2016

Orientation/Reorientation Handbook

Los Angeles County – Department of Health Services

Olive View-UCLA
MEDICAL CENTER

This handbook was prepared as a collaborative effort of many individuals.
We appreciate their contributions.

CONTRIBUTORS

Tillie Acosta	Health Information Management
Rosa Adams	Social Work
Alma Alvarez, RN	Infection Prevention and Control
Tom Beggane	Human Resources
Jacqueline Lazo-Belangue	Risk Management
Gail Hewes	Hospital Administration/Employee Transportation Coordinator
Sergeant Janice Benning	On-site Sheriff
Frank Colbert	Environment of Care
Rea Jamora, RN	Behavior Restraints
Uchenna Onuekwusi, RN	Behavior Restraints
Sergio Jimenez	Food and Nutrition Services
Steve Lee	Pharmacy
Teri Smith, RN	Patient Safety
Melissa Perlstein, RN	Patient Safety
Jan Love, RN	Population-Specific Guidelines
Joy Matta, RN	Performance Improvement
Lori Saillant, RN	Pain Assessment Tools
Monica Parfait, RN	Pain Assessment Tools
Rose Mayfield	Information System Department
Stephanie Johnson	Interpreter Services
Monica Parfait, RN	Nursing Education
Lori Saillant	Nursing Education
Teri Smith, RN	Chief Quality Officer
Bob Ross	Facilities Management
Joann York, MPT	Rehabilitation Services
Nina Vasillian, MPH, MCHES	Office of Diversity & Cultural Competency
La Tonya Calloway	DHS Human Resources

Revised December 2015

Quick Reference

Olive View – UCLA Medical Center   (818) 364-1555 General Line
14445 Olive View Drive
Sylmar, CA 91342

DEPARTMENT	CONTACT PERSON	PHONE
Administration		
Chief Executive Officer	Carolyn Rhee	(818) 364-3001
Interim Chief Operating Officer	Ann Robinson	(818) 364-3002
Chief Nursing Officer	Dellone Pascascio, RN	(818) 364-3170
Chief Medical Officer	Shannon Thyne, MD	(818) 364-3025
Interim Chief Financial Officer	Carolyn Rhee	(818) 364-3001
Chief Information Officer	Susan Aintablian	(818) 364-4515
Personnel Officer	Thomas Beggane	(818) 364-3313
Ambulatory Medicine		(818) 364-3632
Ambulatory Medicine – Dentistry		(818) 947-4028
Admitting		(818) 364-4255
Anesthesiology	Rima Matevosian, MD	(818) 364-4350
Appointment Desk		(818) 364-3184
Audiology		(818) 364-3118
Bed Control		(818) 364-5959
Cafeteria	Sergio Jimenez	(818) 364-6177
Cardiology	Robin Wachsner, MD	(818) 364-4287
Cashier		(818) 364-3189
Central Plant		(818) 364-3092
Central Processing		(818) 364-4207
Chaplain	Claudia Zentmyer	(818) 364-3080
Child Care Center		(818) 364-3444
Clinical Resource Management		(818) 364-3388
Clinic A		(818) 364-3126
Clinic B		(818) 364-3129
Clinic C		(818) 364-3133
Clinic D		(818) 364-3137
Clinic E		(818) 364-3676
Compliance Officer		(818) 364-3005
Continuity of Care (Home Health)	Diana Loring, RN	(818) 364-3352
Contract Administration	Debra Lett	(818) 364-3418
Credit Union		(818) 367-1057
Emergency Medicine	Gregory Moran, MD	(818) 364-3107

DEPARTMENT	CONTACT PERSON	PHONE
Emergency Room		(818) 364-4320
Employee Assistance Program (EAP)	Dr. Herman Rodriguez	(213) 738-4200
Employee Health Services		(818) 364-3403
Environmental Health and Safety	Frank Colbert	(818) 364-3405
Environmental Services	Stephen Linhart	(818) 364-4110
Expenditure Management	Cynthia O'Donnel	(818) 364-3421
Facilities Division	Bob Ross	(818) 364-3325
Service Center (Equip. and Bldg. Repairs)		(818) 364-4900 (818) 364-4100
Food and Nutrition Services	Sergio Jimenez	(818) 364-4219
Health Information Management	Tillie Acosta	(818) 364-4215
HIPAA Privacy Officer	Terri Smith, RN	(818) 364-3026
Human Resources	Thomas Beggane	(818) 364-3311
Employee Relations	Alvaro Cardona	(323) 869-7140
Family Medical Leave		(323) 869-7892
Payroll	Sonia Recinos	(323) 890-7884
Performance Management	Maria Lorena Andrade Guzman	(323) 890-7928
Return To Work (DHS Risk Management)	Isidra Borquez	(661) 471-4459
DHS-HR Regulatory Compliance	Sharon Robinson	(323) 869-8001
Infection Prevention and Control	Alma Alvarez, RN	(818) 364-3172
Information Systems	Susan Aintablian	(818) 364-4515
Service Desk		(818) 364-4522
Interpreter	Healthcare Interpreter Services/LEP Administrator	(818) 364-3005
Library	Irene Lovas	(818) 364-4240
Medical Administration	Shannon Thyne, MD	(818) 364-3025
Medicine Department	Soma Wali, MD	(818) 364-3205
Neurology Department	Christopher DeGiorgio, MD	(818) 364-3104
Nursing Administration		(818) 364-3170
Office of Communications	Olivia Johnson	(818) 364-3050
Patient Financial Services	Doris Hish	(818) 364-4227
Patient Safety Officer	Leslie Carranza, MD	(818) 364-3026
Patient Service Center		(818) 364-4813
Pharmacy	Steve Lee	(818) 364-3059
Outpatient	Thomas Hall	(818) 364-3064
Psychiatric Inpatient	Alex Kopelowicz, MD	(818) 364-3343
Nursing		(818) 364-4433
Quality Services	Teri Smith, RN	(818) 364-3025
Radiology Administration	Denise Andrews-Tang, MD	(818) 364-4079

DEPARTMENT	CONTACT PERSON	PHONE
Radiology – Scheduling		(818) 364-4086
MRI		(818) 364-3535
Ultrasound/CT/Mammography		(818) 364-4075
Radiology Safety Officer	Cecilia Jude, MD	(818) 364-4094
Referral Center		(818) 364-3180
Rehabilitation Services	Joann York, MPT	(818) 364-4245
Release of Information	Alicia Adams	(818) 364-4129
Respiratory Therapy	Edward Lind, RCP	(818) 364-4422
Risk Management	Jacqueline Lazo-Belangue, RN	(818) 364-3026
Safety Officer	Frank Colbert	(818) 364-3405
Sheriff's Department	Sergeant Janice Benning	(818) 364-3409
1st Floor Lobby Security Desk		(818) 364-5075
1st Floor MRI Entrance Security Desk		(818) 364-5084
2nd Floor Lobby Security Desk		(818) 364-5072
Psych ER Entrance Security Desk		Extension 507
Social Services	Rosa Adams, LCSW, DCSW	(818) 364-4236
Supply Chain Command	Chris Quesada	(818) 364-3683
Office Services		(818) 364-4200
Purchasing	Graciela Santos	(818) 364-4019
Warehouse	Audry Thompson	(818) 364-4001
Surgery	Robert Bennion, MD	(818) 364-3194
Utilization Review	Diana Loring, RN	(818) 364-3414
Volunteer Services	Sandra Back	(818) 364-3074

HOTLINES

ADA Information Line...(800) 514-0301
Child Abuse ....(800) 540-4000
DHS Compliance ....(800) 711-5366
DHS Quality Improvement Program ....(800) 611-4365
Elder/Dependent Abuse ....(877) 477-3646
Fraud ....(800) 544-6861
Intimate (Domestic) Partner Violence...(800) 978-3600
The Joint Commission ....(800) 994-6610
Patient Safety .... (213) 989-SAFE or (800) 611-4365
Pharmacy...(818) 364-3059
Poison Center ....(800) 411-8080
Safely Surrendered Baby (SSB)...(877) 222-9723
Sheriff's Department (24 hours) ....(818) 364-3409

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FACILITY MAP

Welcome to Olive View-UCLA Medical Center!

Thank you for choosing to work with us and to apply your talent and energy to this organization. We are very proud of Olive View and its history of caring and commitment to our patients and their communities. We count on you to build upon this commitment and to help us continue to improve the services we provide.

We care for a multi-ethnic, multi-cultural, and multi-lingual patient population. Our staff reflects this diversity and work diligently to meet the Olive View motto of "People First, Quality Always" and deliver services in a way that addresses the special needs of our clients. You will find that working in this environment is a rich and rewarding experience.

At times, delivery of healthcare can be turbulent and change will seem unending. The rules and regulations are complex and sometimes confusing. Documentation requirements will seem needless and the term "data driven" will make you crazy. When you get frustrated, remember that all of the rules and regulations, data, documentation and changes are intended to improve patient care and ensure patient safety.

The materials contained in this booklet provide you with a summary of Olive View and Department of Health Services policies. Please take the time to familiarize yourself with this information. If you have questions about anything, please talk to your supervisor or contact Human Resources.

Again, welcome to Olive View. I hope your employment/assignment here is a positive experience and that you learn many new things and have some fun along the way. But above all, I hope that you also will ensure "People First, Quality Always" in performing your job. By doing so, you will gain great personal satisfaction and our organization will continue to thrive.

Carolyn Rhee
CEO
Olive View-UCLA Medical Center
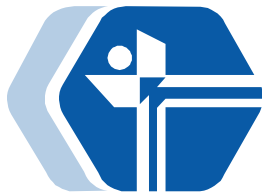
Olive View-UCLA
MEDICAL CENTER

FACILITY PROFILE

- Owned and operated by the County of Los Angeles
- Established in 1920; in present facility since May 1987
- Community hospital status
- A major affiliate of the UCLA David Geffen School of Medicine
- Accredited by The Joint Commission; Laboratory CAP certified with distinction
- 377 Licensed beds
- 213 Budgeted beds
- 196 Current census YTD
- 77,745 Inpatient day FY 2012-13
- 260,615 Outpatient visits (FY 201-13), including 58,401 ER visits
- 2,440 Full-time Employees (FTE)
- 416 Post-graduate physicians (Residents and Interns)

Services:

- Emergency Medicine
- Psychiatry Emergency Room
- Medical Walk-in
- Medical/Surgical Inpatient
- Pediatrics Inpatient
- Suspected Child Abuse Clinic
- Obstetrics and Gynecology
- Psychiatric Inpatient (Locked Ward)
- Intensive Care
- Step-Down
- 7 Operating Rooms
- 3 Operative Delivery Rooms
- Radiology, including UTZ, CT MRI, nuclear, & interventional radiology
- Ancillaries including RT, PT, OT, ST, Nutrition

- Neonatal Intensive Care
- Medicine Specialties
- Plastic Surgery
- Vascular Surgery
- Thoracic Surgery
- Podiatry
- Ear, Nose, and Throat
- Ophthalmology
- Neurology
- Pathology, including FNA
- Inpatient and Outpatient Pharmacy
- Primary Care and Specialty Clinics
- Orthopedic Surgery
- Infectious Disease/Tuberculosis Unit

Services available by referral only (i.e., not available on-site):

- Chronic Dialysis
- Neurosurgery
- Cardiovascular Surgery

Teaching programs sponsored by Olive View:

- Medicine
- Rheumatology
- Nephrology
- Hematology/Oncology

Teaching programs sponsored by Greater Los Angeles VA:

- Psychiatry

Teaching programs sponsored by UCLA: **19 Programs**
Affiliation with several nursing schools

OLIVE VIEW-UCLA MEDICAL CENTER

INTRODUCTION

As a vital resource for the delivery of healthcare, Olive View-UCLA Medical Center is an integral part of the Los Angeles County Department of Health Services (DHS). Olive View serves residents of the San Fernando, Santa Clarita and Antelope Valleys regardless of their ability to pay. Compassion, communication, integrity and improvement are our guiding values.

Olive View provides a comprehensive range of outpatient and inpatient services as well as medical and psychiatric 24-hour emergency services and specialty clinics. Areas of excellence include early detection and treatment of cancer, complex abdominal surgery, tuberculosis, HIV/AIDS, and full range of women's care.

We are providing this informational handbook to you as a responsible and vital member of our service delivery team so that together we can achieve excellence by meeting regulatory standards and the healthcare needs of our patients. It is important that you understand, whether you are a healthcare practitioner, technician, clerical or housekeeping member of our staff, that you make an important contribution to the delivery of quality healthcare at Olive View.

We have designed this handbook so that important information about our facility is readily available. It provides you with general information about Olive View and can be used as a quick reference guide to our key policies and procedures.

HOSPITAL HISTORY

Olive View opened on October 27, 1920 as the tuberculosis sanatorium for Los Angeles County to relieve the overcrowding of tuberculosis patients at County General Hospital. Once tuberculosis could be cured, the census dropped dramatically. Olive View then evolved into an acute care hospital. The first open-heart surgery in the San Fernando Valley, and one of the first in Southern California, was done successfully at Olive View Hospital in 1962.

In 1970, Olive View Hospital became Olive View Medical Center, a teaching hospital affiliated with University of California, Los Angeles (UCLA) School of Medicine. A new 888-bed hospital was dedicated in December 1970, only to be destroyed on February 9, 1971 by the 6.5 Sylmar earthquake.

For the next sixteen years, Olive View served its patients through an interim facility in Van Nuys. On May 8, 1987 the new 377-bed state-of-the-art replacement facility, built on the Sylmar site opened.

In 1992, Olive View incorporated UCLA in its name becoming Olive View-UCLA Medical Center.

In 2011, Olive View-UCLA Medical Center completed construction and opened a new 30,000 square foot emergency room and 30 bed inpatient unit, designed to treat long-term tuberculosis and other infectious disease patients.

MISSION, VISION AND VALUES

MISSION

To improve the health of our patients through the provision of high quality, high satisfaction, patient-centered care.

VISION

To become a medical center that is accessible, delivers excellent care, and is the provider of choice for residents of Northern Los Angeles County.

VALUES

- Compassion
- Innovation
- Integrity
- Respect

MOTTO

People First, Quality Always

STRATEGIC PLAN

Olive View's Strategic Plan defines our Goals as:

- **Customer Service Excellence:** Provide our customers with high quality, high satisfaction, and patient-centered health care services.

  - Provide excellent care to our patients and their families.
  - Meet the needs of our community.
  - Provide high quality, competitive academic services.
  - Be an employer of choice.

- **Organizational Effectiveness:** Improving processes to satisfy our customers.

  - Provide quality services that are above average or superior compared to benchmarks.
  - Improve productivity to above average or superior levels compared to benchmarks.
  - Improve internal open communications.
  - Maintain or improve compliance with all regulatory agency requirements.

- **Workforce Excellence:** Sustain our ability to change and improve.

  - Improve employee satisfaction.
  - Enhance teamwork.
  - Promote succession planning and enhance employee performance.
  - Attract and retain the right people with the right skills.

➢ **Fiscal Responsibility:** Strengthen Olive View's fiscal capacity.

- Maximize revenue generation.
- Reduce and manage costs to optimal levels.
- Improve financial reporting and monitoring.
- Improve data integrity.

LOS ANGELES COUNTY STRATEGIC PLAN

MISSION

➢ To enrich lives through effective and caring service.

VALUES

Our philosophy of teamwork and collaboration is anchored in our shared values:

➢ **Accountability** – We accept responsibility for the decisions we make and the actions we take.

➢ **Can-Do Attitude** – We approach each challenge believing that, together, a solution can be achieved.

➢ **Compassion** – We treat those we serve and each other in a kind and caring manner.

➢ **Customer Orientation** – We place the highest priority on meeting our customers' needs with accessible, responsive quality services, and treating them with respect and dignity.

➢ **Integrity** – We act consistent with our values and the highest ethical standards.

➢ **Leadership** – We engage, motivate and inspire others to collaboratively achieve common goals through example, vision and commitment.

➢ **Professionalism** – We perform to a high standard of excellence. We take pride in our employees and invest in their job satisfaction and development.

➢ **Respect for Diversity** – We value the uniqueness of every individual and their perspective.

➢ **Responsiveness** – We take the action needed in a timely manner.

STRATEGIC PLAN GOALS

Strategic Plan Goals

1. **Operational Effectiveness:** Maximize the effectiveness of the process, structure, and operations to support timely delivery of customer-oriented and efficient public service.

2. **Fiscal Sustainability:** Strengthen and enhance the County's capacity to sustain essential County services through proactive and prudent fiscal policies and stewardship.

3. **Integrated Services Delivery:** Maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

CUSTOMER SERVICE STANDARDS

Customer service is the hallmark of our institution and we are committed to providing the highest quality of care and services in the safest environment to both internal and external customers. To that end, we strive to maintain the highest standards in customer service. Our Customer Service Standards are:

- Personal Service Delivery
- Service Access
- Service Environment
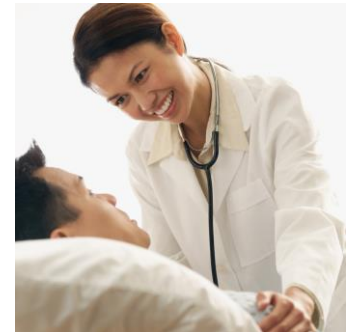
PERSONAL SERVICE DELIVERY

As a member of the service delivery team, it is critical to our mission that you treat customers and each other with courtesy, dignity and respect at all times.

Always:

- Introduce yourself by name and, when appropriate, **SMILE.**
- Treat our customers with courtesy and respect.
- Listen carefully and patiently to them.
- Be responsive to their cultural and linguistic needs.
- Explain procedures clearly.
- Build on the strengths of families and communities.

SERVICE ACCESS

As a service provider, work *PROACTIVELY* to facilitate customer access to services by:

- Providing service as promptly as possible.
- Providing clear directions and service information.
- Reaching out to the community to promote available services.
- Involving families in service plan development.
- Following-up to ensure appropriate delivery of services.

SERVICE ENVIRONMENT

In order to provide services to our customers in a clean, safe, and welcoming environment, you must:

- Ensure a safe environment. Report any unsafe conditions to your supervisor or the Safety Officer at (818) 364-3405.
- Ensure a professional atmosphere.
- Display vision, missions, and values statements.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers.
- Post complaint and appeal procedures.

CORE COMPETENCIES

Olive View's core competencies direct workforce members to demonstrate respect, empathy and regard for the dignity of all patients, families, visitors, and all workforce members to ensure a professional, responsible, and courteous environment.

WORKFORCE MEMBER ESSENTIAL FUNCTIONS (CORE COMPETENCIES)

Customer Relations: Demonstrate respect, empathy and regard for the dignity of all patients, families, visitors, and all workforce members to ensure a professional, responsible, and courteous environment.

Performance Criteria

1. Interact with others in a professional, responsible and courteous manner.
2. Maintain professional composure and confidence during stressful situations.
3. Maintain confidentiality of all hospital and patient information according to HIPAA. Protect patients' privacy at all times.
4. Present a neat appearance and wears proper attire and identification as required by the position and policy.
5. Display a positive, compassionate, responsive and caring attitude.
6. Respect and respond to the diversity of the customers.
7. Hold self-accountable for meeting customer service standards.

MANAGEMENT ESSENTIAL FUNCTIONS (CORE COMPETENCIES)

Customer Relations: Foster a sound customer service philosophy through role modeling, education, coaching and feedback.

Performance Criteria

1. Communicate and clarify customer service goals and performance expectations in department.
2. Monitor and measure performance according to established customer service standards.
3. Coach and manage performance through role modeling, reward and recognition, and established Human Resources Employee Discipline Guidelines.
4. Hold self and staff accountable for meeting patient/customer service standards.

Please refer to Olive View Policy, Customer Service Standards, and the Core Competencies for more information.

TEAMWORK

The essential element in a healthcare setting is teamwork. Teamwork is achieved through a shared vision, positive attitudes, mutual respect and effective sharing and application of skills by each team member. Essential elements of teamwork are effective communication, collaboration, coordination of care and conflict resolution.

EFFECTIVE WORKPLACE COMMUNICATION

Communication is the exchange of thoughts, messages, or information between individuals and groups through speech, signals, writing or nonverbal behavior. Staff must communicate effectively with each other about patient care, treatment and services. Communication takes place in many places, including formal (as in a meeting), informal (as in a hallway), two-way or multi-way (as in a group). Ineffective communication can lead to failed patient outcomes (patient harm, pain), medical errors, increased medical and malpractice costs, reduced patient trust, decreased staff satisfaction and retention, and poor productivity and motivation. Barriers to effective communication which include language, age, skill level, poor listening and verbal skills, negative attitudes, time constraints, cultural differences, etc. can lead to misperception, inaccurate messages, embarrassment and failed outcomes. Good communication skills can be learned, practiced, and continuously improved.

Communication can take place in any setting (break rooms, meetings, nurses' stations) and it can be in any form:

Written: charting notes, reports, e-mail, documents, logs
Verbal: talking, teleconferences, telephone
Visual: demonstrations, videos
Electronic: computer, e-mail, text messages
Nonverbal: facial expressions, hand gestures, body movement, stance, tone of voice

Leadership must model effective communication by clearly explaining the facility and departmental goals, mission, vision, and values; establishing a culture and environment that encourages communication of ideas, reporting errors and failed outcomes without punishment, and promoting and supporting clear, consistent, open communications and an environment where ideas and suggestions are shared and learning is enhanced.

For teamwork to be successful, use these strategies to help improve communication:

- Be clear and accurate in speech and make sure the other party(ies) understands you.
    o Use short explanations, whenever possible.
    o Demonstrate process/procedure.
    o Ask questions to obtain feedback.
    o Ask listener to repeat to confirm instructions and demonstrate, when possible.
- Be a good "active" listener.
- Don't take comments and suggestions personally.
- Create a less stressful environment by having a positive attitude.
- Be objective.
- Document accurately.
- Remember nonverbal communications such as facial expressions, tone of voice, body language and movements, and hand gestures express messages (both negative and positive), intended and unintended.
- Remember to follow patient privacy and confidentiality laws and regulations when dealing with patient information in any format.

> **KEY POINT**
>
> Team members should learn what information other team members need in order to make decisions about treatment and to create positive outcomes in the workplace.

PRINCIPLES OF INTERDISCIPLINARY COLLABORATION

Collaboration involves working together to satisfy the needs of our patient population. High quality patient care is achieved when all workforce members contribute their best efforts in a coordinated manner. Hierarchy, or perceptions of strict levels of power, should not be a barrier to the collaborative effort. DHS workforce members, at all levels of the organization, need to contribute their expertise in order to achieve the best outcomes.

- In communicating and collaborating, each discipline must accept the concept that each team member has a different priority related to the issue(s), care planning or task at hand.
- It is important to identify time commitment, personal expectations, dependencies, and final expected outcomes.
- An agreement must be obtained on the plan, action(s) to be taken, and responsibility for implementation of each action step.

For example: A Physical Therapist schedules to see the patient at 9:00 a.m. When she/he tells the RN about this, they discuss the patient's need for medication prior to the therapy appointment. The RN contacts the physician to discuss the patient's medication needs. The physician sees the patient for reassessment and to discuss the patient's condition and concerns and then renews the medication order.

Or another example: The environmental service worker collaborates with the nurse or his/her supervisor through multiple methods (signs, verbal, training) about the isolation precautions that need to be taken for a safe environment for the patient, staff and visitors.

COORDINATION OF CARE

Coordination of care requires adequate and efficient communication and collaboration of services. Adequate communication and collaboration between disciplines reduces the potential for errors or oversights. A lack of coordination and collaboration between team members or within a system can lead to:

- Increased conflicts between team members about a patient's care treatment and services.
- Compromised patient health and safety.
- Confusion among team members about what is expected of them and what they can expect from others.
- Crises caused by false assumptions that someone else is responsible for handling the patient's care or treatment.
- Patient care decisions being carried out in a delayed or ineffective manner.

Communication and accurate documentation of services between disciplines is the key to providing effective coordination of care. Up-to-date information about a patient's care, treatment or services, condition, expected outcomes and anticipated changes must be maintained to ensure appropriate care of the patient. Effective coordination of care makes it possible for patients to feel secure in the knowledge that they are receiving appropriate and timely care. This is a necessary part of the process of developing patient trust.

> **KEY POINT**
>
> Teamwork through effective communication, collaboration, and coordination of care across disciplines can result in positive patient outcomes.

CONFLICT RESOLUTION THROUGH TEAM BUILDING

It is not unusual for conflict to arise in the workplace. Conflict in the workplace can lead to positive outcomes for team members as well as patients. Effective problem resolution can lead to a better understanding of processes, systems, and procedures. It allows team members to better understand how other team members'

responsibilities and views fit into the scheme of things. Addressing conflict openly and constructively can generate new ideas, approaches and process improvements; and promote increased respect for each team member and improve team cohesion. Workforce members should remember these strategies when dealing with conflicts in the workplace:

- Learn to respect the ideas, suggestions, processes, and contributions of all members of the team, however varied and diverse. For example, physicians, pharmacists, nurses, social workers, and psychologists have been educated to view and process problems in various ways. Each one may have a unique and different perspective on the problem.

- Acknowledge and appreciate other disciplines' processes and contributions to ensure that thorough and complete care planning is patient and family-focused and outcome oriented.

- Minimize competition. Each party should feel a sense of contribution to the care plan and the resolution of patient care issues.

- Ask and respond to questions in a respectful manner, based on the premise that additional exploration of issues is an important method to enhance knowledge and foster collaboration between team members to provide the best possible patient care.

- Evaluate the facts of the situation and make a determination of the problem.

- Promote open dialogue and allow all voices to be heard in the exploration of appropriate methods to resolve problems and issues.

- Keep an open mind and listen to the idea or suggestion being presented. Explore all options before discarding them.

- When discussing problems remember, the problem is not the person, separate the person from the equation so that the problem is the focus.

KEY POINT

Optimism is an effective method of patient care delivery, which promotes success in team building.

REMEMBER

TEAMWORK

This section describes The Joint Commission's accreditation process.

SURVEY PROCESS

During an accreditation survey, The Joint Commission evaluates an organization's performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-centered and organizational functions that support the safety and quality of care, treatment, and services. The assessment is accomplished through evaluating an organization's compliance to applicable Joint Commission standards, based on the following activities and information:

➢ Tracing the care, treatment, and services delivered to the patient.
➢ Verbal and written information provided to The Joint Commission.
➢ On-site observations and interviews by The Joint Commission surveyors.
➢ Review of documents provided by the organization.

The Joint Commission's accreditation process seeks to help organizations identify and correct problems and improve the safety and quality or care, treatment, and services provided.

When The Joint Commission surveyors visit our facilities, they will spend 60 – 70% of their time tracing the delivery of patient care throughout the facility in what is known as a tracer. This means the surveyors will select specific inpatients and review their medical records to determine the services each patient received during their hospitalization. By tracing the course of care and services experienced by the patient (a real time review), the surveyors will interact with direct care providers and/or other applicable workforce members to determine the relationship among departments involved in the care, the integration and coordination of important processes, opportunities for improvement and education (as appropriate) and validation of findings through review of additional records. The surveyors will observe:

> ### KEY POINT
>
> Most surveys are <u>unannounced,</u> so it is important to maintain continuous compliance with all Joint Commission Standards.

- Direct patient care
- Medication administration
- Care planning processes
- Environment of care (including security)
- Medical record documentation

OTHER SURVEY ACTIVITIES

- System Tracers
    - o Medication Management
    - o Data Use
    - o Infection Control
- Life Safety Building Code Tour
- Leadership Session
- Human Resources Interview
- Environment of Care Review and Facility Tour
- Physician Credentialing Review

ACCREDITATION PARTICIPATION REQUIREMENTS (APR.09.02.01)

Under The Joint Commission's Accreditation Participation Requirements, any workforce member who has concerns about the safety or quality of care provided in the organization may report those concerns to The Joint Commission.

Safety or quality of care concerns/complaints may be made through the workforce member's supervisor, the facility risk manager, and/or the DHS Quality Improvement Program hotline at (800) 611-4365.

Olive View will not take disciplinary action against a workforce member for making a good faith report. However, any workforce member who deliberately makes a false accusation will be subject to discipline/release of assignment.

Workforce members may also contact The Joint Commission with their concerns in the following manner:

Complaint Hotline:	(800) 994-6610
Fax Number:	(630) 792-5636
E-mail:	**patientsafetyreport@jointcommission.org**
Online:	**www.jointcommission.org**
Mailing Address:	Office of Quality Monitoring
	The Joint Commission
	1 Renaissance Boulevard
	Oakbrook Terrace, IL 60181

PATIENT SAFETY

PATIENT SAFETY PROGRAM

Olive View is dedicated to providing the highest quality care in the safest environment. We are committed to creating a culture where:

- Members of our staff feel encouraged and supported to identify and report safety issues. This includes ideas on how we can improve.
- We acknowledge that errors in healthcare occur.
- We view mistakes as opportunities to learn and identify system failures.
- We focus on designing or re-designing systems that make it harder to make mistakes.
- We partner with our patients and families and appreciate their active participation in making their care as safe as possible.

We have a proactive, multifaceted, and integrated Patient Safety Program. The goal of the program is to be proactive and prevent adverse occurrences rather than just react to them. The **Patient Safety Committee** is a multidisciplinary group providing leadership and direction to the program and for all safety initiatives.

YOUR RESPONSIBILITY

You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental condition, or "near miss" that causes you concern for the safety of patients, visitors, or staff as soon as possible. You can report safety concerns anonymously.

It is also your responsibility to follow Olive View's policies and procedures regarding the National Patient Safety Goals (see the National Patient Safety Goals section of this handbook).

WAYS YOU CAN REPORT SAFETY VIOLATIONS

You may report events by completing an event notification via the *University Health System Consortium* (UHC) Safety Intelligence/Event Notification System located on Olive View's intranet site.

You may call:

- Hospital Risk Manager's Office (Ext. 3026)
- Pharmacy Hotline (Ext. 3353) to report Adverse Drug Events
- Medical Administration (Ext. 3035)
- Patient Safety Officer (Ext. 3035)
- Employee Health Services (Ext. 3403)

WAYS YOU CAN STAY UPDATED ON PATIENT SAFETY INITIATIVES

One of the ways you can keep updated is by reading the *Patient Safety Goals* posted in each unit. Olive View also provides a laminated copy of the Patient Safety Goals in the front of each patient's medical record to serve as a reminder for you.

Other ways to stay current include reviewing the poster presentations of important safety information posted in each unit, participating in patient safety discussions in your unit staff meetings, executive patient safety walk arounds, and attending hospital-sponsored educational presentations.

WAYS YOU CAN MAKE SUGGESTIONS REGARDING PATIENT SAFETY

You can give your supervisor any safety suggestions you have or you can share them directly with the Patient Safety Officer or Patient Safety Coordinator.

WAYS YOU CAN INVOLVE PATIENTS AND THEIR FAMILIES IN SAFETY

Olive View provides patients with a Patient Information Handbook to encourage them to participate in making their care as safe as possible. The following are some of the tips shared with patients in the handbook and what you need to know:

- ❖ **Olive View encourages patients to know who is in charge of their care.**

  - Always introduce yourself to patients and their families and wear your hospital ID badge at all times while on duty. Wear your badge on the outermost garment, at chest level or above, with your photo, name and position/title visible.

- ❖ **Olive View instructs patients about their medications.**

  - Always tell patients the name of the medication(s) you administer, what it is for and the possible side effects.
  - Always check the patient's ID band for name and date of birth (name and Olive View Number for minors) to confirm the patient's identity even if you are already familiar with the patient.

- ❖ **Olive View instructs patients to speak up if they have questions or concerns.**

  - Your patients have the right to know about their care and question any member of the care team. For example, Olive View instructs patients on the importance of hand washing. Don't be surprised or offended if a patient asks you if you have washed your hands. Remember, he/she may not have seen you do it!

- ❖ **Olive View instructs patients to ask about their test results.**

  - Always refer their questions to the appropriate caregiver.

- ❖ **Olive View also instructs patients that, if they need surgery, they should make sure that all the caregivers involved agree on what is to be done.**

  - Always include your patients in all pre-procedure verification checks and encourage their participation in marking the surgical site. (See the Time-Out process section of this handbook)

SAFE AND JUST CULTURE

A safe and just culture is one in which safety is a personal and organizational priority, and where frontline personnel feel comfortable reporting errors, including their own, while maintaining professional accountability. A safe and just culture provides a fair and balanced environment in which human behaviors and the systems that support those behaviors are evaluated in response to an event.

DHS strives to build, maintain, and support a safe and just culture. This goal is achieved by recognizing the difference between system failures and human behaviors that lead to an event.

Create and Maintain a Just Culture by:

- Encouraging staff to recognize and report patient safety issues, and suggest ideas of how we can improve.
- Acknowledging that errors in healthcare occur and provide a supportive environment for the staff should an error occur.
- Viewing mistakes as opportunities to learn and then identify system failures.
- Focusing on designing/re-designing systems that will ultimately prevent mistakes.
- Partnering with patients and their families and letting them know how much we appreciate their active participation in making their care as safe as possible.

NATIONAL PATIENT SAFETY GOALS

The Joint Commission accredited healthcare organizations are surveyed for the implementation of the National Patient Safety Goals (NPSGs) and requirements or acceptable alternatives. The Joint Commission approved the first set of NPSGs in July 2002 with specific requirements for improving the safety of patient care in healthcare organizations. Olive View Patient Safety initiatives are based on meeting the NPSGs, and focusing on system-wide solutions. Olive View is required to comply with the NPSGs. Each workforce member should be knowledgeable of the NPSGs and how to directly apply them to their service unit.

KEY POINT

You are responsible for reviewing and complying with the current NPSGs that are applicable to your duties.

See The Joint Commission's 2016 NPSGs on Next Page

2016 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01

Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01

Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01

Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify patient safety risks

NPSG.15.01.01

Find out which patients are most likely to try to commit suicide.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission
Accreditation
Hospital

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

2016 Ambulatory Care
National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01 — Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01 — Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use medicines safely

NPSG.03.04.01 — Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 — Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01 — Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

NPSG.07.01.01 — Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.05.01 — Use proven guidelines to prevent infection after surgery.

Prevent mistakes in surgery

UP.01.01.01 — Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01 — Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01 — Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission
Accreditation
Ambulatory Care

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

2016 Laboratory National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

The Joint Commission
Accreditation
Laboratory

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

DETERIORATING PATIENT CONDITION

RESPONDING TO DECLINE IN PATIENT CONDITION

Your job duties may or may not involve direct patient care, and you may not have special training in assessing patients. Nonetheless, any of us working in a hospital/patient care area may at times notice a patient/visitor who does not seem to be doing well. What do you do if a patient/visitor appears to you to have fallen, is having trouble breathing, appears unconscious, or is behaving strangely? If you notice a patient/visitor whom you believe is in distress or a state of medical emergency, there are facility-specific actions you should take. **All Workforce Members** should be aware of how to seek medical assistance.

If you are in a patient care area, always immediately notify the patient's nurse. If you cannot determine which nurse to notify, please tell any doctor or nurse in the area that you are concerned about the patient/visitor.

- Rapid Response Team (RRT): The team that is available 24-hours per day, 7 days a week to respond to urgent clinical patient situation.
- Code Assist Team: The team that is available 24-hours per day, 7 days a week to respond to urgent clinical situations that occur in non-clinical area of the First and Second Floor Lobbies, the adjacent patient loading zones, and Parking Lot I.

Registered Nurses in the areas covered by Rapid Response Team and Patient Assist Team have been trained in how and when to activate the teams. This is why notification of the patient's nurse is the first step in getting assistance for a person who is in possible distress. In other non-patient areas, anyone can call a code blue or patient assist in response to a patient, visitor or employee in distress by calling Ext. 114. At **Olive View-UCLA Medical Center** it is important that you know that anyone can call for emergency medical assistance:

Code Rapid Response	Ext. 114
Code Assist (1st & 2nd Floor lobbies, adjacent patient loading zones and Parking Lot I only)	Ext. 114

If a medical emergency occurs outside the main hospital building (e.g. buildings other than the main hospital, parking lots, adjacent streets or areas near the facility, etc.), call x111 from a campus phone or from a cellular phone call (818) 364-1555 and ask the Operator to call 9-1-1. **If you encounter a situation that you feel requires emergency assistance then you should always act on it by calling for help!**

OLIVE VIEW-UCLA MEDICAL CENTER:

Code Blue: Adult Medical Emergency	Call Ext. 114
Code Rapid Response: Urgent Medical Attention to Inpatients	Call Ext. 114
Code Assist (1st & 2nd Floor lobbies and adjacent patient loading zones and Parking Lot I only)	Call Ext. 114
Medical emergencies outside the main hospital	Call Ext. 111

AMBULATORY CARE NETWORK HEALTH CENTERS:

ALL medical emergencies	Call 9-1-1

FALL PREVENTION AND RESPONSE

Prevention of patient falls is the responsibility of **EVERY** workforce member.

A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, such as a trash can or piece of other equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.
You may encounter visitors, registered or unregistered patients, and staff who may have fallen and who may be in need of assistance.
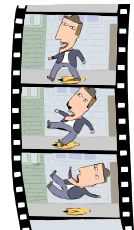
Prevention is the key factor to reduce injury from falls. It is crucial to know how to respond to a fall situation at your facility or in your work environment.

PREVENTION

Workforce members can be proactive by being aware of their surroundings and identifying risks for falls.

- **Identifying and Eliminating Hazards:** If you see a hazard and you can fix the hazard (e.g. a water/liquid spill), do so. If you can't fix the hazard, promptly notify the proper department, maintenance worker, clinician, and/or area supervisor; according to your facility protocols. Try to secure the area to avoid a potential fall victim.

- **Environmental risks and hazards** include: Wet or slippery floors, spills, debris, clutter, obstructions, stairs, change in surfaces, rugs/floor mats, extension cords, power cords of equipment in use or not in use, ladders, etc.

- **Physical/Cognitive Risks**: The elderly and the very young make up the highest percentage of fall victims. Some factors that contribute to fall risk for elderly are: medication usage, confusion, unsteady gait, declined hearing and vision. Some factors that contribute to fall risk for children are: running, climbing, jumping, illness or injury.

- **Fall Risk Communication:** Communicating potential hazards anywhere on campus to the correct people in a timely manner can keep staff, visitors, and patients safe from falls and injuries and provide a safer, healthier environment. When a patient is identified as high risk for falls, the nursing staff will place them on "fall risk" alert. Nursing staff might place a sign on the door or wall alerting staff to the patient's fall risk, and have the patient wear a wristband or some other modality based on the facility protocols. We must use precautions to prevent patient falls.

Fall Risk

TIPS FOR PREVENTING FALLS

Environmental

♦ Identify and eliminate environmental hazards throughout the facility, the parking lot, waiting rooms, clinic areas, and patient's rooms.
- Maintain adequate levels of lighting.

- Report wet floors, spills, blocked passageways immediately.
- Remove obstacles and trash on the ground or in passageways/hallways.

Inpatients

♦ Check for "Fall Alerts" such as patient's wristband, signage on patient's chart and inside patient's room.

♦ Ensure bed and wheelchair brakes are locked.

♦ Ensure patients have non-skid footwear.

♦ Keep bed side rails raised during patient transport.

♦ Keep children's bed rails raised when child is not attended by adult.

♦ Ensure personal items and call button are within patient's reach.

♦ Orient patient and family to the patient's room environment and bathroom facilities.

♦ Assist patient in transfers or ambulation, as needed.

RESPONSE

Workforce members need to know what to do should they encounter a victim of a fall.

- <u>Expectations to respond to a fall victim</u>: If the person who has fallen is alert and oriented, ask them if they are alright. If there is no apparent injury and the fall victim indicates that they have sustained no injury, offer assistance to help them back to their feet and to resume normal gait. If the fall victim is injured, unsure of injury or disoriented, immediately call for help and remain with the victim.

Process for Obtaining Medical Assistance

  o Notify your supervisor/manager.
  o Activate Code Assist Team by calling Ext. 114.
  o Document the incident via Safety Intelligence system and follow other reporting procedures.

Report environmental hazards to Facilities Management at x4900 (after hours/weekends x4100) or the Safety Office at x3405.   Safety concerns/complaints may be made through the workforce member's supervisor, department/unit safety coordinator, safety officer, risk manager, and/or the DHS Quality Improvement Program hotline at (800) 611-4365.

In order to monitor, measure, and analyze conditions associated with falls, it is critical that you report **ALL** falls. If you encounter, witness a fall, help or assist someone whom has fallen; follow the facility's reporting process (or immediately notify your supervisor) so conditions associated with falls can be corrected and documented. **Falls are to be reported in the UHC Safety Intelligence/Event Notification System**. Patterns and risks leading to falls can be identified and processes can be developed to improve the safety of the environment. Workforce members without access to the UHC Event Notification System should report falls to their supervisor, or the facility risk manager, patient advocate or patient safety officer.

ELIMINATING OCCUPATIONAL HAZARDS

Worksite hazards need to be identified and eliminated to improve occupational safety. From parking lots, to your work area/unit, we can all improve occupational safety by being AWARE of the surroundings. Workforce member exposure to wet floors or spills and clutter can lead to slips/trips/falls and other possible injuries. Workforce members can reduce or eliminate these hazards by following these tips for providing a safe environment.

Tips for a Safer Workplace Environment

- Keep exits free from obstruction. Keep floors clean and dry. Access to exits, hallways and walkways must remain clear of obstructions at all times.
- Where wet processes are used, maintain drainage, and wear appropriate footwear.
- Provide warning signs for wet floor areas if you encounter them or are cleaning them. Also, In addition to being a slip hazard, wet surfaces promote the growth of bacteria that can cause infections.
- Use the handrail on stairs, avoid undue speed, and maintain an unobstructed view of the steps ahead.
- Use adequate lighting especially during night hours. Use flashlights or low-level lighting when entering patient rooms.
- Ensure spills are reported and cleaned up immediately.
- Be extra cautious in slippery areas such as toilet and shower areas, and outside areas especially in the rain.
- Use only properly maintained ladders to reach items. Do not use stools, chairs, or boxes as substitutes for ladders.

BE A GOOD SAMARITAN

If you encounter a co-worker who looks as though he/she needs assistance, (e.g. co-worker carrying an unstable load, or following unsafe practices), offer him/her assistance to eliminate potential falls or injury.

If you see a person with a disability struggling to get out of the car, to stand up, or in apparent need of assistance, you should respectfully offer to help. The County's mission is:

"To enrich lives through effective and caring service"

STAFF RIGHTS AND RESPONSIBILITIES

DHS WORKFORCE MEMBER EMERGENCY PROTOCOL

All personnel in DHS are considered part of the emergency response system. County Code 2.68.060 states that:

"The county emergency organization shall be comprised of all officers and employees of the county, volunteer forces registered to aid the county during a duly proclaimed emergency, and all groups, organizations and persons who may by agreement or operation of law (including persons impressed into service under the provisions of Section 2.68.220(C) of this chapter), be charged with duties incident to the protection of life and property in Los Angeles County during such emergency."

DHS employees are members of the County's Emergency Response Team and in the event of an emergency are expected to report to their pre-designated assignment locations and their regularly assigned shifts, unless they have been instructed otherwise.

It is important to monitor the Emergency Alert System (via radio and/or TV) for information about where to report, what facilities are open or closed, what transportation routes are viable, etc.

WHAT TO DO WHEN A DISASTER OCCURS

When initially alerted, stay calm, ensure your personal safety, and then confirm the safety of your family and property. Once the personal safety of your family is verified, employees should assist in the County's disaster response.

If you are at work and have a pre-designated emergency response assignment, you must respond in accordance with that assignment. If you do not have a pre-designated assignment, report to your supervisor or the Hospital Command Center to receive instructions.

If you are off duty when a disaster occurs, contact your facility to receive your assignment. If you are unable to contact your facility, call the Department of Health Services ComLine at (323) 890-7750 for information on the status of DHS facilities and what actions employees are expected to take.

DISASTER SERVICE WORKER

The California Emergency Service Act designates public employees as Disaster Service Workers (DSWs) that may be deployed to perform activities outside the course and scope of their regular employment which promote the protection of lives and property or mitigate the effects of a disaster (such as fire, flood, earthquake, or other natural or man-made disasters). This is mandatory for all eligible County employees and requires DSWs to receive training on basic emergency management principles, take the oath, and sign an affirmation of allegiance (also referred as the affirmation of loyalty) card and document specialized skills.

All new full-time, permanent County employees are required to take the DSW training within 60 days of hire. Check with your supervisor/manager or Human Resources office to determine if you are required to complete DSW training.

STAFF RIGHTS

Olive View seeks to provide high quality patient care in an environment that protects all members of our service delivery team and respects their cultural values, ethics, and religious beliefs. Olive View leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious belief conflicts with the rendering of patient care. Olive View Policy No. 196 entitled "Staff Rights" describes the procedure by which you may formally submit a request to your supervisor for such considerations. Non-County workforce members should contact the facility contract administrator for terms and conditions of their contract/agreement.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The DHS Compliance Program is a comprehensive strategy to prevent, detect and correct instances of unethical or illegal conduct. DHS is committed to conducting its business with honesty, integrity and in full compliance with all applicable laws and regulations. DHS recognizes that its greatest strength lies in the talent and skills of workforce members who perform their jobs competently, professionally, with dedication, and a deliberate focus to provide outstanding customer service. The Compliance Program is committed to working with the entire workforce to make responsible conduct the hallmark of our patient care and the Department's overall performance.

The Chief Compliance Officer located at DHS headquarters is responsible for directing the DHS Compliance Program. Each hospital has a Local Compliance Officer who is responsible for implementing compliance-related activities at each of their respective facilities. The Local Compliance Officer for Olive View can be reached at (818) 364-3001.
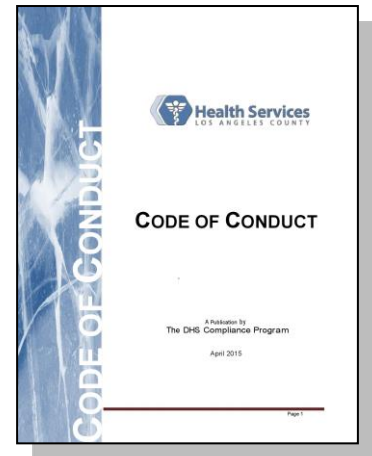
A significant element of the DHS Compliance Program is the DHS Code of Conduct which is our guide to appropriate conduct and behaviors. Together with applicable laws, County and Department policies, and program-specific guidelines, we have set standards to ensure that we all do the right thing. These legal and ethical standards apply to our relationships with patients, workforce members, affiliated providers, third-party payers, contractors, subcontractors, vendors, and consultants. Each workforce member has a personal responsibility to comply with the Code of Conduct and must sign an acknowledgement stating they will abide by the Code of Conduct and understand that non-compliance with the Code of Conduct can subject them to disciplinary action up to and including discharge from service or termination of assignment.

Additionally, workforce members are responsible for reporting any activity that appears to violate the Code of Conduct. The Code of Conduct outlines several resources workforce members can use to obtain guidance on ethics or compliance issues or to report a suspected violation. These resources include:

- His/her supervisor or manager
- Local Compliance Officer
- DHS Audit and Compliance Division:
  - 313 North Figueroa Street, Room 801
  - Los Angeles, CA 90012
  - Telephone: (213) 240-7901
  - Fax: (213) 481-8460
  - DHS Compliance Hotline: (800) 711-5366

Calls to the Compliance Hotline may be made anonymously; however, anonymous calls may be difficult to investigate. The Department will make every effort to maintain within limits of the law and the practical necessities of conducting an investigation, the confidentiality of the caller's identity.

Please note that the Los Angeles County Fraud Hotline at (800) 544-6861, operated by the Auditor Controller continues to be available to report fraudulent activity.

DHS will not retaliate against anyone who reports a suspected violation in good faith. Workforce members are protected from retaliation by County Code Section 5.02.060, as applicable, as well as by California and federal "whistle-blower" protections for persons who report or assist in the investigation of certain illegal behavior. DHS will not discharge, release, demote, suspend, threaten, harass, or in any manner discriminate against workforce members who exercise their rights under any federal or state whistleblower laws.

Compliance Awareness Training is mandatory and provided to workforce members at the start of service and approximately every two (2) years thereafter. This training provides workforce members with a better understanding of the Code of Conduct and their role in the Compliance Program.

FALSE CLAIMS ACT

DHS is compelled, by Section 6032 of the federal Deficit Reduction Act (DRA) of 2005, to provide information to all workforce members regarding the consequences of submitting false claims and statements; protections for workforce members who report wrongdoing (whistleblower protections) under those laws and regulations, and policies and procedures to detect and prevent fraud, waste and abuse.

DHS workforce members are also required to abide by the federal False Claims Act (FCA) as well as other federal and state laws, rules and regulations. Workforce members are also afforded with protection through these laws, rules and regulations, for reporting violations.

The laws described in the federal False Claims Act are intended to control fraud in federal and state healthcare programs by giving certain governmental agencies the authority to seek out and investigate violations and prosecute violators.

DHS Policy 1003, False Claims Act, discusses both federal and state law provisions which protect health care programs against false claims and protect individuals who detect and report fraud.

The policy discusses the federal FCA, 31 U.S.C. §§3729 et seq., which precludes, among other things, the submission to the federal government of false claims and false documentation to support such claims, as discussed in more detail below. The policy also describes a federal law, 31 U.S.C §§3801-3812, which allows certain federal agencies, including the U.S. Department of Health and Human Services, to impose penalties for the submission of false or fraudulent claims or false supporting documents. Those laws, as well as the California False Claims Act are discussed in more detail below.

The policy also describes the following state law provisions:

- Penal Code §72 – Makes it a crime to knowingly and deliberately submit a fraudulent claim to the government;
- Penal Code §550 – Makes certain types of improper claiming practices criminal acts;
- Welfare and Institutions Code §14123.2 – Imposes administrative fines for presenting or causing to be presented various kinds of improper claims to Medi-Cal;
- Welfare and Institutions Code §14123.25 – Allows civil monetary penalty to be imposed and/or a provider to be excluded from participation in Medi-Cal for improperly billing Medi-Cal or making improper calculations on a cost report; providers may also be excluded for a variety of other prohibited behaviors;
- Welfare and Institutions Code §14107.4 – Makes it a crime to submit false information in a cost report or to falsely certify a cost report;
- Welfare and Institutions Code §14107 – Makes it a crime, under certain circumstances to submit or support false claims, or obtain an authorization with false documents, where the claim is to the Medi-Cal Program;

- Business and Professions Code §810 – Makes it unprofessional conduct, punishable by the various licensing bodies, to make false claims under an insurance policy, or to create false or fraudulent supporting documents, among other prohibited behaviors;
- Health and Safety Code §100185.5 – Allows the California Department of Health Care Services, under certain circumstances, to suspend or disenroll from any program a provider who is suspended or disenrolled from another program it administers; and
- Labor Code §1102.5 – Protects employees from retaliation, employees who share non-privileged information about wrongdoing with the government.

THE FEDERAL FALSE CLAIMS ACT (FCA) 31 U.S.C. §§3729-3733

Actions that violate the federal FCA include:

1. Presenting or causing to be presented a false or fraudulent claim for payment to the federal government or to someone else who will pay all or part of the claim using federal funds;
2. Making or using, or causing to be made or used, a false record or statement which is material to a false claim. A statement is "material" if it has a natural tendency to influence the payment;
3. Conspiring to violate the federal False Claims Act;
4. Making, using or causing to be made or used a false document which is material to an obligation to pay the government; and
5. Concealing, avoiding or decreasing an obligation to pay money or property to the federal government.

Any individual or business found to violate the federal FCA is liable to the federal government for a payment of three (3) times the amount of damages that the government sustains plus a civil penalty of not less than $5,500 and not more than $11,000, and may also be liable for the actual costs of the civil actions regarding the violation. This amount can be reduced if the individual or business that committed the violation provides federal officials with certain timely information (within 30 days of discovery), fully cooperates with authorities and these actions begin before any federal or state action has begun on the violation.

Generally, the federal Department of Justice investigates and may bring civil actions against an individual or business believed to be in violation of the federal FCA. The federal FCA also allows a private party to bring, on behalf of the federal government, a civil action against an individual or business that violates the federal FCA, as a "qui tam plaintiff", "relator", or "whistleblower." The individual must have knowledge of the circumstances around the false claim and the information must not have been made public as specified in the law, unless he or she is the original source of the information and made disclosures to the government before filing the action. The government has the right to investigate and decide whether it wants to be involved in the prosecution of the case. If the government intervenes and there is a settlement or judgment against the defendant, the relator is generally entitled to 15-25% of the money which is recovered, but this amount can be reduced in certain situations. If the relator proceeds alone, he or she is entitled to 25-30% of the recovery. However, the relator may be responsible for the defendant's attorney's fees if he or she loses and the case was clearly frivolous, or was brought for purposes of harassment.

The whistleblower must first inform the government of the facts and circumstances of which he or she knows before he or she files the complaint.

Under federal FCA, any workforce member who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee to support or assist an action under the Act or because the workforce member took actions to prevent one or more false claims, is entitled to all relief necessary to make the workforce member whole. Such relief may include reinstatement, double back pay, and compensation for any special damages including litigation costs and reasonable attorney's fees.

Administrative Remedies for False Claims

In addition to administrative procedures that may exist under a particular government program such as Medicare, federal law gives certain federal executive departments, such as the Department of Health and Human Services, the right to impose administrative penalties (i.e., penalties that are not imposed by the courts) for false claims and statements. Other laws, not discussed below, allow the federal Office of the Attorney Inspector General to impose administrative penalties. Administrative penalties can consist of monetary penalties as well as exclusion from participation in federal healthcare programs. These penalties may be imposed, for a variety of offenses, which include violation of Medicare or Medicaid rules, kickbacks or other inappropriate behaviors as well as for false claims and statements.

The federal administrative penalty provisions found at 31 U.S.C §§3801-3812, allow the Department of Health and Human Services to impose penalties for the following actions:

1. Making, presenting or submitting, or causing to be made, presented or submitted a false claim or fraudulent claim; or
2. Making, presenting, or submitting or causing to be made, presented or submitted, a claim that is supported by a "statement" which is false or fraudulent either because of what it says, or because it leaves out a material fact which is supposed to be in the statement; or
3. Making, presenting, or submitting a written statement which contains a false or fraudulent fact, or leaves out a material fact which the person has a duty to include and is therefore false or fraudulent, if the statement is accompanied by a certification of the truthfulness and accuracy of the contents of the statement.

A civil penalty up to $5,500 will be assessed for each claim submitted, although that amount may be increased by inflation. In addition, if a false claim was paid, the responsible person will have to repay an amount equal to two times the amount of the claim. This second amount acts as payment for the government's damages.

CALIFORNIA FALSE CLAIMS ACT (GOVERNMENT CODE §§12650-12656)

The State of California has also enacted the California False Claims Act (CFCA), which applies to fraud involving state, city, county or other local government funds. It is similar to that of the Federal False Claims Act in that it provides for civil penalties for making false claims and also encourages individuals to report fraudulent activities and allows individuals to bring suit against an individual or entity that violates provisions of the Act.

Actions that violate the CFCA include:

1. Presenting or causing to be presented to the State or a county government, or to an entity that will use State or county funds in whole or in part to pay the claim, a false or fraudulent claim for payment;
2. Making or using, or causing to be made or used, a false record or statement that is material to a false or fraudulent claim. A statement is "material" if it has a natural tendency to influence the payment;
3. Conspiring to violate the CFCA;
4. Making, using, or causing to be made or used, a false document material to an obligation to pay the State or county government;
5. Concealing, or improperly avoiding or decreasing an obligation to pay the State or county government; and
6. Failing to inform the State or county government within a reasonable period after discovery, that it is the beneficiary of an inadvertent submission to the State or county government of a false claim. In essence, this provision makes individuals responsible for telling the State or county government about a payment they received which they should not have received, even when they did not intend to get the incorrect payment.

If a person or entity has been found to violate the CFCA, the person/entity will be responsible for paying three times the amount of actual damages and a penalty of between $5,500 and $11,000 per violation. These penalties can be reduced by self-disclosure of the facts and cooperation with the government.

Individuals acting as whistleblowers can sue for violations of the CFCA. However, if the whistleblower is a government employee who discovers the fraud in the course of his or her job, he or she must use, to the fullest extent possible, internal agency processes for reporting the fraud and seeking recovery through official channels, and the agency must have failed to act on the information within a reasonable time period, before the employee has a right to file the action.

Individuals who bring an action under CFCA may receive between 15 and 33% of the amount recovered (plus reasonable costs and attorney's fees) if the State and/or county prosecutes the case, and between 25 and 50% (plus reasonable costs and attorney's fees) if the whistleblower litigates the case on his or her own. The individual must have knowledge of the circumstances around the false claim and the information must not be public information unless he or she is the original source of the information.

The CFCA does not apply to certain claims including those with a value of less than $500, workers' compensation claims; or claims, records, or statements made under the Revenue and Taxation Code.

Such as with the federal FCA, the CFCA bars employers from interfering with an individual's ability to bring or cooperate with the government's action under CFCA. Employees who report fraud and are discriminated against may be awarded (1) reinstatement at the seniority level they would have had except for the discrimination; (2) double back pay plus interest; (3) compensation for any costs or damages they have incurred; and (4) punitive damages, if appropriate. Employees who participated in the violation, but were coerced into doing so and cooperated with the government, are also protected from discrimination and may receive the same types of awards.

PROCUREMENT PROCESS

No DHS workforce member has independent authority to purchase supplies, equipment or services, or commit County funds.

COUNTY AUTHORITY

Only the County Purchasing Agent or the Board of Supervisors can commit County funds. State Statute and the County Charter provide authority to 1) the Purchasing Agent to acquire goods, equipment, and limited services and 2) to the County Board of Supervisors to approve service-related contracts over $100,000.

DHS AUTHORITY

The County Purchasing Agent has delegated limited purchasing authority to DHS. This authority is exercised through the responsibilities assigned to the Supply Chain Network (SCN) Purchasing Group/Procurement Offices. All acquisitions that will commit County funds must be in accordance with this delegated authority and the DHS Director's Office signatory approval designation and process. An approved requisition is required to initiate the purchasing process. Only the Purchasing Agent or the SCN Purchasing Group/Procurement Offices can issue purchase orders. The DHS Contracts and Grants Division processes service contract requests to the Board of Supervisors.

DHS FACILITY AUTHORITY

Each Facility has an established process to requisition, purchase and distribute supplies, equipment, and required services. Workforce members are to contact their manager or facility Supply Chain Director for specific instructions on obtaining essential supplies, equipment and services. Workforce members are to refer any unauthorized or unsolicited contact from vendors to their facility Supply Chain Division.

UNAUTHORIZED PURCHASES

Do not request <u>or accept</u> any goods or services without a purchase order or contract, as this may commit the County to a purchase obligation. Goods or services that are acquired without the proper authority will be identified as unauthorized. Any workforce member who obtains goods or services from any vendor, without official approval, may be held responsible for payment of goods or services rendered and may also be subject to disciplinary action or release of assignment.

Workforce members should contact their facility Supply Chain Division if they have any questions regarding the procurement process or acceptance of goods or services.

TRAINING AND COMPETENCY

You are mandated to complete Olive View's organization-wide orientation within 30 days of hire and/or transfer of assignment to the hospital. Olive View will document completion in your official personnel folder and/or area file. Your supervisor will also document your unit-based, job specific orientation and initial competency assessment in your area file. Documentation of initial competency assessment must be initiated immediately upon hire/assignment and completed **within the first 90 days** of your assignment to the actual unit/division. Your supervisor should ensure that you know how to use equipment in the performance of your job and should apprise you of the policies and procedures you must follow. Assignments shall include only those duties and responsibilities for which competency has been validated. Ongoing competency assessment is required annually or as needed (i.e. new equipment, new procedure/policy, remedial education process, etc.) and must be documented in your area file. You must also complete all mandatory training and competency certification requirements for your position (e.g., orientation, infection control, fire/life safety, emergency management, CPR and other core competencies).

PROFESSIONAL CREDENTIALS (LICENSE/CERTIFICATION/REGISTRATION/PERMIT)

Any workforce member whose position requires a current valid professional credential to perform the duties of his or her position shall produce evidence of license, certification, registration and/or permit to Human Resources upon entering County service or assignment. Some positions require secondary or additional licenses to fulfill regulatory/legal requirements. If you are a licensed professional, it is your responsibility to renew all required professional credentials or other requirements and to ensure the professional credential is kept in good standing with the appropriate issuing board or agency. Failure to comply with professional credential requirements may subject you to corrective action, which may include discharge/release from County service or assignment.

Primary source verification must be conducted during in-processing/onboarding, upon new assignment, promotion, professional credential renewal (licenses, etc. must be renewed prior to license expiration date), contract renewal (independent contractor), transfer to new work location, and during the performance evaluation process. Primary source documents dated after the initial date of hire/assignment/promotion or greater than five (5) days prior to the initial date of hire/assignment/promotion are considered invalid/untimely.

> **REMEMBER**
>
> It is your responsibility to renew all required licenses or other requirements with the appropriate issuing board or agency.

If you are required to maintain a current valid professional credential to perform your job duties, it is your responsibility to provide a copy of a renewal professional credential to your supervisor prior to the expiration date. You will not be allowed to work with an expired, suspended, or revoked, professional credential.

You must notify your supervisor within 24 hours of being notified by the issuing agency that a disciplinary action is being brought against your professional credential.

Persons recruited for positions requiring a professional credential may be appointed to that classification on a temporary basis. Such an appointment is permissible only to the extent allowed by the California Business and Professional Code and/or other applicable regulatory provision. This exception shall not apply to medical, dental, and other professionals if such action would constitute a breach of the Business and Professions Code. Persons so employed/assigned must obtain their professional credential within the provisions of the applicable regulatory code or as established within the minimum requirements of the applicable class specification. Failure to obtain a valid professional credential within the applicable time specifications will result in corrective action, which may include discharge from County service or immediate release from assignment.

Workforce members may only work within the scope of their professional credential or within any restrictive conditions, as applicable.

If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report as follows:

Medical Staff ....**Medical Administration – (818) 364-3035**

Nursing Staff ....**Nursing Administration – (818) 364-3170**

OR you may contact:

Human Resources and/or Performance Management..**(818) 364-3313**

CRIMINAL BACKGROUND CHECKS

DHS acknowledges that patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, harassment, exploitation and the reporting thereof without fear of retaliation. DHS is responsible to safeguard those patient rights by conducting criminal background checks on all potential workforce members, including those transferred or promoted to sensitive positions, as defined below.

All candidates selected for hire, promotion to a sensitive position or transfer from another department and non-County workforce members as specified in DHS Policy 703.1 will participate in a criminal background check. The criminal background check will include fingerprinting/Live Scan conducted by the California Department of Justice (CADOJ) and the Federal Bureau of Investigation (FBI). State and federal licensing and administrative agencies may also be contacted. As part of the criminal background check process all candidates are also screened through the following exclusion lists:

- Office of Inspector General (OIG) exclusions list on the OIG Internet website to ensure the workforce member has not violated any federal regulations pertaining to Medicaid or Medicare or any other healthcare related regulations.
- General Services Administration/Excluded Parties List System (GSA/EPLS) exclusions list to ensure the workforce member has not violated any administrative or statutory federal regulations.
- Medi-Cal Suspended and Ineligible Provider List (S&I List) to ensure eligibility to participate in Medi-Cal programs.

All information resulting from the criminal background check will be reviewed for conduct incompatible with County employment/assignment. Any such conduct will be evaluated based on the nature of the conviction, job nexus, and amount of time elapsed since the conviction.

In accordance with Civil Service Rule 6.04, the Department may refuse to accept an application for a position if the candidate has been convicted of a crime or who is guilty of conduct incompatible with County employment/assignment, whether or not it amounts to a crime. The conviction may not be disqualifying if it is determined that mitigating circumstances exist or the conviction is not related to the position and poses no threat

to the County or the public. Prospective workforce members with criminal convictions may still be accepted and placed in a position for which they qualify and in which their previous conviction does not pose a risk.

Prospective workforce members who do not answer questions related to conviction information will be rejected.

If you are arrested or **charged** with a crime (including traffic violations, if position requires driving on County business) you must report being arrested or charged with such crime to DHS Human Resources within 72 hours of the arrest/charge. If you are **convicted** of a crime (including a traffic violation, if position requires driving on County business), you are required to report the conviction to DHS Human Resources (HR) Performance Management (PM) within 24 hours of the conviction. Failure to report may result in disciplinary action, including discharge or termination from assignment. DHS HR PM will review the charges/conviction to determine if a job nexus exists. All information reported to DHS Human Resources will only be released on a "need-to-know" basis as required to determine a job nexus.

All positions within the Department of Health Services are considered "sensitive." Sensitive positions are positions that involve duties that may pose a threat or risk to the County patients or to the public when performed by workforce members who have a criminal history incompatible with those duties, whether those workforce members are paid or not paid by the County. Such duties may include, but are not limited to:

- Positions that involve the care, oversight, or protection of persons through direct contact with such persons.
- Positions having direct or indirect access to funds or negotiable instruments.

PROFESSIONAL APPEARANCE

Your personal appearance on the job is important. It is part of how you represent DHS and Olive View. All workforce members are expected to comply with DHS and Olive View dress code standard in an effort to promote a positive and professional image and to ensure the delivery of safe patient care.

All clothing must be professional and consistent with our business atmosphere, health care standards and workplace safety. It must not interfere or detract from our mission. It must be appropriate to the type of work being performed and take in consideration the expectations of our patients, and customers served. Your DHS photo identification badge must be worn at all times while on duty and in County-facilities. You may not obscure your name or photo on the identification badge.

No matter what your assignment is, it is important that you present a neat, professional appearance appropriate to the work being done.

ATTENDANCE/TARDINESS

You are expected to report to work each day, and arrive on time in accordance with your work schedule. You are required to notify your supervisor if you're going to be late or absent as established by DHS, facility and/or departmental policy. You must follow your work schedule, including observing your lunch and break times. Your supervisor will explain the attendance requirements for your work area.

HEALTH SCREENING

All Olive View workforce members (including all students, volunteers, and non-DHS/non-County workforce members) must have an initial and annual health screening including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease status, and/or any other medical tests, as required. **You and your supervisor** are responsible to comply with DHS policy, and ensure you obtain a health screening annually as a condition of continued employment/assignment. Documentation of annual health clearance is to be kept up-to-date in your area file. Annual health screening meeting DHS standards can be obtained from non-DHS locations (e.g. private physician) and returned to Employee Health Services office. You may contact Employee Health Services at (818) 364-3403 to find out when your health screening is due.

REMEMBER

You must complete your health screening annually.

You will not be allowed to work inside a County medical facility without appropriate documentation of health clearance or required health evaluation. It is a violation of Joint Commission, Title 22, and CMS standards for a workforce member to work without appropriate health clearance and will subject the facility to possible fine and/or loss of accreditation. Workforce members evidencing symptoms of infectious disease or reasonably suspected of evidencing symptoms of infectious disease shall be medically screened prior to providing patient care or performing work duties. Workforce members determined to have infectious potential shall be denied or removed from patient contact and work duties as deemed necessary to protect the safety of patients and workforce members.

SMOKING POLICY

Olive View is a smoke- and tobacco-free campus. Smoking is not permitted anywhere on the Olive View campus, including all buildings, structures, parking lots, roads, and hiking trails. This policy applies to anyone who comes onto the hospital campus, including members of the workforce, students, medical residents, and contract vendors. Anyone who wants to smoke must leave the campus and go to the sidewalk in front of the hospital on Olive View Drive.

SUBSTANCE ABUSE

We are committed to an alcohol and drug-free work environment. All workforce members must report to work free of the influence of alcohol, illegal drugs or prescription drugs used improperly. Reporting to work under the influence of alcohol, illegal drugs, prescription drugs used improperly, or possessing or selling illegal drugs while on County time/business will result in appropriate discipline.

Workforce members who observe any usage of alcohol, illegal drugs or misuse of prescription drugs must report the incident to their supervisor, Human Resources, a member of management, their Local Compliance Officer or the Compliance Hotline at (800) 711-5366.

CONTROLLED SUBSTANCES

Some of our colleagues have access to prescription drugs, controlled substances and medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by physician order only. It is extremely important that these items are handled properly and only by authorized individuals. Any workforce member who becomes aware of the diversion or improper use or distribution of drugs from the Department, must report the incident immediately to their supervisor, Human Resources, a member of management, their Local Compliance Officer or the Compliance Hotline at (800) 711-5366.

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES ONLY)

The Employee Assistance Program (EAP) is a program that provides assessment, brief counseling, and referral services to County employees from professional mental health counselors. EAP provides counseling services to address both personal and job-related issues. The program's goal is to help employees and/or their family members who are experiencing emotional, substance-related, situational, or relationship problems that are creating distress and posing difficulties in their daily lives. There is no charge to see an EAP counselor. However, if the counselor recommends specialized or more extensive services through another source, such as the employee's health plan, the employee assumes responsibility for any co-payments or fees associated with those services.

To schedule an appointment, call (213) 738-4200 during regular office hours, which are Monday-Friday from 8:00 a.m. to 5:00 p.m. The first appointment may be on County time with the permission of the employee's supervisor. Subsequent EAP appointments, if any, will require usage of employee's own time. Again, the employee will need to advise their supervisor and request time off as with any other time-off requests, if appointment(s) are during work hours.

COUNTY POLICY OF EQUITY

The County Policy of Equity is intended to preserve your right to work in an environment that encourages workforce members to treat each other with dignity and respect and is free from discrimination, sexual harassment, unlawful harassment (other than sexual), inappropriate conduct toward others and retaliation based on a protected status. Any form of harassment in any facility within the Department of Health Services is unacceptable and will not be tolerated from any workforce member, it is illegal under federal and State law and DHS policy. The County of Los Angeles has established a "zero tolerance" policy for any conduct that could reasonably be interpreted as harassing, offensive, inappropriate, or retaliatory in the workplace.

DISCRIMINATION

Discrimination is the disparate or adverse treatment of an individual based on or because of that individual's sex, race, color, ancestry, religion, national origin, ethnicity, age (40 and over), disability, sexual orientation, gender or gender identity/expression, genetics information, military or veteran status, marital status, medical condition or any other protected characteristic protected by state or federal employment law.

SEXUAL HARASSMENT

- ❖ Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors and/or other verbal or physical conduct of a sexual nature. It may present in three forms: Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
- ❖ Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
- ❖ Such conduct has the purpose or effect of unreasonably interfering with the individual's employment or creating an intimidating, hostile, offensive, or abusive working environment.

Facts about Sexual Harassment

1. Sexual harassment has consequences. Anyone who chooses to harass another in the workplace is subject to appropriate corrective action, which can range from a warning to termination.
2. Sexual harassment can occur anywhere in our facility and at any activity sponsored by Olive View, the DHS or County including off-site conferences, lunch meetings, or clients' homes or businesses.
3. Sexual harassment can occur between people of the opposite sex and people of the same sex. The aggressor can be male or female.
4. The aggressor can be the staff member's supervisor, manager, customer, co-worker, supplier, peer, or vendor.
5. A workforce member can be a victim of sexual harassment because sexual harassment exists in the work environment, even if it does not specifically involve or is directed toward that individual.
6. Sexual harassment can **be verbal, physical, written or visual in nature.**

UNLAWFUL HARASSMENT (OTHER THAN SEXUAL)

Unlawful harassment of an individual because of the individual's race, color, ancestry, religion, national origin, ethnicity, age (40 and over), disability, sexual orientation, marital status, medical condition or any other characteristic protected by state or federal employment law is also discrimination and prohibited. Unlawful harassment is conduct which has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, offensive, or abusive work environment.

THIRD-PERSON HARASSMENT

Third-person unlawful harassment is indirect harassment of a bystander, even if the person engaging in the conduct is unaware of the presence of the bystander. When an individual engages in harassing behavior, he or she assumes the risk that someone may pass by or otherwise witness the behavior. The County considers this to be the same as directing the harassment toward that individual.

INAPPROPRIATE CONDUCT TOWARD OTHERS

Inappropriate conduct toward others is any physical, verbal, or visual conduct based on or because of sex, race, color, ancestry, religion, national origin, ethnicity, age (40 and over), disability, sexual orientation, marital status, medical condition or any other characteristic protected by state or federal employment law when such conduct reasonably would be considered inappropriate for the workplace.

This provision is intended to stop inappropriate conduct based on a protected status before it becomes discrimination or unlawful harassment. As such, the conduct need not meet legally actionable state and/or federal standards of severe or pervasive to violate this Policy. An isolated derogatory comment, joke, racial slur, sexual innuendo, etc. may constitute conduct that violates this policy and is grounds for discipline. Similarly, the conduct need not be unwelcome to the party against whom it is directed; if the conduct reasonably would be considered inappropriate by the County for the workplace, it may violate this Policy.

RETALIATION

Retaliation for the purposes of this Policy is an adverse employment action against another for reporting a protected incident or filing a complaint of conduct that violates this Policy or the law or participating in an investigation, administrative proceeding or otherwise exercising their rights or performing their duties under this Policy or the law.

EXAMPLES OF PROHIBITED ACTIVITIES (NOT A COMPLETE LIST)

❖ Sexual propositions, stating or implying that sexual favors may be required as a condition of employment/assignment or continued employment/assignment, preferential treatment or promises of preferential treatment to a workforce member for submitting to sexual conduct; repeated unwanted sexual flirtations, advances, or invitations; unwanted physical conduct, such as touching, pinching, grabbing, kissing, patting, or brushing against another's body;

❖ Sexually oriented or suggestive jokes, comments, teasing, or sounds such as whistling or cat calls; unwelcome comments about a person's body or questions about or discussions of another person's or one's own sexual experiences/preferences or desires; sexually derogatory or stereotypical comments; verbal abuse of a sexual nature or based on sex/gender; sex/gender-based hostility; sexual orientation/preference;

❖ Offensive leering, unwelcome flirtatious eye contact, staring at parts of a person's body, sexually oriented gestures;

❖ Verbal conduct such as comments or gestures about a person's physical appearance which have a racial, sexual, disability-related, religious, age or ethnic connotation or derogatory comments about religious differences and practices;

❖ Posting, sending, forwarding, soliciting or displaying in the workplace any materials, documents, or images that are, including but not limited to, sexually suggestive, racist, "hate-site" related, letters, notes, invitations, cartoons, posters, facsimiles, electronic mail or web links;

❖ Inappropriate e-mail usage and transmissions containing sexually explicit messages, cartoons, jokes, and unwelcome propositions; as well as accessing or viewing pornographic websites, computer/video games depicting sexual situations or behaviors; and

❖ Adverse employment actions like discharge and/or demotion.

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

As a member of Olive View workforce, you are responsible to ensure sexual harassment does not occur in the workplace. If you believe you have been the object of, have witnessed, or have been affected by sexual harassment in the workplace, you should immediately report the action or incident to your manager/supervisor, hospital or Comprehensive Health Care Center Chief Executive Officer, facility Human Resources office, or the following:

- County Equity Oversight Panel

  Kenneth Hahn Hall of Administration, Room B-26
  Los Angeles, CA 90012
  Telephone: (213) 974-9868
  Fax: (213) 613-2258
  Hotline: (800) 855-999-CEOP (2367)
  Website: https://CEOP.bos.lacounty.gov

It is a violation of DHS policy for a workforce member, supervisor or manager to retaliate against anyone for filing a complaint and/or participation in an investigation. There will be no retaliation against anyone who reports a violation of this policy in good faith. However, any workforce member who deliberately makes a false accusation will be subject to discipline/release of assignment. Moreover, reporting a violation does not protect individuals from appropriate disciplinary action regarding their own misconduct.

CULTURAL AND LINGUISTIC COMPETENCE

(Source: U.S. Department of Health & Human Services, Office of Minority Health)

WHAT IS CULTURAL AND LINGUISTIC COMPETENCE?

Cultural and linguistic Competence: The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter. *(Source **http://www.innovations.ahrq.gov/CulturalCompetence.aspx**)*

By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes. The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are rights of all and not the privileges of a few.
*(Source: **https://www.thinkculturalhealth.hhs.gov/Content/clas.asp**)*

WHY IS CULTURAL COMPETENCY IMPORTANT?

Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground. *(Source: **http://www.nih.gov/clearcommunication/culturalcompetency.htm**)*

Nondiscrimination: Section 1557 of the Affordable Care Act extends the application of existing federal civil rights laws prohibiting discrimination on the basis of race, color or national origin, gender, disability, or age to any health program or activity receiving federal financial assistance; any program or activity administered by an executive agency; or any entity established under Title 1 of the Act or its amendments. **Entities subject to § 1557 must provide information in a culturally and linguistically appropriate manner in order to comply with the relevant anti-discrimination provisions of Title VI of the Civil Rights Act of 1964.**
*(Source: **http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**)*

CULTURAL COMPETENCE

Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.
*(Source: **http://www.nih.gov/clearcommunication/culturalcompetency.htm**)*

Culture and language may influence:

- Accurate communication with providers and the healthcare system;
- Health, healing, and wellness belief systems;
- How illness, disease, and their causes are perceived; both by the patient/consumer;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; and as well as

- The delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country. The provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care.

In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture *(Katz, Michael. Personal Communication, November 1998).*

Culture – the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how: - health care information is received;

- How rights and protections are exercised;
- What is considered to be a health problem;
- How symptoms and concerns about the problem are expressed;
- Who should provide treatment for the problem; and
- What type of treatment should be given?

> New workforce members will receive more in-depth training on cultural competence when it is available. Check with your supervisor.

Cultural and linguistic competence in healthcare – a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. *[Based on Cross, T., Bazron, B., Dennis K., & Isaacs, M., (1989). Towards a Culturally Competent System of Care Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center).*

ROLE OF CULTURAL AND LINGUISTIC COMPETENCY IN DHS' TRANSFORMATION OF SERVICE DELIVERY IN PREPARATION FOR THE FULL IMPLEMENTATION OF AFFORDABLE CARE ACT

Cultural and Linguistic Competency plays a key role in DHS' system transformation in our efforts to prepare for the full implementation of the Health Care Reform.

Cultural and Linguistic Competency results in improved outcomes in delivery of healthcare services to DHS patients who represent a wide range of language, ethnicity, and cultural backgrounds. Improved patient care outcomes are identified by the following key elements:

- ✓ Improved quality in the delivery of care.
- ✓ Improved patient safety compliance.
- ✓ Improved patient adherence with the medical regimen.
- ✓ Improved patient experience and customer satisfaction.

✔ Last, and equally important as each of the elements mentioned above, by ensuring cultural and linguistic competency, DHS puts itself in a much better position in our efforts to become the **"Provider of Choice"** to patients and their families.

DHS-wide Language Data Report

All DHS hospitals, multi-service ambulatory care centers, and comprehensive health center facilities capture the *"preferred language"* of the limited English-proficient (LEP) patients. According to DHS' "Language Report" database for FY '12 – '13, DHS facilities provided healthcare services to a total of 1,297,219 patient visits with LEP skills, representing 53% of our total patient visits (2,461,363). During the same time period, a total of 660,037 unique patients sought healthcare services throughout DHS facilities, 338,965 (51.4%) of whom spoke English and 321,072 (48.6%) spoke other than English. Furthermore, our patient utilization data indicated that over 86 languages were spoken by our LEP patients, including the top 12 languages that are heavily utilized, and therefore, are in much greater need for interpreter (voice/verbal) and translation (written) services.   The top 12 languages are Spanish, Armenian, Korean, Tagalog, Mandarin, Cantonese, Vietnamese, Russian, Arabic, Thai, Hindi, and Khmer (Cambodian).

Olive View Patient Population

African American	6.0%
Asian/Pacific Islander	6.0%
Caucasian	21.0
Hispanic	65.0%
Native American	0.5%
Other/Unknown	1.5%
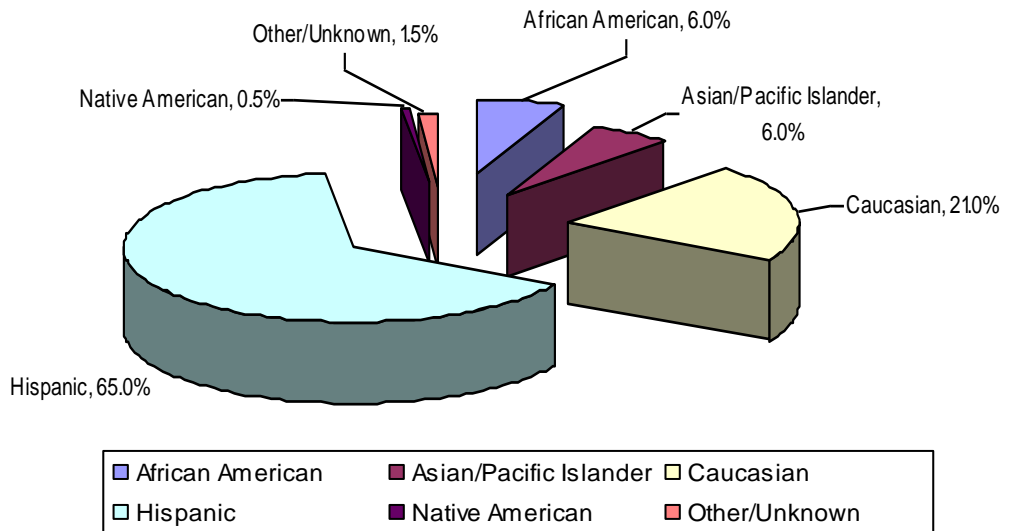
DHS Cultural Bill of Rights

We Believe in

- Respecting one another.
- Recognizing the diversity of patient/clients, workforce members and communities.
- Prohibiting discrimination on the basis of age, color, religion, gender, sexual orientation, disability, national origin, language, or other characteristics.
- Informing patients/clients of their rights and responsibilities in exercising their rights.
- Maintaining that medically indicated care shall be provided without regards to ethnic group identification, race, color, national origin, sex, creed, age, sexual orientation, physical or mental disability, or medical condition.
- Providing considerate care while respecting the spiritual and cultural values that influences perception and behaviors of health and illness.
- Providing culturally-sensitive care for the dying patient and his/her family/significant other.
- Making every effort to meet the spiritual needs of patients/clients.
- Protecting the patient/client's rights to access basic health care when limited by language proficiency or disability by utilizing interpreters who are consistent with the patient's/client's linguistic background.
- Providing appropriate service through assessing the needs and requirements of patient's/client's and considering their family's and/or significant other's input.
- Involving the patient's/client's, their family's and significant other's requests in the management of their care.
- Maintaining a safe environment which fosters privacy, security, and comfort.
- Celebrating Diversity!

DHS/Office of Diversity
Approved on October 30, 2001

THREAT MANAGEMENT "ZERO TOLERANCE"

All workforce members are entitled to a safe work environment. The Department of Health Services will not tolerate any workplace acts of violence or threats in any form directed towards another workforce member, the public or patients. Examples of such behavior include but are not limited to:

- Verbal and/or written threats, including bomb threats, to a County facility or toward any workforce member and/or member of that person's family.
- Psychological violence such as: bullying, verbal and/or written threats, threats against any property of the workforce member.
- Item(s) left in a workforce member's work area or personal property that is meant to threaten or intimidate the workforce member.
- Off-duty harassment of workforce members, such as phone calls, stalking, or any other behavior that could reasonably be construed as threatening or intimidating and could affect workplace safety.
- Physical actions against another employee that could cause harm.
- Carrying a weapon on County property or while engaged in County business.
- Domestic violence/conflicts – restraining orders/injunctions.
- Suspicious activity.
- Incidents involving a call of local law enforcement.

Provisions of the policies and procedures described herein are to serve the Department's managers, supervisors and workforce members in meeting their responsibility to maintain workplace safety and security. Consequences of violating these provisions may include any or all of the following:

- Arrest and prosecution for violation of pertinent laws. (Threats of harm are illegal.)
- Removal of the threatening individual from the premises pending investigation.
- Departmental discipline up to and including discharge.

Any workforce member who witnesses any threatening or violent behavior, is a victim of, or has been told that another person has witnessed or was a victim of any threatening or violent behavior is responsible for reporting the incident to his/her supervisor or manager.

Supervisors/managers are responsible for enforcing and ensuring all workforce members are informed of their responsibilities to report violations of the "zero tolerance" policy. Failure to enforce the provisions of this policy may subject the supervisor/manager to disciplinary action, up to and including discharge. Department Heads shall hold managers accountable for their role in reporting threats or acts of violence and enforcing the provisions of the policy.

Licensed workforce members who violate the provisions of this policy may, depending upon the circumstance, be reported to the appropriate professional credential issuing agency/board.

Managers/supervisors and workforce members must take all reasonable steps to ensure the workplace is free from violent incidents.

Safety of workforce members should be foremost in determining the initial response to an act of violence or threat. Each threat, alleged threat, or act of violence must be assessed and managed according to the particular circumstances presented. Based on the clarity, severity, and imminence of the threat or act of violence, the situation may warrant the immediate summoning of emergency resources, and/or separation of parties to allow sufficient time to investigate the facts of the incident and determine the most appropriate course of action.

IMMEDIATE DANGER OR IMMINENT THREAT OF VIOLENCE

Any workforce member who is a witness or victim to an act of violence or an imminent threat in the workplace, or who is advised of an imminent threat directed at or expressed by another workforce member and believed by the victim or witness to constitute an immediate danger requiring an emergency response, shall take the following actions:

- Immediately notify on-site security personnel/L.A. County Sheriff's Department at Ext. 3409.
- Warn potential victim(s).
- Seek personal safety.
- Post event, the victim or supervisor/manager shall contact the Chief Executive Office, Office of Security Management (OSM) at (213) 893-2069 within 24 hours of incident.
- The supervisor/manager shall ensure a Security Incident Report form is completed and submitted to OSM.

NON-IMMINENT THREATS

If a non-imminent threat is directed at someone within a County facility by an identifiable party currently or not currently at that facility, the following timely notifications shall be made by the reporting workforce member, supervisor, and/or manager:

- On-site facility security personnel/L.A. County Sheriff's Department.
- A Department supervisor or manager.
- The potential victim(s).

Supervisors/managers shall ensure a Security Incident Report (SIR) is completed by the person reporting or involved in the incident and submitted to the Office of Security Management, Chief Executive Office by the end of the business day in which the incident occurred.

WORKFORCE BEHAVIORAL EXPECTATIONS

It is the expectation that all workforce members including medical and professional staff conduct themselves in a courteous, cooperative and professional manner.

DHS and Olive View will not tolerate any disruptive, inappropriate, or unprofessional behavior/conduct by any workforce member towards another workforce member, the public, or patients.

Disruptive behavior may include behavior that interferes with teamwork or safe patient care, or when the behavior has the effect of intimidating or suppressing legitimate input by other workforce members. Disruptive behavior can be obvious, for example, angry verbal outbursts, throwing objects, or disrespectful language. However, it can also be passive or less obvious such as failing to engage in necessary work communication or not performing assigned tasks.

Workforce members should report disruptive, inappropriate or unprofessional behavior. Some inappropriate or unprofessional behavior will need to be reported to the appropriate professional credential issuing agency/board.

Any workforce member, including medical or professional staff, who engage in inappropriate conduct, or exhibit disruptive or unprofessional behavior, or who fail to exercise sound judgment in dealing with other workforce

members, patients, or the public may be subject to appropriate corrective action, up to and including discharge or dismissal from assignment.

All workforce members are accountable for demonstrating desirable behaviors. The policy will be enforced consistently and equitably among all staff regardless of seniority, clinical discipline, or classification through reinforcement as well as discipline.

There will be no retaliation against anyone who reports a violation of this policy in good faith. However, any workforce member who deliberately makes a false accusation will be subject to appropriate corrective action. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

Corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances will be considered cumulatively and action taken accordingly.

ABUSE PREVENTION, SEXUAL ABUSE, SEXUAL COERCION (INAPPROPRIATE BEHAVIOR TOWARD A PATIENT)

DHS acknowledges that patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, harassment, exploitation and the reporting thereof without fear of retaliation. DHS is responsible to safeguard those patient rights by conducting criminal background checks on all potential workforce members, including those transferred or promoted to sensitive positions.

Sexual contact between a healthcare worker and a patient is strictly prohibited; is unprofessional conduct; and will constitute sexual misconduct and/or abuse. Examples of inappropriate sexual conduct include but are not limited to, intercourse, touching the patient's body with sexual intent, inappropriately watching the patient undress/dress, making inappropriate comments, and conducting physical exams not needed or not within the scope of the treatment or complaint.

Sexual conduct that occurs concurrent with the patient-physician/healthcare provider relationship constitutes sexual misconduct. If a physician/healthcare provider has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's or healthcare provider's ethical duties include terminating the physician or healthcare provider-patient relationship before initiating a dating, romantic, or sexual relationship with a patient. Sexual or romantic relationships with former patients are unethical if the physician or healthcare provider uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

Unwanted or nonconsensual sexual conduct (with or without force) involving a patient and healthcare worker, another patient, contract staff, unknown perpetrator or spouse/significant other, while being treated or occurring on the premises of a DHS facility may constitute a criminal act punishable by law.

Each patient, his/her family member, or legal representative has the right to file a complaint or grievance, without fear of retaliation, with the patient advocate, patient relations, or other designated section of the hospital and to have timely review and notification. Each DHS facility shall provide the patient, his/her family member, and/or legal representative with information on how to file a patient complaint/grievance. The facility patient advocate or other responsible party must report patient abuse incidents to the facility Human Resources (HR) Administrator or designated staff. Cases involving patient sexual assault on hospital grounds may be reportable to the State under the adverse event reporting law and should be evaluated immediately in accordance with DHS policies.

Any workforce member who witnesses or reasonably suspects a patient was or is being subjected to inappropriate sexual conduct and/or sexual abuse shall report it to his or her supervisor and to the facility Los Angeles County Sheriff's Department. The supervisor/manager shall immediately report, within 24 hours, complaints and allegations of sexual abuse, exploitation, neglect, or harassment to the facility HR Administrator/designated staff. The reporting party shall report the suspected abuse using a Security Incident Report (SIR) and in the UHC Event Notification System in accordance with Departmental policy.

The Department is prohibited from taking disciplinary action against a workforce member for making a good faith report. However, any workforce member who deliberately makes a false accusation will be subject to appropriate corrective action. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

During the investigation of patient sexual abuse, exploitation, neglect or harassment, the workforce member or other person shall be removed from providing care, treatment and/or services to the patient and/or all patient contact, as appropriate.

A workforce member determined to have violated this policy shall be subject to appropriate corrective action which may lead up to termination. The workforce member may also be subject to criminal and/or civil prosecution and reporting to the appropriate professional credential issuing agency/board. Non-County workforce members will be subject to termination of assignment and placed on the "Do Not Send" database.

Each DHS facility has a complaint/grievance process which must be followed to ensure appropriate actions are taken to provide the patient with adequate protections and that a timely investigation is completed.

REPORTING OF ABUSE/NEGLECT INCIDENTS

The State of California Penal Code requires a mandated reporter report incidents of suspected or identified child abuse/neglect, and elder or dependent adult abuse/neglect. Any mandated reporter who fails to report abuse may be found guilty of a misdemeanor punishable by imprisonment or a fine. All workforce members employed or assigned to a DHS facility are considered "mandated reporters."

In addition, a mandated reporter who fails to report abuse may be held liable for civil damages for any subsequent injury to the victim. Professionals who are legally required to report suspected abuse have immunity from criminal and civil liability for reporting as required or authorized.

- **Child Abuse** includes emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years. Healthcare providers are mandated to report incidents of suspected abuse to Department of Children and Family Services at 1-800-540-4000 immediately or as practicably as possible. A written report must be submitted (within 36 hours of the telephone report) through their website at **http://dcfs.lacounty.gov**. Abuse that is sexual in nature also must be reported to law enforcement by calling the Los Angeles County Sheriff's Department or other local law enforcement agency within the jurisdiction.

- **Elder Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Healthcare providers are mandated to report incidents of suspected elder/dependent abuse immediately or as practicably as possible by calling the Elder Abuse Hotline at 1-800-992-1660. A written report must be submitted within two (2) working days of the telephone report by fax at (213) 738-6485.

- **Dependent Adult Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals between the ages of 18-64. This includes individuals who are mentally or physically challenged. Healthcare providers are mandated to report incidents of dependent adult abuse by calling 1-800-992-1660. A written report must be submitted within two (2) working days of the telephone report by fax at (213) 738-6485.

- **Domestic/Intimate Partner Abuse** involves any individual who has been abused by their domestic/intimate partner. Domestic/intimate partners are those individuals who are currently dating, married, cohabitating, or separated. The abuse includes physical violence, sexual assault, severe emotional distress and economic coercion. Domestic/intimate partner abuse must be reported if there is a current injury. Healthcare providers are mandated to report the violence as soon as practicably possible to the Sheriff Department at (818) 364-3409 or local law enforcement and follow up report within 48 hours. In addition, contact the Olive View's Clinical Social Work Department at (818) 364-4236 for assistance with evaluations, reporting forms and referrals.

REPORTING SUSPICIOUS INJURIES

A suspicious injury includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury was by means of a firearm; or
- Is suspected to be the result of assaultive or abusive conduct inflicted upon the injured person.

In accordance with California Penal Code Section 11160, DHS requires any health practitioner working in a DHS health facility who in his or her professional capacity or within the scope of his or her assignment provides medical services to a patient/inmate who he or she knows or reasonably suspects has a suspicious injury to report such injury by telephone to local law enforcement immediately or as soon as practicable. Section 11160 requires the reporter to make a written follow-up report within two (2) business days to the same local law enforcement agency.

If the suspicious injury is to a patient/inmate, per BOS mandate, it must be reported to the Internal Affairs Unit or the Captain of the jail facility where the patient/inmate is housed. The Los Angeles County Sheriff's Department Internal Affairs Bureau can be reached at: 4900 South Eastern Avenue, Suite 100, Commerce, CA 90040; (323) 890-5300 or (800) 698-8255.

It should be noted that the health practitioner's reporting obligation applies to any law enforcement agency delivering a patient/inmate for intake with a suspicious injury.

Reports made to the local law enforcement agencies regarding suspicious injuries to patients/inmates should be escalated to the facility Regulatory Affairs Unit for tracking and enterprise reporting purposes.

Health practitioners working in a DHS health facility who are engaged in compiling evidence during a forensic medical examination for a criminal investigation or sexual assault may be asked to release the report to local law enforcement and other agencies, the reports must be prepared on specific forms as required by statute. Health practitioners must follow DHS HIPAA procedures documenting the release of such information.

AMERICANS WITH DISABILITIES ACT (ADA)

The ADA ensures civil rights protections to individuals with disabilities and guarantees equal opportunity in public accommodations, employment, transportation, local government services, and telecommunications. The ADA defines an individual with a disability as one who has a record of having or is regarded as having a physical or mental impairment that substantially limits one or more major life activities. Temporary impairments lasting for a short period of time, such as a few months, do not pose substantial limitations.

The ADA prohibits discrimination against any qualified individual with a disability in any employment practice. A qualified individual with a disability is a disabled person who meets legitimate skill, experience, education or other requirements of an employment position that he or she holds or seeks, and who can perform essential job functions with or without reasonable accommodation. Illegal use of drugs is not a disability covered by ADA. Persons who have a disability covered under ADA may be entitled to reasonable accommodations that do not pose undue hardship to the department. Workforce members requiring an accommodation are referred to DHS Risk Management, Return to Work for review of needs and to initiate the interactive process for a reasonable accommodation. For specific information on reasonable accommodations, contact DHS Risk Management, Return to Work Unit at (323) 869-7122.

If you have a disability that is covered under the ADA and you are a qualified individual, you are entitled to reasonable accommodation. Please contact Thomas Beggane, the facility HR Manager and ADA Coordinator at (818) 364-3313 for assistance.

SAFELY SURRENDERED BABY (SSB) LAW

California law, SB 1368 (Brulte) Chapter 824, Statutes of 2000, and Olive View Policy No. 838-Abandonment of Newborns provides criminal immunity for any person with lawful custody of a newborn who is less than 72 hours old, if he or she voluntarily surrenders physical custody of the child to a workforce member at the facility. Newborn babies may also be safely surrendered at hospitals with emergency rooms and fire stations designated by the County Board of Supervisors. For a list of Los Angeles County's Safely Surrendered Baby Sites visit **www.babysafela.org** or call 1-877-BABY SAFE.

Child Protective Services must be notified as soon as possible, but no later than 48 hours. Person surrendering newborn must be given a Medical Information Questionnaire to complete and should be given a copy of the unique, coded, confidential ID bracelet placed on the infant, in the event they wish to reclaim the infant. (This must be completed within 14 days of surrendering a newborn.) EMTALA regulations apply to the care of the infant. In addition, information regarding the parent or individual surrendering the infant should not be shared under any circumstances.

PATIENTS' RIGHTS AND SERVICES

This section explains Olive View's patient rights and services such as interpreter services, the Chaplaincy Program, Advance Health Care Directives, Americans with Disabilities Act, Service Animals, organ/tissue donation, and EMTALA.

PATIENTS' RIGHTS

To ensure that our patients' rights are protected, Olive View has a Patients' Rights and Organizational Ethics Committee. This committee is multi-disciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises Olive View staff concerning such issues related to patient care decisions, and offers consults to Olive View departments. If a staff member feels there is an ethical issue related to the patient, they should request an ethics consult by calling the Hospital Operator and requesting the Bioethics Point Person.

Patients of Olive View have both rights and responsibilities. Each patient is given a Patient Information Handbook upon admission. Patients who are not admitted through the Admitting Office are provided a Patient Information Handbook by the nursing staff in the unit. In addition, Olive View has posted these rights and responsibilities throughout the hospital to inform patients and our staff.

PATIENTS' RIGHTS

1. Patients have the right to impartial access to available medically indicated treatment, regardless of race, creed, sex, national origin, or source of payment for care.
2. Patients have the right to considerate and respectful care.
3. Patients have the right to know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of other physicians and non-physicians who will see them.
4. Patients have the right to receive information about their illness, the course of treatment and prospects for recovery in terms that they can understand.
5. Patients have the right to receive as much information about any proposed treatment or procedure as they may need in order to give informed consent or to refuse their course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternative courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6. Patients have a right to pain management.
7. Patients have the right to reasonable responses to any reasonable requests made for service.
8. Patients have the right to refuse care, treatment and services.
9. Adult patients are given written information about their right to accept or refuse medical or surgical treatment including foregoing or withdrawing life-sustaining treatment or withholding resuscitative services.
10. Patients have the right to leave the hospital even against the advice of physicians, (except when limited by law).
11. Patients have the right to form advance directives and appoint a person to make health care decisions on their behalf, to the extent permitted by law. The person selected to make the decisions for the patient may be the patient's guardian, next of kin, or legally authorized responsible person. The legally authorized representative shall have the same rights as the patient if a physician finds the patient to be incompetent and medically incapable of understanding or providing an informed consent to proposed treatments or procedures.
12. Patients have the right to have all *Patient Rights* apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

13. Patients have the right to full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. They have the right to be advised as to the reason for the presence of any individual.

14. Patients have the right to confidential treatment of all communications and records pertaining to their care and their stay in the hospital. Written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with the case.

15. Patients have the right to reasonable continuity of care and to know in advance the time and location of an appointment as well as the identity of the persons providing their care.

16. Patients have the right to be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. They have the right to refuse to participate in such research projects.

17. Patients have the right to be informed on continuing health care requirements following discharge.

18. Patients have the right to expect reasonable safety in areas controlled by hospital staff.

19. Patients have the right to be free from physical or mental abuse and corporal punishment.

20. Patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff member, or others and must be discontinued at the earliest possible time.

21. Patients have the right to examine and receive an explanation of the bill regardless of source of payment.

22. Patients have the right to know which hospital rules and policies apply to patients' conduct while a patient.

23. Patients have the right to a copy of the contents of their medical record, to the extent permitted by law. Olive View charges a per page fee for copies of medical records. Patients have the right to duplicate their records after signing a Release of Information form. They also have the right to expect confidential treatment of all communications and records pertaining to their medical care and must give written permission if records are to be made available to anyone not directly concerned with their care.

24. Patients have the right to designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage.

25. Patients have the right to have his or her cultural, psychological, spiritual, and personal beliefs and preferences respected.

26. Patients have the right to have the hospital accommodate their desire for pastoral and other spiritual services.

27. Patients have the right to address grievances concerning these rights or any other policy or procedure of the hospital agency or government body having jurisdiction over this facility.

28. Patients and their families have the right to file complaints or grievances. Complaints within Olive View are handled by the Patient Service Center. At Olive View-UCLA Medical Center the Patient Service Center is located on the second floor, Room 2D101, telephone number (818) 364-4813. For the health centers, Customer Service is located at the Mid-Valley Comprehensive Health Center on the fifth floor, Room 520, telephone number (818) 947-4033. Staff is available to help customers Monday through Friday between 8:00 a.m. and 4:30 p.m.

Patients have the right to participate in ethical issues involving their care by contacting their physician or the Patient Service Center.

Patients have the right to schedule an interview with a licensing or credentialing agency listed below:

Division of Accreditation Operations Institute for Medical Quality
221 Main Street, Suite 210
San Francisco, CA 94105
Phone: (415) 882-5151
E-mail: **liacopi@imq.org**

California Department of Public Health
Licensing and Certification
Information Hotline: (800) 236-9747

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Fax: (630) 792-5636
E-mail: **patientsafetyreport@jointcommission.org**

CUSTOMER SERVICE

The Customer Service Department helps ensure that we are protecting our patients' rights. If a patient, family member or visitor comes to you with a complaint about any part of his/her hospital visit, make every attempt to resolve the issue or refer them to your supervisor. At Olive View-UCLA Medical Center, if the problem cannot be resolved in your department or if the problem is not related to your department, call the Customer Service Department at (818) 364-4813 or send the person to Room 2D101 on the second floor. For the Health Centers, customers may file a complaint at the Mid-Valley Comprehensive Health Center (818) 947-4033 or send them to the fifth floor, Room 520.

Patients, family members, and visitors can make verbal and written complaints. If you or the patient/family believes the patient's rights are being violated, the Customer Service Coordinator will help resolve the problem.

After regular business hours of 8:00 a.m. to 5:00 p.m., weekends and holidays, please ask for the Nursing Shift Supervisor to resolve any patient complaints.

INTERPRETER SERVICES

It is our responsibility to provide interpreter services, free of charge, for our Limited English Proficient (LEP) and non-English speaking patients. The use of family members or friends as interpreters is strongly discouraged. It is prohibited to use minors as interpreters in any situation.

Olive View is on the vanguard when it comes to meeting our patient population's needs in their own language. We have a system in place called Healthcare Interpreter Network (HCIN) and we have a Healthcare Interpreter Department in Trailer "O-4". We currently have a network system that can access into 120 different languages for our Limited English Proficiency (LEP) patients. We also accommodate persons who are hard of hearing, deaf, and the speech impaired community via our Video Monitor connection and contracts with American Sign Language providers. Any question, issues, or assistance please contact the LEP Administrator at (818) 364-3005.

Always check to ensure the patient's preference of written or spoken language is documented in the medical record. We encourage you to use our network throughout the hospital via different methods and equipment made available to you:

Video Monitors
To access any spoken language and also the best way to access American Sign Language (video component). The monitor is wireless, so no computer jack is needed and they are mobile to any area the patient may need to be (i.e., at bedside, lab, clinic, therapy, test area, surgery, radiology, etc.).

Cordless Dual Phones
To access any spoken language by bringing the phone to the patient's bedside or clinical area.

Polycom Speaker Phone

Accessible and allowed ONLY in the Emergency Room and Medical Walk-In areas due to HIPAA rules and regulations.

Regular Desk Phones

You have the ability to set up a conference call. This way, you, the interpreter, and your LEP patient are on the same line to communicate.

To reach an interpreter for any language dial Ext. 3298 (Olive View's client ID number is needed – check with your supervisor for the client ID number.)

> **REMEMBER**
>
> Speak directly to the patient, not to the interpreter, and remember the policies and procedures. Be careful not to break confidentiality.

SPIRITUAL NEEDS OF PATIENTS

The Chaplaincy Program at Olive View provides for the spiritual health and well-being of the patients, their families, friends and staff through active listening and prayer. We seek to promote wellness and comfort for those desiring the services of our interdenominational volunteer Chaplains. If the patients or their families so desire, the chaplains will call for a minister of their choice. A "clergy call list" is at each nursing station and offices of administration. Our Chaplains minister to all patients, their family members, friends and hospital staff, regardless of their religious preference.

Referrals to the Chaplaincy Program or specific sacramental requests may be made by contacting the Pastoral Services Department at (818) 364-3080. Olive View Chaplains are usually available Monday through Friday from 9:30 a.m. to 4:30 p.m. The Pastoral Services office is located at 1D142, across from Volunteer Services. The Hospital Chapel is located at 1D145.

ADVANCE HEALTH CARE DIRECTIVES

The Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give directives regarding healthcare decisions. The AHCD allows patients to determine whether or not they want life-sustaining treatment if terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so. Olive View Admissions Staff is responsible for informing patients of their options regarding an AHCD. A patient can also give an AHCD verbally to a physician who will document it in the patient's medical record.

If you are directly involved in the care of a patient who wishes to execute an AHCD, or to discuss this option, please contact the Hospital Social Work Department at (818) 364-4236 or the patient's physician. Remember patients can change their minds at any time regarding AHCDs.

AMERICANS WITH DISABILITIES ACT (ADA)

DHS does not discriminate on the basis of disability in access to services, programs or activities. Qualified individuals with disabilities may not be denied access to or use of facility services, programs or activities. A "qualified" individual is one who meets the eligibility criteria for the services being offered.

To ensure treatment, a program access standard must be met; each service must be accessible to and usable by people with disabilities when viewed in its entirety. Programs and services must be designed to accommodate all persons regardless of disability. Patients and their family and/or visitors who have a disability covered under the ADA are entitled to request reasonable accommodations that do not pose an undue hardship to DHS.

Effective communication will be ensured in the form of auxiliary aids or services, including sign language interpreters, alternate format materials or assistive listening devices, to the extent possible. All access services will be provided at no cost to the user, as long as they do not create undue hardship on County resources. Departmental policy, practice or procedure may need to be reasonably modified to accommodate the needs of a

person with a disability. Primary consideration shall be given to the specific auxiliary aid and/or service requested by the person with a disability.

A patient has the right to not participate in any program or service designed specifically for persons with disabilities. The Department has adopted an informal complaint procedure to investigate and resolve general complaints that allege DHS has not complied with the ADA. Patients may address concerns regarding access to services or reasonable accommodations to their care provider, the facility Patient Advocacy Office, or the Departmental ADA Coordinator. Although complaints may be addressed at this level, the patient or the public retain the right to file a complaint directly with the appropriate state or federal agency.

SERVICE ANIMALS

(Source: California Hospital Association, ADA-Revised Service Animals Requirements, Effective March 15, 2011)

Service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals. The work or tasks performed by a service animal must be directly related to the handler's disability. Example of work or tasks include, but not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling wheelchairs, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks. **Service animals are working animals, not pets.**

A sight-impaired individual who is allergic to dogs may use a miniature horse (generally range in height from 24 inches to 34 inches and generally weigh between 70 and 100 pounds). However, the miniature horse must be trained to provide assistance to the individual with a disability and must be house broken.

Under the Americans with Disabilities Act (ADA), businesses and organizations that serve the public must allow people with disabilities to bring their service animals into all areas of the facility where customers are normally allowed to go. This federal law applies to <u>all</u> businesses open to the public, including restaurants, hotels, taxis and shuttles, grocery and department stores, hospitals and medical offices, theaters, health clubs, parks, and zoos.

- Businesses may ask if an animal is a service animal and ask what tasks the animal has been trained to perform, but cannot require special ID cards for the animal or ask about the person's disability.

- The service animal must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.

- People with disabilities who use service animals cannot be charged extra fees, isolated from other patrons or treated less favorably than other patrons. However, if a business normally charges guests for damage that they cause, a customer with a disability may be charged for damage caused by his/her service animal.

- A person with a disability cannot be asked to remove his/her service animal from the premises unless:

    1. The animal is out of control and the animal's owner does not take effective action to control it; or
    2. The animal poses a direct threat to the health and safety of others.

    In these cases, the business should give the person with disability the option to obtain goods and services without having the animal on the premises.

- Businesses that sell or prepare food must allow service animals in public areas, even if state and local health codes prohibit animals on premises.

- Businesses are not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

If you have additional questions concerning ADA and service animals, please call Thomas Beggane, HR Manager and ADA Coordinator at (818) 364-3313, DHS Risk Management at (323) 869-7122, or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

ORGAN/TISSUE DONATION

Olive View recognizes the need for organ/tissue donations, the importance of managing the patient prior to donation, and supporting the needs of the patient's family members. All potential organ/tissue donors must be referred to *OneLegacy* 24-hour donor referral line at (800) 338-6112 within one hour of meeting the following clinical triggers:

- Ventilated patients (with a devastating injury/illness)
  - with a loss of one or more brainstem reflexes and/or
  - initiating discussion for end of life care (withdrawal of life support and changes in "Do Not Resuscitate" DNR status).
- All cardiac deaths

The physician in charge of the patient's care is responsible for ensuring that a call is made to the 24-hour referral line. It is extremely important to call in a timely manner which is defined as within one hour following the identification of clinical triggers to comply with the Center for Medicare and Medicaid Services (CMS) regulations. *OneLegacy* is a nonprofit, federally designated transplant donor network serving 19 million people in seven Southern California counties. Organ donation may include patients who are not brain dead whose family have elected to withdraw the ventilator. Death is therefore declared on the basis of cardiopulmonary criteria (irreversible cessation of circulatory and respiratory function) and is called specifically "Donation after Cardiac Death" (DCD).

EMTALA

EMTALA Statute: 42 USC 1395 dd. Examination and treatment for emergency medical conditions and women in labor; also known as Section 1867 of the Social Security Act; also known as Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985. Common names: COBRA, EMTALA, Anti-dumping law.

EMTALA contains two basic requirements:

1. For any person who comes to a hospital emergency department, "the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition exists" (see 42 USC § 1395dd[a]).[1]
2. If the screening examination reveals an emergency medical condition, the hospital must "stabilize the medical condition" before transferring or discharging the patient.

MEDICAL SCREENING EXAM

Any person requesting emergency services, who presents to a facility that provides emergency services, must receive a medical screening exam (MSE). This includes a woman in labor and her unborn child, and psychiatric emergencies. The purpose of the MSE is to identify whether an emergency medical condition (EMC) exists.

This request can come from the patient, someone accompanying the patient, a law enforcement officer bringing someone to the ED, or someone walking into the ED requesting a blood pressure check.

If the MSE reveals an emergency medical condition, it is the obligation of the treating hospital to stabilize the patient prior to discharge or transfer.

EMTALA compliance is regulated by the CMS, a division of the Department of Health and Human Services (HHS). There are significant financial consequences for violating EMTALA rules. A hospital and/or the responsible physician may face individual fines imposed by the government as well as civil damages claims. Additionally, the hospital can be excluded from participating in the Medicare program, which may be financially devastating. It is imperative that ED physicians be fully aware of their obligations under EMTALA regulations.

ENFORCEMENT

EMTALA legislation is enforced by CMS. A hospital that has more than 100 beds may be fined up to $50,000 per violation, and a hospital with fewer than 100 beds may be fined up to $25,000 per violation. Individual physicians may be fined as well, including on-call physicians who fail to appear. On-call physicians who request that an unstable patient be transferred when the risk of transfer outweighs the benefit may also be fined. Ultimately, a hospital may have its Medicare provider agreement revoked in response to EMTALA violation.

HUMAN TRAFFICKING

Effective April 1, 2013, SB 1193, Chapter 515, Statutes of 2013 added Section 52.6 to the Civil Code, regarding Human Trafficking; it requires posting of public notice in prominent areas or near the entrance, in clear view of the public and employees. The postings shall be printed in English, Spanish, and one other prevalent language widely spoken in the county the facility is located. The posted notice will provide resource information regarding where the victim can obtain help. The liability for business or establishment failing to comply with the requirements of this section, results in a penalty of $500 for the first offense and $1000 for each subsequent offense.   The following resource numbers will be included on the posted public notice: *National Human Trafficking Resource Center at 1-888-373-7888 or the California Coalition to Abolish Slavery and Trafficking (CAST) at 1-888-KEY-2-FRE(EDOM) or 1-888-539-2373 to access help and services.*

DEFINITION: The United Nations Office on Drugs and Crimes (UNODC) defines Trafficking in Persons as the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, or the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a

If you or someone you know is being forced to engage in any activity and cannot leave -- whether it is commercial sex, housework, farm work, construction, factory, retail, or restaurant work, or any other activity -- call the National Human Trafficking Resource Center at 1-888-373-7888 or the California Coalition to Abolish Slavery and Trafficking (CAST) at 1-888-KEY-2-FRE(EDOM) or 1-888-539-2373 to access help and services.

Victims of slavery and human trafficking are protected under United States and California law.

The hotlines are:

- Available 24 hours a day, 7 days a week.
- Toll-free.
- Operated by nonprofit, nongovernmental organizations.
- Anonymous and confidential.
- Accessible in more than 160 languages.
- Able to provide help, referral to services, training, and general information.

person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or

services, slavery or practices similar to slavery, servitude or the removal of organs. (Article 3, paragraph (a) of the **Protocol to Prevent, Suppress and Punish Trafficking in Persons**).

This section describes the requirements for a safe patient care environment. Included are descriptions of the Olive View Environmental Health and Safety Program; hospital emergency codes; security procedures; safety awareness; and policies and procedures concerning bomb threats, workplace violence, hazardous materials, emergency preparedness and management, fire/life safety, work-related injuries, injury and illness prevention, and body mechanics and ergonomics.

It is our ongoing priority here at Olive View to provide a safe environment for our patients, visitors and workforce members. Our Safety Program looks for and identifies hazards through surveillance rounds and data collection. The Safety Officer investigates all identified hazards. All findings are reported and evaluated by the Environment of Care Committee. **Address any concerns you have regarding safety to your supervisor or the Safety Officer at (818) 364-3405.**

While at work, know:

1. **How to eliminate or minimize safety risks.**

   Examples include:

   - Being informed on proper lifting techniques.
   - Using needle safety devices.
   - Wearing proper personal protective equipment.
   - Using ladders/step stools only on level ground.
   - Checking for frayed cords and ensuring proper equipment maintenance, etc.

2. **How to report safety concerns:**

   - Notify your supervisor/manager.
   - Complete a "Report of Safety Hazard/Suggestion form".
   - Mail Safety Hazard/Suggestion form to the Safety Office via inter-office mail.
   - Notify the Safety Officer at (818) 364-3405.

OLIVE VIEW HOSPITAL CODES

Emergency overhead paging is used at Olive View to alert workforce members to potential emergency situations and to summon workforce members who are responsible for responding to specific emergency situations, among other things.

See Emergency Codes on Next Page

Olive View uses the following list of codes to identify specific emergencies.

Code	Reason	Telephone Ext.
Code Assist	Urgent Medical Attention to Outpatients, Visitors and Staff	114
Code Blue	Adult Medical Emergency	114
Code Gold	Mental Health/Behavioral Response	111
Code Gray	Disruptive/Combative Person Response	111
Code Green	Patient Elopement	111
Code Orange	Hazardous Material Spill/Release	111
Code Pink	Infant Abduction (Newborn to 12 months)	111
Code Purple	Child Abduction (1 year to 17 years)	111
Code Rapid Response	Urgent Medical Attention to Inpatients	114
Code Red	Fire	113
Code Silver	Person with Weapon; Active Shooter; Hostage Situation	111
Code Triage Alert	Potential Disaster	111
Code Triage External	External Disaster	111
Code Triage Internal	Internal Disaster	111
Code White	Pediatric Medical Emergency	114
Code Yellow	Bomb Threat	111

SECURITY

The Los Angeles County Sheriff's Department provides Olive View with sworn law enforcement and security services. They strive to provide a safe environment for patients, visitors, patrons, and workforce members. The Sheriff's Department consists of full-time sworn Sheriff Deputies and Sheriff Security Officers who provide law enforcement services such as making arrests, report writing, and issuing both traffic and parking citations. The Sheriff's Department is also responsible for overseeing the contract security personnel assigned to Olive View.

THE ROLE OF THE SHERIFF'S DEPUTIES AND SECURITY OFFICERS

The Sheriff's Department, as full-time, State-certified peace officers, enforces California Penal codes, Federal and State laws, County ordinances, and assists in attaining compliance with hospital policies. Sheriff Deputies and Security Officers conduct foot and vehicle patrols of Olive View buildings and campus.

THE ROLE OF CONTRACT SECURITY GUARDS

- Contract Security Guards observe and report any suspicious activities to the Sheriff's Department.
- Contract Security Guards monitor the entrances to the hospital building and conduct weapons screening and workforce member badge checks.

SAFETY AWARENESS

In the interest of protecting yourself and your personal property, please leave valuables such as expensive jewelry and portable media players (MP3, *iPods*, etc.) at home. Also, do not leave wallets, purses, cell phones, laptop computers, tablets, or any electronic devices unattended in the work area. Other security safeguards that you may employ include:

- Walking in groups when leaving the workplace after dark.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.
- Always be aware of your surroundings. If you see something, say something! Report any suspicious activity to the Sheriff's Department at (818) 364-3409.

BOMB THREATS

If you receive a bomb threat by telephone, **stay calm**. *Do not hang up*. Keep your voice calm and professional. Do not interrupt the caller and keep the caller on the line as long as possible. Signal a co-worker that you have received a bomb threat and have him/her initiate a facility code.

Obtain as much information as possible by asking the caller questions, such as:

- When is bomb going to explode?
- Where is the bomb?
- What kind of bomb is it?
- What does the bomb look like?
- What will cause the bomb to explode?
- Why did you place the bomb?
- What is your name?

Also, pay attention to details, such as:

- Is the caller male or female?
- Does the caller have an accent?
- Are there background noises?

At the hospital, contact the Sheriff's Department immediately at (818) 364-3409 as well as notifying your supervisor. Ambulatory care health centers, call 9-1-1.

WEAPONS

Workforce members shall not carry a prohibited weapon of any kind while in the course and scope of performing their job, whether or not they are personally licensed to carry a concealed weapon. Workforce members are prohibited from carrying a prohibited weapon anywhere on County property or at any County-sponsored function.

Prohibited weapons include any form of weapon or explosive restricted under local, state or federal regulation. This includes all firearms, illegal knives or other weapons prohibited by law. Violations may result in any or all of the following:

- Arrest and prosecution for violations of pertinent laws.
- Immediate removal of the threatening individual from the premises pending investigation.
- Disciplinary action up to and including discharge from County service or assignment.

The Sheriff's Department will strictly enforce all weapons related laws here at Olive View.

WORKPLACE VIOLENCE

The County and Olive View will not tolerate any form of violence. For example, threatening gestures, intimidating behaviors or verbal threats. The County of Los Angeles promotes a safe work environment for all its workforce members.

The County of Los Angeles has a zero tolerance policy that addresses workplace violence and violent behavior. Violation of this policy may result in disciplinary action up to and including discharge from County service or assignment. If you observe violence or signs of violent behavior, notify your manager or supervisor and the Sheriff's Department. Please refer to Threat Management "Zero Tolerance" in this handbook or Olive View's policy on workplace violence for further information.

INFANT OR CHILD ABDUCTION

A "Code Pink" is called whenever there is a suspected **infant** abduction. When a "Code Pink" is called, all available workforce members are required to immediately cover exits in their areas and report any suspicious persons to the Sheriff's Department. All workforce members should be aware that the contract security officers will temporarily lock down the entrances and prevent anyone from entering or leaving the facility when a "Code Pink" is initiated.

A "Code Purple" indicates suspected **child** abduction. Staff should follow the same procedures for a "Code Purple" as they do when a "Code Pink" is called.

CHEMICAL SPILL/HAZARDOUS MATERIALS/HAZARD COMMUNICATION

Whenever there is an actual release or spill of a hazardous material or waste, the following emergency procedures shall be placed into effect in accordance with Olive View Policy Selecting, Handling, and Disposal of Hazardous Materials.

The Safety Officer or the Hazardous Materials Specialist shall be the Hazardous Materials Spill Response Team Leader and shall coordinate all emergency response measures.

1. The first person at the scene shall immediately follow the Hazardous Material Spill Procedure. He/she shall also notify the supervisor and all staff in the room that a spill has occurred. If necessary, notify the hospital operator by dialing x111
2. The hospital operator shall notify the **Hazardous Material Spill Response Team or Safety Officer** of the spill location.
3. Staff who are trained and familiar with the material spilled/released, shall take the following actions until the Hazardous Materials Spill Response Team arrives at the scene:

   a. Keep unnecessary people away and deny entry.
   b. Isolate hazard area and place yellow tape around the seclusion zone.

    c.   Remove injured or exposed personnel from the release site if condition permits safe removal.

    d.   Control the leak and the spread of the material.

Should you encounter a hazardous waste spill or if you or anyone else is exposed to hazardous waste, perform the following First Aid Procedures:

> **REMEMBER**
>
> You must know the names of the hazardous materials that you work with and that you may come in contact with in your area.

    a.   <u>Eye Contact</u> – Wash the eye with copious amount of water for 15 minutes.

    b.   <u>Ingestion</u> – Drink a lot of water but do not induce vomiting.

    c.   <u>Skin Contact</u> – Flush the affected area with water for 15 minutes.

    d.   <u>Inhalation</u> – Remove victim to fresh air.

The Safety Data Sheet (SDS) formerly Material Safety Data Sheet (MSDS) describes what hazards a chemical presents and how to handle spills/exposures. You should know the location of the SDSs in your work area. If you do not know where they are kept, ask your supervisor or safety coordinator. SDSs can be downloaded from your department's SDS e-binder, which is located on the Olive View intranet. If you are unable to locate a particular SDS, contact your department safety coordinator or Safety Office at x3405.

New universal hazardous materials labeling standards have been implemented. Labels must include the following pictograms that provide specific information about the hazards of a chemical. You should familiarize yourself with the new hazardous materials symbols.

Health Hazard Carcinogen Mutagenicity Reproductive Toxicity Respiratory Sensitizer Target Organ Toxicity Aspiration Toxicity	**Flame** Flammable Pyrophorics Self-Heating Emits Flammable Gas Self-Reactive Organic Peroxides	**Exclamation Mark** Irritant (skin and eye) Skin Sensitizer Acute Toxicity (harmful) Narcotic Effects Respiratory Tract Irritant Hazardous to Ozone Layer (Non Mandatory)
Gas Cylinder Gases Under Pressure	**Corrosion** Skin Corrosion / Burns Eye Damage Corrosive to Metals	**Exploding Bomb** Explosives Self-Reactives Organic Peroxides
Flame over Circle Oxidizers	**Skull and Crossbones** Acute Toxicity (Fatal or Toxic)	**Environment** (Non Mandatory per OSHA) Aquatic Toxicity

RADIATION EXPOSURE

1. Personnel radiation monitoring devices (film badges) must be worn only on the collar. Film badges must be returned to Radiation Physics Section in Radiology by the 20th of each month for accurate analysis and readings.

2. Safety, including radiation safety, is everyone's responsibility. Notify your supervisor immediately for all safety related issues.

> **REMEMBER**
>
> DISTANCE, SHIELDING, and TIME are the best defenses from radiation exposure.

EMERGENCY PREPAREDNESS AND MANAGEMENT

What Is An Emergency (Disaster) Preparedness Plan?

- It is a master plan instructing staff on necessary steps to take to save lives when disaster strikes.
- It provides you with guidance to respond quickly and effectively in the event of a disaster.

What Is Considered A Disaster?

- Natural disasters are typically caused by earthquakes, wildfires, floods, etc.
- National emergencies are usually the result of terrorist attacks, wars, or nuclear accidents.
- Mass casualties such as fires, explosions, building collapses, transportation accidents, etc.

What Are Two Types Of Disasters?

- ***Internal disasters:*** Such as fires, power losses, explosions, bomb threats, radiation accidents, or water/fuel shortages which may cause injury to patient and staff or damage to our facility.
- ***External disasters:*** These require us to admit and treat casualties.

OLIVE VIEW HOSPITAL EMERGENCY OPERATIONS PLAN (DISASTER PLAN)

The Olive View Hospital Emergency Operations Plan defines each workforce member's role and/or responsibility during a disaster. All workforce members are involved to some degree in the disaster plan. It is important that you know the plan, know what your role is and take disaster drills seriously. The detailed plan can be found on the Olive View intranet under "Emergency Management". Be familiar with the Emergency Operations Plan and where it is kept in your area/department.

The Hospital's evacuation procedure can be found in the Safety Manual and the Fire Manual.

Hospital Incident Command System (HICS)

The Hospital Incident Command System is an incident management system based on the Incident Command System (ICS) that assists hospitals in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events.

- Hospital Incident Command
- Operations Section
- Planning Section
- Logistics Section
- Finance Section

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                        │     Incident     │
                        │    Commander     │
                        └────────┬─────────┘
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│      Public       │                          │   Safety Officer  │
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│  Liaison Officer  │                          │ Medical/Technical │
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│Operations │   │ Planning  │   │ Logistics │   │Finance/Admin│
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│Chief      │   │ Chief     │   │ Chief     │   │ Chief      │
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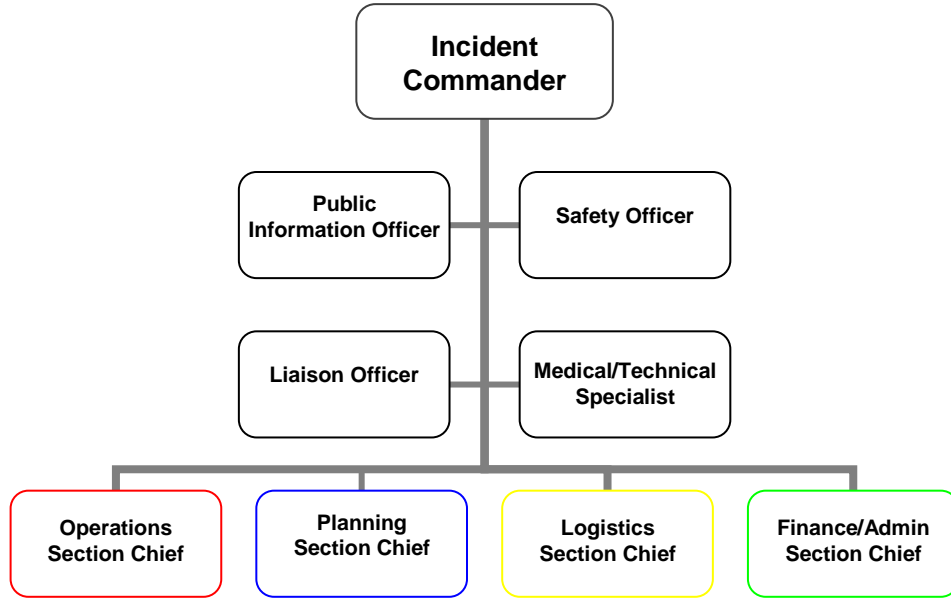
Emergency Operations Plan (EOP) Initiation Process
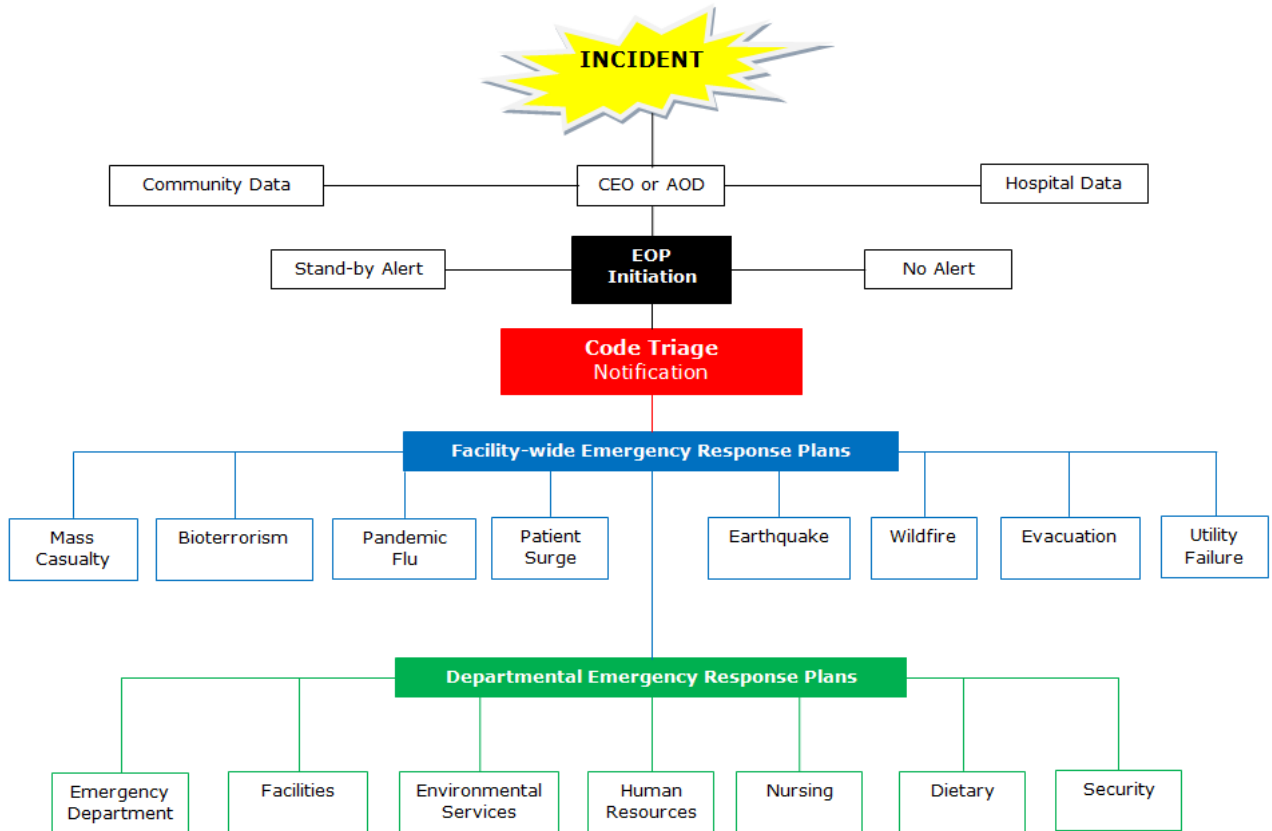
ARE YOU PREPARED AT WORK FOR A DISASTER?

EMERGENCY PREPAREDNESS AND RESPONSE FOR **HOSPITAL WORKERS**

The ability of a hospital to respond to an emergency depends upon having staff that know what to do, and have the needed skills. As a hospital worker, you should be able to:

1. **LOCATE** and **USE** the section of the hospital emergency response plan that applies to your position.

2. **DESCRIBE** your emergency response role and be able to **DEMONSTRATE** it during drills or actual emergencies.

3. **DEMONSTRATE** use of any equipment (such as personal protective equipment or special communication equipment) required by your emergency response role.

4. **DESCRIBE** your responsibilities for communicating with or referring requests for information from other employees, patients and families, media, general public or your own family, and **DEMONSTRATE** these responsibilities during drills or actual emergencies.

5. **DEMONSTRATE** the ability to seek assistance through the chain of command during emergency situations or drills.

6. **DEMONSTRATE** the ability to solve problems that arise carrying out your role during emergency situations or drills.

EMERGENCY PREPAREDNESS AND RESPONSE FOR **HOSPITAL LEADERS**

The following core emergency competencies are those you need as a hospital leader (hospital-wide manager, department head or senior manager in a large department) though you may demonstrate them in a variety of ways, depending upon your exact role and the specific emergency or drill. These competencies provide a template for your continued development, and can be used flexibly with other emergency preparedness activities within your institution.

1. **DESCRIBE** the mission of the hospital during response to emergencies of all kinds, including the disaster response chain of command and emergency management system.

2. **DEMONSTRATE** the ability to review, write, and revise, as needed those portions of the hospital emergency response plan applicable to your management responsibility.

3. **MANAGE** and **IMPLEMENT** the hospital's emergency response plan during drills or actual emergencies within your assigned functional role and chain of command.

4. **DESCRIBE** the collaborative relationship of your hospital to other facilities or agencies in the local emergency response system and **FOLLOW** the planned system during drills and emergencies.

5. **DESCRIBE** the key elements of your hospital's emergency preparedness and response roles and policies to other agency and community partners.

6. **INITIATE** and **MAINTAIN** communication with other emergency response agencies as appropriate to your management responsibility.

7. **DESCRIBE** your responsibilities for communicating with other employees, patients & families, media, the general public or your own family, and **DEMONSTRATE** them during drills or actual emergencies.

8. **DEMONSTRATE** use of any equipment (such as personal protective equipment or special communication equipment) required by your emergency response role.

9. **DEMONSTRATE** flexible thinking and use of resources in responding to problems that arise carrying out your functional role during emergency situations or drills.

10. **EVALUATE** the effectiveness of the response within your area of management responsibility in drills or actual emergencies, and **IDENTIFY** improvements needed.

ARE YOU PREPARED AT HOME FOR A NATURAL DISASTER?

One thing you need to do if you have school age children is to ensure that you have arranged pick-up for your children at school if a disaster should occur. As health care providers, it is likely that your assistance may be required at work.

The office of Environmental Health & Safety has handouts available outlining what you should do at home to be prepared. Call (818) 364-3405 for further information.

Other resources are also available at:

  ➢ http://publichealth.lacounty.gov/eprp/plans.htm
  ➢ http://ems.dhs.lacounty.gov/Disaster/DisasterMaterials.htm

EMERGENCY TRANSPORT (CARRIES)

Emergency carries are used to transport patients in the event of an emergency evacuation.

EMERGENCY TRANSPORT-SAFELY

When fire or another emergency dictates quick removal of patients, and they can't be transported via their beds, stretchers, or the OR table, the appropriate carry or support technique will save them, and you, unnecessary injury.

Although you may assistance (the "Swing" and "Extremity" carries can then be used), it's conceivable that you might have to use one of the three one-person carries for non-ambulatory patients, as illustrated below.

ONE-PERSON CARRIES

HIP CARRY

1. Put patient's arm over your back and slide your arm under patient's back

2. Lean backward, into patient's abdomen, and grip patient behind his knees.

3. Hold patient snugly against your back, then lean forward to carry.

down

4. Lean patient against wall, and slide to floor as you drop to one knee.

PACK STRAP CARRY

1. Cross patient's arms and grab both wrists.

2. Pull up as you turn to step under patient's arms, cross his arms in front.

3. Lean forward, and step to the head of the bed, patient will roll out, onto your back.

down

4. Lean patient against wall and slide to floor as you drop to one knee.

CRADLE DROP

1. Place blanket on floor next to bed, then grip patient under shoulders and knees.

2. Slide patient to edge of bed

3. On one knee, lower his legs then his body, to blanket, or on both knees, slide patient down your chest to blanket.

remove
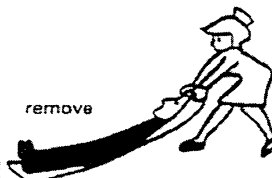
4. Pull patient out, head first, on blanket.

TWO-PERSON CARRIES

SWING

1. Each nurse grasps the other's shoulder with one hand, as patient places his arms around both of their shoulders.

2. Reaching under patient, each nurse grasps the other's wrists.

EXTREMITY
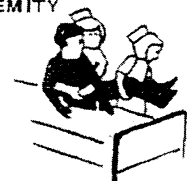
1. Patient must be sitting on the edge of the bed.

2. One nurse hugs patient from behind, grasping her own wrist.

3. The other nurse stands between patient's legs, and lifts him from behind his knees.

SEMI-AMBULATORY
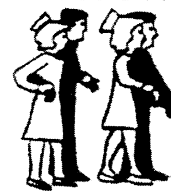
1. Stand next to patient, and place one of his arms around your waist.

2. Reach behind and around patient's waist and grasp his other arm.

3. "Hug from behind" and walk in step, grasping your wrist.

FIRE/LIFE SAFETY

FIRE RESPONSE

The acronym **S A F E** refers to steps you should take in the event of a fire. The steps are:

S	**S**afety of Life. Remove all people in the immediate fire area and close the door to the room.
A	**A**larm – Activate the alarm. Pull the nearest fire alarm and report the fire by dialing Ext. 113. Give the operator your name, location of fire, and type of fire. Relay location of fire and type of fire to other employees.
F	**F**ight the Fire. Close doors to all other areas, adjacent rooms and fire doors. Return to fire with proper extinguisher; if possible and practical, extinguish fire until the arrival of the Fire Department.
E	**E**vacuate as Necessary. Remove patients and visitors from the adjoining area. Make sure that all Fire Doors and doors to patient rooms remain closed until their turn to be moved or rescued.

STEPS IN THE USE OF THE FIRE EXTINGUISHER

The acronym **P A S S** refers to the proper use of the fire extinguisher and stands for:

P	**P**ull the pin out. Some extinguishers require release of a lock hatch, pressing a puncture lever or other motion.
A	**A**im the extinguisher nozzle (horn or hose) at the base of the fire.
S	**S**queeze or press the handle.
S	**S**weep from side to side at the base of the fire until it goes out.

Classification of Fires	
CLASS A	Fires in ordinary solid combustibles such as paper, wood, cloth, rubber, and plastics.
CLASS B	Fires involving flammable liquids such as gasoline, acetone, greases, oils or flammable gases such as methane or hydrogen.
CLASS C	Fires involving energized electrical equipment, appliances, and wiring. The use of non-conductive extinguishing agent protects against electrical shock.
CLASS D	Fires involving combustible metals such as magnesium, lithium, potassium, etc.

TYPES OF EXTINGUISHERS

Type A: Silver canister. Symbol A

- Pressurized water tank used for wood, paper, cloth (Class A) fires. Do not use on flammable liquids or electrical fires.

Type B-C: Red canister. Symbols B C

- Contains either carbon dioxide or dry chemical, which smothers the fire; used for flammable liquids (Class B) or electrical (Class C) fires.

Type A-B-C: Red canister. Symbols A B C

- Contains a dry chemical (monoammonium phosphate) which smothers the fire; used on ordinary combustibles (Class A), flammable liquids (Class B), and electrical (Class C) fires.
- Whenever an A-B-C extinguisher is used on a Class A fire, always follow with water.

Class D fires require special extinguishing agents and procedures.

NEVER re-hang an extinguisher once it has been discharged, even if it is only for a few seconds. Notify Facility Management or the facility safety coordinator for recharging. Place used extinguisher on floor (on its side).

WHO SHOULD RESPOND TO A CODE RED (EXT. 113) IN THE HOSPITAL?

REMEMBER SAFETY FIRST! EVEN IF THE FIRE IS SMALL.

➢ **Weekdays (8:00 a.m. – 4:30 p.m.)** The following on-duty staff responding to the scene – Senior Administrator, Sheriff and/or Security staff, Facilities staff, and one available staff from other areas of the hospital. Staff in the affected area will also respond.

➢ **Weekends, Holidays and After-Hours –** Nursing Administrator on duty, Sheriff and/or Security staff, Facilities staff, and one workforce member (if staffed) from each department will respond with appropriate fire extinguishers.

Code Red (All other areas): Check your department/unit-specific fire plan.

If the Fire is not on your unit:

Workforce members throughout the hospital <u>are responsible</u> for returning all patients to their rooms and closing their doors. All carts and equipment must be moved out of corridors and away from fire exits. A Code Red is a hospital-wide response.

If the Fire is on your unit:

You are responsible for all of the above, plus you are expected to be ready to take direction in the event an attempt is made to extinguish the fire or in the event evacuation of patients becomes necessary.

The staff must be aware that during a "Code Red" **all visitors should be escorted to a waiting room away from hospital corridors.** If you observe co-workers, visitors and patients opening fire doors, please remind them that they are <u>not</u> to enter these areas until they hear an overhead page stating "All Clear Code Red."

DEPARTMENT SPECIFIC FIRE PLAN

In addition to the Safety Plan, each department manager is required by Cal/OSHA to have a **Department Specific Fire and Safety/Evacuation Plan for their departments.** On an annual basis, each workforce member is responsible for reading and signing an acknowledgment of the Olive View and departmental safety plan and disaster plan.

In order to protect yourself and your patients, you must be familiar with the department-specific fire plan in your area. You can expect The Joint Commission surveyors to ask you about these issues during their surveys of Olive View. Remember, be careful, and think safety!

SMOKE COMPARTMENTS

Smoke Compartments are created by the closure of fire/smoke doors. The hallway doors will close automatically during a "Code Red" and form smoke compartments. These doors contain the fire/smoke to a specific area of the hospital. Once these doors close, you are asked to stop and wait until you hear the overhead announcement "All clear Code Red" before you open any closed hallway doors.

The only two acceptable reasons for breaching a fire door are to respond to the "Code Red" (preferably with a fire extinguisher) or responding to a "Code Blue" (a life threatening emergency).

SUPPLY STORAGE

- **DO NOT STORE SUPPLIES ON TOP OF CABINETS.** You must leave an 18" clearance from the ceiling when utilizing shelving for storage of boxes, etc.
- Supplies must not be stored on the floor. It is recommended you make more frequent, lower volume supply requests from the Warehouse. If you can't store an entire case of Xerox paper, how about splitting one with another department, then letting them order the case next time?

EMERGENCY POWER

In the event of a **Power Failure**, most of the electrical outlets will not work. **Only the Red Color outlets will be functional.** You must make sure all life support systems are plugged into the red outlets. Turn off all non-essential equipment. Be sure you have flashlights ready. Be prepared to ventilate patients (if necessary).

Please take a look around your department and identify **white outlets and red outlets.**

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

In order to ensure the safe operation of medical equipment, the Facilities Division is responsible for testing selected medical equipment on a scheduled frequency. You can find the dated inspection label on the upper right side of the equipment. If the medical equipment is not functioning properly, remove the malfunctioned equipment from the clinical area and tag it (such as "Out of Order"). Report all medical equipment and utilities malfunctions to your supervisor and the Facilities Division. When there is an equipment malfunction, do not leave a patient unattended. In life-threatening emergencies involving medical equipment, send a co-worker to get a replacement from the nearest location. When a device failure or operator error results in serious negative consequence to a patient, you must inform the Safety Officer (818-364-3405) and Risk Management (818-364-3026) as soon as possible (within 24 hours) and immediately impound the device. You must also submit an incident report via the Safety Intelligence online incident reporting system which is located on Olive View's intranet.

ELECTRICAL SAFETY

Before using any piece of electrical equipment, check:

- The sticker on the equipment to ensure that testing is current.
- On-Off switch for proper function (it must work 100% of the time).
- Body of equipment for cracks, holes, protruding wires.
- Condition of the cord (intact insulation, presence of ground prong, intact plug, snug fit of cord to outlet).

Other points to remember:

- Keep long cords coiled and out of way of traffic.
- Unplug all electrical equipment that is not in use.
- Keep rechargeable batteries plugged in.
- Never touch the patient and electrical equipment at the same time.
- Do not try to make electrical repairs yourself.

Avoid using any electrical equipment if:

- The cord or plug is warm to the touch.
- Any suspicious odors are coming from the equipment.
- Equipment operates inconsistently.

Red emergency electrical outlets are electrically energized at all times. In the event of a power outage these outlets will receive power from our electrical generator system. These emergency outlets can be used at all times; **however** their use is restricted to life support equipment (e.g., ventilators and balloon pumps) only.

Facilities Division should be called in the event of the failure of a gas outlet to shut off or to supply medical gases. Only Facilities, Respiratory Therapy, or the Fire Department are authorized to shut off medical gas valves.

To report a mechanical emergency, mechanical failure, or the need for mechanical repair, **call (818) 364-4900 or (818) 364-4100.**

REPORTING WORK RELATED INJURIES/ILLNESSES

You must immediately report any work-related injury, accident, or illness to your supervisor or the supervisor's designee. Even if you decline medical treatment, you are still required to report the incident to your supervisor or the supervisor's designee. Failure to report an injury, accident, or illness may result in denial of benefits.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

The County Department of Health Services shall maintain a healthy work environment and comply with various regulations/mandates applicable to workplace safety. As part of our workplace safety efforts, the IIPP is designed to:

- Prevent the pain, suffering, and loss which workforce members and their families experience due to work-related injuries or illnesses.
- Enhance productivity by reducing lost time caused by work-related injuries or illnesses.
- Comply with California Code of Regulations, Title 8, Section 3203.

- Conduct periodic inspections to identify unsafe conditions and work practices.
- Investigate occupational injury or occupational illness.
- Correct unsafe or unhealthy conditions in a timely manner based on the severity of the hazard.
- Provide safety training and instruction to all workforce members.

The Musculoskeletal Injury Prevention Plan (MIPP), an adjunct to the IIPP, describes the elements of the Hospital's Safe Patient Handling Program and is available upon request from the Safety Office

BODY MECHANICS

Body mechanics is utilization of the correct muscles to complete a task safely and efficiently, without undue strain to a joint or muscle. Proper body mechanics can help prevent injuries to you and others while at work.

Why You Should Practice Good Body Mechanics

- To prevent injury to yourself, patients, and others.
- To prevent cumulative trauma disorders, such as carpal tunnel syndrome.
- To maintain good general health.
- To increase capacity to work comfortably.
- To reduce stress and fatigue while working.

Maintaining Good Body Mechanics

Think of your body as a machine that needs to be maintained in good working order in order to run smoothly and work efficiently. Things that you can do to avoid injury include:

- Maintain good posture.
- Avoid bending and lifting with your back.
- Keep physically fit. Perform regular exercise and maintain flexibility.

GUIDELINES FOR DECREASING MUSCULOSKELETAL INJURY

General Guidelines for Maintaining Proper Body Mechanics During Activity

- Plan your actions!
    - Test the load making sure that you can handle the weight.
    - Get help when necessary.
- Use proper footwear. Look for properly fitting shoes that are low heeled.
- If wearing a lab coat, minimize items carried in your pockets and distribute the load evenly between the pockets to minimize strain on the neck and shoulders.
- Wear clothing that allows your body to move   .

Reaching

- Avoid stretching out with your arms to reach for items. This straightens out the natural curves in your spine and puts you at risk for injury. Reach only as high as is comfortable for you.
- Use a ladder or step to bring yourself closer to the object prior to grabbing it.
- Test the weight of the load prior to pulling it down.
- DO NOT stand on rolling chairs or stools to reach for items!

- Store commonly used items on shelves that are at heights easily accessible to you.

Twisting/Turning

- Turn with your feet, not your back. This means that you should move with your hips and shoulders together when moving and turn your entire body.
- Position frequently used items in front of you, so you can easily access them without turning or twisting.
- Do not keep your feet fixed when turning. They need to move with you!

Standing

- When standing, keep your knees slightly bent to take pressure off your lower back.
- If standing for longer periods of time, rest one foot up on a low step, shelf or stool (non-wheeled).

Sitting

- Adjust the chair to position the hips, knees and elbows at about a ninety degree angle.
- Feet should be flat on the floor. If they are dangling, rest feet on a footrest to avoid strain on the lower back.
- Use the backrest of the chair to support the curves of the spine and to decrease fatigue. Avoid slouching in the chair.

Patient Transfers

- Before transferring a patient, make sure the brakes are locked on wheeled equipment.
- Never let the patient put their arms around your neck.
- Transfer/gait belt is recommended if patient requires assistance.
- Allow the patient adequate time to assist with the transfer, if able. Often times, the patient may be able to do the transfer with minimal assistance, instead of the workforce member doing a total patient lift.
- Use a lift or transfer device to move dependent patients.
- Get extra staff to assist, if the patient is too heavy or difficult for one person to transfer.

Equipment/Object Transfer

- Get a firm footing prior to lifting.
- Bend your knees and hips to get close to the load. Use the muscles of your legs to lift. DO NOT use your back to lift!
- Keep the object close to your body when lifting and moving it.
- Keep your back as upright as possible and hold your stomach muscles tight when lifting/moving the object.
- Try to use wheeled carts to move bulky, larger or heavier objects further than a few feet.
- Bring wheeled carts to the area you are working in, instead of carrying the item to the cart, i.e., carrying linen to the linen cart.
- If the item is too much for one person to handle, get help!

The wrong way! The right way!
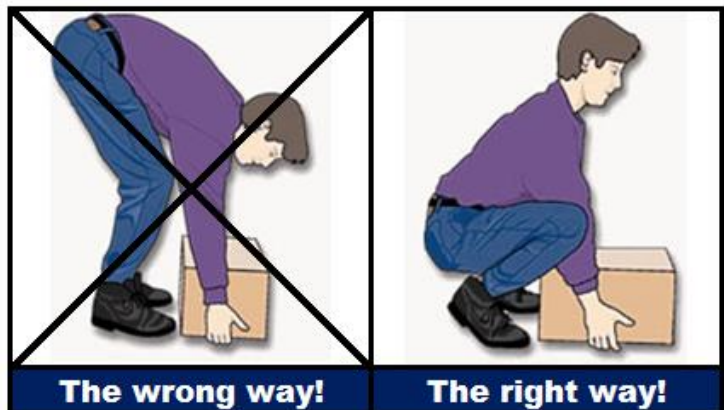
ERGONOMICS

Ergonomic safety is achieved by adapting equipment, procedures and work areas to fit individuals. This helps to prevent injuries – and improve efficiency.

COMMON CAUSES AND TYPES OF ERGONOMIC INJURIES

- Strains and sprains (most often to the back, fingers, ankles and knees due to improper lifting or carrying techniques).
- Repetitive motion injuries (most often to fingers, hands, wrist, neck and back from repeating a motion over and over, or from poor posture or positioning).
- Eyestrain, headaches and fatigue (due to noise, poor lighting, posture or positioning).

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:

- **Adjust** the height of your chair to achieve proper posture.
  - Position hips, knees and elbows at approximately a ninety degree angle. Your shoulders should be relaxed and elbows kept close to your body.
  - Feet should be flat on the floor or supported by a step if they are dangling.
  - Avoid stretching, twisting or bending beyond what is comfortable for you.
  - Know how to adjust your chair. If the chair controls are not working properly, notify your supervisor.
- **Position** your monitor directly in front of you.
  - Adjust the monitor screen so it sits at or below eye level.
  - Sit at least an arm's length away from the computer screen.
- **Check** the lighting to reduce monitor screen glare.
  - Aim the light at the task, not the screen.
  - Adjust the contrast and brightness of your monitor to improve viewing comfort at your computer workstation.
- **Change** your position, stretch and change your pace of work regularly throughout the day.
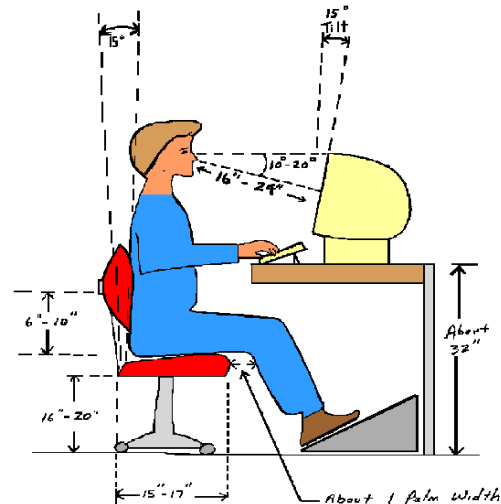
RISKS FACTORS TO REMEMBER

1. Your ***posture***. Poor body mechanics overworks your body and puts stress on your joints. Even with good posture, a position if held for too long, can tense your muscles. It is always important to change your position frequently throughout the day to relieve pressure and stress on your body.
2. Your ***tasks***. Watch for activities that require excessive force or frequent repetition. Also be aware of contact forces, such as pressing a body part against a hard surface or a sharp edge for prolonged periods of time. An example would be leaning against the edge of the desk. Frequent repetition for long periods make the muscles tense and tired.
3. Your ***work area***. Environments with high stress, noise, poor lighting, poor seating, uncontrollable room temperature, vibrations etc., can add extra strain to your body. Be aware of broken equipment, chairs or stools. Do not use them and report them to your supervisor immediately.

TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

1. **Recognize** the force or strain placed on your body caused when you grip, push, pull or lift heavy materials. Think about ways to minimize these strains or avoid some of these movements. Be aware of pain or numbness in the neck, shoulders, arm, wrist, fingers and back. Report any work related injuries to your supervisor immediately.

2. **Alternate** tasks to use different muscles and to give you time to recover. Pace yourself.

3. **Use** eyeglasses, if needed. Remember uncorrected vision problems can cause eyestrain. Remember to blink and look away from the monitor frequently to decrease strain on your eyes.

4. **Use** tools in a safe and appropriate manner. Keep your worksite safe and clean. Do not use unsafe tools. Remove them and report them.

5. **Report** any concerns to your supervisor about making your worksite safe. This will help your manager to identify harmful patterns or environmental conditions so that necessary changes may be made.

6. **Keep** yourself fit with regular exercise and proper diet, and manage your daily stress.

PERFORMANCE IMPROVEMENT

This section includes a description of organizational performance procedures, Performance Improvement Model, various review processes, and data collection activities.

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

The goal of Quality Assessment and Performance Improvement is to continuously improve patient safety and health outcomes. Every department within the organization performs and reports improvement activities in an effort to provide the safest, highest quality healthcare services possible.

OLIVE VIEW'S PERFORMANCE IMPROVEMENT MODEL

To achieve sustainable improvement, Olive View-UCLA Medical Center uses quality improvement principles such as the Institute for Healthcare Improvement (IHI) Model for Improvement, Lean Six Sigma, and other methodologies for performance and process improvements. The goals of Lean Six Sigma are to eliminate waste. The Model for Improvement asks three questions: What are we trying to improve? How will we know a change is an improvement? What change can we make that will result in an improvement? These questions are combined with PDSA cycles (Plan, Do, Study, Act) to conduct small tests of change for rapid cycle improvement. Quality improvement techniques are taught as "just in time" training when a project is needed to address a quality problem. These methods incorporate robust tools such as control charts, fishbone diagrams, and process maps. Olive View-UCLA Medical Center also conducts root cause analysis and failure modes and effect analysis to accomplish its goals for performance improvement.

Examples of performance and process improvements made at Olive View:

- Improving turn-around time discharge prescriptions.
- Improving compliance with hand hygiene.
- Improving appropriate use of telemetry beds.
- Improving patient satisfaction by reducing inpatient noise at night.
- Communications with patients.
- Reducing sepsis mortality.
- Improving outpatient clinic cycle time.

While the Quality Service Division oversees hospital-wide performance and process improvement, each department and some committees have identified performance improvement indicators around four perspectives: The Customer, Internal Processes, Learning and Growth, and Financial. These four perspectives comprise a balanced scorecard approach to performance improvement. The Joint Commission is always interested in discussing performance improvement activity with workforce members, so it is important that you are aware and can verbalize the recent accomplishments of both the organization and your department. For more information, please speak to your department supervisor.

MEANINGFUL USE

In November 2015 OVMC implemented ORCHID an Electronic Health Record (EHR). The U.S. Department of Health and Human Services is offering incentive payments to Medicare and Medicaid providers who adopt EHRs. Meaningful Use is using a certified EHR technology to:
- Improve quality, safety, efficiency. and reduce health disparities
- Engage patients and families in their health care

- Improve care coordination
- Improve population and public health
- Maintain privacy and security

Meaningful Use is mandated in law to receive incentives. Examples of these initiatives are:
- Computerized provider order entry (CPOE)
- Maintain up-to-date problem list of current and active diagnoses
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status for patients 13 years or older
- Report hospital clinical quality measures to CMS

CORE MEASURES

Just as Olive View's Quality Services Division strives to improve the health and safety of patients locally, The Joint Commission has designed quality standards and safety initiatives aimed at improving the quality of healthcare nationwide. These standards were developed as a result of evidence-based research data, and are geared toward improving illness outcomes, decreasing lengths of stay, and avoiding patient harm and medical errors.

Olive View currently participates in the following six Core Measure data sets:

- Emergency Department Throughput measures
- Venous Thromboembolism (VTE)
- Immunizations
- Sepsis
- Hospital-Based Inpatient Psychiatric Services
- Perinatal Care
- Hospital Outpatient Measures

This process requires that Olive View collect and electronically submit data directly to The Joint Commission. Once the data is collected, The Joint Commission publishes a report detailing the performances of all participating healthcare organizations. This information is made available to the public at **www.hospitalcompare.hhs.gov** and to State surveyors through the Center for Medicare/Medicaid Services (CMS).

HOW ARE WE DOING COMPARED TO OTHER HOSPITALS?

Overall, Olive View is doing well in many areas. Typically we perform well in giving the appropriate medications, and generally have low mortality rates. It is important to note, however, that data collection results are based on your medical record documentation, and the organization continues to struggle with some key elements of Core Measures set documentation. Some areas of concern are:

- Documentation of assessment of tobacco use and therapy provided.
- Documentation of assessment of immunization status and administration of required vaccinations.

WHAT COULD A SURVEYOR ASK YOU ABOUT CORE MEASURES?

When performing tracers, if the patient has a diagnosis of stroke or has developed a venous thromboembolism (VTE), the surveyor may ask you about the related Core Measure indicators. Be prepared to speak to how you

assure that Olive View provides evidence-based care to your patients. Some examples of evidence-based care include:

- Providing smoking cessation education to your patients that smoke.
- Standardized protocol for Pneumococcal and Influenza vaccinations.
- Utilization of nurse driven protocols or structured interdisciplinary care plans which organize the timing of major clinical interventions for hospitalized inpatients with select diagnoses. These care plans are designed to optimize the use of resources while maximizing the quality of patient care, and have been proven to reduce unwarranted variations in care, decrease inappropriate Emergency Department visits, achieve shorter inpatient lengths of stay and improve patient safety.

HEDIS MEASURES

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measure in the United States. HEDIS rates are designed to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in its preventive care and quality measures to the plan's members. HEDIS measures address a broad range of important health issues. It is important to meet HEDIS measures to retain our managed care population.
Some HEDIS Measures are the following:

- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Cervical Cancer screening
- Childhood and Adolescent Immunization Status
- Childhood and Adult Weight/BMI Assessment

RISK MANAGEMENT

Risk Management involves the identification, evaluation, and reduction of the risk of injury and/or loss to the County and Olive View. This section provides policies and procedures on how to report adverse events, sentinel events and near miss incidents, and responding to subpoenas and summons.

RISK MANAGEMENT GOALS

- ❖ Identify close call/near miss, adverse, and sentinel occurrences.
- ❖ Promptly report and investigate such occurrences.
- ❖ Educate all concerned in the causation of such incidents in order to prevent them from recurring.
- ❖ Maintain risk management data for tracking/trending and performance improvement purposes.

As a County workforce member, indemnification is provided while you are performing duties within the course and scope of your employment/assignment and professional credentials (license, etc.), and while on duty at your assigned work station. However, **you are not legally protected from:**

- Liability resulting from willful misconduct or malice.
- Liability for any injury by one workforce member to another workforce member during the course of their employment/assignment.
- Any acts performed outside the course and scope of employment/assignment with Los Angeles County.
- When you rotate to facilities that are not owned or operated by Los Angeles County.
- When you are performing outside employment (non-County facilities).

If you are not a County employee, check with your contract or contract agency regarding terms of indemnification.

REPORTING CLOSE CALL/NEAR MISS, ADVERSE AND SENTINEL EVENTS

DEFINITIONS OF EVENTS

A **close call/near miss** is an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention.

An **adverse event** is an incident, therapeutic misadventure, injury, or other adverse occurrence directly associated with care or services provided. These events may result from acts of commission or omission.

A **sentinel event** is a type of adverse event. A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, including serious injury specifically loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

A **sentinel event** is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition), but not limited to:

- Unanticipated death or major loss of function, not related to the natural course of the patient's illness or underlying condition.
- Suicide of any patient in a setting where the patient receives around-the-clock care or suicide of a patient within 72 hours of discharge.
- Unanticipated death of a full term infant.
- Abduction of any patient receiving care, treatment, or services.
- Infant abduction or discharge to the wrong family.

- Rape (by another patient, visitor or staff).

- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

- Surgical or non-surgical invasive procedure performed on the incorrect patient or incorrect body part, or wrong procedure.

- Unintended retention of a foreign object in a patient after surgery or other procedure.

- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).

- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

EVENT REPORTING PROCESS – UHC SAFETY INTELLIGENCE/EVENT NOTIFICATION

If you are involved, witness or become aware of any event (adverse event, near miss, unsafe working condition, or medication error) you must report it using the UHC Event Notification System which can be found on the Olive View intranet.

You may enter an event from any computer in the facility. Please see Olive View Policy and Procedure "Reporting Adverse/Sentinel Events, Incidents, and Near Misses" for information on close call/near miss, adverse and sentinel event notification, reporting and documentation.

You must report events as soon after the event as possible. The Risk Management Office is available for consultation:

- During normal business hours at (818) 364-3026.
- 24-hour Hotline (ANO) at (818) 364-3170.

> **REMEMBER**
>
> Olive View requires you to report **sentinel events immediately at the time of the event to your Department Supervisor.**
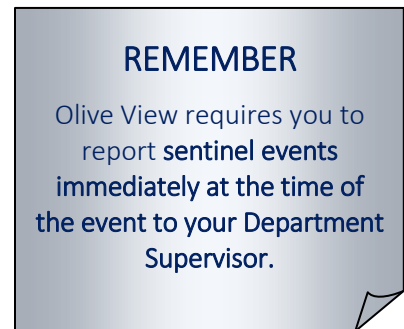
TIMELY REPORTING

When you become aware of an event involving a patient, visitor or staff that may result in a claim or lawsuit against the County or one of its workforce members, the event must be reported to your Department Supervisor and Olive View's Risk Manager using the following steps:

- Complete an Event Notification Report on the UHC Event Notification System for all events without exception as soon as possible.
- **Sentinel events** (as defined above) must be reported **immediately** to your Department Supervisor and entered into the UHC Event Notification System.
- Your Department Supervisor is responsible for **immediate** notification of the Administrator of the Day and the Risk Manager.
- The Risk Management Office can be reached by calling **(818) 364-3026 or the hotline number at (818) 364-3170 (ANO)** at any time, 24 hours a day, 7 days a week.
- When in doubt, call the Risk Manager at **(818) 364-3026.** Follow all calls by submitting an Event Notification Report in the UHC Event Notification System.
- In the case of power failure affecting the UHC Event Notification System downtown, use the paper Event Notification Form (HS-10).

DOCUMENTATION – *A KEY DEFENSE*

The medical record is the most important part of the defense against any potential litigation alleging malpractice. It is the permanent record of documented care and treatment rendered to a patient. A well-kept record is the most important key in any defense.

Document all care and treatment given and changes in the patient's condition in a timely manner in his/her medical record. **Do not make reference to a UHC Event Notification Report or Risk Management in the patient's medical record.** Please also note that comments regarding coverage discussions, disputes among services, or clinician/staff behavior, etc. should not be recorded in the medical record, which is a document whose sole purpose is to accurately record the care provided to a patient. As applicable, such issues can be reported to Medical, Nursing or Hospital Administration or recorded through the UHC Event Notification System or Event Notification Report form as appropriate.

Your documentation must include:

- Date
- Time
- Care and treatment provided
- Signature of the provider with title and assigned number (Medical Staff)

> **REMEMBER**
>
> **DO NOT MAKE COPIES** of the Event Notification Report. Send all copies of the Event Notification Report to Risk Management.

Make your documentation:

- Objective.
- Clear
- Legible.
- Relevant
- Accurate and complete
- Sequential
- Late entries must be identified as such, with a reason

Correct handwritten errors in the medical record by:

- Using one line to cross out the error(s). Write the correction along with the date, time, and initials.
- Do not "white out", erase or otherwise obliterate entries.

SUBPOENA AND SUMMONS

A subpoena is a written request to appear (usually in court) to testify in civil and criminal cases. A summons is a notice issued to a person summoning or ordering him or her to appear in court.

If you receive a subpoena or summons relative to County business, contact the Risk Management Office (Ext. 3026) immediately. Additionally:

- Document the date and time you received the subpoena or summons.
- Keep the original envelope that the notice came in.
- Bring the documents to the Risk Management Office.

The 24-hour Hotline number is (818) 364-3170

MANAGEMENT OF INFORMATION

CONFIDENTIALITY OF PATIENT INFORMATION (HIPAA)

OBJECTIVES

Privacy of Patient Information

Every patient has a right to privacy. To earn our patient's trust we must protect their health information. If the patients cannot trust us with their health information they will not want to be our patients. All requests for PHI from patients, law enforcement or any other entity must be referred to the facility Health Information Management (HIM) department.

A. **Why do we need to protect patient information?**

1. Federal laws, the Health Insurance Portability and Accountability Act (HIPAA)

    and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and California laws require us to protect the privacy and security of all patient health information.

2. The HITECH Act:

    a. Requires DHS to make a report when a patient's health information kept on a computer/electronic device is not coded in a way to prevent access and is misused or wrongly given out.

    b. Gives patients more rights and increases fines for violating the law.

3. The privacy laws cover all forms of patient health information, including paper, electronic, verbal, video, photos, etc.

4. Privacy laws require DHS to take additional steps to keep patient information safe. This includes providing additional training for workforce members to assure patient information on computers is kept safe.

B. **What is Protected Health Information?**

A patient's health information is called **protected health information (PHI)**. PHI is any health information created, used, stored, or transmitted by us that could be used to describe the health and identity of a patient. This includes the physical or health condition of the individual, the services or treatment provided, payment information, and information about past, current and future health problems.

Some examples of PHI include name, address, telephone number, medical record number, social security number, and photos or x-rays of a patient.

There is another form of personal information similar to PHI that we also need to protect; that is Personally Identifiable Information (PII). PII is information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. PII includes, for example, name; home or business address; e-mail address; telephone, wireless and/or fax number; short message service or text message address or other wireless device address; instant messaging address; credit card and other payment information; demographic information and/or other information that may identify an individual or allow online or offline contact with an individual.

PII and PHI share some similarities under the law but are governed by distinctively different regulatory bodies. Generally, patient information contains health information but like PII, PHI also includes address, Social Security Number, credit card number (used for billing) to name a few. The best practice is to

protect all information associated with a patient and follow the Department's policies related to patient privacy.

C. Privacy Laws Give Patients Certain Rights

Along with a patient's right to privacy, laws give patients other rights. This includes how we can use their information and to whom we can disclose it. Under HIPAA, patients have the right to:

1. Get a copy of the Notice of Privacy Practices.
2. Access, inspect, and request copies of most of their PHI, except information the healthcare provider feels might be harmful to them.
3. Ask us to send their health information to someone.
4. Restrict who can see it or to whom we can send it.
5. Ask us to send their mail or call them at another address or telephone number.
6. Get a list of people or places where we sent their health information.
7. File a complaint.

All requests for PHI from patients, law enforcement or any other entities must be referred to the facility Health Information Management (HIM) department.

D. Use and Disclosure of Patient Information

1. The patient's written permission is usually needed for us to use or disclose their health information to someone.
2. The patient's permission is not needed if the use or disclosure is for treatment, payment, healthcare operations; or to certain agencies that protect the public.
3. You may take pictures or video of patients for clinical or medical reasons, as permitted in the General Consent.
4. Taking pictures or video of patients for any other reason, such as research, education, news media, or for the patient's family, friends or personal lawyer require written authorization from the patient.
5. The authorization must describe the purpose and use of the pictures or video and list any restrictions the patient or his legal representative has placed on its use.
6. The authorization is only good for that use. Another authorization will be needed to use the pictures or video for something else.

E. Protecting Patient Information

1. Safeguards

   a. Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients' PHI.
   b. We must take reasonable *safeguards* or *steps* to make sure patient health information is kept private.

2. Incidental Disclosures

   a. We know that we cannot guarantee the privacy of patient information all of the time.
   b. Some activities we do for business reasons, such as calling out a patient's name in the waiting area or talking to a patient on the phone or in an area where others might hear are called *incidental disclosures*.

    c. Incidental disclosures do not violate laws as long as we take steps to protect the patient's privacy, such as moving close to the patient, closing doors or privacy curtains, eliminating the use of patient name while talking on phone, or using lowered voices**.**

3. Disclosing Information to Spouses, Family Members, and Friends

    a. Workforce members should use good professional judgment when disclosing health information to a patient in front of a spouse, family members or friends. If in doubt or to be sure, ASK.

    b. You can disclose this information if the patient says it is okay or when asked, does not object, or if the person is the patient's legal representative.

    c. You should only talk about current relevant information.

4. Disclosing Information to the Media

    a. It is against the law to sell patient information to the media.

    b. Call the facility Public Information Officer or the facility Privacy Coordinator if the press or news media request information about one of our patients.

5. Social Networks

    a. Do not post information about patients or work-related issues on social networking sites such as *Facebook, Twitter, Google+, YouTube*, etc.

    b. It does not matter if you are not using County equipment or if you are at home or on your break.

    c. Due to the nature and type of work you do, just small bits of information put together, can reveal identifying information about patients and cause you to violate privacy laws.

F. Access to PHI

1. In order to access PHI, you must have a legal or business "need-to-know." Your job duties determine how much patient information you can view or access.

2. Your supervisor will arrange for you to obtain access to systems and networks necessary for you to do your job.

G. Inappropriate Access to PHI

1. If you acquire, view, or access patient information that you do not need to do your job, or give patient information to someone who should not receive it you will violate DHS policies, HIPAA, HITECH, and/or the State law.

H. Minimum Necessary

1. Minimum necessary means you must only access the ***information*** you need to do your job.

2. Just because you have access to a system or network or to patient records, does not mean you have the right to access or view confidential or patient information that you do not need to do your job.

3. Only give out just enough information for someone else to do their job.

4. Never look at confidential or patient information "just because you want to know," even if you are not going to do anything with it.

5. It does not matter if the information is about a movie star, someone in the news, someone you work with, a close friend, or a family member.

6. All patient information is confidential and must be protected at all times.

7. You are not allowed to look at your own patient information.

I.   Reporting Violations and Breaches of Patient Information

1. You must report anything a workforce member does that might be against DHS Policy or federal or state laws.
2. If a workforce member peeks at a patient's medical record we have to report it even if the workforce member did not tell anyone or the patient was not harmed.
3. You will not be retaliated against for reporting a suspected or actual violation in good faith.
4. If you falsely accuse someone on purpose you will be subject to discipline.
5. If you report a violation and you were involved, you will still be subject to discipline.
6. You MUST report suspected or actual breaches to your supervisor or the facility Privacy Coordinator at (818) 364-3001.
7. If you feel you need to report it somewhere else, you can report it to any of the hotlines listed below.

   o   DHS Compliance Hotline at 1-800-711-5366
   o   County Fraud Hotline at 1-800-544-6861

8. Report suspected or actual security breaches to your supervisor or your facility Information Technology (IT) Service Desk at (818) 364-4522

J.   Fines and Penalties

1. Use good judgment when working with patient information.
2. Violations will not only result in discipline, but may result in fines against the DHS facility involved and you being fined and put in prison.
3. If you need to have a professional credential to do your job, you may be reported to the issuing board or agency for more discipline.

SECURITY OF PATIENT INFORMATION

A. The HIPAA Security Rule covers all electronic Protected Health Information (ePHI) when stored on computers and while being sent from computer to computer.

B. ePHI is patient health information that is kept on computers and electronic media. Examples of electronic media include:

1. Computer networks, desktop, laptop and handheld computers, personal digital assistants (PDAs) and handheld digital equipment such as cameras, tablets (*iPads, Androids, eReaders, etc.)*, and cellular telephones;
2. Computer software and databases; and
3. Compact discs (CDs), digital versatile discs (DVDs), diskettes, USB storage devices such as flash/thumb drives and micro storage media, magnetic tapes, and any other means of storing electronic data.

C. Each DHS facility must take steps to make sure ePHI is complete, it is protected, and it is available when someone needs it. Some of the steps include:

1. Developing policies and procedures,
2. Making sure computers do not get stolen, and
3. Ensuring workforce members do not share their passwords.

D. You must review and comply with the County and departmental IT security policies.

E. The Acceptable Use Policy for County Information Technology Resources (DHS Policy No. 935.20) mandates the following:

1. The County's computers and electronic devices belong to the County, and are to be used only for County business.

2. You must protect all information created using County computers. Access to use a County computer is not a right. Your access may be modified or taken away at any time for abuse or misuse.

3. DHS may log, review, or monitor any data you have created, stored, accessed, sent, or received, and these activities may be subject to audit.

F. Privacy and security policies are posted on the DHS intranet (361.1 – 361.30 and 935.00 – 935.20). You should review and familiarize yourself with these policies and those of your facility/unit so you fully understand your role in the protection of patient health information as it pertains to your job responsibilities.

> **REMEMBER**
>
> Usage of County equipment is for approved County business purposes only. See DHS Policy No. 935.20 for details.

PATIENT CONFIDENTIALITY QUICK REFERENCE/KEY POINTS

As a DHS workforce member, it is very important that you keep patient health information confidential. Here are the key points about patient confidentiality.

Four primary ways patient confidentiality is most often violated:

- Lost or stolen unencrypted thumb drive/laptop or other portable device containing patient information.
- Patient care staff talks to patient about his/her illness in front of a family member without giving the patient a chance to agree or object.
- Workforce members looking at medical information about a family member, friend, coworker, or high profile patient.
- Workforce members not locking or logging off the computer when leaving the area.

Privacy and Security Do's

➢ Immediately remove all PHI from printers, fax machines, and photocopiers.
➢ Place PHI in confidential bins or shredders.
➢ Talk about patients in a private place or speak quietly.
➢ Keep medical records and other documents that contain PHI out of public view.
➢ Close patient/exam room doors or draw curtains and speak softly when discussing patient care.
➢ Treat patient information as if it were your own.
➢ Report suspected patient privacy violations through the UHC Event Notification System <u>AND</u> by phone to the facility Privacy Coordinator at (818) 364-3001.
➢ Cover carts when transporting medical records so that patient names are not visible.
➢ Remove, if safe to do so, or secure PHI found in trash cans and report it to your supervisor and/or the facility Privacy Coordinator.
➢ Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside the DHS e-mail domain.
➢ Obtain permission to store e-PHI on a laptop or other portable device, or USB thumb/flash drive and make sure the device is encrypted.
➢ Store paper records and medical charts in locked rooms and locked cabinets.
➢ Access to computers or computer systems containing e-PHI must be restricted to authorized users.
➢ Position computer workstations and monitors away from public view.
➢ Log off the computer when you are away from the work area or when the computer is not in use.

Privacy and Security Don'ts

➢ Don't access information about a patient unless you need it to do your job.
➢ Don't share confidential patient information with anyone who does not need to know it to do their job.
➢ Don't share passwords or your computer while logged on. You are responsible for all information viewed using your password.
➢ Don't store or save patient information on the computer's hard drive. All patient information must be stored on the network drives.
➢ Don't e-mail PHI outside of the County e-mail network without authorization.
➢ Don't send patient information through internet-based e-mail sites such as *Yahoo Mail, Google Mail, Hotmail,* etc.
➢ Don't use online web-based document sharing services (e.g., *Google Docs, Microsoft Office Live, Open-Office,* etc.) to store or share patient data.
➢ Don't post patient information or discuss patient care such as diagnosis, treatment, patient location, or other information that may be used to identify the patient on social networking websites (e.g., *Facebook, Twitter, Google+, YouTube, etc.).*
➢ Don't walk away from open medical records, lab results, etc. Make sure all medical records and lab results are placed in a secure location, out of public view.
➢ Don't discard documents or medical supplies that contain PHI in the trash.
➢ Don't store documents containing PHI in an area where it can be mistaken for trash.
➢ Don't store patient information on personal computers, notebooks, or other electronic devices.
➢ Don't forget to log off shared/public use computers and workstations.

INFECTION CONTROL

TRANSMISSION OF INFECTIOUS DISEASES

The goal of the Infection Control program is to prevent the spread of infectious diseases between patients, visitors, and workforce members. Infectious diseases can be spread through direct or indirect physical contact or by air, when infectious organisms enter the body or blood stream through open skin (cut, puncture, rash, wound or burn) or mucous membrane (eyes, nose or mouth). Removing the elements of transmission by implementing procedures of cleaning, disinfection, sterilization, hand hygiene and isolation precautions can interrupt transmission of infectious diseases. It is impossible to know who is infected and who is not, therefore it is important to follow Standard Precautions and consider ALL blood and body fluids from ALL persons as potentially infectious.
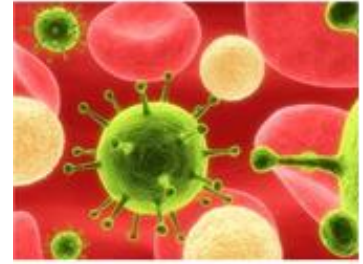
STANDARD PRECAUTIONS

Standard Precautions applies to all Olive View patients receiving care in Olive View facilities, regardless of their diagnosis or presumed infection status. **Standard Precautions** are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. These apply to 1) blood; 2) all body fluids, secretions, and excretions, except sweat, regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes.

REMEMBER

Even if you feel that you may not be susceptible to a particular disease, the next patient you work with may. Therefore, these standards are to be followed by all workforce members at all times.

Elements of Standard Precautions

- Hand Hygiene.
- Use of Personal Protective Equipment (for workforce members and patients).
- Respiratory Hygiene/Cough Etiquette.
- Safe Infection Practices.
- Use mask during epidural spinal access.
- Care of the Environment.

HAND HYGIENE

Practicing good hand hygiene is the most important intervention in preventing the spread of infection. **Hand washing requires water, soap and rubbing the soap and water in your hands with friction for a minimum of (15) fifteen seconds**. When using alcohol-based hand rub, apply the product to the palm of one hand and vigorously rub both hands together, covering all surfaces of the hands including in between fingers, fingertips, cuticles, and around the thumb until the hands are dry.

Hand hygiene, also referred to as hand antisepsis, reduces the number of healthcare associated infections. Hand Hygiene can be accomplished by using two approved methods:

- Generously apply soap, rub hands well under running water for a minimum of **15 seconds** then dry hands with paper towel.
- Apply alcohol-based hand sanitizer to palm of one hand, rub hands together to cover all surfaces including between the fingers, thumbs and nail beds. Allow to dry. Alcohol-based hand sanitizer should not be used if hands are visibly soiled or contact with Clostridium difficile (C. diff) is suspected.

Hand Hygiene should be performed:

- Before and after <u>any</u> contact with patients.
- Before donning sterile gloves.
- Before eating, preparing and serving food.
- Before applying make-up and handling contact lenses.
- After contact with body fluids, mucous membranes, non-intact skin and wound dressings.
- After removing gloves (clean or dirty).
- After using the bathroom, sneezing, coughing or blowing your nose.

Hands Must be Washed with Soap and Water

- When hands are visibly soiled or contaminated.
- Before eating or preparing food.
- After using the restroom.
- After direct contact or indirect environmental contact with patients.
- After removing gloves if gloves are visibly soiled with blood or body fluids.
- After every 5-10 applications of the alcohol-based hand rub (follow the manufacturer's guidelines).

Use Alcohol-based Hand Rub or Wash Hands with Soap and Water

- Before direct contact with patients.
- After contact with patient's intact skin.
- After contact with inanimate objects (medical equipment, bed, etc.) in patient's immediate area.
- After removing gloves (if gloves not visibly soiled with blood or body fluids)
- Before start of shift and end of shift.

Patients are encouraged to remind their healthcare providers to wash/clean their hands prior to providing care. Staff should encourage patients to perform hand hygiene prior to meals and after using the toilet or commode.

FINGERNAILS

Natural nails must be clean, with tips less than ¼ inch long. If fingernail polish is worn, it must be in good condition, free of chips, and preferably clear in color. Wearing rings with stones on fingers is also discouraged because they can harbor bacteria and may tear gloves.

Artificial fingernails are **not** permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or equipment that will be used by a patient or used directly on a patient, or for those who have contact with food.

➔ Artificial fingernail is defined as any material applied to the fingernail for the purpose of strengthening or lengthening nails (e.g., tips, acrylic, porcelain, silk, jewelry, overlays, wraps, fillers, superglue, any appliqués other than those made of nail polish, nail-piercing jewelry of any kind, etc.).

CLEANING AND DISINFECTION

Patient Care Equipment managed by patient care units or services must be cleaned with a hospital-approved detergent/disinfectant and follow manufacturers' instructions for appropriate contact time. Only clean equipment is to be stored in the clean equipment area.

Equipment must not be stored on or immediately around the sink to avoid contamination. All other equipment that is not cleaned or cannot be cleaned immediately after use shall be placed in the dirty equipment area or sent to Central Services. Only soiled equipment is stored in the soiled or "dirty" area. If it is unclear whether patient care equipment has been cleaned, it must be cleaned before patient use.

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Individuals with signs and symptoms of a respiratory infection should:

   a. Cover the nose/mouth when coughing or sneezing.
   b. Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
   c. Wash hands or use alcohol-based hand sanitizer after having contact with respiratory secretions and contaminated objects/materials.
   d. Utilize the "Respiratory Hygiene Stations" which have been installed in the lobby areas and in the outpatient clinics, to obtain masks and tissues if needed.
   e. Sit at least three feet away, (if possible) from others in common waiting areas.

2. Healthcare Workers: Precautions to minimize exposure to respiratory droplets.

   a. Healthcare workers should wear a mask for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection, particularly if fever is present.

3. Security Guards at the hospital entrances SHOULD DIRECT PATIENTS TO THE respiratory Hygiene Stations who are coughing, sneezing or have visible cold/influenza-like symptoms upon entrance to the facility.

TRANSMISSION BASED PRECAUTIONS

In addition to Standard Precautions, follow Isolation Precautions for any patient diagnosed with or suspected of having a contagious disease. Know the precautions and work practices to use in your work area or job duties to prevent exposure to blood or body fluids or to airborne infections. Report a suspected exposure or outbreak of communicable diseases to your supervisor. Supervisors are to report these exposures or outbreaks to Infection Control and Employee Health.

There are three categories of isolation: Droplet, Airborne, and Contact Precautions.

DROPLET	For patients known or suspected to be infected with pathogens transmitted by large respiratory droplets that travel short distances (<3 ft.) and are generated by a patient who is coughing, sneezing or talking, such as, Influenza, Bacterial Meningitis, Mumps, Scarlet Fever, Pertussis, and Rubella.
	PPE Needed: Yellow surgical mask is required during contact with the patient.
AIRBORNE	For patients known or suspected to be infected with microorganisms transmitted by small respiratory droplets from person to person by the airborne route over long distances (>3 ft.) such as, Measles, Tuberculosis, Severe Acute Respiratory Syndrome (SARS), Smallpox and Chickenpox. These patients must be placed in a negative pressure room with the door kept closed.
	PPE Needed: N95 or PAPR is required when entering the room.
CONTACT	For patients with known or suspected infections that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment. Infections such as MRSA, VRE, and C. difficile require the use of gown and gloves.
	PPE Needed: Gown and gloves.

Special Precautions may be used for patients who are Neutropenic. When a patient is neutropenic, the level of white blood cells in their body is considered low. Neutropenia affects the body's ability to fight off infections. The following are preventive measures may be used:

- A private room with closed door.
- Hand washing upon entering room.
- No visitors or staff with infectious illnesses may enter the room.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE's such as gown, gloves, mask, goggles, and face shield are barriers that should be used to prevent exposure to blood, body fluids, and airborne organisms (i.e. during direct contact with the patient, indirect contact with the patient's environment, or during procedures that may produce splashes). PPE is for workforce members and patients.

PPE Guidelines:

- Located in isolation cart and clean utility room.
- Must be applied prior to an anticipated exposure.
- Caution must be used to avoid contaminating the environment during patient care activities (i.e. during specimen collection and patient transport).
- Remove and discard PPE at the conclusion of the activity prior to leaving the work area (except for the N95 respirator which must be discarded outside of the room).
- PPE are single use only and are not to be used between patients.

- Hand hygiene must be performed after removal of PPE.
- Gloves:

    1. Do not substitute for hand hygiene.
    2. Must be changed between patients.
    3. Must be removed if damaged/torn/punctured.
    4. Must be worn when hands have any open areas, cuts, or abrasions.

- Disposable gown options:

    1. Sterile/fluid resistant (blue).
    2. Non-sterile fluid resistant (blue).
    3. Non-sterile non fluid resistant (yellow).

BLOODBORNE PATHOGENS
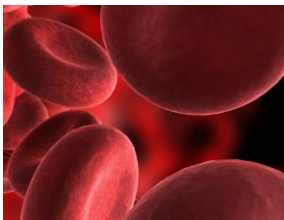
Healthcare workers are at risk for occupational exposure to bloodborne pathogens, including Hepatitis B virus (HBV), Hepatitis C virus (HCV), Human Immunodeficiency Virus (HIV), and other bloodborne diseases. Exposures occur from an infectious patient's blood or body fluid containing blood (e.g., semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pericardial fluid, amniotic fluid, saliva in dental procedures, breast milk, urine) through needle sticks, sharp instrument punctures to the skin, or splashes to the eyes, nose, or mouth.

HEPATITIS B VIRUS (HBV) AND HEPATITIS C VIRUS (HCV)

HBV and HCV cause serious liver disease. Some people are infected and have no symptoms. Infection may range from no symptoms at all to flu-like symptoms (nausea, vomiting and fever). Transmission of HBV and HCV occurs primarily after exposure to blood or body fluids from a person who has acute or chronic HBV/HCV infections.

HBV and HCV are transmitted in four primary ways:

1. Sexual contact (e.g., unprotected intercourse).
2. Parenteral exposure (e.g., needle sharing, blood exposure or tattooing).
3. Perinatal exposure (may be transmitted from mother to fetus).
4. Recipient of blood/blood products.

Most people infected with HBV recover and clear the infection. Most people infected with HCV become chronically infected. HBV is preventable by the Hepatitis B vaccine. Currently, there is no vaccine for Hepatitis C.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV attacks the immune system and causes it to break down. A person infected with HIV may carry the virus without developing symptoms for years.

HIV is transmitted in four primary ways:

1. Sexual contact (e.g., unprotected intercourse with an HIV positive individual).
2. Parenteral exposure (e.g., needle sharing, blood exposure or tattooing).
3. Perinatal exposure (may be transmitted from mother to fetus during pregnancy and in breast milk).
4. Transfusion of blood/blood products.

There is no known cure for HIV infection. However, post-exposure prophylaxis, if given early enough, may prevent seroconversion.

BLOODBORNE PATHOGEN EXPOSURE PREVENTION

Work Practice Controls reduce the likelihood of exposure by altering the manner in which a task is performed, such as, hand hygiene, use of PPE, proper handling of sharps, good hygiene (clean/ hair pulled back and off the shoulders), cleaning/disinfection of the environment, properly handling contaminated linen, proper transport of specimens (in leak-proof containers), proper disposal of trash, and use of resuscitation bags.

Do not eat, drink, apply cosmetics or lip balm or handle contact lenses in work areas where exposure may occur, per Cal/OSHA regulations. Do not keep food or beverages in refrigerators, freezers or cabinets, on countertops or bench tops, or in any other area where they might be exposed to potentially infectious materials.
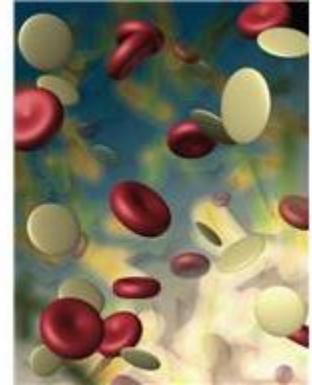
Workforce members with exudative lesions or weeping dermatitis should refrain from direct patient care and handling of patient-care equipment until the condition resolves. Workforce members with lesions or unexplained rash should go to Employee Health for evaluation.

Engineering Controls isolate or remove the bloodborne pathogen hazards from the workplace, such as autoclaving, self-sheathing needles and other sharp-safety devices, sharps disposal containers, and hand washing sinks.

HANDLING BLOOD AND BODY FLUID SPILLS

- Contain area so that others are not exposed.
- Call Environmental Services for cleanup.
- Wear gloves and other protective equipment as necessary during cleaning and decontamination procedures.

EXPOSURE TO BLOOD AND BODY FLUIDS

Exposures occur when blood or body fluids come in contact with your open skin (rash, wound or burn) or mucous membrane lining (eyes, nose or mouth).

If you are exposed, ***IMMEDIATELY***

- Wash the exposed area.
- Report the exposure to your supervisor.
- Go to Employee Health/MWI for follow up.

Bloodborne Pathogen Training is a mandatory annual requirement.

> **NOTE**
>
> The most effective treatment is treatment that is started within 1-2 hours of exposure.

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS

Central line associated bloodstream infections (CLABSIs), are a leading cause of sepsis in the healthcare setting. These infections can occur in any patient who has a central line catheter. Central line catheters may include catheters such as triple lumen catheters, PICC lines, Hickman catheters, urinary catheters, and dialysis catheters. Certain risk factors may contribute to the occurrence of CLABSIs, including prolonged hospitalization prior to catheterization, prolonged duration of catheterization, microbial contamination at the insertion site or catheter hub, internal jugular catheterization, low immunity, prematurity, and intravenous total parenteral nutrition administration.

Prevention Strategies for Reducing the Incidence and Risk of CLABSIs

- Use a catheter checklist to ensure adherence to infection prevention practices at the time of central venous catheter insertion.
- Perform hand hygiene before catheter insertion or manipulation.
- Avoid using the femoral vein for central venous access in adults.
- Use an all-inclusive catheter cart or kit.
- Use maximal sterile barrier precautions during insertion (requires the use of a cap, mask, sterile gown, sterile gloves, and large sterile drape).
- Use a chlorhexidine based antiseptic for skin preparation in patients older than 2 months.
- Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter.
- Remove nonessential catheters and review daily the necessity for the catheter.
- Do not routinely replace central line catheters unless there are clear indications for replacement.

SURGICAL SITE INFECTIONS

Surgical site infections (SSIs) occur in 2-5% of patients undergoing inpatient surgery. Certain risk factors may contribute to the occurrence of SSIs including diabetes, obesity, smoking, a weakened immune system, use of razors for hair removal, current infected status, improper aseptic technique, and inadequate skin prep.

Prevention Strategies for Reducing the Incidence and Risk of SSIs

- Administer prophylactic antibiotics within 1 hour before surgery.
- Do not remove hair at the operative site unless the presence of hair will interfere with the operation; if you need to remove hair do not use a razor.
- Use a chlorhexidine-based prep agent.
- Follow hand hygiene policy.
- Aseptic techniques.

VENTILATOR ASSOCIATED PNEUMONIA (VAP)

Ventilator-associated pneumonia (VAP) is a form of nosocomial pneumonia that occurs in patients receiving mechanical ventilation. VAP is associated with increases in morbidity and mortality, hospital length of stay, and cost. Interventions to prevent VAP begin at the time of intubation and should be continued until extubation.

Prevention Strategies for Reducing the Incidence and Risk of VAP

- Perform Hand Hygiene before and after contact with mucous membranes, respiratory secretions, ventilators or objects contaminated with respiratory secretions even if gloves are used.
- Maintain head of bed elevated.
- Perform routine mouth care and oral care with chlorhexidine.
- Perform daily sedative interruption and daily assessment of readiness to extubate.
- Peptic ulcer disease prophylaxis.

PREVENTION OF CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

CAUTI's are the most common hospital associated infections (HAI); 80 percent are attributable to an indwelling catheter. Limiting catheter use and duration are important to preventing infection. AS of January 1, 2013 hospitals were required to implement a plan to prevent CAUTI's based on evidence-based practice. OVMC has implemented a Nurse Driven Urinary Catheter Assessment and Removal Protocol. A physician order is not required for removal of an indwelling catheter.

CAUTI Evidence-Based Prevention Strategies

1. Insert catheters only for appropriate indications.
2. Remove unnecessary catheters.
3. Perform Hand Hygiene.
4. Insert catheters using aseptic technique and sterile equipment.
5. Properly secure indwelling catheters after insertion.
6. Maintain a closed drainage system.
7. Maintain unobstructed urine flow.
8. Daily review for catheter necessity.
9. Keep bag off the floor and maintain below level of bladder.
10. Use silver impregnated catheters.

MULTI DRUG RESISTANT ORGANISMS (MDROS)

A Multi Drug Resistant Organism (MDRO) is a strain of bacteria that is resistant to common antibiotics used to treat infections. Infections can vary, depending on the organism. MDROs can cause skin infections (boils, abscesses), urinary tract infections, bloodstream infections, and pneumonia, and they can infect wounds, the respiratory tract and surgical sites.

Prevention Strategies for Reducing the Incidence and Risk of MDROs

- Follow hand hygiene policy.
- Ensure proper cleaning and disinfection of equipment and the environment.
- Use contact precautions for patients with MDROs.

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Methicillin-Resistant Staphylococcus Aureus (MRSA), or Oxacillin-Resistant Staphylococcus Aureus (ORSA), is an antibiotic resistant type of bacteria that can cause skin, blood, surgical site, urinary, and respiratory infections.

Prevention strategies for reducing the incidence and risk of MRSA infections

- Follow hand hygiene policy.
- Use contact precautions for MRSA colonized or infected patients.
- Educate patients and their families about MRSA and how to prevent its spread.
- Ensure proper cleaning and disinfection of equipment and the environment.

MRSA Screening Protocol

All patients admitted to the hospital must be screened for MRSA if they are scheduled for inpatient surgery, have been previously discharged from a hospital within the last 30 days, are being admitted to the intensive care unit, are receiving dialysis, or have been transferred from a Skilled Nursing Facility. The patient must be provided with MRSA education. In addition, the physician responsible for patient's medical care must inform the patient or the patient's representative of a positive MRSA screen. It's the Law!

VANCOMYCIN-RESISTANT ENTEROCOCCI (VRE)

Vancomycin-resistant enterococci (VRE) is a type of bacteria normally found in the intestines and female genital tract that is resistant to Vancomycin. VRE can cause infections of the urinary tract, the bloodstream, or of wounds. VRE occurs more frequently in patients who have been previously treated with Vancomycin or other antibiotics for long periods of time, are hospitalized, have weakened immune systems, have undergone surgical procedures of the abdomen or chest, or have long term urinary or central line catheters.

Prevention strategies for reducing the incidence and risk of VRE infections

- Follow hand hygiene policy.
- Use contact isolation for VRE colonized or infected patients.
- Educate patients and their families about VRE and how to prevent its spread.
- Ensure proper cleaning and disinfection of equipment and the environment.

CLOSTRIDIUM DIFFICILE (C. DIFFICILE)

Clostridium difficile infection (CDI) is the most common cause of antibiotic associated diarrhea. Risk factors for CDI include prior or current antibiotic administration, gastric acid suppression, hospitalization, and advanced age. C. difficile can survive in the environment for long periods of time in a spore form and therefore may be difficult to kill with usual cleaning products.

Prevention strategies for reducing the incidence and risk of CDI

- Use soap and water as the preferred method for hand hygiene.
- Use contact precautions for C. difficile patients.
- Educate patients and their families about C, difficile and how to prevent its spread.
- Ensure proper cleaning and disinfection of equipment and the environment (bleach products are recommended).

PREVENTING SHARPS INJURIES

Injuries can occur while handling or passing a sharps device after it has been used, recapping a device, manipulating a device in a patient, transferring potentially infectious material between containers, or during disposal and clean up. Any health care worker handling sharps devices or equipment such as scalpels, sutures, hypodermic needles, blood collection devices, or phlebotomy devices is at risk.

Simple measures to reduce the risk of sharps injuries include:

DO	DO NOT
■ Use and activate needle/sharps safety devices (e.g., safety needles, angel wings, point loc). ■ Get help with uncooperative patients. ■ Let falling objects fall. ■ Dispose of sharps into covered, labeled, and ridged puncture resistant sharps container. ■ Use tongs or brush & dustpan to pick up broken glass. ■ Practice safe handling techniques.	■ Bend, break or recap needles. ■ Rush or take shortcuts. ■ Leave needles and sharps at the patient's bedside. ■ Reach into disposal containers. ■ Touch broken glass. ■ Overfill sharps container. ■ Carry loose sharps in your pockets.

Notify your department safety coordinator for any additional Bloodborne Pathogen questions. Failure of workforce members to comply with Olive View policies will result in disciplinary action per hospital policy. Three product evaluation forms are available on the intranet: Generic Safety Device Evaluation, Phlebotomy Device Evaluation and Safety Needle/Syringe Evaluation.

SAFE INJECTIONS PRACTICES

(**Source:** Centers for Disease Control and Prevention's (CDC) HICPAC "*Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007*")

The following recommendations apply to the use of needles, cannulae that replace needles, and, where applicable, intravenous delivery systems:

- Use aseptic technique to avoid contamination of sterile injection equipment.
- Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.
- Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient.
- Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use.
- Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
- Use single-dose vials for parenteral medications whenever possible.
- Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
- If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile.
- Do not keep multi-dose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

INJECTION SAFETY TIPS FOR PROVIDERS

(**Source**: *Centers for Disease Control and Prevention (CDC), March 2008*)

In particular, providers should NOT administer medications from the same syringe to more than one patient, even if the needle is changed. Additional protection is offered when medication vials can be dedicated to a single patient. It is important that:

- Medications packaged as single-use vials never be used for more than one patient;
- Medications packaged as multi-use vials be assigned to a single patient whenever possible;
- Bags or bottles of intravenous solution not be used as a common source of supply for more than one patient; and
- Absolute adherence to proper infection control practices be maintained during the preparation and administration of injected medications.

Safe injection practices and sharps safety go hand in hand. By following safe injection practices to protect patients, healthcare providers also protect themselves. For example, the unsafe practice of syringe reuse also puts healthcare providers at risk of needlestick injury and potential bloodborne pathogens exposure. Once a needle and syringe are used on a patient, they should be discarded in a sharps container.

REMEMBER

ONE Needle,
ONE Syringe,
ONLY ONE Time!
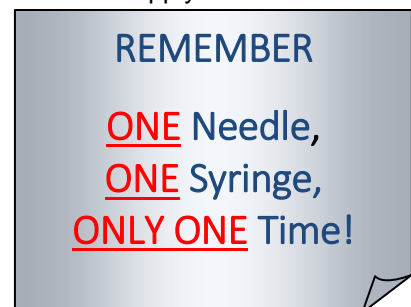
For more information about sharps safety, please see:

- **www.cdc.gov/sharpssafety**
- **www.oneandonlycampaign.org**

VACCINATIONS

Hepatitis B Vaccine is provided free of charge for County employees at risk of exposure to blood and body fluid per their job duties. Varicella (Chickenpox) and MMR (measles, mumps, and rubella) vaccines are recommended and/or may be required for workforce members per their exposure risk in their job duties. Acellular Pertussis is available for high risk workforce members and those who have had a bloodborne pathogen exposure. Workforce members may decline to accept a recommended vaccination by completing a mandatory declination form. If the workforce member later decides to accept the vaccination(s), it will be provided to them. Non-County workforce members should obtain vaccinations from their physician or licensed healthcare professional; services provided through DHS will be billed to the contractor agency, as appropriate.

SEASONAL INFLUENZA

As a condition of employment/assignment and continued employment/assignment, an annual influenza vaccination is mandatory for every workforce member who works in a DHS facility that provides patient care unless the workforce member completes and signs an informed declination form. DHS will determine the dates of the anticipated influenza season based on local and/or state public health official data and provide instructions to the workforce to begin obtaining vaccination.   Generally the influenza season extends from September to March. Compliance with annual mandatory influenza vaccination will be required by November 1st of each year. All workforce members who have not received the influenza vaccination by November 1st will be required to wear a surgical mask whenever they work in a health care area that provides patient care beginning November 1st and extending for the duration of the influenza season. DHS will offer onsite influenza vaccination to all workforce members at no cost to the workforce member. For more information, see DHS Policy No. 334.200.

AEROSOL TRANSMISSIBLE DISEASE (ATD)

An Aerosol Transmissible Disease (ATD) or Aerosol Transmissible Pathogen (ATP) is a disease or pathogen that is transmitted by aerosols, which requires either Droplet or Airborne Isolation.   The complete list of Aerosol Transmissible Disease/Pathogens which require Airborne or Droplet Isolation can be found in the Infection Control Manual. In addition, annual ATD/TB training is mandatory for employees.

EARLY IDENTIFICATION

Efforts to identify suspected or confirmed ATD infectious patients will begin as soon as the patient enters the hospital. Patients should be assessed for ATD symptoms when they enter the facility. If a cough or other symptoms are present, a surgical mask will be placed on the patient. If the patient is admitted, an order for either **Airborne** or **Droplet** Isolation must be part of the admitting order.

WORKFORCE MEMBERS PRECAUTIONS

Workforce members are to wear a NIOSH approved "N-95" respirator mask for airborne isolation or a surgical mask for droplet isolation if the patient is coughing or unable to wear the mask.

TRANSPORTING PATIENTS

Patients leaving the room for urgent procedures must wear a surgical mask, be escorted by a healthcare worker, and the department or area must be notified prior to transporting the patient for any procedure or evaluation.

EXPOSURES

An "ATD Exposure Incident" is defined as an event in which a patient or employee sustains a substantial exposure to a ATD case without having had the benefit of all applicable and required control measures (i.e. respiratory protection, isolation, treatment). An employee who is exposed is to notify their supervisor as soon as possible. The supervisor who becomes aware of an exposure is to notify Employee Health and Infection Control and provide a list of employees suspected to have had an exposure. Exposed employees will be notified as soon as possible of potential exposures. A post exposure evaluation will be conducted for those employees with a significant exposure by Employee Health.

TUBERCULOSIS (TB)

TB spreads through the air in droplets generated when a person with active TB coughs, sneezes or speaks. These droplets are so small that regular air currents within a building can keep them airborne for hours. If you inhale these droplets, you can become infected with TB. When inhaled, the bacteria may become established in your lungs and spread throughout your body. TB is most commonly spread by close, prolonged, intense and unprotected contact indoors to an active TB patient.

TB precautions include the following:

- Annual TB screening for all workforce members who work or must perform duties inside a healthcare facility.
- Early triage and identification of TB suspects.
- Isolation of suspect and confirmed TB patients.
- Proper engineering and maintenance of negative pressure TB isolation rooms (door is to be kept closed at all times).
- TB patient wears a barrier (yellow surgical) mask when outside of isolation room and in enclosed area.
- Any workforce member providing direct patient care to respiratory isolation patients is to be fit tested and use an N95 respirator mask:
    - In a TB patient's isolation room.
    - During procedures that generate airborne secretions.
    - When caring for suspected or confirmed TB patient(s).
    - During vehicle transport of suspected or confirmed TB patients.
- Patients who have or are suspected of having TB should be placed in a negative pressure room where the air is vented to the outside.

ACTIVE TB DISEASE

Signs of illness are usually present and may include the following:

- Prolonged cough (2 or more weeks).
- Feel weak.
- Have a fever.
- Have weight loss.

- Loss of appetite.
- Night sweats.
- Coughing up blood or have chest pain when coughing.
- This person can infect others unless he or she is taking the TB medicine as directed.

TB INFECTION (LATENT)

This person carries the TB germ but:
- o   Does not look or feel sick.
- o   Cannot infect others.

Preventative treatment is recommended for some people.

INFECTION CONTROL FOR COMPUTERS

Computer hardware, especially keyboards, can be contaminated with microorganisms when touched by contaminated hands. Computer access without proper hand hygiene can deposit organisms on the keyboard.

DO'S AND DON'TS ON PORTABLE DEVICES

DO	DON'T
▪ Perform Hand Hygiene prior to using device. ▪ Clean and disinfected device regularly or when visibly soiled or contaminated with blood. ▪ Clean device before moving to another patient room. ▪ Remove devices from patient room following use; this includes isolation rooms. ▪ Keep computer at least 3 feet from sink.	▪ Lay a device on a patient bed or any furnishings in the patient room. ▪ Place food or drinks on any mobile cart or in any wall unit. ▪ Use gloves during computer use.

INFECTION CONTROL MANUALS

- Infection Control Plan
- Requirements for Reportable Communicable Diseases
- Hand Hygiene Policy
- Standard Precautions Policy
- Isolation Precautions Policy
- Blood borne Pathogen Exposure Control Plan
- ATD/Tuberculosis Exposure Control Plan
- Medical Waste Management
- Department Specific Policies and Procedures
- Cleaning and Disinfection Policies

REMEMBER

Practicing good hand hygiene is the most important intervention in preventing the spread of infection!

For additional information contact:

- Infection Control Department – (818) 364-3624
- Employee Health – (818) 364-3403
- TB Liaison Nurse – (818) 364-4590

Remember
Infection Control – It's in Your Hands!

ALL STAFF (What a Joint Commission Surveyor Is Likely to Ask You)

The following information lists some of the key points that are important to remember as they are an integral part of providing outstanding patient care while fulfilling the accreditation standards of The Joint Commission. If a Joint Commission surveyor is on site, they are likely to ask you questions that relate to the information below.

LEADERSHIP

- Our mission, vision and values statements are included in various training programs. In addition to the definition of Olive View's mission, vision and values contained in this handbook, the hospital makes it available in a wallet-size format so that you can insert it in your identification (ID) badge holder.

- All licensed professionals are expected to adhere to the highest ethical and professional standards of behavior and performance.

- If you observe behavior in a licensed professional that may compromise patient or environmental safety; you should report it to the appropriate office (see telephone numbers listed under "Professional Credentials (License/Registration/Certification/Permit)").

- It is important that you understand, whether you are a healthcare practitioner, technician, clerical or housekeeping member of our staff, that your job supports our organization's mission to improve the health of our patients.

THE JOINT COMMISSION ACCREDITATION

- Under The Joint Commission's Accreditation Participation Requirements, any workforce member who has concerns about the safety or quality of care provided in the organization may report those concerns to The Joint Commission.

- All surveys are unannounced, so it is important to maintain continuous preparedness.

- During the survey process, the surveyors will observe: direct patient care; medication administration; care planning processes; environment of care (including security); and medical record documentation.

PATIENT SAFETY

- We have a proactive, multifaceted and integrated Patient Safety Program. The goal of the program is to prevent adverse occurrences rather than just react to them.

- You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmentally unsafe condition, or "near miss" that causes you to have concern for the safety of patients, visitors, or staff as soon as possible.

- The Joint Commission annually establishes National Patient Safety Goals (NPSGs) which Olive View workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.

- Universal Protocol **applies to all surgical and non-surgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery.

- If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility's response mechanism and stay with the patient/visitor until help arrives.

- Prevention of patient falls is the responsibility of **every** workforce member.

- Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.

STAFF RIGHTS AND RESPONSIBILITIES

- All Olive View's staff must complete all mandatory training and competency validation requirements for their respective positions (e.g., orientation, compliance awareness, infection control, fire/life safety, emergency management, CPR, unit/area-specific orientation, and other core competencies.)
- Workforce members are responsible for reporting any activity that appears to violate the Code of Conduct. DHS will not retaliate against anyone who reports a suspected violation in good faith.
- Compliance Awareness training is mandatory and provided to workforce members at the start of service. Compliance update training is provided every two years thereafter.
- The County of Los Angeles has established a "zero tolerance policy" for any conduct that could possibly be interpreted as harassing, offensive or inappropriate in the workplace, including actions of a sexual nature.
- It is the responsibility of the licensed professional to renew required professional credentials. Failure to comply with licensure requirements may subject the person to disciplinary action, up to and including discharge/release from County service or release from a contracted assignment. Professional staff that must maintain a current professional credential to perform the duties will not be allowed to work with an expired professional credential.
- It is your responsibility to obtain a health screening annually.
- Refer to the Training Matrix at the end of this handbook for additional training requirements.

PATIENTS' RIGHTS, RESPONSIBILITIES, AND SERVICES

- Olive View Patients' Rights and Responsibilities are posted throughout the hospital for reference.
- An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their healthcare decisions.
- The AHCD allows a person to give directives regarding healthcare decisions, such as whether or not they want life-sustaining treatment should they become terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so.
- Olive View admissions staff informs patients of their options concerning AHCD's.
- Patients can fill out an AHCD document or give oral direction to a physician who will document it in the patient's medical record.
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Customer Services Department. At Olive View-UCLA Medical Center Customer Service is located on the second floor, Room 2A103, telephone number (818) 364-4813. For the health centers, Customer Service is located at the Mid-Valley Comprehensive Health Center on the fifth floor, Room 520, telephone number (818) 947-4033. Staff is available to help customers Monday through Friday between 8:00 a.m. and 4:30 p.m.

ENVIRONMENT OF CARE

- The Environmental Health and Safety Program and Environment of Care Committee investigate all recognized hazards to patient safety.
- Safety concerns must be reported to your supervisor and the Safety Officer. You can report safety concerns anonymously.
- The Safety Data Sheets (SDS) tell what hazards a chemical presents and how to handle spills/exposures.
- You should know the location of the SDS sheets in your work area. If you do not know where they are kept, ask your supervisor. The master SDS manual is located in the hospital's Safety Office.
- In the event of a fire, follow the **SAFE** and the **PASS** procedures as appropriate.

- You must know where the fire alarm, fire extinguisher, and exits, closest to your work area are located. If you are unable to find them, check with your supervisor.

- Know what all emergency codes mean and how <u>you</u> should respond to each, for example:

    - Code Blue means cardiac (or cardiopulmonary) arrest involving an adult.
    - Code White means cardiac (or cardiopulmonary) arrest involving a child.
    - Code Red means fire emergency.
    - Code Gold means "Behavior Response Team".
    - Code Gray means "Disruptive/Combative Person".
    - Code Silver means person with a weapon and/or active shooter and/or hostage situation.
    - Code Green means patient elopement.
    - Code Purple means child abduction.
    - Code Pink means infant abduction.
    - Code Orange means hazardous spill/radiation incident.
    - Code Yellow means bomb threat.
    - Code Rapid Response means urgent medical assistance is needed for inpatients.
    - Code Assist means urgent medical assistance is needed for outpatients, visitors, or staff.
    - Code Triage Alert means potential disaster situation.
    - Code Triage Internal means internal disaster situation.
    - Code Triage External means external disaster situation.

PERFORMANCE IMPROVEMENT

- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
- How have you been involved in the improvements made in your department in the past 12 months? How have you worked with other departments to improve care/services? If you don't know, speak to your supervisor.
- Olive View uses Lean Six Sigma and other performance improvement methodologies, such as the Plan Do Study Act Model (PDSA).

RISK MANAGEMENT

You may report events in one of the following ways:

- UHC Event Notification System.
- Risk Manager's Office at (818) 364-3026.
- Medical Administration at (818) 364-3035.
- Patient Safety Officer at (818) 364-3026.
- Employee Health Services at (818) 364-3403.

- A **sentinel** event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, including serious injury specifically loss of limb or function, not related to the natural course of the patient's illness or underlying condition.

MANAGEMENT OF INFORMATION

- Protect Patients' Right to Personal Privacy.
- Protect the privacy of Personally Identifiable Information as well as Protected Health Information.

- Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside the DHS e-mail domain.

- When conducting a conversation regarding a patient, do so in a private place or speak quietly to minimize the possibility of being overheard.

- Keep medical records and other documents containing PHI out of public view.

- If a patient requests a restriction regarding sharing information about them such as diagnosis and/or treatment with family and/or others, document the request and make sure the treatment teams is aware of the request.

- Make sure all documents belong to the patient and use the two identifier process before providing patients with documents such as appointment reminders, discharge summaries, and eligibility packets.

- Treat other people's confidential information as if it were your own.

- Report suspected HIPAA violations to the facility Privacy Coordinator at (818) 364-3001.

- Always check two patient identifiers to make sure you are providing the right information to the right patient.

- It is the responsibility of every member of our service delivery team to maintain reasonable and appropriate administrative, physical and technical safeguards to protect the privacy and confidentiality of our patients' PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form.

- Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment and healthcare operations (TPO).

- Personally Identifiable Information (PII), information similar to PHI, must be protected.

- Olive View uses the following safeguards to protect patient-specific information:

    o Use shredders and locked bins to discard PHI documents.
    o Cover carts used to transport medical records.
    o Lock doors and use sign-in logs to limit access to the Health Information Management Department.
    o Required Compliance Awareness Training and Privacy & Security Survival Training: Protecting Patient Information for all staff.
    o Implement a need to know level of security to access PHI.
        ♦ If you access or disclose patient information that is not related to your job or that does not have the patient's authorization, you are in violation of DHS policy, HIPAA and State law and may be subject to monetary fines, civil or criminal penalties, or corrective action including discharge from County service or assignment. Licensed professionals may be reported to their licensing board/agency for disciplinary action.
    o Use automatic log-off of PC's after non-use of systems.
    o Use user-ID and Password to access PHI.
    o Encrypt of laptops, external storage devices and portable medical equipment that store ePHI.
    o Regularly review reports to Information Technology (IT) showing outgoing, incoming and transferring staff to ensure valid users.
    o Limited remote access is provided to user by Virtual Private Network (VPN).

- In the event of a disaster, Olive View ensures against loss of data by activating the IT Disaster Recovery Plan. Additionally, IT performs daily data backup on all servers and stores the backed-up information at an off-site location.

- Olive View management conducts an annual IT Needs Assessment Survey to determine information needs of all staff, including physicians. The information is then included in the County-wide Business Automation Plan for budgeting.

- Olive View has instituted "read back", "repeat back" procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

- Olive View direct patient care staff obtains clinical information from other treatment sites by requesting the patient's medical record from the Health Information Management (HIM) Department. Patient information may also be accessed through the electronic patient information system. Access to the system is controlled through a security clearance process.

- Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.

- Olive View provides "knowledge-based data and information" through the Olive View Health Science Library, located at Olive View Library. Leaders and care providers can access journals, textbooks, audiovisual materials etc. The library is accessible online.

INFECTION CONTROL

- Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection.

- You must wash your hands before and after direct patient contact, after removing gloves, before/after eating, drinking, smoking, after using the toilet, whenever there is any doubt about contamination, and when hands are visibly soiled.

- Follow the Respiratory Hygiene/Cough Etiquette guidelines.

- Artificial fingernails are not permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or equipment that will be used by a patient or used directly on a patient, or for those who have contact with food.

- Use gloves before contact with mucous membranes, open skin, blood/body fluids, or the handling of contaminated substances or surfaces. Always change your gloves between patients. Glove use does not substitute for hand hygiene.

- The three categories of Isolation/Transmission-Based Precautions are: Airborne, Droplet, and Contact Precautions.

- You must follow the Personal Protective Equipment guidelines to prevent exposure to blood or body fluids or to airborne infections.

- In the event of a sudden influx of a large number of infectious patients, Olive View will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the disaster manual; all departments have copies of the disaster manual.

All clinical workforce members who provide care, treatment or services to patients should complete this section of the Orientation. This includes direct and indirect caregivers. Examples* of direct and indirect caregivers include:

Registered Nurses	Diagnostic Ultrasound Technicians
Licensed Vocational Nurses	EEG Technicians
Nursing Attendants	Lab Assistants
Physicians	Medical Technologists
Dentists	Pharmacists
Respiratory Care Practitioners	Pharmacy Technicians
Occupational Therapists	Nuclear Medicine Technologists
Radiology Technologists	Phlebotomy Technicians
Physical Therapists	Recreation Therapists
Speech Pathologists	Clinical Social Workers
Rehabilitation Therapy Technicians	Surgical Technicians
Licensed Physical Therapy Assistants	Dental Assistants
Nurse-Midwives	Dental Hygienists
CRNA'S	Registered Dietitians
Physician Assistants	Occupational Therapy Assistants
Nurse Practitioners	Cardiac Monitor Technicians
Certified Medical Assistants	

* Also anyone as required by his or her classification and who provides patient care.

PATIENT CARE PRACTICES

This section addresses general patient care principles related to population-specific guidelines, infection control, read back requirements, pain assessment/reassessment, medication management, behavioral restraints, Universal Protocol and medical records requirements for physicians/LIP.

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

Staff members with direct patient care responsibilities are trained in working with the appropriate population-specific (age-related) groups (neonate, infant, child, adolescent, adult and geriatric patients) during the initial area/job-specific orientation. If you interact with patients as part of your job, you must possess/develop skills and competencies for delivering population-specific appropriate communications, care and interventions in order to assure that each patient's care meets his/her unique needs. People grow and develop in stages that are related to their age and share certain qualities at each stage. By adhering to these guidelines, you can build a sense of trust and rapport with your patients and meet their psychological needs as well. Our population-specific guidelines are:

NEONATES (BIRTH TO 28 DAYS)

- Neonates may include newborns.
- Provide security and ensure a safe environment.
- Involve the parent(s) in care.
- Limit the number of strangers around the neonate.
- Use equipment and supplies specific to the age and size of the neonate.

INFANTS (1 MONTH TO 12 MONTHS)

- Use a firm direct approach and give one direction at a time.
- Use a distraction, e.g., pacifier or bottle.
- Keep the parent(s) in the infant's line of vision.
- Use equipment and supplies specific to the age and size of the infant.

CHILDREN (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 6-12).
- Give praise, rewards, and clear rules. Encourage the older child to ask questions.
- Use toys and games to teach the child and reduce fears.
- Always explain what you will do before you start; be age appropriate. Involve the older child in care.
- Provide for the safety of the child. Do not leave the younger child unattended.
- Use equipment and supplies specific to the age and size of the child.

ADOLESCENTS (13 YEARS THROUGH 17 YEARS)

- Treat the adolescent more as an adult than a child. Avoid authoritarian approach and show respect.
- Explain procedures to adolescents and parents using correct terminology.
- Provide for privacy.

ADULTS (18 YEARS THROUGH 64 YEARS)

- Be supportive and honest.
- Respect the patient's personal values.
- Support the person in making healthcare decisions.
- Recognize commitments to family, career and community.
- Address age-related changes.

GERIATRICS (65 YEARS & OLDER)

- Avoid making assumptions about loss of abilities, but anticipate the following:

  a. Short term memory loss.
  b. Decline in the speed of learning and retention.
  c. Loss of ability to discriminate sounds.
  d. Decreased visual acuity.
  e. Slowed cognitive function (understanding).
  f. Decreased heat regulation of the body.
  g. Ability to chew food properly.

- Provide support for coping with any impairment.
- Prevent isolation; promote physical, mental, and social activity. Provide information to promote safety.

PAIN ASSESSMENT AND REASSESSMENT

The distress of pain can be overwhelming. It can drain patients and their families: physically, emotionally, and financially. Pain interferes with healing. Pain has been described as anything from a slight twinge of discomfort to sharp, stabbing sensations. The International Association for the Study of Pain and the American Pain Society (APS) define pain as, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." In healthcare we use the following definition of pain: "Pain is whatever the patient says it is."

WHAT IS PAIN MANAGEMENT?

According to Joint Commission Patient Rights standards, all patients have the right to effective pain management. The ultimate goal of pain management is to help patients be as comfortable and as pain-free as possible. Effective pain management consists of a multidisciplinary team approach to assessing, treating and educating the patient and their family regarding pain.

PAIN ASSESSMENT: PAIN IS THE 5TH VITAL SIGN

The first step to effective pain management is assessment. All patients are assessed for pain upon admission, with vital signs, and with painful procedures. Patients are also reassessed after any interventions. On admission, patients are educated on the use of the pain tool and a pain goal is established for optimal patient comfort/function. This goal may change at any time. There are a variety of methods to assess for pain.

Here at Olive View we have four approved pain scales:

- Numerical Rating (0-10) Scale
- Faces Scale
  - 24 Hr. Pediatric Pain Assessment-FLACC Scale- Used in patients under 5 years of age. Can be used in patients greater than 5 years who are developmentally delayed, unable to verbalize, or are non-communicative.
  - 24 Hour Neonatal Pain Assessment Form- NPASS (Neonatal Pain, Agitation, and Sedation Scale). The NPASS is used for those infants less than 28 days unless still in the NICU in which case it will be continued.

The Numerical Rating (0-10) scale is taught by discussing the concept of pain and describing that zero is no pain and at the other end of the spectrum, 10 is the worst pain.

The FACES rating system is used for children age 3 to 7 years, those who are developmentally disabled as well as adults who speak a different language. The child/adult is shown a series of faces ranging from happy and smiling to sad and tearful, and instructed to select that face that best correlates with how they feel.

Pain assessment scales to be used include:

> **NOTE**
>
> The same pain scale should be used throughout the child's hospital admission to promote consistency.

a. Infants <30 days of age (corrected for gestational age) use 24 Hour neonatal Pain Assessment Form (N-PASS) in the NICU.
b. Infants to 5 years (and cognitively impaired) use FLACC Scale. **NOTE:** This scale can also be used for the non-verbal patient (e.g., MRCP, severe developmental delay). This scale is used in Pediatrics and Mother-Baby unit.
c. School Age (5 years – 12 years) may use Wong-Baker FACES pain rating scale.
d. School Age/Adolescent (7-18 years) may use either FACES or 0-10 scale according to the patient's preference.

PAIN INTERVENTION

The second step of the pain management processes the intervention or treatment of pain. According to Olive View policy, a pain rating **greater** than the patient's established **goal** indicates the need for pain intervention. Treatment of pain consists of more than just administering pain medication. Other interventions such as heat/cold packs, breathing exercises, relaxation techniques, and imagery can also be effective. The key to successful pain management is to involve the patient and family in the plan of care. Patients should be questioned regarding the effectiveness of pain interventions. Unrelieved pain or ineffective medication must be reported to the physician immediately.

PATIENT EDUCATION

Patient education is an ongoing process in pain management. Patients must be educated in the use of the appropriate pain scale and the importance of prompt reporting of pain. They should be taught that pain will be assessed regularly, and that they should report pain any time they experience it. The patient must be instructed in the therapeutic effects of medications, the appropriate dosage, common side effects, and indications for contacting the physician or clinic.

Remember that patients have a right to effective pain management. Include pain assessment as part of the overall assessment process. Be aware of ineffective pain management and take appropriate steps to notify the health care provider. Educate patients and their families about why pain management is so important.

PAIN SCALES

Wong-Baker FACES Pain Scale

2	Mild Pain
4 – 6	Moderate Pain
8 – 10	Severe Pain

0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST
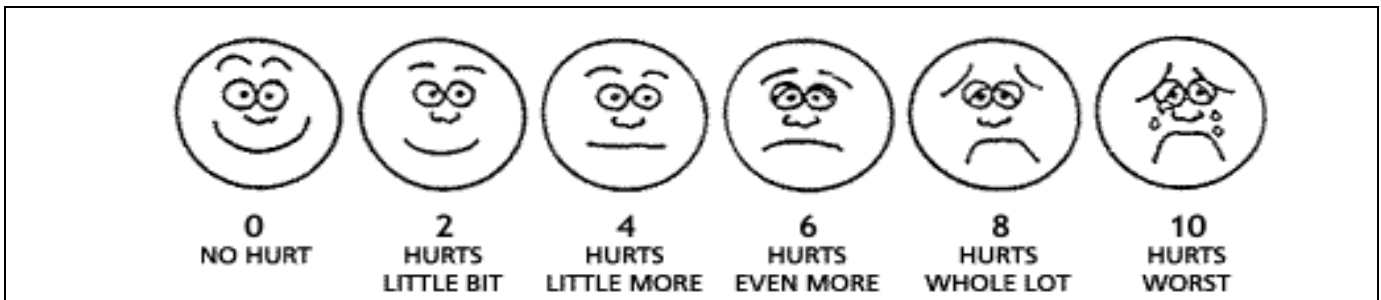
*From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: **Wong's Essentials of Pediatric Nursing**, 6/e, St. Louis, 2001, P. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.*

24 Hr. Newborn-Pediatric Pain Assessment-FLACC Scale

Criteria	Score 0	Score 1	Score 2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, uninterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whispers; occasional complaint	Crying steadily screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Assessment **Reassessment**

Time	Procedure	F	L	A	C	C	Total	Intervention	Time	F	L	A	C	C	Total	Initials

Interventions: Ph: Pharmacologic; SS: Soothing sounds/gentle talking; SW: Swaddling; H: Holding; R: Rocking; P: Pacifier; F: Feeding; PP: Presence of parent; SO: Securing object/favorite toy; T: Touching; C: Comforting; QE: Quiet, peaceful environment.

24 Hour Neonatal Pain Assessment Form

Document Baseline Vital Signs

	HR	RR	BP	SpO2	Print Name, Title	Signature
Days						
Evenings						
Nights						

N-PASS: Neonatal Pain, Agitation, & Sedation Scale © Hummel & Puchalski

24 Hour Neonatal Pain Assessment					
Assignment	**Sedation**		**Normal**	**Pain/Agitation**	
Criteria	**-2**	**-1**	**0/0**	**1**	**2**
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate Crying Not irritable	Irritable or crying at intervals Consolable	High pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally/no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex Decrease muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or fingers splay Body is tense	Continual clenched toes fists, or finger splay Body is tense
Vital Signs: HR, RR BP Sa02	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	Within baseline or normal for gestational age	↑10-20% from baseline SaO_2 76-85% with stimulation - Quick recover	↑20% from baseline SaO_2 ≤ 75% with stimulation-slow recovery Out of sync with vent

Premature Pain Assessment

+ 3 if < 28 weeks gestation/corrected age
+2 if 28-31 weeks gestation/corrected age
+1 if 32-35 weeks gestation/corrected age

24 Hour Neonatal Pain Assessment Form

Routine with Vital Signs Pain Assessment & Management																					
Time	N-PASS Score							Treatment (if necessary)	Time	Reassessment N-PASS Score							Comments	Initials
	CI	BS	FE	ET	VS	GA	T			CI	BS	FE	ET	VS	GA	T		

Procedural Pain Assessment & Reassessment & Management																								
Time	N-PASS Pre-Procedural							N-PASS Procedural							Procedure	Tx	N-PASS Post Procedure							Comments	Initials
	CI	BS	FE	ET	VS	GA	T	CI	BS	FE	ET	VS	GA	T			CI	BS	FE	ET	VS	GA	T		

Interventions: SW: swaddling, H: holding, F: feeding, R: rocking/patting, P: pacifier, S: Sucrose, L: lidocaine, E: EMLA, N: narcotic, T: Tylenol

N-PASS: CI: crying irritability, BS: Behavior State, FE: Facial Expressions, ET: Extremities Tone, VS: Vital Signs, GA: Gestation, T: Total

FOOD AND NUTRITION SERVICES

Food & Nutrition Services (FNS) provides food service to patients at Olive View-UCLA Medical Center following Hazard Analysis Critical Control Point (HACCP) safe food handling guidelines.

1. Patient trays are delivered by FNS staff according to the posted schedule in FNS department which ensures that no more than 14 hours elapses between dinner and breakfast. Meals are served at the following times:

Breakfast	Lunch	Dinner
7:25 am – 8:30 am	11:25 am – 12:30 pm	5:25 pm – 6:30 pm

2. Used trays are picked up by FNS personnel, usually 1 hour after meals were served.

3. "NOW" (late) trays are ordered by calling Diet Office at Ext. 6171. Prior to calling, all diet changes must be entered into the electronic health record (EHR) to support the new order. The NOW tray delivery guidelines are found below.

	Breakfast	Lunch	Dinner
Delivery (hot meal)	8:30 am - 10:00 am	12:30pm - 2:00 pm	6:30pm - 7:30 pm
Pick-up (cold meal)	10:00 am – 10:30 am	2:00 pm – 4:00 pm	7:30 pm – 8:00 pm

4. Physician writes patient diet orders, referring to the Manual of Clinical Nutrition Management, as needed. This manual is located on the hospital intranet. FNS will call nursing units for diets that are not clearly defined in the medical record.

5. FNS offers select menus daily to patients on the following diets: Regular, Low Sodium, Cardiac, mechanical soft, National Dysphagia Diet (NDD) 3 chopped, GI Soft/Low Fiber, Consistent Carb, GDM (gestational diabetic diet), Vegetarian, Renal, High Calorie/High Protein, and Pediatric (4-18 yrs). Non-select menus are sent to the following diets: baby (6-11 months of age), toddler (12-35 months of age), liquid, puree, NDD I, NDD2, wired jaw, post-gastrectomy, and kosher.

6. Patient trays are identified with diet, name, birth date, unit/room, and any known food allergies.

7. Unit Floor Stock is delivered daily by FNS according to established par levels. FNS is responsible for stocking supplies, recording refrigerator temperatures, acting on temperatures not meeting standard, checking for outdated product, and discarding any non-patient items in unit kitchenette refrigerators. Environmental Services maintains cleanliness of the kitchenettes, including the refrigerators.

8. FNS prepares and delivers between meal snacks to patients on the following diets: GDM, Post-Gastrectomy, Toddlers (1-3 years) and High Calorie/High Protein. Other patients requiring snacks may be provided food items from the unit floor stock or get a physician's order for snacks between meals. Nursing may use the Nourishment Serving Guide in providing snacks.

9. Patients on Radioactive Isolation receive meals on disposable-ware and Nursing staff pass their trays.

10. Patients in the psychiatric unit and medical patients with a psychiatric disorder receive plastic utensils on their tray.

11. FNS sends enteral products for tube feeding when ordered via the EHR.

12. Extended stay patients may be offered items from the Café menu if applicable to their diet.

13. Guest trays may be ordered for a member of a patient's immediate family during an emergency situation. The decision for ordering a guest tray should be made based on the patient's medical condition and not on the family's financial status. Physician or Nurse will decide when a visitor should receive a guest tray and obtain verbal approval from Nursing Administration for the guest tray. If approved, the tray should be ordered via the EHR as a "Guest tray". Other applicable guest trays are for parents of children admitted to the NICU or 4C. These trays can be ordered via the EHR or by calling the diet office at x6171.

14. Patients are not excluded from the public Cafeteria unless they do not meet the dress codes requirements. Patients are encouraged to ask for any additional food requests from FNS.

15. See hospital policy No. 306, Food Brought into Patients from Outside. Bringing food from the outside is highly discouraged as FNS cannot guarantee its safety or oversee the proper holding of the food.

16. FNS follows HACCP safe food handling guidelines in its receiving, storing, preparing, holding, and serving practices.

Principles Standards include:

Refrigeration Temperature	41º F or below
Freezer Temperature	0º F or below
Internal Cooking Temperatures	**Poultry**: 165º F **Pork, ground beef, eggs:** 155º F **Roast beef, fish:** 145º F **Reheating** (one time only): 165º F
Food Holding Standards	**Hot foods:** 140º F or above **Cold foods:** 41º F or below
Dish Machine Temperatures	**Wash:** 150º F **Final rinse:** 180º F

CAFÉ SERVICES

The Food & Nutrition Services Department shall provide food services for staff, patients and visitors through cafeteria operations.

1. Regular Hours: 6:15a.m. – 7:30 p.m. seven days a week. Full service hot food shall be available from 6:15 a.m. to 10:30 a.m.; 11:00 a.m. to 2:00 p.m.; and 4:00 p.m. to 7:30 p.m.

2. Payment: Patrons may pay cash, debit/credit card, utilize the Meal card system, or present a meal ticket through Volunteer or Nursing Administration offices. No authorized employee discounts.

3. Cash Control: Cash banks and revenue are justified daily. Cashiers may not leave cash drawers unattended.

4. Smoking: Olive View is a smoke-free campus.

5. Take-Out Food: Due to operational parameters and sanitation regulations, no food may leave the cafeteria unless it is on disposable service ware/covered.

6. <u>Refund Requests:</u> Should be directed to Food & Nutrition Services supervisor or manager.

7. <u>Children:</u> Under age of 11 should be supervised by an adult.

8. <u>Conference Dining Room:</u> Must be reserved through Administration by calling (818) 364-3001.

9. <u>Dress Code:</u> No person may be permitted to the cafeteria service or dining area unless properly attired. Proper attire includes: shoes or slippers and street attire or robe. To reduce trip hazards in the confined space of the Café, no IV poles are permitted in the Café.

NUTRITION SCREENING/MEDICAL NUTRITION THERAPY/CONSULTS

NURSING (INITIAL NUTRITION SCREEN)

1. Gathers information from patients within 24 hours of admission based on pre-determined nutrition criteria and documents the initial assessment in the medical record. Criteria includes, but is not limited to:
   - Adults
     - Malnutrition Screening Tool (MST) $\rightarrow$ score of 2 or higher indicates patient with nutrition risk
     - Nutrition support
     - Pressure ulcers
   - High risk pregnancy – GDM; <18 years old; multiple gestations
   - Pediatrics – failure to thrive; picky eaters; eating disorders; weight status using growth charts
     - Infants (Birth to 36 months)
       - Weight-for-length
       - Head circumference-for-age
       - Weight-for-length
     - Children & Adolescents (2 to 20 years)
       - Stature-for-age
       - Weight-for-age
       - BMI-for-age-and-gender
2. Based on results of the initial assessment, consults a dietitian

PHYSICIAN

1. Requests dietitian consult for patients via the EHR, by paging the dietician directly, or by calling the diet office at extension 6171.

DIETITIAN (OR SUPERVISED DIETITIAN)

1. 1.   Acts on consults resulting from Nursing Admission Assessment and from physicians within the timeframes specified in policy D006A

Further Prioritization Procedures: Assessment

1. Reviews/evaluates information from the following sources as it becomes available to further assess patients identified at nutrition risk and to identify patients with developing nutritional risks:
   - Nursing: anthropometric measures, pressure ulcer reports, and food allergies and intolerances
   - Information Services: diet orders & changes, new TF orders, and patient length of stay
   - Pharmacy: New orders for TPN/PPN
   - Consults from physicians, nurses, & other healthcare professionals
   - Multidisciplinary team meetings

- FNS: meal rounds; # days patient has been NPO/CL; "Patient Alert Notes" from hospitality staff
- Biochemical data, medical tests, and procedures
- Dietitian: comparative standards for meeting energy requirements, education & discharge needs

2. Patients are continuously assessed and prioritized and will receive nutrition intervention when applicable

NUTRITION DIAGNOSIS & INTERVENTION

1. Based on the Nutrition Assessment findings, the RD identifies a Nutrition Diagnosis and gains patient agreement on the appropriate Nutrition Intervention that will follow.
2. When recommendations are made which require a physician order, the dietitian will follow-up within 48 hours to verify a response to the recommendation. If the physician does not respond to the recommendation by ordering the requested intervention or by another entry in the medical record, the RD will do one or all of the following:
   - Contact the physician to discuss the recommendation(s) made and document the results of the discussion
   - Resubmit the intervention on the approved Medical Record form, requesting a response. If still no response, the RD will contact the physician to discuss the recommendation and documents the results of the discussion.

NUTRITION MONITORING & EVALUATION

1. The RD monitors and evaluates the patient's response to care according to Reassessment and Follow-Up Guidelines (D006A). Nutrition monitoring and evaluation may include any or all of the following: nutrition reassessment, meal rounds, medical rounds and/or care plan rounds/meetings. Monitoring and evaluation may or may not result in new nutrition recommendations. The results of monitoring and evaluation are documented in the patient's medical record by the Dietitian/designee.
2. When nutrition goals are met or are no longer applicable a dietitian may "sign off" on a patient. The dietitian will document in the medical record that future involvement will be provided by consult or when additional information regarding the patient's medical condition warrants it.
3. Hand-off Communication: When the care of a patient transfers from one dietitian to another, there is a "hand-off" of information about the patient. While the information may be written or verbal, there must always be the opportunity to ask and respond to questions, in a timely fashion. Information communicated during the "hand-off" includes the patient's current condition, nutrition interventions implemented and the patient's response to the interventions.

*Academy of Nutrition & Dietetics. *International Dietetics & Nutrition Terminology (IDNT) Reference Manual*, 2015.

PATIENT SAFETY

"READ-BACK", "REPEAT BACK" REQUIREMENTS

In an effort to improve communication among care providers, Olive View has several processes in place to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

- **_Telephone Orders_** – while the physician issues the order, the nurse writes the order down on his/her order sheet. Before ending the telephone call, the nurse "reads back" the order to the prescriber to confirm that he/she understood and transcribed it correctly.

- **_Verbal Orders_** – It is not always feasible to do a formal "read back" for a verbal order (e.g., during a code blue or in surgery). In such circumstances, a "repeat back" is an acceptable means of confirming the accuracy of the order.

- **_Critical Test Results_** – When a caller provides a critical test result or value to the patient care area, as a licensed member of our service delivery team, Olive View requires you to "read back" the test result or value to the caller. Then, telephone the physician caring for the patient. Olive View also requires the physician to do a verification "read-back".

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.

- All values defined as critical by the laboratory are reported directly to a responsible licensed caregiver within the time frames established by the laboratory (defined in cooperation with the nursing and medical staff). When the patient's responsible licensed caregiver is not available within the time frames, there is a mechanism to report the critical information to an alternative response caregiver.
  (Applicable to laboratory only)

DETERIORATING PATIENT CONDITION

RESPONDING TO THE DECLINE IN PATIENT CONDITION

As patient caregivers, you need to know the signs and symptoms of the decline in a patient's condition, within your scope of practice. The assessment and recognition of the deteriorating patient is an ongoing challenge throughout the patient's stay or visit to your facility. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going health assessments, handoff communication reports, chart documentation and other communication modalities are good methods to use in recognizing declination in the patient's condition. **Every** member of the healthcare team is responsible to ensure that he/she give the highest level of care, and to immediately react upon emergencies, potential emergencies and/or incidents. Olive View-UCLA Medical Center has two response teams that can assist:

- Rapid Response Team (RRT): The team that is available 24-hours per day, 7 days a week to respond to urgent clinical patient situation.

- Patient Assist Team: The team that is available 24-hours per day, 7 days a week to respond to urgent clinical situation in First and Second Floor Lobbies, including the first and second floor patient loading areas and Parking Lot I.

RAPID RESPONSE TEAM

Depending upon your scope and/or level of practice, these are some of the warning signs that a patient is deteriorating:

- Acute change in level of consciousness, mental status, new seizure or prolonged seizure.
- Acute change in heart rate.
- Acute decrease in systolic blood pressure.
- Acute change in respiratory rate or effort.
- Acute decrease in oxygen saturation.
- Acute decrease in urinary output.
- Abnormal bleeding.
- Chest pain.
- You are concerned about the patient; "Something is wrong."

The RRT is set up to evaluate and stabilize patients who are deteriorating. If you are concerned that a patient is deteriorating, activate the RRT right away, and explain what concerns you. Any staff member can call to activate an RRT by calling the ICU at (818) 364-4415. In addition, the patient's RN must notify the patient's Primary Team or Cross-Cover Team.

PATIENT ASSIST TEAM

If you see a patient/visitor needing medical assistance in the First or Second Floor Lobbies, including the adjacent patient loading zones and Parking Lot I, activate the Patient Assist Team by calling the Hospital Operator at Ext. 111. The Hospital Operator will announce Patient Assist Team (PAT) by overhead page. The PAT will respond to any urgent clinical outpatient situations whereby the patient's condition warrants medical assessment and clinical intervention.

PAT does not replace the Code Blue Team. Anyone can call a Code Blue for cardiac arrest by dialing Ext. 114 from a hospital phone. In areas outside the main hospital building, call 9-1-1 for a medical emergency.

FALL REDUCTION AND PREVENTION

Prevention of patient falls is the responsibility of **EVERY** workforce member. Creating a safe environment, enforcing fall prevention through education and training, and teaching patients reduces fall rates.

Outpatient Clinics (Hospital-Based and Ambulatory Care Network) will screen patients and mitigate risks for falls and harm, based on the patient population, setting, and environment. Documentation, as applicable, will include:
- Fall screening.
- Fall risk.
- Fall prevention measures implemented and patient education provided.

Hospitalized inpatients (1 year of age and older) will be asses on admission, and reassessed daily, on transfer to another unit, with condition change, and post fall. The staff will document the following in the medical record:
- Using the appropriate Fall Risk Assessment Tool, the initial assessment and ongoing reassessments.
- Patient/family education related to falls.
- Ongoing safety precautions.
- Any fall incident, related assessment, and notification of physician/family.

Emergency Department patients will be screened for fall risk using specific assessment screening elements. The staff will document all fall reduction interventions and patient/family education in the medical record.

Appropriate fall prevention measures will be implemented for all patients identified as 'at risk for falls'. If any screening criteria element is positive, a licensed healthcare professional will implement and document interventions to reduce the 'risk of falls; to include patient/family education.

Organization/Facility Assessment of Fall Risk:

There is, at minimum, an annual assessment of each facility's patient fall risk to determine prevention and intervention measures. The assessment may include, but not limited to, periodic environmental rounds, patient safety rounds, medical staff committee determination of risk based on clinical conditions, and review of adverse events (related to falls).

Performance Improvement, Quality Control, Monitoring, Reporting, and Benchmarking will be performed on a quarterly basis utilizing the identified DHS Fall Database.

DHS Employee Fall Prevention Program education will include training to all current DHS providers, nursing and clinical ancillary staff on the DHS System-Wide Fall Prevention Program. Additionally, the DHS System-Wide Fall Prevention Program will be incorporated into the New Employee Orientation Program.

Definition

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

Rehabilitation Fall: A fall is a loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair, excluding falls resulting from "purposeful actions'.

Purposeful Action: A rehabilitation therapy session performed with the intent of challenging a patient's balance or to attempt a functional activity the patient is unable to perform without assistance.

HOSPITAL BASED OUTPATIENTS

Outpatient Setting (Hospital-Based and Ambulatory Care Clinics):
  A. Screening for fall risk may be applied across a clinic or patient-specific:
  1. Certain patient populations, settings, and environments pose an equivocal increased risk for falls. Risk may be based on factors, including but not limited to, patient demographics, diagnoses, medical condition, clinical situation, mobility, and ambulatory/mobility equipment needs.

Clinic-wide screening may include:
  o Periodic Environmental Rounds
  o Validation of clinic-wide safeguards (e.g. hand rails, level flooring/surfaces, wheelchair/walker access, grab bars)
  o Patient Education
  o Staff Education
  o Evaluation of previous year's fall data

To screen each adult and/or pediatric patient (over 1 year of age) for fall risk using the age appropriate screening tool.

- Adult Ambulatory Care Fall Screening Criteria
- Pediatric Ambulatory Care Fall Screening Criteria (patient >1 year of age)

B. Patients identified as high risk during either screening methods will have a licensed professional further determine, implement, and document appropriate prevention measures including patient/family education.

C. Outpatient Fall Prevention Measures.
1. Maintain a safe, hazard free environment (remove any obstacles from patient pathway).
2. Place 'as-risk' patients who are identified as needing assistance on exam table only at the time of examination, with staff present.
3. Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so).
4. Ensure adequate lighting.
5. Use wheelchair locks when indicated.
6. Keep beds, stretchers, and/or gurneys in lowest, locked position with side rails up, as appropriate.
7. Keep call light, as applicable, within reach.
8. Identify and manage areas of concern during Environmental/Safety Rounds.
9. Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
10. Notify appropriate professional for focused fall reduction interventions and patient/family education, including, but not limited to:
    - Diagnosis and treatment underlying etiology of fall risk
    - Ensure 'fall risk' alert armband is in place based on patient condition and determination of fall risk.
11. Provide patient/family education regarding:
    - Fall risk determination.
    - Safety measures for prevention of falls during their outpatient visit.
    - Rising slowly from a sitting or lying position.
    - If possible, consider having patient relocate to an area that allows closer nursing observation.
12. Offer wheelchair, if appropriate.
13. Ensure assistive devices (e.g., cane, crutches, walker, wheelchair) are within reach of the patient.
14. Assist patients walking with medical equipment, as appropriate (e.g., wound vacuum devices, IV poles, oxygen tubing, tanks, etc.)
15. Alert subsequent providers that patient is a fall risk (e.g., during transfers or hand-off to another clinical area/service).

D. Post-Fall Procedure

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm and complete all post fall documentation in the medical record.

Outpatient Fall Prevention Measures	
For ALL Patients	**For at RISK Patients**
• Maintain a safe, hazard free environment (remove any obstacles from patient pathway). • Ensure adequate lighting. • Use wheel locks when indicated. • Keep beds, stretchers, gurneys in lowest, locked position. • Keep call light (as applicable) within reach. • Identify and manage areas of concern during Environmental Safety Rounds. • Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.	• Ensure "Fall Risk" alert arm band is in place. • Provide education to patient/family regarding. • Fall risk determination. • Place "at-risk" patients identified as needing assistance on exam table only at time of examination, with staff present. • Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so). • Offer wheelchair if appropriate. • Be sure assistive devices (cane, crutches, walkers, wheelchairs, etc.) are within reach of the patient. • Assist patients walking with medical equipment (wound vac, IV, etc.). • Alert subsequent provider that patient is a fall risk. • Notify appropriate professional for focused fall reduction interventions and patient/family education.

INPATIENTS

Falls screening in the outpatient area does not replace the requirement to complete a population and age-appropriate falls risk assessment on admission.

ASSESSMENT/REASSESSMENT

1. Upon admission, the RN will assess all adult inpatients and children > 1 year of age for their risk for falls utilizing the appropriate Fall Risk Assessment Tool.

   • Adults: Morse Fall Assessment Scale
   • Pediatrics: Humpty Dumpty Scale

Morse Fall Risk Assessment

Risk Factor	Scale	Score
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / Walker	15
	None / Bed Rest / Wheel Chair / Nurse	0
IV / Heparin Lock	Yes	20
	No	0
Gait / Transferring	Impaired	20
	Weak	10
	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

Morse Fall Score

High Risk	51 and higher
Moderate Risk	25 – 50
Low Risk	0 – 24

Morse, J.M. (1997). Preventing Patient Falls. Thousand Oaks, Sage Publication

Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. Canadian Journal Aging, 8,366-377.

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Humpty Dumpty Scale and Prevention – Inpatient Program

Parameter	Criteria	Score (Circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alteration in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitation	3
	Forgets Limitations	2
	Oriented to Own Ability	1
Environmental Factors	History of Falls or Infant – Toddler Placed in Bed	4
	Patient Uses Assistive Devices or Infant – Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/Anesthesia	Within 24 Hours	3
	Within 48 Hours	2
	More Than 48 Hours/None	1
Medication Usage	Multiple usage of: Sedatives (excluding I.C.U. patients sedated and paralyzed), Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotic	3
	One of the Meds Listed Above	2
	Other Medications/None	1
	Total	

Hill-Rodriguez D, Messmer PR, Williams PD, Zeller RA, Williams AR, et al.
The humpty dumpty falls scale: A case-controlled study. JSPN. 2009;14(1):22-32

2. Patients not initially identified as moderate or high risk for falls on admission will be reassessed daily, upon inter-unit transfer, upon change of status, or upon fall to determine the need for Fall Prevention Measures (FPM) implementation.

RISK DETERMINATION

Adults	
Low Risk	Any adult patient who receives a score of 0-24 on the Morse Fall Scale is considered as low risk. Level 1 interventions will be implemented for these patients.
Moderate Risk	Any adult patient who receives a score of 25-50 on the Morse Fall Scale is considered as moderate risk. Level 2 interventions will be implemented for these patients in addition to Level 1 interventions.
High Risk	Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients in addition to Level 1 and 2 interventions.

- When a patient is identified as moderate or high risk for falls, the nursing staff will initiate a plan of care related to the patient's identified risk factors and place a colored "fall risk" alert arm band on the patient.
- Place a sign at the entrance to the patient's room and/or head of the patient's bed.
- Place a fall precaution sticker on front of patient's chart.

Pediatrics	
Low Risk	Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and "General Fall Prevention Interventions for All Children" will be implemented for these patients.
High Risk	Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for High Risk for the duration of his/her hospitalization.

- If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a falls risk reassessment may be performed and documented to justify the discontinuation of the high risk for falls identification and implementation of Falls Prevention Measures.
- If, in the nurse's judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures.

INITIATION OF PLAN OF CARE

When a patient is identified as moderate or high risk for falls, the RN will initiate a plan of care related to the patient's identified risk factors. Injury and/or fall prevention strategies, including patient/family education will be incorporated into the plan of care for at risk patients.
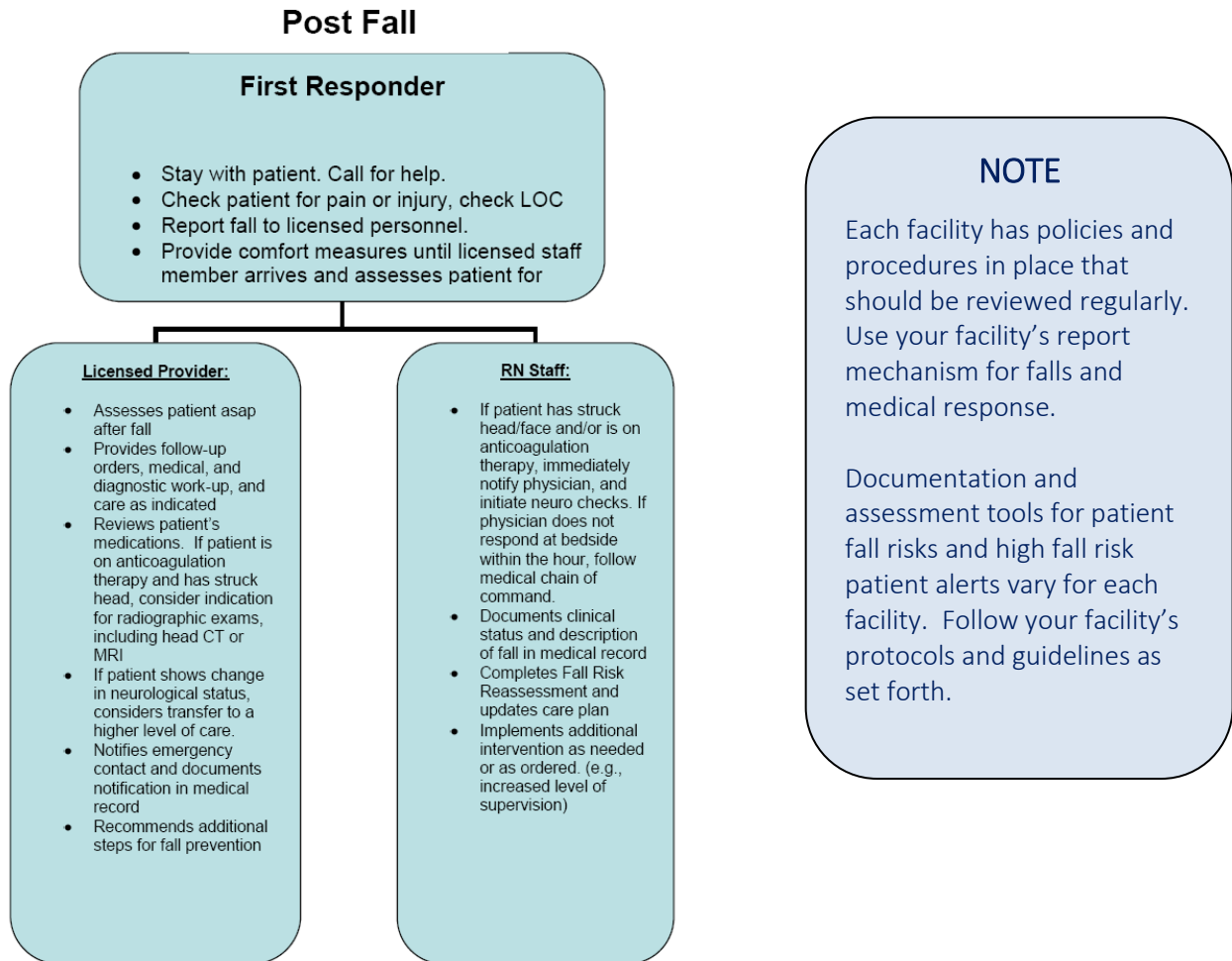
FALL PREVENTION MEASURES

When a patient is identified as moderate or high risk for falls either on admission or during his/her hospitalization, the RN will implement the following fall prevention measures:

Adults

**Level 1
Low Risk**
Score: 0 – 24
	• The patient's risk for falls will be discussed with interdisciplinary team members.
	• Provide patient/family education related to fall prevention.
	    o Purpose and importance of fall/injury prevention measures.
	    o Use of call light.
	    o Maintain bedrails in appropriate position.
	    o Safe ambulation/transfer techniques.
	    o Importance of wearing non-skid footwear.
	    o Reporting environmental hazards to nursing staff (e.g., spills, cluttered passages).
	• Family/ significant others may assist with fall reduction strategies once fall management training is completed. (**Note:** staff remains responsible for overall safety of patients even with family in attendance.).
	• Perform intentional rounds.
	• Orient patient to surroundings and hospital routines.
	• During exchange of patients between staff, hand off communication should include fall risk level, supervision provided, and observation of unsafe behaviors.
	• Set the bed in the lowest position with brakes locked
	• Place personal belongings within reach on the bedside stand/table.
	• Reduce room clutter. Remove unnecessary equipment and furniture.
	• Provide non-skid (non-slip) footwear.

Level 2 Moderate Risk **Score: 25 – 50**	• Attach fall prevention stickers to the front of the medical record. • Place a sign at the entrance to the patient's room and/or head of the patient's bed. • Offer toileting, minimally, every 2 hours. • Activate the bed alarm and wheelchair seat belt alarm, if appropriate.

**Level 3
High Risk**
Score: 51 and higher
	• Increase intentional rounds based on patient need.
	• Collaborate with interdisciplinary team for therapy schedule/ activities.
	• Cohort patients, when possible.
	• Restraints are discouraged, however, if needed, apply per Hospital Specific Restraint Policy.
	• Provide continuous in-person observation with a trained staff member as needed for safety reasons.
	• Place the patient in a room or area where they can be easily observed.
	• Offer toileting, minimally, every 2 hours.
	• Stay with patient at all times while toileting out of bed.
	    o Refusal by patient for direct observation during toileting must be documented in the patient's medical record, as applicable. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.)
	    o Notify the appropriate licensed professional of patient's refusal.

Pediatrics

General Fall Prevention Measures	Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all children:
	• Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
	• Leave crib side rails up at all times unless an adult is at the bedside.
	• Bed type and size shall be determined based on child's developmental and clinical needs.
	• Instruct patient/parent on how to prevent falls in the hospital setting:
	  o Maintain side rails in appropriate position.
	  o Maintain crib rails up.
	  o Do not allow the child to jump on the bed.
	  o Do not allow the child to run in the room or hallway.
	  o Do not allow the child to climb on hospital furniture or equipment.
	  o Importance of wearing non-skid footwear.
	  o Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.
	  o Notify nursing staff of environmental hazards (e.g., spills, cluttered passages).
	Supervise the child's activities, e.g., walk next to the child and provide support as strength and balance are regained.

Fall Prevention Measures for High Risk	• Consider locating the child closer to nursing station for closer observation.
	• Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion and pain.
	• Offer Assistance with toileting, minimally, every 2 hours while awake.
	  o Stay with child at all times while toileting out of bed.
	  o Refusal by the child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
	  o Notify the appropriate licensed professional of child's parent/guardian's refusal.
	• Provide calming interventions and pain relief.
	• Accompany patient with ambulation.
	• Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications).
	• Set bed alarms, as appropriate, to alert when child is exiting the bed.
	• Evaluate need for and encourage family to remain at the child's bedside.
	• Assess need for continuous in-person observation with a trained staff member, as needed, for safety reasons.
	• Provide patient/family education related to fall prevention (in addition to education related to general injury prevention above):
	  o Purpose and importance of fall/injury prevention measures.
	  o Use of call light/maintaining bedrails in appropriate position.
	  o Safe ambulation/transfer techniques.
	  o Instruct family of pediatric patients to inform the nurse and/or physician if the child seems to be less coordinated than usual, or complains of dizziness or feeling weak.
	  o Instruct family of pediatric patients that until the child regains his/her strength, someone should walk alongside him/her to provide support and protection in case he/she loses his/her balance.

POST-FALL PROCEDURE

After a patient fall initiate the Post-Fall Evaluation and Management Algorithm and complete all post fall documentation in the medical record.

Post Fall

First Responder

- Stay with patient. Call for help.
- Check patient for pain or injury, check LOC
- Report fall to licensed personnel.
- Provide comfort measures until licensed staff member arrives and assesses patient for

Licensed Provider:

- Assesses patient asap after fall
- Provides follow-up orders, medical, and diagnostic work-up, and care as indicated
- Reviews patient's medications. If patient is on anticoagulation therapy and has struck head, consider indication for radiographic exams, including head CT or MRI
- If patient shows change in neurological status, considers transfer to a higher level of care.
- Notifies emergency contact and documents notification in medical record
- Recommends additional steps for fall prevention

RN Staff:

- If patient has struck head/face and/or is on anticoagulation therapy, immediately notify physician, and initiate neuro checks. If physician does not respond at bedside within the hour, follow medical chain of command.
- Documents clinical status and description of fall in medical record
- Completes Fall Risk Reassessment and updates care plan
- Implements additional intervention as needed or as ordered. (e.g., increased level of supervision)

NOTE

Each facility has policies and procedures in place that should be reviewed regularly. Use your facility's report mechanism for falls and medical response.

Documentation and assessment tools for patient fall risks and high fall risk patient alerts vary for each facility. Follow your facility's protocols and guidelines as set forth.

DOCUMENTATION

Outpatient	Inpatient
For patients at risk for falls, staff will document the following on appropriate outpatient record: - Falls screening. - Fall risk. - Fall prevention measures and patient education provided.	The RN will document the following on the appropriate forms: - Using the appropriate Fall Risk Assessment Tool, document the initial assessment and ongoing reassessments. - Patient/family education related to falls. - Ongoing safety precautions. - Any fall incident, related assessments, and notification of physician/family.

Emergency Department (ED)

A. Screening (adult, pediatric, psychiatric, and all other ED areas) will take place at the time of triage assessment using age appropriate fall risk screening criteria:

Adult
1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure or syncope
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit-sight/hearing/speech impairment
7. Unsteady gait/weakness

Pediatrics
1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure in the last 6 months
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit – sight/hearing/speech impairment
7. Developmental problems causing difficulty walking
8. Neurologic diagnosis/condition causing difficulty walking (e.g., Muscular Dystrophy)

B. Identify all patients who meet any one of the criteria as a possible fall risk.
C. All patients who are identified as a fall risk will have a fall risk armband placed.
D. Additional interventions will be implemented as applicable for the individual patient.

Adult Interventions
1. Provide assistance with ambulation
2. Move patient to allow closer nursing observation
3. Place the patient directly on bed (or on gurney)
   a. Bed or gurney in lowest, locked position
   b. Side rails up
4. Provide patient/family education on fall prevention measures
   a. Environmental orientation
   b. Call light
   c. Call for assistance, as needed
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
7. Assess for elimination needs every 2 hours
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons.
   a. Provide privacy when patient is toileting, if requested
   b. Refusal by patient for direct observation during toileting must be documented in the patient's medical record.
   c. Notify the appropriate licensed professional of patient's refusal.

Pediatrics Interventions
1. Assist with ambulation
2. Move patient to allow closer nursing observation.
3. Place the patient directly on bed (or on gurney)
   I. Bed or gurney in lowest, locked position
   II. Side rails up
4. Provide patient/family education on fall prevention measures
   I. Environmental orientation

II.   Call light
III.   Call for assistance, as needed
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons
7. Assess for elimination needs every 2 hours
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons
I.   Provide privacy when patient is toileting, if requested
II.   Refusal by child's parent/guardian for direct observation during toileting must be documented in the patient's medical record
III.   Notify the appropriate licensed professional of child's parent/guardian's refusal
9. Encourage family to stay at patient's bedside

E. Post Fall Procedure

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm and complete all post-fall documentation in the medical record.

UNIVERSAL PROTOCOL

Olive View has adopted all components of The Joint Commission's Universal Protocol intended to prevent wrong site, wrong procedure and wrong person surgery or procedure. The Protocol establishes a process for a defined series of pre-procedure verifications designed to maximize patient safety and well-being. It applies to invasive procedures performed in the operating room as well as those performed in non-operating room settings (e.g., endoscopy, interventional radiology, cardiac catheterization, and bedside procedures). You share in the responsibility of conducting this verification process in cooperation with the patient.

The three main components are:

1. **Pre-Operative/Pre-Procedure Verification** – Olive View uses a checklist to ensure that all relevant documents are available and correct before sending a patient for an invasive procedure. We ensure that the patient's history and physical is present and current, that we obtained the patient's informed consent, and that the patient agrees to the planned surgery/procedure. If you find any information missing or any discrepancy, postpone the procedure until the information is clarified and/or corrected.

2. **Marking the Operative Site** – Olive View requires site marking for all surgical sites/invasive procedures involving right/left distinction, multiple structures, or levels. Whenever possible, involve the patient in the marking process.

3. **"TIME OUT" –** Immediately before starting the procedure, all members of the service delivery team conduct a final verbal verification to confirm the following: correct identity of the patient, operative site and side, consent on the procedure to be done, correct patient position, availability of correct implants and any special equipment or special requirements. In the Operating Room (OR) and other dedicated procedure areas, the nurse documents the "TIME OUT" in the electronic health record. In non-specialty areas (e.g., bedside procedures), the physician documents the occurrence of the "TIME OUT" in his/her procedure note.

MEDICATION MANAGEMENT

MEDICATION USE

The medication use process involves multiple steps in order to ensure the delivery of the right medication to the right patient, at the right dose, at the right time, using the right route. The following are several important medication use practices to ensure medication safety and reduce the potential for medication-related events.

ORDER TRANSMISSION

Medication orders must be promptly "scanned" to the pharmacy through the Pyxis scanners in areas equipped with this hardware. This facilitates the timely dispensing of medications. To insure rapid dispensing of STAT orders, nurses must transmit prescriptions using the red STAT mode on the Pyxis screen. Orders in ICU are an exception because they are all automatically transmitted in STAT mode.

MEDICATION PRESCRIBING

As a practitioner, you have the responsibility of ensuring the appropriate prescribing of medications to your patients in an effort to decrease the potential risk for medication errors. You must clearly understand the correct indication, dose, route, and the pharmacological effects of each medication that you prescribe to avoid adverse drug events. Olive View encourages you to review the formulary on an ongoing basis, and utilize formulary-approved medications.

Safety Tips for Safe Medication Prescribing

Write **CLEARLY, BOLDLY, AND LEGIBLY** in the patient's orders, specifying the name of the medication, drug dosage, route, and frequency. Make your medication orders clear and complete by:

- Identifying your patient with **TWO** identifiers (***Patient Name and Date of Birth***).

- Placing the date and time on all orders.

- Using generic drug names on all medication orders.

- Including specific dose, route, and frequency.

- Not using range orders (Pharmacy will not accept ranges such as 1-2 tabs; q 4-6h in orders.).

- Qualifying all as needed (PRN) orders (e.g., PRN pain).

- Signing all orders and printing your name and physician number so that you may be located for any questions.

- Entering the patient's diagnosis, allergies, and height/weight on all admitting orders to avoid delay in dispensing.

- Using weight-based dosing on all pediatric patients less than 40 kg of weight.

- Defining exactly which dose to put on "Hold" orders ("Hold today's AM digoxin dose" is acceptable, "Hold digoxin" is not acceptable.).

- Use addressograph machines or patient identification stickers for patient identification on ALL patient orders. Do not write out patient names. You **must** list unit location on ALL patient medication orders.

Avoid the use of unapproved abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire name of the drug.

DANGEROUS ABBREVIATIONS

DO THE "WRITE" THING!"

The following dangerous abbreviations are banned:

U	Write instead "Units"
IU	Write instead "International Units"
QD	Write instead "once daily" or "q day"
qd	Write instead "once daily" or "q day"
QOD	Write instead "every other day"
MS	Write instead "morphine sulfate"
MSO$_4$	Write instead "morphine sulfate"
MgSO$_4$	Write instead "magnesium sulfate"
Trailing zeros are not allowed	Write 20, not 20.0
Leading zeros are required	Write 0.75, not .75

MEDICATION DISPENSING

Before dispensing medications, the pharmacist must review all medication orders for appropriate indication, dose, route, frequency, and drug/allergy interactions. The pharmacist utilizes the patient age, height, weight, diagnosis provided to determine appropriateness, and reviews the patient medication profile to avoid therapeutic duplication and drug interactions. If orders are incorrect or require clarification, the pharmacist will contact the prescriber to clarify before dispensing the medication.

MEDICATION ADMINISTRATION

If you administer medication to patients, you are responsible for properly performing patient identification (using two identifiers, *Patient Name and Date of Birth*, per hospital policy). Bring the Medication Administration Record (MAR) into the patient's room to verify and document the dose administered. The pharmacy routinely provides a daily copy of a printed MAR, generated from the pharmacy computer system. The nurse reviews all physician orders, and reconciles the pharmacy-generated MAR on a daily basis before use, sending the reconciled MAR copy to the pharmacy daily.

Patient's Own Medications

Deliver medications brought into the hospital by the patient to the pharmacy for safe storage until the patient is discharged from the hospital. Olive View will not administer a patient's personal medication to the patient unless **ALL** the following conditions are met:

1. The physician writes an order in the patient's medical record, indicating that the patient's personal supply of medication should be used.
2. The medication is not on the Olive View drug formulary.
3. The pharmacist is able to make a positive identification of the medication by verifying the product's physical shape, size, color, and other manufacturer imprinted identification information. Olive View will not administer oral liquids, ophthalmic drops, intravenous admixtures, topical agents and other products that have the potential to have additional additives and/or adulterants and cannot be identified short of chemical analysis.

ADVERSE DRUG REACTION REPORTING

Please report all adverse drug reactions (ADR) through the Olive View Safety Intelligence (SI) system. Provide the patient's name, Olive View number, location, date of occurrence, name of the suspected medication, type of reaction, and your name. Signs and symptoms of an ADR are (but not limited to): anaphylactic shock, hives, bleeding, itching, rashes, change of lab value, change of vital signs, or shortness of breath. Nausea, vomiting and diarrhea should also be reported. Remember: it is better to OVER report than to UNDER report.

MEDICATION ERRORS

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.

Report all medication events, whether an actual medication error or an identified potential to lead to a medication error, through the Olive View Safety Intelligence (SI) Process. Report all medication errors on the UHC Event Notification System.

NON-VIOLENT (NON-SELF-DESTRUCTIVE) & VIOLENT (SELF-DESTRUCTIVE) RESTRAINTS

Olive View is dedicated to preventing, reducing, and ultimately eliminating, the use of restraints throughout our facility. We are committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints. When restraint is used for the management of violent self-destructive behavior, restraint shall be implemented in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques and used only when less restrictive measures have been found ineffective to protect the immediate physical safety of the patient and others. During such an emergency where a patient's violent or self -destructive behavior jeopardizes the immediate physical safety of a patient, a staff member or others, a Code Gold is activated and the response team is dispatched to assist in the management of the violent or self- destructive behavior.

The Code Gold Response Team works collaboratively with other staff present in an attempt to de-escalate the emergency. If efforts to de-escalate fail, and physical intervention is necessary, the Response Team may initiate restraints. The Response Team provides coverage 24 hours, 7 days/week throughout the hospital to assist in these emergencies. All members of the Response Team are specially trained in CPI non-violent crisis intervention, least restrictive alternatives and restraint application.

PRINCIPLES FOR HANDLING AGGRESSIVE BEHAVIOR

1. Implement your self-control plan (e.g., take slow, deep breaths) to enable critical thinking. Focus on the problem, not your emotions.

2. Assess the situation before you act. Identify the possible triggers for violence and offer alternative responses that reduce the risk of harm. Accurately identify the visual and auditory signals that come before an assault (e.g., pacing, rapid speech, whining, threatening, demanding, standing very close, tapping, head banging or shouting).

3. Keep communication open, simple, direct, and brief. In crisis intervention, use no more than 5 words (e.g., "Jim, put down the chair.")

4. Be PATIENT if interventions are not immediately successful. Avoid under or over-reacting. The crisis will pass even if crisis intervention is not successful.

5. Switch your response if the cause of an assault changes as the incident progresses (e.g., manipulation to frustration or frustration to fear).

POSSIBLE ALTERNATIVE INTERVENTIONS PRIOR TO CALLING A "CODE GOLD"

Verbal:

- Engage patient in dialogue to identify reasons for anger and hostility.
- Set limits (e.g., communicate expectations, offer choices and relevant consequences).
- Contract for safety (e.g., have patient verbally agree not to harm self or others).
- Explain consequences for not changing behavior.
- Provide teaching (e.g., teach patient the importance of compliance to ward rules and/or treatment plan).

Physical:

- Environmental manipulation – reduces stimuli or remove patient from the stimuli causing agitation or undesirable behavior (e.g., decrease noise level, dim lights, take to a private room).
- Companionship – 1:1 observation.
- Diversion activities (e.g., television, reading, exercise, games, arts & crafts).
- Offer time-out or seclusion (inpatient psych units only).

Medical:

- Pharmacologic intervention – offer PRN or STAT medications, if ordered, to reduce agitation.

Other:

- Family involvement – encourage family members to sit or talk to the patient.

If the above Standards of Performance and Alternative Interventions are ineffective, and the patient poses an immediate danger to self or others, call a "Code Gold" (dial Ext. 111 to call the Hospital Operator).

RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR	RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR
Definition: The use of any physical device to assist with treatment or a diagnostic procedure. For example, soft restraints to protect G.I. tube, I.V. line, and so on. Excluded from this definition is a medical immobilization restraint; the use of a physical or mechanical device to <u>temporarily</u> immobilize the patient in order to facilitate medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes. For example, surgical positioning, IV arm board, radiotherapy procedures, etc. are based on standard practice for the procedure **NOTE:** Devices and mechanisms, such as helmets, orthopedic appliances, braces and wheelchairs, when used for postural support, facilitation of mobility, protection, or to obtain/maintain normative bodily functions are not considered restraint interventions. Full side rails per se are not considered a restraint unless they are intended to restrict the patient's movement.	**Definition:** The use of a physical or mechanical device to involuntarily restrain physical activity of the patient with violent or self-destructive behavior in order to protect the patient or others from injury. For example, a patient who is a danger to others as evidenced by his/her physically threatening behavior. • Restraints are used to manage violent or self-destructive behavior when unanticipated, severely aggressive or destructive behavior (i.e. physical outburst, punching, banging of head) places the patient or others in imminent danger and nonphysical interventions would not be effective. • Seclusion is defined as the involuntary confinement of a patient alone in a room in which the patient is physically prevented from leaving for a period of time. <u>Seclusion is utilized in the inpatient psychiatric unit(s) only</u>.
• Use <u>only</u> when alternative measures have been found to be ineffective.	• Use <u>only</u> when alternative measures have been found to be ineffective.
No **standing orders on an as needed (PRN) basis.**	No **standing orders on an as needed (PRN) basis.**
Maximum order duration: **24 hours**	Limited to specific timeframes (1-4 hours as determined by the Physician). Maximum order duration: • Four hours for adults (18 years of age and over) • Two hours for children and adolescents (9-17 years of age) • One hour for children under 9 years of age.
MD RESPONSIBILITIES: • Place an MD order in electronic health record. • Face to face evaluation within 24 hours (of the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition and the need to continue or terminate the restraint). • Renew order every 24 hours if restraint use continues to be clinically justified.	**MD (OR CLINICAL PSYCHOLOGIST) RESPONSIBILITIES:** • Place an MD order for restraint or seclusion in electronic health record. • Complete a face-to-face evaluation within one hour after the initiation of restraint or seclusion (of the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition and the need to continue or terminate the restraint).

RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR	RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR
	• Conduct an 'in person' patient assessment at least every eight hours for adult patients (18 years of age and over) and every four hours for adolescent patients (17 years and younger). • Identify ways to help the patient regain control and revise the treatment plan, as needed. • Participate in the daily reviews of restraint use related to his/her patients. **IN ADDITION, FOR PSYCHIATRIC INPATIENT UNIT(S) ONLY:** • Clinical leadership is notified of any instance in which an individual remains in restraints and/or seclusion for more than 12 hours, or experiences 2 or more separate episodes of restraints and/or seclusion of any duration within 12 hours. • Staff will inform the patient's family of the restraint and/or seclusion episode, as appropriate, and in conjunction with the patient's rights to confidentiality. • A post-restraint/seclusion debriefing will occur as soon as possible following each episode but no longer than 24 hours after the episode.
NURSING RESPONSIBILITIES: • Initiate use of restraints, only in an emergency situation, without a physician order. • Notify the physician during or immediately after the application of emergency restraints and obtain an order <u>within one hour</u> of emergency initiation. • Provide education, i.e. purpose of restraint to the patient (and as appropriate, family and/or significant other) regardless of his/her physical and mental condition. • Inform the patient under what circumstances the restraint will be discontinued. • Complete an initial assessment and reassessments to determine need for continuation or early removal. • <u>Reassessment frequency</u> – a <u>minimum</u> of every shift. Document all assessments/reassessments on the electronic health record restraint management portion.	**NURSING RESPONSIBILITIES:** • Initiate use of restraints, only in an emergency situation, without a physician order. • Notify the physician **immediately** as the physician must complete a face-to-face evaluation and provide written order within one hour of restraint incident. • Provide education, i.e. purpose of restraint to the patient (and as appropriate, family and/or significant other) regardless of his/her physical and mental condition. • Inform patient under what circumstances the restraint will be discontinued. • Complete an initial assessment and reassessment to determine need for continuation or early removal. • <u>Reassessment frequency</u> – Not to exceed 4 hours for adults; 2 hours for children and adolescents (9-17 years of age); and 1 hour for children under 9 years of age. Document all assessments/reassessments on the electronic health record restraint management portion.
NURSING STAFF WILL: • Perform/deliver patient care services and document on the electronic health record restraint management portion. **Every 15 Minutes** • Monitor for safety including nerve and circulatory impairment.	**NURSING STAFF WILL:** • Perform/deliver patient care services and document on the electronic health record restraint management portion. • **Observe patient face-to-face <u>continuously</u> for safety.**

RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR	RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

Every 2 Hours
• Re-position restrained limbs and check circulation.
• Release restraints on restrained extremity.
• Offer fluids.
• Offer use of toilet facilities.
• Document care every 2 hours or more often as needed.
 	
Scheduled Meal/Snack Times
• Offer nourishment and assist the patient, as needed, to ensure safety and adequate nutritional intake.
 	
Document nourishment at scheduled meal/snack times or more often as needed.
	Every 15 Minutes
	• Monitor for:
	  1) Safety, physical, psychological status and comfort.
	  2) Nerve and circulatory impairment
	  3) Readiness for discontinuation
	  4) Hygiene and elimination.
	  5) Vital signs <u>when indicated by physical and/or psychological assessment.</u>
	• Document every 15 minutes.
	
	Every 2 Hours
	• Reposition restrained limbs and check circulation.
	• Release restraints on restrained extremity.
	• Offer fluids.
	• Offer use of toilet facilities.
	• Document care every 2 hours or more often as needed.
	
	Scheduled Meal/Snack Times
	• Offer nourishment and assist the patient, as needed, to ensure safety and adequate nutritional intake.
	• Document nourishment at scheduled meal/snack times or more often as needed.

Scenario #1 Mrs. P.E., a 79-year-old female, is admitted with a diagnosis of pneumonia. She continually removes her oxygen mask and desaturates to 80%. Mrs. P.E. is confused and states, "I need to catch the bus…I'll be late for my appointment". Q) Are restraints indicated? Why or why not? **A) Yes. The patient's behavior (continually removing her oxygen mask) is impeding treatment and her recovery from the medical condition (pneumonia).** Q) Is a physician's order required? **A) Yes.** Q) Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why? **A) Restraints for Non-violent Behavior. The patient's behavior (continually removing her oxygen mask) is impeding treatment and her recovery from the medical condition (pneumonia).** Q) What type of restraint would be most effective? **A) The choice of a safe, effective and least restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used.**	*Scenario #1* Mr. P.S., a 55-year-old male, admitted to 5A with a primary diagnosis diabetic acidosis. The patient has a history of paranoid schizophrenia. He was found wandering the street naked and incoherent; talking nonsense about his involvement with the CIA. The patient's behavior becomes out-of-control on admission. He suddenly runs wildly down the hallway screaming obscenities; rams his fist into the door and strikes out at the CNA attempting to intervene. Q) Are restraints indicated? Why or why not? **A) Yes. This is an <u>emergent</u> situation (i.e. sudden aggressive outburst) in which there is an imminent risk that the individual will physically harm self or others.** Q) Is the physician's order required? **A) Yes.** Q) Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why? **A) Restraints for Violent/Self-Destructive Behavior. The patient's behavior (out of control, running around wildly, ramming his fist into the door and striking out at staff) is physically harmful to himself and others.** Q) What type of restraint would be most effective? **A) The choice of a safe, effective and least**

RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR	RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR
Q) How often does nursing assess/observe the patient for safety, comfort, and circulation? **A)** **A <u>minimum</u> of every 15 minutes (the 15 minute observations must be documented once a shift by signing the appropriate space on the Restraint Management Flow Sheet – Medical Management).** **Q)** How often is nursing required to document on the Restraint Management Flow Sheet? **A)** ***Initial assessment* - Once** ***Reassessment* – Every shift; include clinical justification for continuation.** ***Every two hours* – Circulation check; Fluids, elimination, ROM or exercise.** ***Mealtimes* – Offer of nutrition**	**restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used.** **Q)** How often does nursing assess/observe/document the patient for safety, comfort, and circulation? **A)** **The patient will be observed continuously face-to-face. Document every 15 minutes.** **Q)** How often is nursing required to document on the Restraint Management Flow Sheet? **A)** ***Initial assessment* – Once** ***Reassessment* – Not to exceed 4 hours for adults; 2 hours for children/adolescents (9-17 years) and 1 hour for children under 9 years old. Reassessment must include clinical justification for continuation.** ***Every two hours* – Fluids, elimination, ROM** ***Mealtimes* – Offer of nutrition**
Scenario #2 I.D., a 20-year-old female, is brought to the hospital by paramedics following an overdose. She states, "I only want to be left alone." She pulls out her IV and NGT. **Q)** Are restraints indicated? Why or why not? **A)** **Yes. The patient is pulling her IV and NGT which is impeding her treatment and medical recovery. The restraint is used as an adjunct to medical surgical care to support medical healing.** **Q)** Is a physician's order required? **A)** **Yes.** **Q)** Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why? **A)** **Restraints for Non-violent Behavior. The patient's behavior (pulling out her IV and NGT) is impeding treatment and her recovery from the overdose.** **Q)** What type of restraint would be most effective? A) **The choice of a safe, effective and least restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used. Always use the lowest level restraint needed to allow staff to work safely to meet the patient's needs.**	***Scenario #2*** I.D., a 20-year-old female, is brought to the hospital by paramedics following an overdose. She screams at the staff "leave me alone!...don't come near me again!" She slaps the physician in the face and kicks the nurse attempting to insert the IV line. **Q)** Are restraints indicated? Why or why not? **A)** **Yes. This is an <u>emergent</u> situation (i.e. sudden physical outburst) in which there is an imminent risk the individual will physically harm himself or others.** **Q)** Is a physician's order required? **A)** **Yes.** **Q)** Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why? **A)** **Restraints for Violent/Self-Destructive Behavior. The patient's behavior (slapping and kicking) is physically harmful to herself or others.** **Q)** What type of restraint would be most effective? **A)** **The use of a soft or hard restraint will be determined based on the assessed needs of the patient and the situation.**

MEDICAL RECORD REQUIREMENTS FOR PHYSICIANS AND LICENSED INDEPENDENT PRACTITIONERS (LIPS)

- Begin medical record entry with an identifier (e.g., Attending note, Cardiology Fellow note).

- Legibly sign and indicate provider identification number (and level of training for postgraduate physicians) on all entries. If signature is not readable, then it is required to print complete name and title in large uppercase letters with the provider identification number next to your signature (e.g., JOHN DOE, M.D. ID # 999999). Electronic signatures do not require a separate time or date if that information is automatically recorded by the system.

- All verbal orders must be validated/authenticated within 48 hours. Olive View accepts verbal orders from a prescribing physician only in extreme emergencies, in the course of treatment, or during a surgical procedure. No verbal orders for high alert medications are allowed except for cases of code blue and rapid sequence intubation.

- Specify reason(s) when prescribing the medication on all as needed (PRN) orders (i.e., conditions/symptoms, etc.).

- If a handwritten error is made while charting in a medical record, make the corrections by drawing a line through the error and write the date, time, and initials above the error. Erasing or using "white out" is not allowed in a patient's medical record. If an error is made in the electronic medical record, follow procedures in accordance with established protocols.

MEDICAL RECORD REVIEW CHECKLIST

Use the checklist below to review the medical records of the patients for whom you are responsible. Use this checklist as a reminder:

☐ All orders and progress notes must have legible physician signature and identification number. Electronic signatures do not require a separate signature if the information is automatically recorded by the system.

☐ Did the patient sign the consent to treatment?

☐ Are any language or cultural accommodations required?

☐ Was the History and Physical (H&P) dictated or completed no more than 30 days prior to or within 24 hours of admission or surgical admissions within seven (7) days before surgery?

☐ Are the telephone orders in the record? Is the read back/repeat back verification documented? Did the physician sign off on the orders within 48 hours?

☐ Were restraints used? If so, did the physician fill out the order form completely? Is there evidence that members of the service delivery team tried other alternatives before applying restraints?

☐ Are H&P and progress notes legible/organized and informative?

☐ Are all orders dated, timed and signed?

☐ Are allergies identified in the orders?

☐ Are banned abbreviations used? If so, was the order clarified?

☐ Are the resident's orders and notes cosigned by the attending physician (when required)?

☐ Is there evidence of multidisciplinary care planning?

☐ Is pain management well documented?

☐ Does the patient have an advance directive? If so, is there a copy in the record? If not, is there evidence of multidisciplinary care planning?

☐ Do all as needed (PRN) orders include indications?

☐ If this is a surgical case, was the pre-op checklist completed to confirm that all required documentation was present before surgery?

☐ If a procedure was performed was the operative report dictated immediately after surgery or within 24 hours after surgery?

☐ Was the handwritten postoperative report noted in the medical record immediately after surgical procedure providing information until the dictated operative report reaches the medical record?

☐ Was the discharge record (Part 1 & 2) completed at the time of discharge?

☐ Was the dictated summary done within 48 hours of discharge for patients hospitalized over 48 hours? (A dictated summary is required for all patients in the hospital over 48 hours.).

CLINICAL STAFF (What a Joint Commission Surveyor Is Likely to Ask You)

The following information lists some of the key points that are important to remember as they are an integral part of providing outstanding patient care while fulfilling the accreditation standards of The Joint Commission. If a Joint Commission surveyor is on site, they are likely to ask you questions that relate to the information below.

PATIENT CARE PRACTICES

- If you interact with patients as part of your job, you must possess/develop skills and competencies for delivering population-specific appropriate communications, care and interventions in order to assure that each patient's care meets his/her unique needs.
- Patients have the right to effective pain management.
- All patients are assessed for pain upon admission, with vital signs, and with pain assessment/ reassessment procedures.
- Olive View's approved pain assessment tools are:
  - o Numerical Rating Scale
  - o Faces Scale
  - o Face, Legs, Activity, Cry and Consolability (FLACC) Scale
  - o Assumed Pain Present (APP)
  - o N-PASS (Neonatal Pain, Agitation, and Sedation Scale)
- Effective pain management consists of a multidisciplinary team approach to assessing, treating, and educating the patient and their family regarding pain.
- Nursing performs initial nutrition screening on all patients admitted to Olive View-UCLA Medical Center within 24 hours of admission.
- Know that Code Blue means cardiac (or cardiopulmonary) arrest.

PATIENT SAFETY

- Use "Read-Back" procedures to ensure important information is accurately communicated and recorded.
- Olive View has instituted "Read-Back" procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.
- As caregivers, you need to know the signs and symptoms of the decline in patient's condition, within your scope of practice.
- If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility's response mechanism and stay with the patient/visitor until help arrives.
- Prevention of patient falls is the responsibility of EVERY workforce member. Become familiar with the Olive View Fall Prevention Program.
- Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.
- You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental unsafe condition, or "near miss" that causes you concern for the safety of patients, visitors, or staff as soon as possible.

- The Joint Commission annually establishes National Patient Safety Goals (NPSGs) which Olive View workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.

- Universal Protocol **applies to all surgical and non-surgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery or procedure.

- The Universal Protocol's three main components are: **conduct the pre-procedure verification process, mark the operative site, and perform a "Time Out" before the procedure.**

- The medication process must ensure that the right medication is administered to the right patient, at the right dose, at the right time, using the right route.

- Identify your patient with **TWO** identifiers (**Patient Name and Date of Birth**)

- Avoid the use of unapproved abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire name of the drug.

- Report all medication events, whether an actual medication error or an identified potential medication error, through the Olive View UHC Event Notification System.

- Olive View is committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints.

- Use of restraints should be limited to those emergency situations in which the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or visitors, and when maintaining safety requires an immediate physical response.

- Olive View will dispatch a Behavioral Response Team for a "Code Gold" emergency.

- All medical records must contain an identifier, legible signature and identification number, counter signature for verbal orders, and a rationale for medicine prescribed.

HUMAN RESOURCES

PERFORMANCE EVALUATION

As a DHS workforce member, it is important that your work is evaluated. During the course of your employment/assignment, you may receive both informal and formal performance evaluations. Evaluations let you know how you're doing and give you guidance on how to do your job even better. All DHS workforce members shall be evaluated at least once each year and probationary employees by the end of the specified probationary period. A revised rating may be submitted by the appointing power at any time. Each workforce member's performance evaluation shall include a signed copy of the related job description or acceptance of work plan in Performance Net. **Exception:** Physicians and mid-level providers must comply with privileging requirements.

Although non-County workforce members are not governed by Civil Service Rules, appropriate evaluation of performance, similar to that of County workforce members must be conducted. Non-County workforce members must receive performance assessments at 6-months and 12-months from the beginning of their assignment, and annually, thereafter, including competency assessment, as applicable. Certain contract agencies (i.e., Insight) have been approved to independently be responsible for conducting performance assessments of their own staff and to certify that their employees are performing competently. Contract agencies must make the performance evaluations of contract staff available upon request.

The immediate supervisors shall communicate to the workforce members the Department's expectations, the performance standards and expectations for the workforce member's position, and shall provide the necessary leadership and direction needed by their subordinates to meet and maintain the required performance standards.

In accordance with Memoranda of Understanding, annual step advancement for employees is contingent upon a current performance evaluation with a rating of "competent" or better. Physicians subject to the Physician Pay Plan and Management Appraisal and Performance Plan (MAPP) participants must achieve a "met expectations" or better to receive their step/merit increase. If no performance evaluation is on file by the appropriate date, or if an employee receives a "needs improvement" or "failed to meet expectations" rating, the employee will not receive a step advance on their step anniversary date or merit increase, as applicable.

> **NOTE**
>
> See DHS – Human Resources Operational Policy No. 780.000, Performance Evaluations, for detailed guidelines.

All managers and supervisors are expected to ensure performance evaluations are completed and fully executed on time. Managers and supervisors who fail to adhere to the performance evaluation policy and procedures will be subject to disciplinary action in accordance with DHS Policy No. 747, Disciplinary Action. MAPP managers/supervisors are subject to monetary penalties for late submissions of MAPP evaluations.

Managers and supervisors shall refer to DHS Human Resources Procedure No. 780.000 for additional information on the performance evaluation process.

All managers and supervisors are required to attend performance evaluation training and, if applicable, MAPP orientation and goal writing training as determined by, offered by or coordinated through DHS Human Resources or the Los Angeles County Department of Human Resources.

Competency is the application of knowledge, skills, and behaviors that are needed to safely, effectively and ethically perform the duties and expectations of the workforce member's job in accordance with the scope of practice and/or as determined by a specific set of criteria or standards.

Competency is measured in a variety of ways, which includes but is not limited to; possession of current and valid professional credentials, criminal background clearance, clearance of federal and state exclusions lists, and skills validation.

All DHS workforce members who hold a direct or indirect patient care position and are assigned to DHS hospitals and health facilities are required to demonstrate competency in their job responsibilities as required by the standards of their profession, state and federal laws and regulations, and/or accreditation agencies.

All DHS workforce members who hold a direct or indirect patient care position and are assigned to hospitals and health facilities are required to maintain and enhance their job skills, and maintain their professional credential(s), by attending mandatory training and continuing education courses in accordance with the requirements of their professional credential(s), the applicable California Business & Professions Code, the hospital and/or facility, and Los Angeles County.

All DHS workforce members mentioned above must participate in the Department's ongoing competency assessment and skills validation process.

Each clinical department head/ancillary division chief is responsible for establishing and providing competency standards and a job description for each workforce member who holds a direct or indirect patient care position and is assigned to a DHS hospital and/or health facility where care, treatment or services are provided on behalf of Los Angeles County.

DHS Policy 780.200, Competency Assessment, will be distributed to each workforce member at the time of new hire/assignment and annually thereafter during the performance evaluation period or upon request.

Documentation of annual core competencies must be reported to the Director, Nursing Affairs on an annual basis. The appropriate manager, as designated within the specific department/area, is responsible for submitting the report.

All nurses who report to physicians and who are not credentialed and privileged must complete core and specialty competencies (as applicable) initially and annually through the assigned physician. Nurse clinical practice will be evaluated with the assistance of a Nurse Manager or clinical nurse expert over the specialty.

Workforce members holding direct and indirect patient care positions who are not performing the essential duties of the position due to a temporary accommodation associated with the employee's medical work restrictions (e.g. work hardening) must still maintain competencies in core functions and appropriate professional credential.

Workforce members who have not performed the essential functions of the position for an extended amount of time (i.e. 1 year) must complete the following activities prior to resuming patient care duties:
   a. Attend and successfully complete department/unit-based orientation
   b. Complete patient population specific retraining. Time allotted for completion is at the discretion of the clinical department head\ancillary division chief but should not exceed 60 calendar days. Exceptions to this time frame must be documented in writing and retained for a minimum of three (3) years.
   c. Complete a preceptorship. Time allotted for completion is at the discretion of the clinical department head\ancillary division chief but should not exceed 60 calendar days, or as established by approved discipline specific policy. Exceptions to this time frame must be documented in writing and retained for a minimum of three (3) years.

Employees should contact their supervisor prior to the date of the competency test if they feel they need a reasonable accommodation under the Americans with Disabilities Act (ADA) for any portion of the testing. The manager\supervisor shall notify the DHS Risk Management Return-to-Work Division to schedule an interactive process meeting. Further, if the employee's request for an accommodation occurs after the completion of the testing process, the manager\supervisor shall notify DHS HR Performance Management. DHS will engage in the interactive process once placed on notice of employee disability and/or prior to imposing disciplinary action.

All workforce members are given two (2) opportunities each (core and/or specialty) to pass competency assessment. Failure to pass competency assessment will result in appropriate corrective action which may lead to suspension, discharge or release from County assignment.

Refer to DHS Policy 780.200 for additional information on the competency assessment process.

FAMILY AND MEDICAL LEAVE ACT (COUNTY EMPLOYEES)

The Department of Health Services (DHS) is required to comply with the provisions of FMLA, thereby, DHS must designate FMLA leave whenever applicable to any eligible employee (including temporary and part-time employees).

Under FMLA and CFRA an eligible employee is one who meets the following criteria:

- Has completed an aggregate of 12 months of County service, which need not be consecutive;

<div align="center">and</div>

- Has worked at least 1,250 hours during the 12-month period immediately preceding the first day of leave.

FMLA and CFRA entitle eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- The employee's own serious health condition;
- The care of a child, spouse, or parent with a serious health condition;
- The birth of a child and to care for the child within one year of birth (baby bonding);
- Newly adopted child or a foster care placement; or

FMLA (only) entitles eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- Prenatal care.
- Any qualifying exigency arising from a spouse, child, or parent's call to active duty.

FMLA (only) also entitles eligible employees up to 26 workweeks of unpaid job protected leave in a 12-month period to care for a spouse, child, parent, or next of kin, who is an Armed Forces member recovering from an injury or illness sustained within the last five (5) years.

CFRA (only) entitles eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- The care of a domestic partner with a serious health condition.
- The care of a domestic partner's child with a serious health condition.

PDL (only) entitles a female employee up to 16 workweeks of unpaid job protected leave in a 12-month period if she is disabled due to pregnancy or any prenatal or childbirth related medical condition. Employees are eligible for PDL from the first day of employment.

> **NOTE**
>
> See DHS Policy No. 756.6 for detailed guidelines.

Management's determination must be based on the information received from the employee or the employee's spokesperson in the event the employee is unable to communicate directly.

An employee on an approved medical leave of absence is subject to the provisions—and limitations—of DHS Policy 740.000 in relation to all (non-conflicting) outside employment or activity. As part of this process employees are responsible for appropriately disclosing outside activity, subject to the provisions mentioned above, that may adversely impact or interfere with existing medical limitations and/or restrictions. Outside activities subject to approval include, but are not limited to: outside employment; expert witness testimony; volunteer activity; and performance of charity medical relief.

BEREAVEMENT LEAVE

Any person employed in a full-time, permanent County position who is compelled to be absent from duty because of death of his/her father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, husband, wife, child, stepchild, grandfather, grandmother, grandchild, domestic partner, domestic partner's father, mother, stepfather, stepmother, child, stepchild or grandchild, shall be allowed the time necessary to be absent from work at his regular pay.

The intent of this Bereavement Leave provision is to allow an eligible employee to be absent from work for a prescribed number of <u>working days</u>, not hours, except in the case of employees on a job with SubTitle D (Monthly Permanent 9/10 time employee).

Definitions of Working Days for Bereavement Leave Purposes

- For employees on a 5/40 schedule, the working day equals 8 hours.
- For employees on a 9/80 schedule, the working day equals 8 or 9 hours (i.e., whatever number of hours are scheduled for the day that is taken as Bereavement Leave).
- For employees on a 4/40 schedule, the working day equals 10 hours.
- For employees on 12 hour flex schedules, the working day equals 12 hours.

Bereavement Leave for Full Time, Permanent Employees

A full time, permanent employee is allowed up to three working days of Bereavement Leave, except that an employee who is required to travel a minimum of 500 miles one-way in connection with a Bereavement Leave may take an additional two working days as Bereavement Leave.

In addition, represented employees are allowed to use other paid or unpaid leave if the employee needs additional time off.

Bereavement Leave for Temporary Monthly Employees

A full time monthly recurrent or monthly temporary employee who qualifies for Bereavement Leave receives 8 hours Bereavement Leave per year if he or she has completed at least 200 days of active service in the preceding calendar year, and four hours if such employee has completed less than 200 days of active service in the preceding calendar year.

Monthly Permanent 9/10 Time Employees (RN's or SubTitle D)

Such employees are allowed 24 hours for each qualifying occasion.

USE OF BEREAVEMENT LEAVE

Bereavement Leave need not be taken on three consecutive working days. For example, if an employee takes two working days of Bereavement Leave at the time of death, he or she may take a third day later to attend the business affairs of the deceased. Any additional time that may be needed beyond the three working-day limit must be charged to Vacation, Personal (Sick) Leave, Compensatory Time Off (CTO), or Holiday time with prior management approval. **Bereavement leave must be taken within a one-year period from the death of the family member. Bereavement leave can only be taken in full shift increments.**

In the event that two or more qualifying family members die at the same time, the employee receives three or five working days for each qualifying family member in accordance with the policy.

If a qualifying family member dies while an employee is already off work and using (100% paid leave benefit) Personal Leave, CTO, Holiday time, or Vacation Leave, the employee may substitute the allowed amount of Bereavement Leave in lieu of the foregoing leave types. Except, when the employee is using part pay sick leave, this leave cannot be interrupted with bereavement leave.

The foregoing provisions also apply to Title Sub D employees whose leave is defined in hours rather than working days.

PROOF OF BEREAVEMENT

The Employee must complete and submit to his/her supervisor a Bereavement verification slip with attached proof of bereavement and travel within 30 days following his/her return to work. Copies of the Bereavement verification slip and proof of bereavement and or travel must then be forwarded to Payroll. Failure to provide this will result in the employee using his/her own leave benefits to cover absence taken as bereavement leave

Acceptable evidence to document the death of a qualifying family member for the purpose of Bereavement Leave, include:

- Death Certificate.
- Obituary Notice.
- Letter from attending physician, clergyman, or mortician attesting to the death and identifying relationship to the deceased.
- Funeral program.

PROOF OF TRAVEL

If an employee is required to travel a minimum of 500 miles one way, the employee will be eligible to receive two additional working days of Bereavement Leave. In order to qualify for these additional days the employee must provide proof of travel. The following are acceptable evidence of travel 500 miles or more:

- Train, airline, bus or boat ticket or boarding pass.
- Gasoline receipt showing date(s) of purchase and city(ies) or a credit card receipt.
- Hotel/Motel lodging receipt.
- Other

> **NOTE**
>
> Refer to DHS Policy 756.8, Bereavement Leave or contact DHS Payroll for questions concerning bereavement leave.

JURY DUTY

County employees summoned to serve as jurors will be granted jury duty leave. An employee must notify his/her supervisor as soon as he/she receives a jury duty summons and provide the supervisor with a copy of the summons. All employees in a permanent position (full-time or part-time) who are ordered to serve on a jury shall be allowed the "necessary time to be absent from work" at his/her regular pay. "Necessary time to be absent from work" means the amount of time required to fulfill jury duty service, including travel time. It does not include any time in which the employee is "on call" or when his/her presence is not required. Due to extended work days associated with a 9/80 or 4/40 schedule, employees may be required to return to work following release from court.

Employees who are not on a permanent position shall receive a maximum of two days (16 hours) of pay in any one year if they have completed at least 200 days of active service in the prior calendar year. Employees who do not meet this requirement shall receive a maximum of one working day (8 hours) with pay per year. The leave is not accumulated. Exceptions to this may be defined in applicable Memoranda of Understanding.

Service on any California State (Superior) or Federal Court is covered by Jury Duty Leave. Service on any County's criminal grand jury is covered, but service on a civil grand jury is not covered, because such service is entirely voluntary. An employee may serve on a County grand jury, if the employee's department approves an unpaid leave of absence, but the employee does not receive his or her regular pay or Jury Duty Leave.

County employees are not eligible for jury duty fees, but do receive their regular earnings while on jury duty. Employees may receive mileage reimbursement, beginning on the second day of service, which does not have to be returned to the County.

USE OF JURY DUTY LEAVE

Employees serving jury duty on their regular day off (RDO) are on their own time for that day. Jury duty served on a RDO is not work time for overtime or any other purpose.

If an employee becomes ill during jury service and is excused by the Court from jury duty for that period of time, the absence is charged to Sick Leave.

All employees assigned to night or weekend schedules must convert to a five-day, 40 hour daytime work schedule during jury duty.

Employees who work alternate work schedules may or may not need to convert to a regular five day, 40 hour shift for jury duty, as follows:

➢ **Non-Represented Employees**
   Permanent, monthly temporary and monthly recurrent non-represented employees assigned to other than a five day, 40 hour, day shift schedule may, at the discretion of each County department head, remain on that schedule while serving jury duty. This includes employees whose positions are covered by or exempt from Fair Labor Standards Act (FLSA) requirements.

➢ **Represented Employees**
   Requirements for represented employees are in their respective Memoranda of Understanding (MOU).

PROOF OF JURY DUTY SERVICE

An employee summoned to jury duty must submit a copy of the jury duty certification form(s) obtained from the court to his/her supervisor AND Payroll Services upon return to work. It is the employee's responsibility to obtain proof of jury service from the court. If proof of jury service is not submitted to the supervisor the employee may not be granted jury duty leave.

PAYROLL (COUNTY EMPLOYEES)

TIME REPORTING

Each employee is held accountable for complete and accurate time reporting on a daily basis. Falsification, tampering with and/or failure to properly complete time collection documents shall be cause for appropriate disciplinary action, up to and including discharge.

DHS uses the eHR application for documenting and recording time worked and time off. Each employee shall accurately and timely record time worked and time absent from work in increments of no less than 0:15 (15 minutes), complete the electronic timesheet and submit it as directed within the time period specified by payroll and management.

Time recorded as worked must only reflect time that is actually spent performing work for the County. Employees may not spend time working on non-County/non-DHS related activities during County working hours, such activities may not be reflected as County time on the employee's time collection document/timesheets.

Timesheets are to be submitted as directed by management and Payroll. Each year, the Time Collection Team publishes a calendar for submission and approval of timesheets. Employees are reminded to be diligent in submitting their time sheets on time to avoid delayed paychecks, bonuses and/or accrued/paid compensatory overtime.

Each employee can attend eHR time collection training. Check with your supervisor to schedule the eHR time collection training. For more information, you may also check the DHS Time Collection website from the DHS Enterprise Intranet at **http://myladhs.lacounty.gov**.

HOLIDAYS

Only monthly employees, permanent or temporary are eligible for paid leave for holidays. Currently, the Board of Supervisors has approved 11 annual holidays:

- New Year's Day – January 1st
- Martin Luther King Jr.'s Birthday – Third Monday in January
- Presidents' Day – Third Monday in February
- Memorial Day – Last Monday in May
- Independence Day – July 4th
- Labor Day – First Monday in September
- Columbus Day – Second Monday in October
- Veterans Day – November 11th
- Thanksgiving Day – Fourth Thursday in November
- Friday after Thanksgiving – Fourth Friday in November
- Christmas – December 25th

If January 1st, July 4th, November 11th, or December 25th falls on a Saturday, the previous Friday is a holiday. If any of those dates fall on a Sunday, the following Monday is a holiday.

If a holiday falls on an employee's regular day off, permanent full-time and permanent part-time employees will accumulate that holiday time based on their Sub Title (up to a maximum of 8 hours). For 40-hour week employees, holiday time is accrued at 8 hours.

There is no limit to how long an employee can carry over the time, but management has the option of paying the employee for unused holiday time after two years have elapsed from the date the time was earned.

Employees on the 9/80 or 4/40 work schedule must check with their supervisor regarding the use of accumulated holiday time on a regular workday in their department.

The eHR application keeps up with holidays and automatically codes them on the online timesheet. Coding of the time worked on a County holiday requires determination as to whether the employee's position is a POST position. A POST position is characterized by duties that must be performed at regular intervals regardless of holidays or other regular days off. Such positions are normally found in areas that provide 24-hour coverage every day of the year. An employee assigned to a POST position is a **shift** employee.

A **shift** employee who works a County holiday as part of his/her standard work schedule will code his/her time sheet as regular hours worked, and accrue Holiday time based on their Title/SubTitle (to a maximum of 8 hours) to be taken at a later date upon approval. If a shift employee is off on a Holiday, and said Holiday fulfills or completes the employee's standard work schedule, then the employee will get paid for the Holiday, but will not accrue Holiday time.

A **non-shift** employee who works on a County holiday will get paid for the Holiday and will code his/her timesheet as overtime hours worked. However, if a Holiday falls on an employee's regular day off (RDO), he/she will accrue the fractional number of Holiday hours as indicated by their Sub Title. The accrued Holiday time can be requested as time off at a later date using the appropriate leave event code.

Any part-time non-shift or shift employee employed on a monthly basis shall be allowed paid leave for each holiday in an amount equal to the item subfractional amount indicated by County Code.

TIME OFF REQUESTS

Employees must follow the directions of their manager/supervisor regarding the submission of time off requests. Requests for time off should be submitted as soon as possible/practical so as to allow time for the manager/supervisor to evaluate staff coverage. This includes vacation, jury duty, witness duty, and any other reasons for time away from work.

If an employee needs to request time off with less than three (3) working days written notice, the employee must submit an emergency request in writing to his/her supervisor stating what type of leave he/she is requesting and the reason for the request. Written proof or verification of the emergency may be requested by the employee's manager/supervisor for any occasion on which the employee must be absent from work for an emergency. Written proof or verification must be submitted to the manager/supervisor upon the employee's return to work. Managers/supervisors shall provide a response to the request in a timely manner.

❖ If the emergency is sudden and the employee has not yet reported to work, the employee is to personally call his/her manager/ supervisor, or designee. The employee should state the nature of the emergency and the type of time he/she will be requesting to cover the absence, subject to the manager's/supervisor's approval.

❖ If the employee is not physically able to notify his/her supervisor, he/she should ensure someone notifies his/her supervisor as soon as practical. When practicable, the employee is expected to give an estimated return to work date to his/her supervisor. If the employee does not provide an estimated return to work date, the supervisor may ask the employee for an estimated return date or ask the employee to call in on a regular basis until a return date is identified. An employee must make every reasonable effort to inform his/her supervisor.

❖ If the emergency is sudden and the employee is on duty, he/she must speak to the manager/supervisor immediately to obtain permission to leave work and indicate the amount and type of time to be used. The employee may not leave the work area without first reporting to his/her manager/supervisor or designee.

An employee who is off three (3) or more consecutive work days may be required to present an original verifiable medical certification of illness or injury upon return to work:

- For absences of three (3) consecutive work days, the medical certification, if requested, must be provided to the employee's immediate supervisor on the first day the employee returns to work.
- If the absence is extended to four (4) or more days, the employee, if requested, must provide medical certification to his/her immediate supervisor by the fifth (5th) work day of the absence. If the absence is extended further, the employee must provide updated medical certification to his/her immediate supervisor prior to the expiration of each extension. The employee must have a current medical certification on file with his/her supervisor at all times, or the timesheet will be coded as Absent Without Pay (AWOP).

Acceptable medical certification is an original, signed, and dated document from a licensed physician provided on letterhead stationery of the physician or health care facility providing the care. The certification must include the following:

- The date the employee was seen by the physician.
- Date(s) the illness or injury prevented the employee from performing his/her duties.
- Earliest date the employee can return to work with or without restrictions.
- If there are work restrictions, the certification must include the nature of the restrictions and their duration.

An employee who fails to report an absence within the specified time period, call within the specified time period, or provide medical certification, as required, the absence is considered unapproved. Therefore, the timesheet will be coded unapproved Absent Without Pay (AWOP) for the period of the unreported absence. Unauthorized absences may subject the employee to disciplinary action.

An employee who demonstrates a clear pattern of absenteeism (such as absenteeism in conjunction with regular days off (RDOs), weekends, holidays, or vacation time off) may be placed on medical certification.

An employee who, without prior authorization or notification, is absent or fails to work his/her regularly assigned duties for three (3) consecutive regular working days or two (2) consecutive regularly scheduled on-duty shifts, is considered to have resigned from County service, unless the employee resumes his or her regularly assigned duties at the commencement of the next regular working day or on-duty shift, per County Code 5.12.020. Employee will be subject to release from employment due to voluntary resignation by job abandonment once applicable due process requirements are complete.

SICK LEAVE ACCURAL

Sick Leave, as used in DHS Policy 756.5, Use of Sick Leave Benefits, refers to paid leave for an employee's absence on a relatively short term basis when he\she or the employee's child, parent, spouse, or domestic partners is ill or injured. The term sick leave does not include:
- absences that have been designated as Family Leave, such as an extended absence for the employee's own serious health condition; and
- absences for illnesses and injuries deemed compensable as work-related,
- nor for disabilities approved for coverage by MegaFlex's Short Term Disability plan, since such absences must be medically certified and are subject to review and approval by a third party.

To be eligible to earn Full (and Part-Pay) Sick Leave, non-MegaFlex employees must be on one of the following SubTitle: Full-time, Permanent ("A" or "N"), Monthly Recurrent ("B"), Monthly Temporary ("M" or "O") and Part-

time Daily or Permanent part time, as long as the part time is at 1/2 time or more ("C", "D", "E", "U", "V", "W", "X", "Y", or "Z" SubTitles).

During each pay period, eligible employees earn a fraction of an hour of Full-Pay Sick Leave for performing the following (active service) hours that are counted for leave accrual purposes:

- Regular hours worked or scheduled.

- Full and part-pay leave taken, such as Vacation, Compensatory Time Off (accumulated overtime taken), Part-Pay Sick Leave, etc.

- Industrial Accident Leave covered by County Code or California Labor Code 4850 benefits.

Employees do not earn Sick Leave for:
- Unpaid absence (absent without pay (AWOP), or sick without pay (SWOP));
- Overtime worked;
- Regular weekend RDO hours (i.e., two day (16 hours) based on a 5/40 schedule);
- Long-Term Disability (LTD) hours, or Workers' Compensation hours after salary continuation benefits have ended.

The total amount of Full-Pay Sick Leave earned by each eligible full-time employee each year is defined by County Code or his or her Bargaining Unit and years of County Service. Full-Pay Sick Leave accrual for each year begins January 1st or when an employee enters County service, and ends each year when the employee reaches the maximum number of hours specified for his or her class or Bargaining Unit and years of service, or at the end of the year. The accrual begins over again each January 1st.

Sick leave at full pay may be used for:

- An absence resulting from injury, illness, disability, or pregnancy including childbirth or related medical condition.

- Medical or dental care scheduled in advance, such as physical examinations, dental examinations, or eye examinations for glasses or contact lenses. Using Sick Leave for these purposes requires prior supervisory approval, when practicable.

- Under the California Kin Care Law, an employee is entitled to use that amount of Sick Leave the employee earns in any calendar year during a six-month period to attend to the illness or injury of a child, parent, spouse, or domestic partner.

Non-MegaFlex employees may elect to use Vacation, Compensatory Time Off (accumulated overtime taken), or Holiday time to cover their absences rather than using Full-Pay Sick Leave. When Vacation or other leave is being used for non-emergency care, such as doctor appointments, prior supervisory approval is required when practical and should not be reasonably denied. The request should be submitted in writing.

However, a non-MegaFlex employee may not use Sick Leave for a vacation or any other absence, unless the Sick Leave qualifies as "Personal Leave," as discussed below.

Personal Leave Usage

Non-MegaFlex employees (on a 40-hour work week) who earn Sick Leave may use up to a maximum of 96 hours per calendar year of his/her Sick Leave as Personal Leave as allowed by County Code. Personal Leave is defined as any leave, taken for personal reasons, which does not interfere with the public service mission of the department. Prior supervisory approval must be obtained by an employee before he or she can use Sick Leave as Personal Leave, unless the need to use Sick Leave and Personal Leave arose due to an unforeseen situation or other emergency.

Personal Leave may also be used to care for a spouse (including a domestic partner), child, or parent who is ill. In this case, prior supervisory approval may not always be feasible, but it should be obtained when the need to give care is anticipated.

Part-Pay Sick Leave Accrual/Usage

At the beginning of each calendar year, employees who are eligible to accrue Full-Pay Sick Leave as described above and who have completed six months or more of continuous service are entitled to receive various amounts of Part-Pay Sick Leave hours, at either 65% or 50% pay. The amount an employee receives is based on the employee's length of service. Unused Part-Pay Sick Leave from any year does not carry over to the following year. Part-Pay Sick Leave is used to cover an extended sick leave. Refer to DHS Policy 756.5 for more information on use of part-pay.

Other Sick Leave Provisions

An employee may carry over unused 100% Sick Leave that he/she has earned during the year, there is no limitation to the amount an employee may accrue.

Certain employees who, for a period of six months, do not use any Sick Leave for any reason, including personal reasons, may sell back to the County some number of days of Full-Pay Sick Leave; most employees may sell back three days, but some Bargaining Units have negotiated a different number of days. Consult County Code Section 6.20.030 and applicable MOU for specified number of days. Sick leave buy back occurs each January and July for the previous six month period.

Upon termination from County service, full-time, permanent employees with at least five years of continuous service are paid for one-half of their unused Full-Pay Sick Leave to a maximum of 90 days (720 hours); 56-hour employees, 135 days (1080 hours).

Sick Leave Reporting

Absences for which using Sick Leave is appropriate may be either scheduled or unscheduled.

SCHEDULED ABSENCES

A scheduled Sick Leave absence is any absence, either for a full or a partial workday, that is approved in advance by an employee's supervisor. Such absences are usually for medical or dental office visits, treatments, etc., which can be scheduled in advance. Employees should notify their supervisors as soon as they have scheduled an appointment and submit his or her Request for Time Off.

UNSCHEDULED ABSENCES

Unscheduled absences due to sickness or injury of either the employee or a family member can occur at any time. An employee who needs to be absent because of sickness must immediately notify his or her supervisor of the absence.

The employee must personally notify his or her supervisor or designee of the absence as much as possible in advance of the employee's shift. An employee assigned direct patient care related responsibilities in an inpatient setting must notify management at least two (2) hours prior to his/her scheduled work hour/shift.

An employee assigned direct patient care in an outpatient setting, or non-patient care related responsibilities must notify management 30 minutes prior to the start of the employee's scheduled work hour/shift.

It is the employee's responsibility to call in. Calls will not be accepted from anyone on behalf of the employee except in those cases where the employee is incapacitated and unable to call in. In the event an employee

cannot call his/her manager/supervisor (such as hospitalization, accident, physically unable, etc.) a report will be accepted from a representative. However, the employee must make personal contact with the manager/supervisor as soon as possible.

When practical, the employee is expected to give an estimated return to work date to his or her supervisor. If the employee does not provide an estimated return date, the supervisor may ask the employee for an estimated return date or ask the employee to call in on a regular basis until a return date is identified.

An employee must make every reasonable effort to inform his or her supervisor when he or she is aware that a previously-specified expected return date will not be met, and provide a new date. See "Time Off Request" section above for absences exceeding three (3) workdays.

Unwarranted sick leaves shall be deemed an abuse of the provisions of the salary ordinance allowing leaves of absence on full pay for illness. Any employee found to have abused or is abusing such sick-leave privileges may be subject to suspension for a period of 30 days without pay for a first offense and subject to discharge for a subsequent offense.

Employees may use existing vacation, personal leave, or compensatory time off, for planned absences so that the employee can participate in the school or child day care program activities of their children, grandchildren under their custody, and\or children under their legal guardianship, who are enrolled in kindergarten through twelfth grade or licensed child day care facility. Pursuant to Labor Code Section 230.8, such absences are not to exceed eight (8) hours per month and cannot exceed a total of forty (40) hours per year. Also, the employees must give reasonable notice to their supervisor of the planned absence.

The department may require reasonable written documentation that the employee actually participated in school activities. Such documentation could be a simple statement on school letterhead, flyer and/or email with a description of the school activity.

MegaFlex

MegaFlex employees do not accrue Vacation, or Full-Pay (or Part-Pay) Sick Leave. In lieu of Vacation and Sick Leave, a MegaFlex employee earns or purchases two kinds of annual leave: Non-Elective and Elective Leave. A MegaFlex employee can earn up to 12.5 days of Non-Elective Leave per year, periods of absence without pay will affect the accrual of this leave. MegaFlex employees will earn from four up to five hours of Non-Elective Leave each pay period, depending upon the years of service, to a maximum of 100 hours. This leave may be carried over to the following year and can be accumulated up to a maximum of 60 days (480 hours).

MegaFlex employees can use unused Full-Pay Sick Leave (Code 004) that they earned before they entered MegaFlex when they are sick, but they cannot use the Full-Pay Sick Leave for "Personal Leave" as previously described for non-MegaFlex employees. MegaFlex employees who are not sick may not use Sick Leave, and must use any other accrued leave available to them before using Elective Leave. If they are not sick, and accrued Sick Leave is the only leave available to them other than Elective Leave, then they may use Sick Leave with supervisory/management approval.

MegaFlex participants must use all non-elective annual leave days and any banked and available compensatory time off, vacation, holiday and/or (when sick) sick leave before using any of the elective annual leave purchased for the year.

A MegaFlex employee may not use Non-Elective or Elective Leave without prior supervisory approval. With supervisor's approval, they can be used for any purpose.

Under California Kin Care Law, a MegaFlex employee may use up to five days (40 hours) of Non-Elective Leave for this purpose.

Although MegaFlex employees do not earn Part-Pay Sick Leave, a MegaFlex employee with a serious illness may qualify for the Short Term Disability plan provided by the MegaFlex cafeteria plan.

PAYCHECKS

County employees are paid on a semi-monthly basis on the 15th and 30th. Taxes and most deductions are split and deducted twice a month. Some deductions such as medical, dental and life will be deducted on the 15th of the month. Employees who elect to be paid through direct deposit will receive their paycheck stubs online. Employees must complete the direct deposit form and submit it to Payroll Services to enroll in direct deposit. Employees who elect to receive paper paychecks will also be able to see their paystubs online.

EMPLOYEE PAY STATEMENTS (PAYSTUBS)

Paystubs are available online through the eHR application. Paystubs can be printed or saved to an approved USB thumb/flash drive. To view paystubs online the employee must log onto the eHR application and choose "Paystub Viewer." Paystubs are usually available to view/print within two business days before payday. Current and historical paystubs and W-2's can be viewed, downloaded, and printed. A tutorial on how to read your paystub can also be found under the "Paystub Viewer" tab. Select "Help/Information" tab on the left of the screen to view the tutorial.

WORK HOURS/WORK WEEK

Management is responsible for establishing work hours/shift for each employee that includes a regular start time and end time, and appropriate lunch and rest breaks in accordance with the Los Angeles County Code and applicable Memorandum of Understanding (MOU).

An official work week is defined as five days of work per week for a total of 40 hours. Management shall comply with County regulations, applicable MOUs and the Fair Labor Standards Act when establishing an employee's work week.

A normal workday consists of eight (8) consecutive hours exclusive of at least a 30 minute lunch period and inclusive of two (2) fifteen (15) minute rest periods to be taken as determined by management in accordance with Los Angeles County Code provisions and applicable MOU. A rest period should be taken approximately midmorning and midafternoon, they shall not be accumulated or combined to lengthen the lunch period, shorten the workday or to make up tardiness or absences.

Management shall ensure that the scheduling and taking of rest periods shall not interfere with essential workload coverage nor adversely affect the ability of the facility/organization to accomplish its mission.

The number of work hours per day and week may vary based on employee agreement of an alternate work schedule.

Management shall provide advance written notice to employees of work schedule changes, as required in applicable MOUs. All permanent employees will have their timesheets pre-populated with the work schedule on record. Changes to these work schedules must be reported to Payroll Services using an official Work Pattern ID form which is available online or can be obtained from the employee's timekeeper or payroll clerk.

OVERTIME

Overtime is time requested and authorized by management, in excess of the number of hours regularly worked in the workweek. Departmental managers and/or supervisors may require employees to work overtime in accordance with County Code, Federal Fair Labor Standards Act (FLSA) and MOU provisions. However, overtime shall be kept to a minimum and used when it is the only alternative to meet workload demands.

Employees shall not enter into informal agreements with managers or supervisors allowing unrecorded compensatory time. Employees shall not arrive to work early nor leave late as this may constitute a violation of FLSA. Under FLSA, all overtime "suffered" to be worked by a FLSA-covered employee must be paid whether or

not it is authorized. Some examples include work taken home, work done at a desk while eating during the lunch period, or work performed at the end of a workday or shift. Overtime must be approved in advance in accordance with departmental and facility policy and procedures.

Compensation for overtime is dependent upon the employee's job classification, whether or not they are represented by a labor union. County and Departmental policy will determine the method and rate of compensation for overtime.

SALARY INCREASES

Salary increases are dependent on your pay plan. The types of pay plans are:

- General Step Pay Plan
- Physician Pay Plan
- Management Appraisal and Performance Plan

General Step Pay Plan

The step pay plan is intended to increase an employee's pay in steps as he or she acquires experience. Most County employees are paid on the County Standardized Salary Schedule. A number-and-letter combination is used to define the pay level. The number is referred to as the schedule, and the letter is referred to as the level. For each schedule and level there are five steps, which are approximately 5.5 percent apart.

A few classes are paid on an alternate salary grid. The pay level and the number of steps are identified for each item by the Board of Supervisors. Steps may be in increments of more or less than the standard 5.5 percent.

Step Anniversary Date

Employees normally are initially placed on the first step in the salary schedule for their classification, although some classifications begin at higher steps. Future steps are granted on the employee's step anniversary date, which is usually one year from the appointment date.

Step Advances and Salary Adjustments

Step advances are granted, usually at one-year intervals, until the top step approved for the class is reached. The top step is usually the fifth step, but some classes are paid on a range with more or fewer than five steps. Step advances are granted only if the employee's current annual performance evaluation is rated "Competent" or better.

In addition to step advances, salaries are adjusted periodically by the Board of Supervisors or through negotiations with labor unions to ensure County salaries are sufficient to attract and retain quality employees. All adjustments must be approved by the Board of Supervisors.

Effective April 2012, the step advancement anniversary date will be the actual date of appointment. Employee appointments made prior to April 2012 retain the current 1st of the month as the step advancement anniversary date. Also, employees paid under the Tier II Management Appraisal and Performance Plan (MAPP) will continue to have a step advancement date of October 1st.

Management Appraisal and Performance Plan

The Management Appraisal and Performance Plan (MAPP) is the pay plan for top management and high-level staff positions. Under this pay plan, salary increases are linked to performance.

There are two levels of MAPP participants, Tier I which includes the department head and his or her direct reports and Tier II other high-level staff positions. Tier I MAPP participant merit increases are based on recommendations by the Department Head and approved by the CEO. Tier II MAPP participant step advances are also approved by the CEO. MAPP participants must be rated "competent" or above to receive a merit increase or step advance. At a certain level, Tier II MAPP participants must receive an "exceeds expectations" rating to advance to the top pay steps.

VACATIONS ACCRUAL AND USAGE

To be eligible to earn Vacation Leave, non-MegaFlex employees must be on one of the following SubTitle: Full-time, Permanent ("A" or "N" SubTitles), Monthly Recurrent ("B"), Monthly Temporary ("M" or "O") and Part-time Daily or Permanent part time, as long as the part time is at 1/2 time or more ("C", "D", "E", "U", "V", "W", "X", "Y", or "Z" SubTitles).

Vacation Leave for non-MegaFlex employees who are entitled to earn this leave, is earned and accrued each pay period based on certain hours recorded in each pay period. This accrual process begins for new employees upon appointment to an eligible job. There is no waiting period or minimum service requirement before accrual begins.

Vacation Leave that has been earned in one pay period can be used in the next pay period, unless the employee has less than one year of service. For new employees, Vacation that is earned is held in reserve until the employee completes one year of service, at which time the earned Vacation may be used. The amount of Vacation an employee may earn each pay period or each calendar year increases as the employee reaches certain milestones of County service.

During each pay period, eligible employees earn a fraction of an hour of Vacation for performing the following (active service) hours that are counted for leave accrual purposes:

- Regular hours worked or scheduled.

- Full and part-pay leave taken, such as Vacation, Compensatory Time Off (accumulated overtime taken), Part-Pay Sick Leave, etc.

- Industrial Accident Leave covered by County Code or California Labor Code 4850 benefits.

Vacation Years of Service	40-Hour Employees Vacation Annual Maximum Hours
0-4 years	80
4-9 years	120
9-10 years	128
10-11 years	136
11-12 years	144
12-13 years	152
13 years or more	160

Employee Vacation leave requests should be submitted on the Request for Time Off far enough in advance to provide supervisors time to consider coverage, per Departmental requirements. Supervisors will provide instruction on when and how to submit vacation requests.

An employee may carry over unused and accrued Vacation to the following year. Such carried-over Vacation is called "Deferred" Vacation, while Vacation that is earned during the current year is called "Accrued" Vacation. At

the end of the year, an employee may have some Deferred Vacation and some Accrued Vacation still remaining; these two are combined at the beginning of the following year and become the new year's Deferred Vacation balance. There is a limit (320 hours for most employees) to the amount of vacation that can be deferred. At the end of December of that year, any Vacation in excess of 480 hours (320 hours deferred and 160 hours current) will be paid the following January.

When an employee leaves County service, he or she receives payment for unused Vacation hours. The only requirement for receiving such payment is that the employee must have at least one year of service, unless otherwise provided by a collective bargaining agreement.

MegaFlex Employees

MegaFlex employees do not earn Vacation Leave. They earn Non-Elective Leave and during benefit enrollment are able to purchase up to an additional 20 days of Elective Leave.

If an employee is new to the County and is an eligible MegaFlex participant, or is newly eligible as a result of an appointment from a full-time permanent position covered under Choices or Options benefit plan to an eligible MegaFlex position, the following applies:

- Any vacation the employee earned under Choices or Options will remain available for use after the employee has become a MegaFlex participant, subject to the same policy and procedure for using Vacation leave. However, before they can use any Elective Leave they may have purchased, MegaFlex employees must use all previously accrued leave such as Vacation, Holiday, and Compensatory Time Off. In addition, MegaFlex participants must use their Non-Elective Leave prior to using any Elective Leave.

Elective Leave that is not used during the calendar year when it is purchased may be paid off at the end of that year, and is paid off if not used upon termination, if applicable.

Unused Non-Elective leave may be carried over from year to year until it exceeds 480 hours. The system automatically calculates and pays off the excess at the employee's workday hourly rate in effect on January 1st in the New Year. All Non-Elective Leave is paid upon termination.

VEHICLE TRIP REDUCTION – RIDESHARING

DHS sites employing 100 or more employees are required to participate in the County Rideshare Program. This includes programs with aggregate number of employees situated in a leased building. The purpose of the Rideshare Program is to reduce traffic congestion and pollution resulting from air emissions from vehicles used to commute between home and work. It is also required per County agreement with the South Coast Air Quality Management District (SCAQMD).

Sites required to participate in the County's Rideshare Program have an assigned Employee Transportation Coordinator (ETC) responsible for promoting Rideshare, facility-specific benefits and incentives available to employees that participate in a Rideshare mode as well as conducting the annual Rideshare survey. All employees who arrive to work at the site between the hours of 6 AM to 10 AM are mandated to participate in the survey. The survey not only signifies to SCAQMD how the County is performing in meeting its requirements but also provides valuable information to the County and facility ETCs on the needs of the employees and the effectiveness of Rideshare incentives. Individual employees may elect via the survey to receive a RideGuide that provides them with alternative methods of commuting to work and assists with finding Rideshare partners for vanpools and carpools. The information provided in the survey and the RideGuide is handled confidentially.

There are a number of programs provided through the County to enhance Rideshare:

Telework: Want to work at home? If your work assignment allows it and it is approved by your supervisor, you can work at home and leave the commute behind.   Telework is a management option and you and your supervisor must attend training and sign an agreement.

Guaranteed Ride Home (GRH):   Afraid you won't be able to get home in an emergency? Employees that Rideshare are eligible for a "guaranteed ride home" in emergency situations up to 4 times a year.

Alternative Work Schedules (Compressed Work Week):   A management option, working a 4/40 or 9/80 work schedule can reduce traffic and air pollution. Discuss this option with your immediate supervisor or manager.

Flexible Work Schedules: Rideshare doesn't fit your schedule? Employee work schedule can be flexed 15 minutes (instead of the normal 8 a.m. – 4:30 p.m. work day, the schedule can be flexed to 8:15 a.m. – 4:45 p.m.) to allow an employee who takes public transportation to arrive to work on time.

Vehicle Purchasing Services Program: The County has arranged for employees to receive a discount on the purchase of a "green" vehicle from various car dealerships. Many sites have charging stations to accommodate electric vehicles. Refer to the CEO Rideshare Website for more information.

A rideshare mode includes: Vanpool, Carpool, Public Transit, Metro Light Rail, Metrolink, Telework, and don't forget walking and bicycling.

For additional information on your particular site's Rideshare Program contact your site ETC. For general information on the County Rideshare Program, visit the County CEO Rideshare Website at http://rideshare.lacounty.gov/

TAKE PRIDE: SHARE THE RIDE!
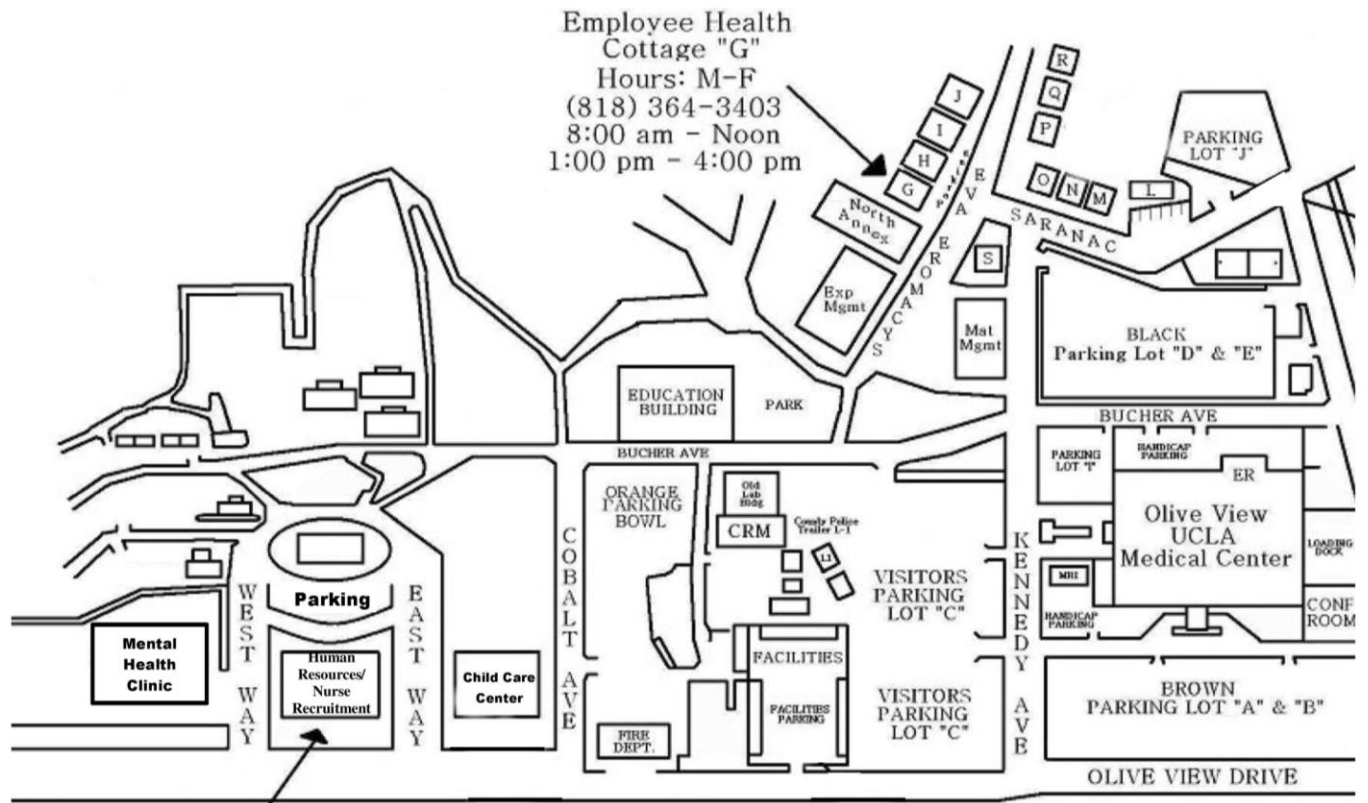
Employee Health Cottage "G"
Hours: M-F
(818) 364-3403
8:00 am - Noon
1:00 pm - 4:00 pm

Human Resources Building
Hours: M-F
8:00 am – 5:00 pm

Provided By:

County of Los Angeles
Department of Health Services
Human Resources
Office of Regulatory Compliance
5555 Ferguson Drive, Suite 120-25
City of Commerce, CA 90022
Tel: (323) 869-8001
Fax: (323) 838-4413

Mitchell H. Katz, MD
Director
Department of Health Services

DHS Mission

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services of DHS facilities and through collaboration with community and university partners.

Board of Supervisors
County of Los Angeles

Hilda L. Solis	Mark Ridley-Thomas	Sheila Kuehl	Don Knabe	Michael D. Antonovich
First District	Second District	Third District	Fourth District	Fifth District

County Mission

To Enrich Lives Through Effective and Caring Service