.

viii. Anticipated post-discharge treatments.

ix. Other information relevant to the care needs of the patient.

g. The PAS must be retained in the patient's IRF medical record.

2. Overall Plan of Care (POC)

a. A physiatrist must develop an overall POC within 4 days of the admission date.

b. An overall POC is individualized to the unique care needs of the patient based on information found in the PAS and what is collected in therapy assessments. The overall POC must support the medical necessity of admission and detail the patient's medical prognosis and anticipated interventions, functional outcomes, and discharge destination from the IRF stay.

c. The admission evaluation may serve as documentation of this plan as long as:

i. The plan is completed within the first 4 days of the acute rehabilitation (IRF) admission.

ii. Documentation:

i. Supports medical necessity of admission.

ii. Includes details regarding the patient's medical prognosis and anticipated interventions (PT, OT, SLP, O&P) required during the IRF stay, including details regarding:

- Expected intensity (numbers of hours/day);
- Expected frequency (numbers of hours/week); and
- Expected duration (number of total days during the IRF stay).

i. Includes expected functional outcomes.

ii. Includes the anticipated destination following the IRF stay.

d. The POC must be retained in the IRF patient's medical record.

3. Physician Orders

   a. The physician must generate orders to admit the patient to the IRF.

   b. A valid physician signature on the physician orders must meet the following criteria:

      i. Services that are provided or ordered must be authenticated by the ordering practitioner;

      ii. Signatures are handwritten, electronic, or stamped (in the event of an inability to sign due to a disability);

      iii. Signatures are dated and timesd; and

      iv. Signatures are legible.

   c. The orders must be retained in the patient's IRF medical record.

4. Multiple Therapy Disciplines

   a. Multiple disciplines (i.e., OT, PT, SLP or O&P) must be actively involved in treating the patient.

5. Intensive Level of Rehabilitation Services

   a. The minimum intensity requirement for therapy services is 3 hours a day at least 5 days a week or 15 hours of therapy in the 7 consecutive day period, unless the documentation supports medical issues justifying a brief exception not to exceed 3 consecutive days.

   b. Non-medical "missed" therapy minutes in one day need to be made up on another day within the same 7 consecutive day period starting with the day of admission.

   c. Therapy treatments must be initiated within 36 hours from midnight the day of admission.

   d. The IRF record must demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.

   e. Documentation must clearly indicate the clinician's name, professional credentials and the amount (in minutes) of each therapy service provided for each date.

6. Intensive Therapy Program

    a. Documentation must consistently support that the patient's condition necessitates the intense interdisciplinary team approach, including close medical management, close physician supervision, and complexity for nursing services that are all necessary for an IRF stay. The patient's condition and functional status must be such that he/she can reasonably be expected to make measurable improvement participating in the intensive therapy program available at the IRF.

    b. The standard of care for acute rehabilitation (IRF) patients is individualized therapy (not group therapy). Group and concurrent treatment minutes can be counted toward meeting the intensity requirement~~,~~ but must not be the majority of the treatment provided.

7. Physician Supervision

    a. The physiatrist must conduct three face-to-face visits with the patient each week throughout the IRF stay ~~(starting with the day of admission)~~ to assess the patient medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

    b. The patient's condition and/or status must require the level of physician supervision for the patient's receiving IRF services.

8. Interdisciplinary Team Approach

    a. Evidence of an interdisciplinary, coordinated team review shall be documented at least once weekly, beginning with the date of admission, to provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care. As such, documentation shall include all of the following:

        i. Evidence of active participation in an interdisciplinary rehabilitation program.

        ii. Evidence of progress towards stated goals documented by objective functional measures.

        iii. Identification of the range and severity of the patient's problems, including medical status, self-care, mobility, psychological status and communication status.

        iv. Consideration of special equipment needs when appropriate.

        v. Projected length of stay and discharge or disposition planning.

        vi. Status of training provided to the patient and family member or caregivers by

various disciplines of the IDT~~RCT~~ regarding post discharge care.

vii. Identification of barriers to progress, including any medical complications likely to impede progress.

viii. Information regarding the status of the underlying medical condition(s).

b. The documentation of each conference must demonstrate that qualified required participants attended.

c. The following IDT~~RCT~~ members must attend interdisciplinary team conferences:

i. Physiatrist;

ii. Registered nurse;

iii. Social worker or case manager; and

iv. A licensed or certified therapist from each therapy discipline involved in treating the patient.

9. Discharge from the IRF is appropriate if one or more of the following is present:

a. Treatment goals necessitating the inpatient setting were achieved.

b. Absence of participation in an interdisciplinary rehabilitation program.

c. The patient's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame.

d. The patient is unable to actively participate in the intensive~~inpatient~~ rehabilitation program (as defined under Background and Procedure 6. Intensive Therapy Program~~Inpatient Rehabilitation Services~~).

e. The overall medical status is such that no further progress in anticipated or only minimal gains that could be expected may be achieved at a lower level of care or through regular daily activities.

10. IRF-PAI

a. An IRF-PAI must be completed and submitted online for all Medicare patients separately at admission and discharge but shall transmitted ~~to the CMS~~ together to CMS only after discharge.

i. The ARD is defined as the 3rd calendar day of the rehabilitation stay, which represents the last day of the 2-day admission assessment time period. If the

stay is less than 3 calendar days, the admission ARD is the last day of the stay. If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days.

~~i. Within 24 hours after admission of a patient, UM shall notify the RCT and Patient Billing if the patient is Medicare A eligible and the ARD.~~

b. The information in the IRF-PAI must correspond with the information provided in the patient's IRF medical record and must support the appropriate claim coding.

c. Members of the IDT~~RCT~~ are responsible for completing their assessments and documentation that will be used to fill out their respective IRF-PAI sections by the ARD. Each discipline is responsible for completing documentation as outlined in Attachment A~~Appendix C~~.

d. Each staff member that entered or validated IRF-PAI information directly in the electronic health record (EHR) shall electronically sign that section.

e. An MDS ~~IRF registered nurse (~~RN~~)~~ shall review the medical record and Medicare A~~the IDT~~ assessments of the IDT~~,~~ and complete the IRF-PAI using the electronic validation and entry system by Day 4.

f. After the patient is discharged and the discharge IRF-PAI has been completed, the MDS RN~~nurse~~ shall notify the Resident Assessment Instrument (RAI) Department charge nurse that the IRF-PAI is completed and ready for transmission.

g. After the patient is discharged, the Admission and Discharge IRF-PAI shall be transmitted to CMS by LHH's RAI Department nurse within 24 hours after the notification of IRF-PAI completion.

i. Admission and discharge IRF-PAI items must be completed before data records are transmitted to CMS. If the patient's stay is less than 3 calendar days in length, the staff of the IRF must complete the IRF-PAI admission items, but do not have to complete all of the discharge IRF-PAI items.

ii. Program interruption: the situation where a Medicare patient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days.

iii. Discharge Date: the date the patient is discharged from the IRF and stops receiving Medicare-covered Part A fee-for-service inpatient rehabilitation services.

11. Provision of Medicare Rights Form

a. A financial counselor will meet with Medicare recipients upon admission to review the Medicare Rights form and secure a signature from the patient or responsible

party.

b. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient is discharged before a copy can be given, a copy shall be mailed to the patient by the Eligibility department.

c. Refer to LHHPP 55-01 Payor Eligibility Certification and Coverage

ASSESSMENT TYPE	ADMISSION ASSESSMENT
Hospitalization Time Period and Observation Time Period	First 3 Calendar Days (Admission day = Day 1)
Assessment Reference Date	Day 3
Patient Assessment Instrument Must Be Completed By	Day 4
Payment Time Covered By This Assessment	Entire Medicare Stay Time Period
Patient Assessment Data Must be Encoded By	Day 10
Patient Assessment Instrument Data Must Be Transmitted By	Same day as discharge data ~~are~~is transmitted: 7th calendar day from the encoded by date

ASSESSMENT TYPE	DISCHARGE ASSESSMENT
Discharge Date	Discharge Date (Day 1)
Assessment Reference Date	Discharge Date
Patient Assessment Instrument Must Be Completed On	Day 4 of Discharge
Patient Assessment Instrument Data Must be Encoded By	Day 10 of Discharge
Date When Patient Assessment Instrument Data Transmission is Late	27 calendar days

ATTACHMENT:
Attachment A: IRF-PAI ~~version 4.0 (effective October 1, 2020)~~ Section by Section

REFERENCE:
LHHPP 55-01 Payor Eligibility Certification and Coverage
IRF-PAI Manual 3.0 (effective October 2019)
Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

~~**CROSSREFERENCE:**~~
~~LHHPP 55-01 Payor Eligibility Certification and Coverage~~

Revised: 21/07/14,19/05/14, 21/09/14, 23/11/14 (Year/Month/Day)

Original adoption: 16/11/08

Attachment A: IRF-PAI Section by Section

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT 4.0	
Section	**Responsible Discipline(s)**
1-12: Identification Information	Admission & Eligibility
13: Assessment Reference Date	Utilization Management
14-20: Identification Information	Admission & Eligibility
21-24: Medical Information	Medicine
25-26: Medical Information	Nursing
40-45: Discharge Information	Nursing & Social Services
46-47: Discharge Information	Medicine
O0401-O0402: Therapy Information	Rehabilitation
Z0400A: Signature of Persons Completing the Assessment	Nursing
INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS	
Section	**Responsible Disciplines(s)**
A: Administrative Information	Medicine
B: Hearing, Speech, and Vision	Nursing
C: Cognitive Patterns	Nursing
D: Mood	Nursing
GG: Functional Abilities and Goals	Rehabilitation
H: Bladder and Bowel	Nursing
I: Active Diagnoses	Medicine
J: Health Conditions	Medicine/Nursing
K: Swallowing/Nutritional Status	Medicine/Dietary
M: Skin Conditions	Nursing
N: Medications	Medicine/Pharmacy
O: Special Treatments, Procedures, and Programs	Medicine/Nursing

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

POLICY:

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

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

PURPOSE:

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

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

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

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

DEFINITION:

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

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

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

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

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

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

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

    a. Death

    b. Permanent harm

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

7. Other Reviewable Events

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

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

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

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

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

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

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

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

PROCEDURE:

1. Sentinel Event Notification

a. During regular business hours, LHH employees will report sentinel events to their Division Heads. The Division Head will immediately notify the Chief Executive Officer and Nursing Home Administrator (CEO), the Assistant Nursing Home Administrator (ANHA), the Directors of Nursing (DONs), the Chief Medical Officer/Medical Director (CMO), the Chief Quality Officer (CQO), the Deputy City Attorney (DCA) and the Director of Risk Management or designee.

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

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

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

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

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

2. Sentinel Event Process

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

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

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

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

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

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

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

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

vi. If the PIPS Committee determines that the corrective measures do not obtain the desired outcomes within specified time frames, the Director of Risk Management or designee will report the matter to the LHH Executive Leadership.

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

3. Reporting

a. The Director of Risk Management or designee will present the results of all investigations, interviews and corrective measures to the Chair of the PIPS Committee. The Chair of the PIPS Committee or designee will report findings to the Medical Executive Committee (MEC) and the Joint Conference Committee

(JCC). These reports will identify systems problems and opportunities for improvement.

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

4. Record Maintenance

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

ATTACHMENT:
None.

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

Revised: 00/03/15; 02/03/14, 07/12/17, 08/01/08, 15/01/13, 16/03/08, 16/07/12, 18/05/08, 20/10/13, 22/05/09, 24/05/14 (Year/Month/Day)

Original adoption: 97/11/10

Revised Medical Services Policies and Procedures

GUIDELINES FOR AUTOPSY REQUESTS

POLICY:
Given the well-recognized value of autopsies for medical education, quality assurance, and to improve patient care, the Medical Staff encourages the attending physician to request an autopsy according to the guidelines below following the death of a patient.

GUIDELINES:

1. Any request for autopsy must be initiated by an attending physician.

2. An autopsy may be requested only after it is determined that the case is not a medical examiner's case or after the medical examiner has released the body.

3. Physicians are encouraged to obtain an autopsy, if possible, in cases of unusual deaths and of medical-legal and educational interest. Permission must be obtained as described in these guidelines.

4. The attending physician must obtain consent from the next of kin or legal conservator, who may place specific restrictions or limitations on the permit. The autopsy permit shall be made part of the permanent medical record.

5. Autopsies shall be performed only after the Death Pronouncement nNote has been placed in the chart. Once the medical record is complete, the body of the deceased will be transported to Zuckerberg San Francisco General Hospital (ZSFG), accompanied by a synopsis of the medical record/death summary, one copy of the autopsy permit signed by the next of kin or legal conservator, and one copy of a signed release to the appropriate mortuary.

6. The attending physician will contact the ZSFG pathologist, or medical examiner, if appropriate, to request notification regarding the time of autopsy if desired and will request a report from the autopsy.

7. Autopsies may be performed on deceased patients without a family or legal conservator only after permission from the State Curator's Office has been obtained. Verbal permission for autopsy may be obtained from the State Curator by, giving providing the name, sex, and age of the deceased, date and cause of death, name of physician signing the death certificate, the type of internment (private or county), and whether or not the decedent has made arrangements for disposal disposition of his or hertheir remains. After verbal permission has been given, the written permit for autopsy will be sent to Health Information Services Management for filing in the decedent's permanent medical record. Autopsies on "unclaimed dead" unrepresented deceased may be performed only after a lapse of 24 hours from the time of death.

In cases involving ~~"unclaimed dead"~~ unrepresented deceased, the death certificate must be signed and forwarded to the Admissions & Eligibility~~tting~~ Office. After the autopsy has been completed, the attending physician shall notify the Admissions~~tting~~ & Eligibility office, which shall notify the Public Administrator's Office.

8. Once the autopsy has been performed, the attending physician will receive a copy of the autopsy report, which will be reviewed as part of Medical Quality Improvement activities.

REFERENCES:

- MSPP C01-01 Patient Expiration
- MSPP C01-02 Attachment 1 (Forms to Request an Autopsy)

MS Approved: July 2009
MS Revised: June 2009
MS Revised: June 21, 2022
MS Revised: August 5, 2024

~~OUTPATIENT CLINIC~~ CONSULTANT RESPONSIBILITIES

POLICY:
All consultants will provide medical and surgical services to residents and Community clients in the Outpatient Clinics and In-patient setting at~~of~~ LHH as delineated in the LHH contractual agreements.

PURPOSE:
The purpose is to outline the responsibilities of the consultants ~~so that there is~~in order to promote effective communication with the referring physicians ~~with the goal of providing~~and ensure continuity of care ~~to~~ for LHH residents and Community clients receiving consultative care.~~.~~

PROCEDURE:
Clinic and Procedural Responsibilities of the Consultant (based on the availability of the Consultant staff as delineated in the LHH contractual agreements)

1. Address the specific questions asked by the referring provider.

2. Provide recommendations that incorporate the patient's complete clinical and psychosocial context, including adherence considerations.

3. Be as clear and specific as possible in the assessment and plan. Provide contingency plans as appropriate in the event ~~of failure of~~ the first recommended option is not successful or cannot be implemented, ~~-~~or there is a change in clinical circumstances.

4. Include academic discussion and references as appropriate, as an addition to, and not in place of a clear assessment and plan.~~n.~~

5. Indicate whether the patient requires ongoing specialty care; if so, indicate the anticipated frequency and duration of visits.

~~4.~~6. Ensure that a consultation note is available for review in the resident's/client's electronic health record in a timely fashion. ~~The notes must be available within 7 days.~~ As is consistent with DPH policy, all electronic~~-~~ health record notes must be signed and completed within 3 days of initiation.

~~5.~~

~~6. Indicate whether the patient requires ongoing specialty care; if so, indicate the anticipated frequency and duration of visits.~~

~~7. Ensure that a consultation note is available for review in the resident's/client's Invision/LCR record in a timely fashion. The notes must be available within 7 days.~~

7. Determine the urgency of the consultation; ~~talk~~ speak directly with the referring or covering provider about any emergent recommendations or any unusual circumstances.

8. If a resident/client requires further ~~treatment with~~ diagnostic studies, invasive procedures,

surgeries ~~and~~ or inpatient admissions the referring/covering provider should be consulted.

9. ~~.~~If the patient is seen in follow-up by the same specialty~~-~~ but by a different consultant, the new consultant should assume the responsibility of communicating with the referring provider. Wherever possible, continuity of consultants should be maintained over time for a given patient.

~~8.~~10. To ensure diagnostic test results are evaluated in a timely manner: ____

~~8. If the patient is seen in follow-up in the same specialty clinic but by a different consultant, the new consultant should assume the responsibility of communicating with the referring provider. Wherever possible, continuity of consultants should be maintained over time for a given patient.~~

~~9. Diagnostic test results are evaluated in a timely manner, the consultant will :~~

a. BThe consultant will bring diagnostic test results to the attention of the appropriate clinicalprimary or covering provider in a timely manner.

a.b. If the consultant is the provider ordering the diagnostic test, they must inform the primary care provider and establish which physician (consultant or primary) will be responsible for follow-up and action on the test results.

a. Ensure that remedial action(s) is initiated (including repeating tests for unsatisfactory specimens) as appropriate.

b.c. In the case of Stat or critical test results the primary care provider is notifiednotified, and the consultant/covering consultant physician will be available to discuss over the phone with the primary care provider.

b. Incorporate the diagnostic test results (e.g., laboratory, pathology, radiology, electro-diagnostic tests) into the medical record in a timely manner.

Original Adoption: 09/24/132013/09/24 (Year/Month/Day)
Revised: 2024/08/22

Deletion Medical Services Policies and Procedures

HIV TESTING AND PREVENTION FOR RESIDENTS

POLICY:

Serologic testing for the presence of HIV infection is recommended for all adults (MMWR Dec 3, 2010). Clinicians at Laguna Honda Hospital will therefore screen residents for HIV infection on admission, and at appropriate intervals thereafter, unless HIV + status is already established, or unless there is a clinical circumstance that contraindicates such testing (for example, end-of-life care with a desire to avoid venupuncture). As with any other test, procedure, or medication, all residents or their surrogate decision-makers will be informed about tests being run, and are free to refuse testing if they wish.

PURPOSE:

To find HIV infection early in its course so as to reduce morbidity and mortality, and to help prevent transmission of HIV.

PROCEDURES:

1. Clinicians will inform residents (or their surrogates) about HIV testing in the context of explaining all recommended screening tests, vaccines, and other preventive-health measures.
2. Clinicians will make certain that residents and families have ample time to ask any questions that they may have.
3. HIV testing will be ordered through the clinical lab by ordering “HIV antibody test.” No special written consent documents are required.
4. If resident (or surrogate) declines HIV testing, declination of the HIV test must be documented in the medical record (“patient declines HIV test”).
5. Clinicians are encouraged to call their colleagues on the HIV specialty unit if they have questions about the frequency of follow-up testing, or about how to counsel newly diagnosed HIV + persons, or about other matters related to HIV infection.

APPENDIX:

- HIV Testing Information and Resources for California Clinicians

MS Approved: September 1996
MS Revised: March 2011

Revised Nursing Policies and Procedures

NURSING STAFF EDUCATION – ACUTE UNIT

POLICY:

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

PURPOSE:

To delineate the responsibilities and procedures related to the provision of nursing staff education and training for the Acute Unit.
To ensure that LHH Acute Unit nursing staff are competent to provide care and services in accordance with current standards and within their scope of practice.

DEFINITIONS:

A. Competency: the ability to perform a particular job in specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, skills and/or behaviors.
B. Orientation: time specific period introduction to the work setting or job for newly hired and transferred employees. The purpose of orientation is to ensure that all new employees meet minimum standards for health and safety, environment of care, and job specific competencies.
C. Training: the provision of knowledge and demonstration of skills related to a particular job or assignment.
D. Required Elements: defined criteria by job classification, regulatory requirements, and San Francisco Department of Public Health (SF-DPH) and LHH policies, programs or initiatives that are evaluated and documented during the annual performance appraisal cycle. These elements are defined at:
E. Required Competencies: defined criteria by specific role that are determine through the evaluation of patient care needs, performance improvement measures, procedures performed, conditions and disease processes, equipment and technology, and professional practice. Like Required Elements, these competencies are differentiated at the organizational, department, and unit level, and are assessed and documented during the annual performance appraisal cycle.
F. Core Staffing: Staff that have a regular assignment on or routinely float to the Acute Unit.

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

PROCEDURE

A. All nursing staff must complete all education, training, and competencies required by the distinct part SNF at orientation and annually.
    a. New employee orientation will be conducted in accordance with policy 80-05 Staff Education Program.
    b. Nursing orientation occurs for all nursing staff in accordance with policy A6.0 Orientation of Nursing Personnel.
    c. Competencies are completed during orientation, annually and as needed, in accordance with policy A 4.0 Nursing Clinical Competency Program.
B. Acute Unit specific orientation
    a. Acute Unit Nurse Manager or Nursing Director will ensure that all newly assigned core Registered Nurses (RN) to the Acute Unit will receive job-specific training and orientation.
    b. Staff receive training to new competencies within their scope of practice and ability to perform per standard is validated prior to performing the competency unsupervised. Refer to policy ~~XX.XX~~Acute-02.0 Documentation of Care – Acute Unit.
    c. All float staff, including RNs, Licensed Vocational Nurses (LVN), and Patient Care Assistants (PCAs), new to the Acute Unit receive a unit-specific orientation to environment of care and unit routine prior to providing patient care. LVNs and PCAs have a limited scope of practice in the Acute Unit and will be supervised by an RN. Refer to policy ~~XX.XX~~Acute-02.0 Documentation of Care – Acute Unit.
    d. Documentation of Acute Unit specific orientation and competencies will be completed consistent with policies A 6.0 Orientation of Nursing Personnel and A 4.0 Nursing Clinical Competency Program.
C. Acute Unit specific annual performance appraisal
    a. Required Elements and Required Competencies may be evaluated throughout the year. Documentation of the annual required elements evaluations and competency assessment is attached to the performance appraisal for incorporation into the personnel record.
    b. Criteria for these competencies may include, but not are not limited to:
        i. Low volume, high risk activities
        ii. Regulatory changes
        iii. Performance improvement and patient safety data
        iv. Practice changes
        v. New equipment or technology
        vi. Problem prone processes

CROSS REFERENCES

Nursing Educational Programs
A 4.0 Nursing Clinical Competency Program

A 6.0 Orientation of Nursing Personnel
80-05 Staff Education Program

REFERENCES

California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on September 24, 2022
§70217 – Nursing Service Staff

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing

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

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

San Francisco Civil Service Commission Policies

NEW: 2022/12/13

Reviewed: 2022/12/13

DOCUMENTATION OF CARE – ACUTE UNIT

POLICY:

1. The Laguna Honda Hospital (LHH) Acute Unit are defined as the Acute Medical and Acute Rehab units. The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF).
2. The responsible Physician, Nurse Manager (NM), Charge Nurse, and the Nursing Director (ND) will be notified of any new admissions.
3. The Registered Nurse (RN) implements and documents the nursing process in the delivery of care to the patient in the electronic health record (EHR): assessments, nursing diagnoses, outcomes and planning, implementation and evaluation.
4. Each nursing role (e.g., RN, Licensed Vocational Nurse [LVN], Patient Care Assistant [PCA], or Home Health Aide [HHA]) will perform and document care delivered that is within the scope of their practice.
5. If no PCA is available, the RN will perform PCA tasks and documentation.
6. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
7. Float LVN or RN assigned to the Acute Unit will receive a unit-specific orientation to the environment of care and unit routine from a trained acute staff or Nursing Supervisor prior to providing care. They may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g., medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Refer to *Nursing Policy & Procedure Acute-01.0 Nursing Staff Education – Acute Unit.*

PURPOSE:

To outline nursing documentation standards and requirements related to patient in the Acute Units.

PROCEDURE:

A. Principles of Nursing Documentation

1. Documentation of Nursing Care:
    a. is recorded in the medical record and is reflective of the care provided.
    b. will be factual, accurate, complete, sequential, and legible.
    c. is subject to legal review and must be without ambiguity in interpretation (e.g., only use standardized/approved abbreviations)
    d. will contain a date, time, and the author's signature and credentials (legibly written or electronic) for each entry.

e.
f. is recorded and signed immediately after the care event or the observation has taken place. When this cannot occur, the author changes the time in the EHR to reflect the time that the action and observation occurred.
g. will not be recorded in advance of care being provided.
h. is entered with any changes in condition and is documented with enough detail to ensure continuity of care and level of care.

2. Documentation identifies late entries (when documentation is completed outside the shift performed) with the date and time of the observation and clearly indicates the added documentation is a late entry. The delay reason must also be included. This information is attached to the component of documentation that is being added as a late entry.
3. Incorrect documentation cannot be deleted or erased as the medical record is a legal documentation. Errors in the EHR require a "correction" comment to be entered with pertinent details for the reason for the correction if applicable.
4. Paper Documentation:
   a. will be completed using a blue or black ink pen.
   b. will be crossed out with a single line and reason written next to it for any errors. This correction must be signed or initialed, dated, and timed. White-out is prohibited.
5. Documenting Nursing Care and Assessments
   a. The LHH Acute Unit uses a combination of documentation methods:
      i. Charting by exception for assessment only (e.g., Within Defined Limits [WDL])
      ii. Documenting changes
      iii. Set, periodic documentation
   b. WDLs can be utilized to document assessments when the definition is available in the EHR for the documenting clinician and the clinician has assessed all elements within the definition.
   c. Fields that do not pertain to the patient's care or condition may be left blank.

B. Nursing Documentation

1. Shift documentation: Document as warranted by patient condition with a minimum of once per shift or as ordered. Documentation includes assessment data, newly identified or changes to nursing diagnosis (care plan problems), interventions implemented, and evaluation of patient's response to interventions.
   a. Head-to-toe assessment is completed at least once per shift, at the beginning of the shift or when first admitted.
   b. Vital Signs are documented at a minimum every shift on Acute Rehab at the beginning of the shift and every 4 hours on Acute Medical.
   c. Pain should also be assessed prior to administering routine pain medication, before and after as needed pain medication, and when clinically indicated. Refer to 25-06 Pain Assessment and Management.

d. Intake and output will be documented each shift for all patients.
e. Weights are documented at a minimum weekly on Acute Rehab and daily on Acute Medical.
f. Complete additional assessments as clinically indicated every shift and as needed (e.g., lines, drains, airways, and wounds [LDA], restraint, coach).
g. Initiate, revise, continue or resolve care plans and write a care plan note reflecting the patient's progress toward goals at a minimum every shift.
h. Document a progress note every shift to provide a narrative of any supplemental information including, but not limited to:
    i. shift events
    ii. physician notification
    iii. interventions and evaluation of patient's response to interventions
    iv. injuries, falls, or accidents
    v. critical labs and abnormal test results (e.g., x-ray)
    vi. medication errors
    vii. any pertinent, relevant information necessary for continuity of care
i. Patient acuity will be documented before the end of every shift and reported to the nursing office.

2. Additional pertinent information about the patient will also be collected and documented as deemed appropriate by the RN, such as critical lab values and physician communication.
3. Allergies: observe for allergic reactions and adverse drug reactions during the patient's stay. For any new reactions, notify the physician. The physician adds new allergies and/or adverse drug reactions to the EHR allergy section.
4. Weekly assessments are determined by the patient's clinical condition and can include wound and behavior. Refer to K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury, K 2.0 Wound Assessment and Management, and G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning.
5. Psychotropic drugs require a consent and may use consents from a previous encounter (i.e., SNF admission). Monitor behavior every shift. Refer to policy 25-10 Use of Psychotropic Medications and J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications.
6. Document the use of interpreters. Refer to policy 29-05 Interpreter Services and Language Assistance.

C. **PCA or HHA shift documentation**:

1. Vital signs, pain, height and weight, consistent with unit frequency and as needed as directed by the RN.
2. Intake and output, except for nephrostomy output and enteral input/output, which is documented by the RN.
3. Activities of daily living

4. Daily Cares
5. Additional documentation as needed per patient condition or assignment (e.g., coach, restraint, etc.)
6. Notes: document any supplement data not noted in other areas as needed (e.g., nurse notifications, changes in condition, etc.)
7. When no PCA or HHA is available, the RN will perform the tasks and documentation.

D. RN and LVN:

1. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
2. If an LVN or RN has not been oriented and is assigned to the Acute Unit, they may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g, medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Trained acute staff may provide a brief unit orientation to ensure safe practice.

E. Plan of Care

1. **Assessment**: the RN will use a systematic approach to collecting and analyzing data about the patient. RN assessment and data gathered include sources such as physician notes, orders, nursing notes, allied health notes and information obtained from the patient/family.
2. **Diagnosis**: the RN's clinical judgment about the patient's response to actual or potential health conditions or needs, including for discharge.
3. **Outcomes/Planning**: based on the assessment and diagnosis, the RN sets measurable and achievable short- and long-range goals for the patient.
    a. The plan of care will include evidence-based care plans that are the most relevant to the patient/family and their clinical condition.
    b. The anticipated end date for those evidence-based care plans will be appropriate for the patient/family and their clinical scenario.
    c. Care plans are multidisciplinary (i.e., Social Services input in the Discharge planning care plan)
4. **Implementation**: nursing care is implemented according to the care plan.
5. **Evaluation**: the patient's status and effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.
    a. Care plans will be resolved when they are no longer applicable to the patient.
    b. The progress to the patient's plan of care should be documented every shift in a care plan note and as needed per the patient's condition and status.

F. Patient/Family Education

Nurses will document patient/family education in the medical record. Documentation will include patient/family response and retention of information provided.

G. Leave of Absence

1. When a patient leaves the hospital for a temporary period of time on a physician's written order, the patient's status is assessed and documented.
2. On return, a focused assessment of status, including the patient's reported adherence to medication or other therapeutic plan will be documented.

H. Admissions

1. Notifications:
   a. Notify the physician and patient care team at the time the patient arrives.
   b. Notify Nursing Operations for off hours admissions.
   c. Notify Admissions & Eligibility when the patient information is incorrect.
   d. Notify Food Services to order the first meal tray after the physician provides the diet order.
   ~~e. For any patients admitted from SNF, request SNF Unit send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) with the patient to the Acute Unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.~~
2. Procedures:
   a. Apply new identification band to wrist.
      i. If resident is allergic or refuses, note on the electronic health record and use alternative method of identification.
      ii. Cut/remove any identification bands that came from LHH SNF or another facility.
      iii. Refer to NPP J 1.0 Medication Administration.
   b. Review allergies.
   c. Itemize clothing, property and valuables on the Inventory Property Sheet and obtain patient signature. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
   d. Obtain MRSA surveillance specimen within 24 hours of admission per order. Check for results within 72 hours. Document any positive MRSA results, and notifications and education provided to the patient, surrogate decision maker (SDM) or receiving unit or facility. Refer to 72-01 Infection Control Manual C21 MRSA Testing.
   e. Admissions to the Acute Unit are new encounters with new a Contact Serial Number (CSN) and orders.
3. Assessment:
   a. Obtain vital signs and pain score. Screen Acute Rehab patients for orthostatic hypotension.
   b. Obtain height and weight. Refer to NPP G 4.0 Measuring Resident's Height and NPP G 7.0 Obtaining, Recording and Evaluating Resident's Weight.
   c. Complete a head-to-toe and admission assessments (e.g., allergies, fall risk).

d. Complete additional assessments at admission (e.g., fall, smoking, elopement, pain) as well as other assessments or repeat assessments when clinically indicated (e.g., lift sling, restraint).
e. Examine skin for any lines, drains, airways and wounds (LDA) and document in the EHR. Complete an Unusual Occurrence for any pressure injuries, suspicious bruises or markings. Report any suspect lice or scabies infestation to Nurse Manager, Infection Control Nurse and Physician. For any wounds, complete a wound assessment and schedule weekly wound monitoring in the EHR. Refer to 24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries and K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury.
f. Initiate care plan within 4 hours of admission.
g. Inventory belongings.
h. If the admitting nurse is unable to complete the entire admission assessment, the following shift's nurse is to continue and the complete the remainder of the assessment as endorsed.

I. Discharges

1. Any transfer to an outside acute hospital for emergency services is a discharge.
2. The physician or nurse will inform the patient, family or surrogate decision maker of any acute medical problem and the reason for transfer to the outside acute facility. Notification and time must be documented in the EHR.
3. The physician must complete a discharge order and medication reconciliation, unless the patient is deceased.
4. The nurse will document the resident's condition at the time of discharge, including skin.
5. The nurse will provide transfer documents from the EHR to send with the patient that contain the interfacility transfer records, resident's profile and diagnosis, hospital course, medications, treatments, dietary requirement, allergies, treatment plan, and advance directive documents.
6. Education at discharge
7. The nurse will arrange transportation/ambulance based on medical urgency. For life-threatening situations requiring immediate response of a paramedic team, the nurse may activate a 911 call per physician order.
8. Reconcile and itemize clothing, property and valuables on the Inventory Property Sheet. Indicate discharge disposition of property. Label and secure the remaining property. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
9. Discharge the patient from the unit in the EHR.
10. For Psychiatric Emergency Services discharges, refer to the Psychiatric Emergency Policy.
11. For expirations:
    a. Complete the expiration documentation.

b. Verify the physician has notified Donor Network West (DNW) organ donation network (1-800-55-DONOR or 1-800-553-6667) within 1 hour of death. The caller will document the date, time and referral number. Refer to C01-03 Organ/Tissue Transplant Donation Program.

12. Notifications:
    a. Nursing operations, food services and social services when a patient is discharged to an outside acute hospital.
    b. For any patients being discharged back to SNF, send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) to the SNF unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.

J. Significant Changes

1. For any significant changes, notify the physician and Nurse Manager or Nurse Supervisor of significant change. The physician or nurse will notify patient, family or surrogate decision maker of the significant change. Document any notification and attempts to notify, with the date, time and individual's name.

K. Acute Rehabilitation (IRF)

1. Interdisciplinary Team Meetings shall occur and be documented weekly, beginning with the date of admission, to discuss the plan of care, provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care.
2. Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) must be completed for all acute rehabilitation patients.
    a. Complete the assessments required for the IRF-PAI by the 3rd calendar day of the rehabilitation stay for the admissions and on the date of discharge for the discharges.
    b. Complete the admission IRF-PAI by day 4. Complete discharge IRF-PAI by day 4 after discharge.
3. Refer to 27-06 Guidelines for Inpatient Rehabilitation Facility Documentation

CROSS REFERENCES:

Hospitalwide Policies & Procedures

20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
20-04 Discharge Planning
21-05 Medical Record Documentation
22-05 Handling Resident's Property and Prevention of Theft and Loss
22-07_A02 Physical Restraints - Acute Units
24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries
25-06 Pain Assessment and Management.
25-10 Use of Psychotropic Medications
27-06 Guidelines for Inpatient Rehabilitation Facility Documentation
29-05 Interpreter Services and Language Assistance
72-01 Infection Control Manual C21 MRSA Testing

Nursing Policies & Procedures

Acute-01.0 Nursing Staff Education – Acute Unit.
C 1.0 Admission and Readmission Procedure
C 1.3 Discharge to Acute
C 3.0 Documentation of Resident Status/Care by the License Nurse
C 3.2 Documentation of Resident Care by Nurse Assistants
C 4.0 Notification and Documentation of a Change in Resident Status
G 1.0 Vital Signs
G 3.0 Intake and Output
G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning
G 4.0 Measuring Resident's Height
G 7.0 Obtaining, Recording and Evaluating Resident's Weight
J 1.0 Medication Administration
J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications
K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury,
K 2.0 Wound Assessment and Management

Pharmacy Policies & Procedures

Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing

Medicine Policies & Procedures

Medicine C01-03 Organ/Tissue Transplant Donation Program

REFERENCES:

California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on August 31, 2022

§70749 – Patient Health Record Content
§70753 – Transfer Summary
§70217 – Nursing Service Staff

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing Section 2725

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

California Code of Regulations, Title 22, Section 70215

Department of Health and Human Services 42 CFR Part 482-Conditions of Participation for Hospitals, California Assembly Bill 631, Section 7184
Public Law 99509, Section 9318

ATTACHMENTS/APPENDICES:

NONE

NEW: 2023/03/14

Reviewed: 2023/03/14; 2024/03/12

Revised: 2024/03/12

Approved: 2021/03/12

DECENTRALIZED STAFFING

POLICY:

1. The Nurse Staffing Office (NSO) is responsible for completing staffing schedules that meets the minimum budgeted staffing requirements based on the ~~residents~~resident's care needs, daily census, and nursing model. Likewise, the Nurse Operations Nurse Manager, Neighborhood Nurse Managers and the Nursing Staffing Assistants (NSA) will collaboratively maintain a daily staffing pattern that responds to variations in acuity and census in the Skilled Nursing Facility and the Acute Care Units.

2. The Nursing Staffing Assistants, under the supervision of Nursing Operations Nurse Manager and/or Nursing Director of Operations, will be responsible for directly entering changes in the schedule in a timely manner, producing Plan Sheets, Schedules and Productivity Reports as necessary to effectively manage the neighborhoods' staffing.

3. All staff are responsible for reviewing their schedules.

PURPOSE:

To provide adequate staffing needs in each neighborhood.

RELEVANT DATA:

ANSOS ONESTAFF is the automated staffing software used at Laguna Honda Hospital Department of Nursing. Hours per Patient Day (HPPD) is the budgeted hours of care designated for neighborhoods. The hardware for the ANSOS ONESTAFF is managed at Zuckerberg San Francisco General Hospital (ZSFGH) campus.

PROCEDURE:

A. STAFFER: ANSOS ONESTAFF'S DEFINITION OF DAILY STAFFING CALCULATIONS. Once the computer has been updated and reset, what was known as Scheduler/Plan Sheet now becomes the final posted schedule in Staffer.

1. **Daily Staffing Changes:** The NSA will enter sick calls, tardy calls, self-cancellation, and AWOLs.
    a. Plan sheets are posted for four weeks for staff to request changes
    b. Requests for time off and other rules on neighborhood scheduling are addressed in the centralized staffing guidelines and will be followed according to Union MOUs (Memorandum of Understanding).

2. **Daily Staffing Worksheet:** The NSA will be responsible for printing and completing a QA of the staffing worksheet per shift daily to ensure that each neighborhood's core coverage and staffing needs are met. The Nursing Operations Nurse Manager is responsible for reviewing this documentation for completeness.

3. **Pavilion Acute Unit:** Pavilion Acute Licensed Staff will calculate the Pavilion Acute Units' [Pavilion Medical Acute, and the Acute Rehab Unit (also known as the Inpatient Rehabilitation Facility's "IRF" unit)] acuity level score. The Acuity Level Score (1.00-2.50 = low, 2.51 - 3.50 + medium, 3.51 - 4.00 = high) is based on a formula which incorporates the total census and each residents' "Patient Acuity Classification" score. The Pavilion Acute staff report this score to the NSA before the next shift. The NSA will staff the unit based on this Acuity Level Score and Pavilion Acute Unit Staffing Grid (see Appendix A).

a. Per Title 22 Regulations § 70053.2 Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1275, Health and Safety Code: Patient Classification System. Means a method for establishing staffing requirements by unit, patient, and shift that includes:
    1. A method to predict nursing care requirements of individual patients
    2. An established method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift.
    3. An established method to discern trends and patterns of nursing care delivery by each unit, each shift, and each level of licensed and unlicensed staff.
    4. A mechanism by which the accuracy of the nursing care validation method described in (a)(2) above can be tested. This method will address the amount of nursing care needed, by patient category in patient populations, skill mix of the staff, or patient care delivery model.
    5. A method to determine staff resource allocations based on nursing care requirements for each shift and each unit.
    6. A method by which the hospital validates the reliability of the patient classification system for each unit and for each shift.
b. Evalisys ® Patient Classification System
    1. Pavilion License Staff complete Acute Acuity Tool (Appendix B) by evaluating the level of care needed using the "Care Indicator Instructions" (Appendix C)

B. CONTROLLER: ANSOS ONESTAFF'S definition for database personnel information

1. Entry of Controller information will be the responsibility of the ONESTAFF Specialist or a designated Staffer.

2. Nurse Managers have access to all functions **EXCEPT:**

    a. Transfer/terminate
    b. Budget positions
    c. Create template
    d. Change Controller Date

3. Newly hired employees shall fill out the Employee Data information as part of the processing done by the Human Resources. This form is then submitted to the Staffing Office for entry into the computer.

4. Information regarding transferred or terminated employees will be submitted by Human Resources personnel to the ONESTAFF Specialist Coordinator via e-mail for entry into ONESTAFF. (Official COB date is determined by HRS). The ONESTAFF Specialist Coordinator assigns all UPOS numbers and creates master schedules for the employees.

C. PRODUCTIVITY REPORTS (under management report on the main menu)

Nurse Operations Nurse Managers/Neighborhood Nurse Managers have access to this function and may print.

D. APPROVAL OF TIME OFF:

The Nursing Staffing Assistants, in collaboration with Nursing Operations Nurse Manager, will review request for approval of benefit time off. In collaboration with the neighborhood Nurse Manager and/or Nursing Director, the Nursing Operations Nurse Manager will ensure that emergency request for time off are approved in a timely manner and communicated in writing with all parties involved.

E. DELINEATION OF ROLES AND DUTIES:

1. Nursing Director of Operations

a. The Nursing Director of Operations oversees and supervises the nursing office staff including: Operations Nurse Managers, Nursing Staffing Assistants and other clerical support staff.

b. The Nursing Director of Operations is available 24/7 for consultation related to staffing issues and problems. He/she will make the decision regarding utilization of staff up to and including authorization for overtime usage to ensure deployment of sufficient staffing on all units.

2. Operations Nurse Manager:

a. The Nursing Operations Nurse Manager, in collaboration with Nurse Managers and Nursing Directors, will assess and evaluate for completion of daily staffing and will monitor for trends to meet the needs of neighborhoods, taking into account both administrative and clinical impact.

b. If staff is re-assigned from their initial assignment made, the Nursing Operations Nurse Manager or NSA will review as necessary with the Nurse Manager of the reason for the re-assignment before the end of the shift.

c. The Nursing Operations Nurse Manager will assess the on-going clinical needs of the neighborhood during the shift and collaborate with the Nursing Director of Operations and/or the Chief Nursing Officer to ensure the provision of sufficient staffing.

d. The Nursing Operations Nurse Manager will be available as a resource for the NSA and other nursing office support staff.

e. For sick calls and emergency time off, the NSA will consult the Nursing Operations Nurse Manager, who will act as a resource in backfilling sick calls and strategizing and reassigning staff according to clinical need.

f. The Nursing Operations Nurse Manager will determine if mandatory overtime is needed to meet resident care needs and will notify staff. Mandatory overtime will be selected based on least senior status on a rotational basis within the neighborhood

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g. <u>Without a Nursing Staffing Assistant:</u>

a. The Nursing Operations Nurse Manager will backfill sick calls and reassign or reallocate staffing to meet the needs of the hospital. The Nursing Operations Nurse Manager will make reassignments with the goal to staff the hospital appropriately, adequately and safely.

b. The Operations Nurse Manager designated to oversee the Temporary Transitional Work Assignment (TTWA) employees will inform the unit Nurse Managers via e-mail if their employee is on TTWA status, including the duration of time.

3. Program Nursing Directors:

a. In the absence of the Nurse Manager, the Nursing Director will designate another nurse manager to collaborate with NSO to maintain adequate staffing for the neighborhoods cover the neighborhood's decentralized staffing.

b. The Nursing Director will oversee the appropriateness, adequacy and safety of the neighborhood.

4. Neighborhood Nurse Managers:

a. The Nurse Manager will collaborate with the Nursing Operations Supervisor and NSA to maintain a daily staffing pattern that responds to variations in residents care needs and census. To ensure that sufficient staffing is achieved, the Nurse Managers will inform the NSA at least fourteen (14) days in advance if urgent staffing changes is needed in completing their neighborhood staffing.

b. As necessary, the Nurse Manager will collaborate with the Nursing operations Nurse Manager and/or NSA in determining approval, and backfill of benefit time off request including but not limited to; floating holidays, holiday in-lieu days, longevity days, vacations, and educational days.

c. The Neighborhood Nurse Manager will obtain approval from the Clinical Nursing Director, then from Nursing Director of Operations and/or CNO and notify the Nursing office staff in writing (via email) of any temporary changes in unit's staffing level, including the utilization of coach staff hours, neighborhood floor waxing, neighborhood relocation (i.e. household to another household or to a different neighborhood), outbreaks related to infection control, and the complexity of resident care needs. The NM must specify the duration of the temporary change.

d. The Neighborhood Nurse Manager will notify the Nursing Office staff and Human Resources via email in the event of employee's resignation, termination, retirement, and death.

5. Nursing Staffing Assistant:

a. Under professional nursing supervision, implements and coordinates, under professional nursing supervision, the daily staffing schedules of inpatient nursing neighborhoods according to census, resident acuity, residents' care needs, and availability of regular and per diem nursing personnel.

b. Prints and reviews staffing worksheets per shift.

c. Receives and records phone calls from nursing personnel that impact on staffing and informs the nursing supervisor and neighborhood staff of changes in staffing. Will replace sick calls up to five days per episode, OT/P103 cancellations, jury duty, bereavement, military leave, and leave of absence. FMLA's will be covered in collaboration with the Nursing Operations Nurse Manager or Neighborhood Nurse Manager.

d. Maintains a variety of data regarding staff and ~~neigborhood~~neighborhood characteristics to assist in the planning, implementation and coordination of daily nursing staffing levels.

e. Prepares and distributes various computer reports such as neighborhood time schedules, license monitoring reports and maintains all records pertaining to staffing and payroll.

f. Collaborates with TTWA coordinator regarding schedules of affected employees.

g. Provides coverage for escort requests submitted in writing by the unit's staff at least 72 hours in advance.

h. Notifies the Nursing Operations Nurse Manager of any AWOL and telephones the employee to determine his/her whereabouts.

i. Communicates with Nursing Operations Nurse Manager in troubleshooting staffing issues in promoting the organization's value that our residents come first.

REFERENCES

NONE

CROSS REFERENCES:

Hospitalwide Policy and Procedure
20-15 Acute Patient Classification System (PCS) and Staffing Requirements

ATTACHMENTS/APPENDICES:

Appendix A: PMA Acuity Staffing Grid

Appendix B: Acute Unit Acuity Tool Form

Appendix C: Care Indicator Guide
~~s~~

Adopted: 10/2007

Revised: 2011/05/13; 2015/03/10; 2020/03/17; 2022/12/13

Reviewed: 2022/12/13; 2024/09/13

Approved: 2022/12/13

DISCHARGE PROCEDURE TO ACUTE

POLICY:

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

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

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

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

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

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

PURPOSE:

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

PROCEDURE:

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

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

A. Process

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

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

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

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

4. For Psychiatric Emergency Services discharges, refer to Psychiatric Emergency Policy

~~4. The LN will document in the Notes section the condition of the resident at the time of discharge and notification of the responsible party.~~

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

~~6. The LN is also responsible for notifying the Nursing Operations and Social Services when a resident is discharge to acute facility.~~

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

B. Documentation

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

Nursing will complete an
~~7.~~8. ~~I~~inventory of ~~r~~Resident~~"~~s ~~P~~property and ~~V~~valuables on the Inventory Property Sheet (Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss):

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

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

~~8.~~9. ~~Enter the discharge to acute facility or PMA on the electronic health record~~Discharge resident from the unit in the EHR

~~9.~~10. Complete the RAI/MDS Discharge within 24 hours.

~~10. Close the medical record:~~

~~11. For Psychiatric Emergency Services discharges, refer to Psychiatric Emergency Policy~~

~~12. If resident requires bed hold, refer to LHHPP File # 20-02 Bed Hold.~~

CROSS REFERENCES

Hospitalwide Policy and Procedure

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

Nursing Policy and Procedure

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

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

Reviewed: 2019/07/09; 2024/09/13

Approved: 2019/07/09

Revised Rehabilitation Policies and Procedures

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. ~~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 at LHH.

2. All referrals will~~must~~ be submitted via the electronic health record (EHR)~~dated, signed,~~ and should include a detailed diagnoses~~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 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 their specific needs.

7. The patient's progress and results of treatment are assessed on a timely basis. For~~, which is weekly for~~ acute-level rehabilitation inpatients this is completed weekly, and periodically as defined by CMS guidelines for skilled nursing facility (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 electronic health~~medical~~ record.

9. Continued rehabilitation care is determined~~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, 24/09/10
Original Adoption: 99/08/23