2015

Orientation/Reorientation Handbook

Los Angeles County – Department of Health Services

RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

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

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Revised
September 2015

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Ultrasound		(562) 401-7472
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HOTLINES

ADA Information Line..... (800) 514-0301
Child Abuse ..... (800) 540-4000
DHS Compliance ..... (800) 711-5366
DHS Patient Safety..... (213) 989-7233
DHS Quality Improvement..... (800) 611-4365
Elder/Dependent Abuse/Adult Abuse ..... (800) 992-1160
Fraud (LA County) ..... (800) 544-6861
Intimate (Domestic) Partner Violence..... (800) 978-3600
The Joint Commission ..... (800) 994-6610
Pharmacy..... (562) 401-7239
Poison Center ..... (800) 411-8080
Risk Services (24 Hours/After Hours)..... (562) 492-1800
Safely Surrender Baby (SSB)..... (877) 222-9723
Sheriff's Department..... (562) 401-7042
Suicide Prevention..... (877) 727-4747

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RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

Los Angeles County Board of Supervisors

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Third District

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Chief Medical Officer

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles residents through direct services at DHS facilities and through collaboration with community and university partners.

Dear Workforce Member,

We are excited that you have chosen to join our team and welcome to Rancho Los Amigos. We are nationally and internationally recognized for our commitment to excellent rehabilitation services. We take pride in providing quality care to the community and on creating a great experience for patients and their families.

Your contributions will help us succeed in living up to our Core Values, which focus on:

- Quality of Life
- Care for those in need
- Teamwork
- Individual pride
- Education, research, advocacy, and service innovation
- Quality environment
- Organizational growth

We believe that you will be a positive addition to the people we serve and your co-workers.

Congratulations and best wishes in your new position here at the “Ranch”.

Sincerely,

Jorge Orozco
Chief Executive Officer

Health Services
www.dhs.lacounty.gov

Facility Profile

Licensed Beds

289 General Acute Care
(189 Budgeted Beds)

12 ICU Beds
150 Rehabilitation Beds (JPI)
127 General Acute Medicine/Surgery Beds
3,824 Inpatient Admissions
75,000 Outpatient Visits

160 Average Daily Census

1,328 Full Time Equivalent Employees (Approx.)

Rancho is accredited by The Joint Commission, California Department of Public Health (CDPH), and Commission on Accreditation of Rehabilitation Facilities (CARF)

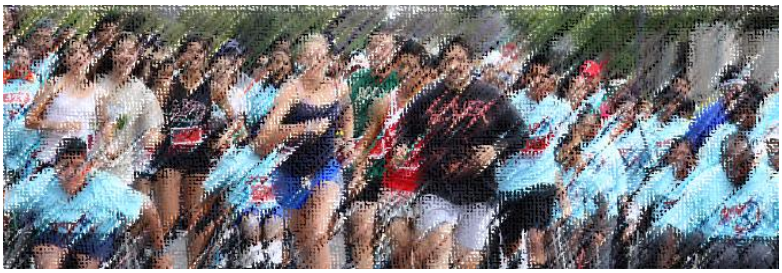
Centers of Excellence

Spinal Cord Injury
Brain Injury
Pediatrics
Neurology
Gerontology
Stroke
Pressure Ulcer Management
Center for Applied Rehabilitation Technology (CART)
Post-Polio Program
Diabetes/Limb Preservation/Amputation
Orthotics/Prosthetics
Pathokinesiology
Vocational Services

Other Services

Audiology
Dental
Driver Training
Nuclear Medicine
Occupational Therapy
Outpatient Services
Physical Therapy
Seating Center
Recreation Therapy
Respiratory Services
Speech Therapy
Social Services

For more information about Rancho, visit the website at www.rancho.org



RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER

This section provides a broad organizational overview of Rancho Los Amigos National Rehabilitation Center's (Rancho) service delivery. Included is Rancho's history, its Mission, Vision, Values and customer service philosophy.

INTRODUCTION

As a vital resource for the delivery of healthcare, Rancho is committed to achieving the goals and objectives of the Los Angeles County Department of Health Services (DHS) and for improving service delivery systems to our community. This includes enhancing the quality of patient care provided at Rancho. We are also committed to meeting our Mission, Vision, and Values. In addition, we must meet quality standards established by accrediting agencies as they evaluate our programs and services by way of surveys, reviews, and other indicating tools.

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

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

RANCHO'S HISTORY

Rancho Los Amigos National Rehabilitation Center (Rancho) is an internationally recognized and pioneering hospital in rehabilitation medicine, consistently ranked among the top rehabilitation hospitals in the nation.

For more than 50 years, Rancho has set the standard in care for persons with physical disabilities, in many cases caused by traumatic brain or spinal injury. The hospital's interdisciplinary and highly specialized teams of caregivers provide a level of expertise unmatched in the region.

The history of Rancho dates back to 1888, when indigent patients from Los Angeles County Hospital were relocated to what was then known as the "Poor Farm." Physical and Occupational Therapies were introduced in the 1920's and in the 1950's Rancho was designated a respiratory center for poliomyelitis (polio). The hospital gradually transitioned to a rehabilitative care center with the waning of the epidemic.

Today, Rancho is a 289-bed rehabilitation hospital owned and operated by the Los Angeles County Department of Health Services. Inpatient admissions average 3,824 annually and outpatient visits number approximately 75,000 among multiple rehabilitation and medical specialty clinics. The medical staff is composed of physicians and dentists representing the major medical, surgical and dental specialties required for the care of the catastrophically disabled.

Among Rancho's historic accomplishments was the development of the halo vest in 1955, a device which is still in use to immobilize the cervical spine following severe neck injury or certain types of surgery. Rancho physicians also contributed to advances in pathokinesiology and breakthroughs in the rehabilitation of orthopedic and neurologic disorders.

The Rancho Los Amigos Cognitive Functioning Scale, a widely used scale to determine the cognitive level in brain injured patients, was developed in the 1970s, and Rancho's spinal cord injury unit was designated as a model system by the U.S. government since 1979 and through 2006. In July 2014, Rancho was ranked among the top hospitals in the Greater Southern California metropolitan area by *U.S. News & World Report*, and ranked 16th among all hospitals in the entire State of California, and has been ranked in the top 20 "Best Rehabilitation Hospitals in the U.S." for 23 consecutive years. Rancho also ranked in the top tenth percentile in patient experience scores.

Rancho is supported through millions in grant and research monies administered by the Los Amigos Research and Education Institute, Inc. (LAREI).

Rancho is affiliated with Schools of Medicine, Dentistry and Allied Health professions and with colleges and universities across the country for training in the medical/surgical/rehabilitation professions.

MISSION, VISION & VALUES

MISSION

To restore health, rebuild life, and revitalize hope for persons with a life changing illness, injury or disability.

VISION

To be the recognized leader and valued partner in the application of world class neuroscience and rehabilitation.

VALUES

The success of Rancho Los Amigos National Rehabilitation Center is dependent upon our ability:

- Patient & Family-Centered Care
- Collaboration
- Integrity
- Quality
- Safety

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

Countywide Goal

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

Programmatic Goals

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 service.

CUSTOMER SERVICE

CUSTOMER SERVICE PHILOSOPHY

We are committed to providing the highest quality of care and services in the safest environment to all of our customers. To that end, we strive to maintain the highest standards in customer service.

PERSONAL SERVICE DELIVERY

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

Always:

Use **AIDET Plus** when appropriate:

A	**A**cknowledge – make eye contact, greet and call them by name, when appropriate. *Sample: "Good morning, Ms. Jones."*
I	**I**ntroduce – state your name and role and, when appropriate, SMILE. *Sample: "Welcome Ms. Jones! My name is Jane; I am Dr. Smith's Nurse and will be assisting her with your exam today."*
D	**D**uration – let the person know how long the procedure/interaction is likely to take. *Sample: "Dr. Smith ordered an x-ray procedure for you today, just to make sure your finger is not broken. The procedure takes about 15 minutes to complete. Go to the Medical Imaging Department to check-in and when you are done, come back to this office to get your result."*
E	**E**xplain – give a brief and clear overview of the purpose of the procedure/interaction. *Sample: "Ms. Jones, I will be taking an x-ray image of your finger with this machine. The machine will produce an image of your bone and will allow us to see if your finger is broken. Do you have any questions for me?"*
T	**T**hank – always express appreciation for the time, attention and participation of the person you're interacting with. *Sample: "Thank you, Ms. Jones, for allowing us to take care of you. Your follow-up appointment with Dr. Smith has been scheduled. Please let me know if you have any questions."*

PLUS:

- Treat all customers with courtesy and respect.
- Listen carefully and patiently to them.
- Be responsive to cultural and linguistic needs.
- Be courteous when having telephone conversations.
- Take the extra step to assist customers.
- If a request cannot be met, explore and suggest other options.
- 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:

- Report any unsafe conditions to your supervisor or the Rancho Safety Officer at Ext. 6672.
- Provide a clean and comfortable waiting area/work environment. Report any unclean areas to your supervisor or Environmental Services at Ext. 7577.
- Protect the privacy and confidentiality of our customers.

TEAMWORK

The essential element in a healthcare setting is teamwork. Teamwork is achieved through a shared vision, positive attitude, 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 include language, age, skill level, poor listening and verbal skills, negative attitudes, time constraints, and cultural differences which can lead to misperceptions, 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-mails, documents, logs
Verbal:	Talking, teleconferences, telephone
Visual:	Demonstrations, videos
Electronic:	Computer, e-mails, 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, promoting and supporting 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.
  - Use short explanations, whenever possible.
  - Demonstrate process/procedure.
  - Ask questions to obtain feedback.
  - 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 communication, 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 patients. 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. All 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 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 provision of care. Addressing conflict openly and constructively can generate new ideas, approaches and process improvements; 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

Knowing that you are using the most effective methods of patient care delivery, promotes success in team building.

REMEMBER

THE JOINT COMMISSION

This section describes The Joint Commission's accreditation process. This includes a description of organizational performance procedures; various review processes, data collection activities, the System Tracer Methodology, the National Patient Safety Goals and Universal Protocol.

THE JOINT COMMISSION'S "SHARED VISION, NEW PATHWAYS"

"Shared Visions, New Pathways" is an initiative that The Joint Commission has undertaken to progressively sharpen the focus of the accreditation process on care systems critical to the safety and quality of patient care. Our focus in preparation for re-accreditation is to use The Joint Commission's standards for achieving and maintaining efficient and effective systems to support patient care. The components of the "Shared Vision, New Pathways" are:

- **Focused Standards Assessment (FSA)** Previously known as Periodic Performance Review (PPR) – A self-review of compliance with standards conducted approximately 12 and 24 months following our triennial survey with The Joint Commission (TJC) focusing on the major risk areas. The risk related standards include: all National Patient Safety Goals (NPSGs), standards related to TJC identified risk areas, direct impact standards, and standards listed as requirements for improvement (RFI) from our triennial survey event. The "R" risk icon appears in the FSA tool and with standards in TJC hospital accreditation manual. Each organization has an Intercycle Monitoring Dashboard and has option for an On-Site Focused Standards Assessment Survey (ICM Option 2 or 3).
- **Priority Focus Process (PFP)** – A process created to collect and analyze information collected about the organization. This helps to focus the survey on areas critical to our quality of care and safety processes.
- **Priority Focus Areas (PFA)** – Processes, systems, or structures that can significantly impact the provision of safe, high-quality care and reduce the risk for negative outcomes. PFAs guide a surveyor in assessing compliance with standards in relation to individual tracer activities.
- **Tracer Methodology** – Process used by the surveyors to analyze the hospital's systems by following individual patients through their hospitalization in the sequence actually experienced. The surveyor visits the multiple care units, departments or areas to 'trace' the care, treatment and services rendered to a patient.
- **System Tracer** – Session devoted to evaluating three high priority safety and quality-of-care issues on a system-wide basis: Infection Prevention and Control, Medication Management, and Data Use.
- **Elements of Performance** – Specific performance expectations in place for each of the standards.
- **Measure of Success** – A quantifiable measure, usually related to an audit that can be used to determine whether an action has been effective and is being sustained.

SURVEY PROCESS

When Joint Commission surveyors visit our facility, they will spend 60–70% of their time in patient care areas conducting **tracers**. This means that 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.

KEY POINT

All surveys are unannounced, so it is important to maintain continuous compliance with all Joint Commission Standards.

The surveyors will observe:

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

OTHER SURVEY ACTIVITIES

- System Tracers
  - Medication Management
  - Data Use
  - Infection Prevention and Control
  - Dietary
- 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)

Any workforce member who provides care, treatment, and services and has concerns about the safety or quality of patient care is encouraged to make a good faith report of those concerns.

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.

The Department of Health Services 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 discipline/release of assignment. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

In accordance with Joint Commission Accreditation Participation Requirement (APR) standard 09.02.01, workforce members may also report their concerns directly to The Joint Commission as follows:

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

PATIENT SAFETY PROGRAM

Rancho 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 Steering Committee is an inter-disciplinary group, co-chaired by the Patient Safety Officer and the Chief Clinical Officer, to provide 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 Rancho’s policies and procedures regarding the National Patient Safety Goals (see The Joint Commission – National Patient Safety Goals section of this handbook).

WAYS TO REPORT SAFETY VIOLATIONS

You may report events in one of the following ways:

- UHC Safety Intelligence Event Report (Datix)

Or you may call:

- Hospital Risk Manager’s Office (Ext. 7842) or the Risk Hotline (Ext. 7475)
- Pharmacy Hotline (Ext. 6050) to report Adverse Drug Events
- Medical Administration (Ext. 7161)
- Employee Health Services (Ext. 6016)
- Hospital Administration (Ext. 7022)

WAYS TO STAY UP-TO-DATE ON PATIENT SAFETY INITIATIVES

One of the ways you can keep updated is by reading the *Patient Safety Goals* posted in each unit. 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, and executive patient safety walk-arounds, and attending hospital-sponsored educational presentations. Information related to the safety program and goals will also be posted on the Rancho Intranet and on the computer start-up screen.

You should also read, review, and maintain a copy of the DHS Patient Safety Handbook which is provided to all workforce members.

WAYS TO MAKE PATIENT SAFETY SUGGESTIONS

You can inform or tell your supervisor about your safety suggestions. You can also e-mail your suggestions to the Risk Manager, Safety Officer, Patient Safety Officer, or mail them to Risk Management Office, Harriman Building, Room 256.

WAYS TO INVOLVE PATIENTS AND THEIR FAMILIES IN SAFETY

Rancho provides patients with a Patient Information Handbook, and a Patient Safety Brochure, "Tips for Safety," 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/brochure and what you need to know:

- Rancho 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. Wear your badge on the outermost garment, at chest level or above, with your photo, name and position/title visible.
- Rancho 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 Rancho Number for minors) to confirm the patient's identity even if you are already familiar with the patient.
- Rancho 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, Rancho 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!
- Rancho instructs patients to ask about their test results.
  - Always refer their questions to the appropriate caregiver.
- Rancho 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 Time-Out process in the Universal Protocol section of this handbook.)
  - Please thank your patient, their family, or visitors if they remind you of these safety practices or when they ask questions. We want them to be participants in activities to better ensure their safety.
- The Patient Handbook also lists the following locations and phone numbers that patient/families can call if they do not feel their safety concerns are being adequately addressed.
  - **Safety Officer – (562) 401-6672**
  - **Patient Advocate – (562) 401-7036**
  - **Director of Quality Resource Management – (562) 401-7900 or (562) 401-6744**
  - **Department of Health Services Patient Safety Hotline – (213) 989-SAFE**
  - **Patient Safety Officer – (562) 401-8090**
  - **The Joint Commission – (800) 996-6610 or www.jointcommission.org**

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). 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. The Joint Commission accredited healthcare organizations are surveyed for the implementation of the NPSGs and the expectation is that the NPSGs or acceptable alternatives are implemented. Rancho Patient Safety initiatives are based on meeting the NPSGs, and focusing on system-wide solutions. Rancho 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 2015 NPSG CHART ON NEXT PAGE

2015 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.

UNIVERSAL PROTOCOL

The Joint Commission's Universal Protocol (UP) was developed to assist in preventing wrong site, wrong surgery/ procedure, and wrong person. The UP, as a National Patient Safety Goal, establishes a process for a defined series of pre-procedure verifications to take place prior to surgery or a procedure. Rancho has adopted each component of the UP as 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 the bedside). Workforce members share in the responsibility of conducting the pre-procedure verification process with the patient.

UP.01.01.01 Conduct a pre-procedure verification process.
UP.01.02.01 Mark the procedure site.
UP.01.03.01 A time-out is performed before the procedure.

DETERIORATING 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.

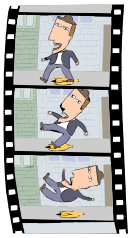
If you are in a patient care area, immediately notify the patient's nurse. If you cannot tell which nurse to notify, please tell any doctor or nurse in the area that you are concerned about the patient/visitor. Some areas of the facility are covered by a Rapid Response Team. Registered nurses in the areas covered by a Rapid Response Team have been trained in how and when to activate the teams. In other areas, nurses may call the patient's doctor, call a code blue or call 9-1-1, in response to a change in patient condition. This is why notification of the patient's nurse is the first step in getting assistance for a person who is in possible distress. At **Rancho** it is important that you know that anyone can call for emergency medical assistance by **dialing Ext. 544** from a hospital phone.

If you are outside the main hospital building (e.g. parking lots or parking structure, adjacent streets or areas near the facility, etc.), you should **call 9-1-1 for any medical emergency. If you encounter a situation that you feel requires emergency assistance, then you should always act on it by calling for help!**

AT RANCHO

Cardiac or Respiratory Arrest: Call Ext. 544 ○ **Activate Code Blue**	**Inside the facility: Call Ext. 544** **Activate the Rapid Response Team**
	Outside the main facility: **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, 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.

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, have the patient wear a wristband or some other modality based on the facility protocols. We must use precautions to prevent patient falls.

TIPS FOR PREVENTING FALLS

Environmental

- Identify and eliminate environmental hazards throughout the facility, parking lots, waiting rooms, or 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" for inpatients.
- 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.

- **Expectations to respond to a fall victim:** 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. Report the fall to a licensed healthcare provider, and provide comfort measures until the licensed staff arrive. Refer to Post Fall Algorithm (Policy B13, Attachment D) for specifics.

Process for Obtaining Medical Assistance

- Notify your supervisor.
- Dial Ext. 544.
- Document the incident via the UHC Safety Intelligence Event Reporting System and follow your facility's reporting procedures.

Report environmental hazards to Facility Management or the Facility Safety Officer. Safety 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.

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 Reporting 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 Safety Intelligence/Event Reporting 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. 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 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 any other needs that are apparent, then you should offer to help in a respectful manner. 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 Building Emergency Coordinator (BEC) 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 if you are required.

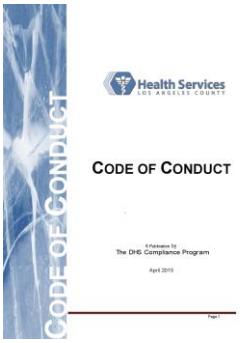
STAFF RIGHTS

It is the policy of Rancho Los Amigos National Rehabilitation Center (RLANRC) to render high quality patient care to all who seek treatment of our facility. However, RLANRC will address an employee's request not to participate in a particular aspect of patient care, due to conflicting cultural values, ethics, or religious beliefs, as the needs of the service allow.

The Medical Center will ensure that patient's care including treatment, will not be negatively affected if the request is granted, and that there is an alternative method(s) of care delivery should such a situation arise. Rancho Administrative Policy and Procedure No. B810, Staff Requests Regarding Not Participating in an Aspect of Patient Care, 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 administrators for terms and conditions of their contract/agreement.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The Department of Health Services is committed to conducting its business in a manner that facilitates quality, honesty integrity, respect and full compliance with all applicable laws and regulations. The Code of Conduct is part of the Department's Compliance Program and is intended to assist the Department in meeting this commitment. The Code provides guidance to all workforce members on general legal and ethical conduct standards to follow. Workforce members include employees, contract staff, volunteers, and others engaged in our work environment or acting on behalf of the Department. 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 Rancho can be reached at (562) 401-7025.

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 they 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 (Ext. 7025)
- DHS Audit and Compliance Division:
  313 North Figueroa Street, Room 801
  Los Angeles, CA 90012
  Telephone: (213) 240-7901
  Fax: (213) 481-8460
  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 (1-800-544-6861), 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 the State of California and federal "whistleblower" protections. DHS will not discharge, 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 provided to workforce members at the start of service. Compliance update training is provided every two 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

As part of its effort to comply with all Federal and State laws and regulations intended to prevent health care fraud and abuse, Rancho will inform its employees, contractors and agents who furnish or authorize the furnishing of Medicaid services, of the laws related to the submission of false claims or the making of false statements.

The laws described in this policy are intended to control fraud in federal and state healthcare programs by giving certain governmental agencies the authority to seek out, investigate and prosecute violators. Enforcement activities are pursued at three different levels: criminal, civil and administrative. This provides a wide range of remedies to help battle fraud and abuse. Additionally, whistleblower statutes and protections for individuals reporting fraud, waste and abuse encourage the reporting of this misconduct by creating financial incentives and employment protections. 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 violations investigate 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 to such claims, and which is 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 Department of Health and Human Services, to impose penalties for the submission of false or fraudulent claims or false supporting documents. These 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, which makes it a crime to knowingly and deliberately submit a fraudulent claim to the government;
- Penal Code § 550, which makes certain types of improper claiming practices criminal acts;
- Welfare and Institutions Code §14123.2, which imposes administrative fines for presenting or causing to be presented various kinds of improper claims to Medi-Cal;
- Welfare and Institutions Code § 14123.25, which 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, which makes it a crime to submit false information in a cost report or to falsely certify a cost report;

- Welfare and Institutions Code § 14107, which 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, which 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; and
- Health and Safety Code § 100185.5, which allows the California Department of Health Care Services, under certain circumstances, to suspend or dis-enroll from any program a provider who is suspended or dis-enrolled from another program it administers; and Labor Code § 1102.5, which protects from retaliation, employees who share non-privileged information about wrongdoing with the government.

The Federal False Claims Act (FCA) 31 U.S.C. §§ 3729

Actions that violate the 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 defraud the federal government by getting a false or fraudulent claim paid or approved;
4. Making, using or causing to be made or used a false document which is material to an obligation to pay the government; and

Any individual or business found to violate the 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 FCA. The 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 FCA, as a "qui tam plaintiff", or "whistleblower." The individual must have knowledge of the circumstances around the false claim and the information must not have been made public in particular ways, unless he or she is the original source of the information and made disclosures to the government before filing the action. The DOJ has the right to investigate and decide whether it wants to be involved in the prosecution of the case. If the DOJ intervenes and there is a settlement or judgment against the defendant, the whistleblower is generally entitled to 15-25% of the money which is recovered, but this amount can be reduced in certain situations. If the whistleblower proceeds alone, he or she is entitled to 25-30% of the recovery. However, the whistleblower 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 DOJ of the facts and circumstances which he or she knows before he or she files the complaint.

The False Claims Act prohibits discrimination, such as discharge, demotion, or harassment against employees who assist in the investigation or prosecution of an action under the False Claims Act, and provides such employees with certain rights such as the right to two times the back pay or reinstatement with comparable seniority if they have been victims of discrimination.

Alternative Administrative Remedies for False Claims

In addition to this statute, there are administrative penalties which can be imposed by the Office of Inspector General (OIG) for the Department of Health and Human Services under laws that specifically address federal healthcare programs. Under that statute at 42 U.S.C § 1320a-7a, the OIG is authorized to impose money penalties and/or exclude from participation in federal healthcare programs, individuals for variety of behaviors,

including, but not limited to, the knowing submission of inaccurate claims, or claims which violate the assignment or other program rules, or which are based on kickbacks, or other inappropriate inducements.

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 monetary penalty of $5,500 per claim will be assessed. 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 defraud the State or county government by getting a false or fraudulent claim approved or paid;
4. Making, using, or causing to be made or used, a false document to avoid or decrease the amount to be paid or delivered to that State or county government; and
5. 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 California False Claims Act, the person/entity will be responsible for paying three (3) times the amount of actual damages and a penalty of up to $10,000 per claim. These penalties can be reduced by self-disclosure of the facts and cooperation with the government.

As in the case under federal law, the whistleblower must inform the government of the facts and circumstances which he or she knows before he or she files the complaint. Additionally, 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. The qui tam plaintiff must file his or her complaint under court seal.

If the government intervenes and there is a settlement or judgment against the defendant, the whistleblower is entitled to 15-33% of the proceeds unless the whistleblower was involved in the violation, in which case his or her share can be reduced. In fact he or she can be denied any compensation altogether. There is also no minimum award if the whistleblower is a government employee who learned about the false claim in the course of his or her

employment. If the government does not intervene, and the whistleblower proceeds alone, he or she is entitled to 25-50% of the recovery. However, under certain circumstances related to publicly disclosed information, the whistleblower may not proceed alone. The whistleblower (as well as the State or county government, if they intervene) may be responsible for the defendant's attorney's fees if the defendant wins and the case was clearly frivolous or designed solely for the purpose of harassment.

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 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 Department of Health Services 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) The County Board of Supervisors to approve service-related contracts over $100,000 unless delegated to the Purchasing Agent.

Department of Health Services (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 in 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

All newly hired employees, including transferred, reinstated, and rehired, are to receive a general orientation to the medical center, their specific work unit, and their job responsibilities. In addition to the hospital-wide orientation, new hires are divided into two categories (Non-Clinical and Clinical Staff) to receive additional orientation that is role-specific to their work assignments. The department/unit or Human Resources Director will evaluate and determine on an individual basis the orientation needs of previous or returning employees (e.g., IAs leaves, etc.).

The hospital-wide orientation is a two-part process facilitated by Human Resources that includes **orientation** and **induction** process. During the induction process, the employee will be provided with a New Hire Employee information which contains various documents and information such as, the mission, general policies, emergency codes, patient rights, governance, and benefits.

The **department/unit-specific** orientation is to familiarize the employee with the policies, procedures, performance expectations, requirements, tasks, equipment, supplies, and key personnel in the department/service area. The department-unit shall maintain verification of employee's orientation in the area's employee file. You are required to complete Rancho's hospital-wide orientation within 30 days of hire/assignment or transfer to the hospital. Rancho 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 department/unit. 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 (e.g. new equipment, new procedure/policy, remedial education process, etc.) and must be documented in the area file. You must also complete all mandatory training and competency certification requirements for your position (e.g., orientation, infection prevention and control, fire/life safety, emergency management, patient safety, CPR and other core competencies).

PROFESSIONAL CREDENTIALS (LICENSE/REGISTRATION/CERTIFICATION/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, 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.

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 Professions 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.

All licensed medical 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 immediately report as follows:

Medical Staff.....Medical Administration (562) 401-7161
Nursing Staff .....Nursing Administration (562) 401-7911
Rehabilitation Therapy Staff.....(562) 401-7061

OR contact:

Human Resources .....(562) 401-7511
DHS Human Resources Performance Management .....(323) 890-8345

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.

As specified in DHS Policy 703.1, newly hired workforce members, both permanent and temporary as well as employees transferring in to the Department from other County departments, will be fingerprinted. Fingerprints are submitted to the State of California Department of Justice (DOJ) and to the Federal Bureau of Investigation (FBI) for criminal records background check. 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 exclusions 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 non-County 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.

Any conviction(s) discovered in the background checks that has not been disclosed at the time of LiveScan may be cause to terminate on-boarding or for dismissal. 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.

The County shall not place a person if convicted of a felony or misdemeanor; except that such conviction be disregarded if it is determined that there were mitigating circumstance or that the conviction is not related to the position and the candidate poses no threat or risk to the County or public. Persons with criminal convictions may still be placed in a position for which they qualify and in which their previous convictions do not pose a risk. Each

case is to be individually reviewed and evaluated by DHS Human Resources Performance Management manager or his/her designee.

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

If you are **charged** with a crime (including traffic violations, if position requires driving on County business) you must report being charged with such crime to DHS Human Resources within 72 hours of becoming aware of the 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 Rancho. All workforce members are expected to comply with DHS and Rancho dress code standards 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 both our business atmosphere and health care standards and must not interfere or detract from our mission. It must be appropriate to the type of work being performed and take into consideration the expectations of our patients and customers served. The DHS photo identification badge must be worn at all times while on duty and in County facilities. Do not obscure photo or name 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

All employees will be present at their jobs and perform their assigned duties during their scheduled work hours. Unscheduled absences and/or tardiness in reporting to work or returning from breaks or lunch periods is unacceptable. 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. Employees will inform their supervisors if they are unable to adhere to their work schedule for any reason. Your supervisor will explain the attendance requirements for your work area. **Lunch and break times cannot be combined.**

HEALTH SCREENING

All workforce members within Rancho's service delivery team as well as all students, affiliate instructors, volunteers, and non-DHS/non-County workforce members must have an initial and annual health assessment, including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease status, vital signs, laboratory tests, and/or any other medical tests, as required.

Prior to the expiration of the annual health screening, workforce members will be given a reminder, in the form of a letter, to comply with the annual health screening requirements. **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. If you do not comply, you will be given a "Direct Order" memorandum indicating you have until the end of the month to comply or face corrective action up to and including discharge/release from County service. Documentation that the annual health clearance was completed must be kept up to date in your area file. You may contact Employee Health Services at (562) 401-6016 to find out when your annual 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 The 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

Smoking is not permitted by any workforce member including a volunteer, patient, visitor, vendor, contractor or anyone else in any building, parking lot, sidewalk, vehicle, or anywhere on the campus at Rancho Los Amigos National Rehabilitation Center. Additionally, it is encouraged that all workforce members including volunteers remain free of the smell of smoke upon arriving to work and throughout their entire shift.

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES ONLY)

The Employee Assistance Program (EAP) is a program that provides assessment, grief 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, anxiety, marital/family discord, bereavement/loss, substance-related, or interpersonal problems that are creating distress and posing difficulties in their daily lives. There is no charge to see an EAP counselor. To schedule an appointment, call (213) 738-4200. 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 the dignity and professionalism of the workplace as well as protect the right of employees to be free from discrimination, sexual harassment, unlawful harassment (other than sexual), retaliation and inappropriate conduct toward others 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, marital status, medical condition or any other 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 which meets any one of the following criteria:

- 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 Rancho, 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.

EXAMPLES OF PROHIBITED ACTIVITIES (NOT A COMPLETE LIST)

Depending on the facts and circumstances, the following are examples of conduct that may violate this Policy:

- 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;
- Verbal conduct such as whistling and cat calls, using or making lewd or derogatory noises or making graphic comments about another's body, or participating in explicit discussions about sexual experiences and/or desires;
- Verbal conduct such as using sexually, racially or ethnically degrading words or names, using or making racial or ethnic epithets, slurs, or jokes;
- 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;
- Physical conduct such as touching, pinching, massaging, hugging, kissing, rubbing the body or making sexual gestures;
- Visual conduct such as staring, leering, displaying or circulating sexually suggestive objects, pictures, posters, photographs, cartoons, calendars, drawings, magazines, computer images or graphics;
- Sexual advances or propositions, including repeated request for a date;
- Adverse employment actions like discharge and/or demotion

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

Any County employee who believes he or she has been subjected to conduct that potentially violates the policy is encouraged to report the matter to:

- Their Department supervisor or manager (whether or not in the County employee's chain-of-command).
- The County Intake Specialist Unit by phone at: **1-855-999-CEOP (2367)** or website: **https://CEOP.bos.lacounty.gov** or is located at: **Kenneth Hahn Hall of Administration, 500 West Temple Street, Room #B-26, Los Angeles, CA 90012**

Non-supervisory County employees are also encouraged to report potential violation of the policy to a supervisor, manager, or to the County Intake Specialist Unit the number for which has been provided about.

Potential violations may also be reported to the Hospital or Comprehensive Health Care Center Chief Executive Officer, facility Human Resources office, or any of the following:

- **DHS Audit & Compliance**

  313 North Figueroa Street, Room 801
  Los Angeles, CA 90012
  Telephone: (213) 240-7901
  Fax: (213) 481-8460
  Hotline: (800) 711-5366

- **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 participating 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 corrective action regarding their own misconduct.

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.

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 effectively respond 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; by the patient/consumer;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; 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

Culture includes 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 THE AFFORDABLE CARE ACT

Cultural & 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 & 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 will be in a much better position in our efforts to **remain as** the **"Provider of Choice"** during the full implementation of Health Care Reform.

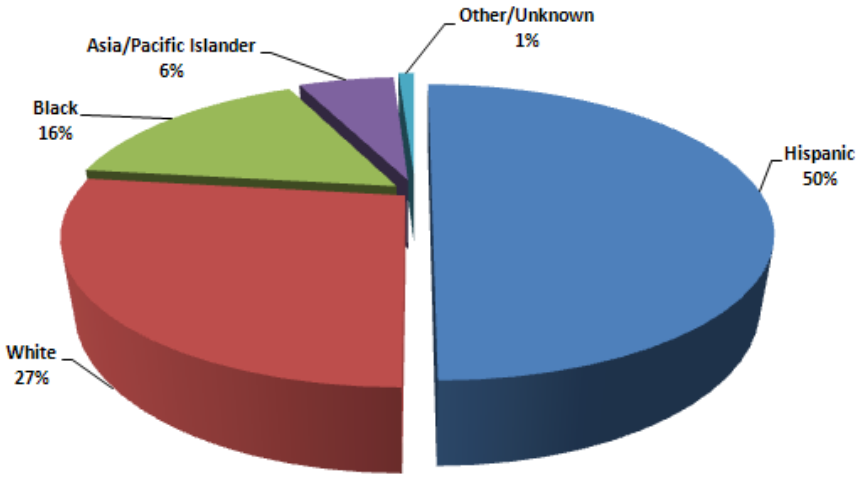
DHS-wide Language Data Report

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 a language 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).

TYPICAL INPATIENT POPULATION

Rancho Patient Population

Hispanic 50%
White..... 27%
Black 16%
Asian/Pacific Islander 6%
Other/Unknown..... 1%



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

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 Rancho 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 credibility 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.

THREAT MANAGEMENT "ZERO TOLERANCE"

All employees, including contract staff, students, affiliates, volunteers, and trainees whether they are permanent, temporary, part-time, or other, are entitled to a safe work environment. The Department of Health Services prohibits any workplace threats, intimidation or harassment by any of its employees. 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.
- Items left in a workforce member's work area or personal property that are 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 workforce member 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 to 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.)
- Immediate removal of the threatening individual from the premises pending investigation.
- Disciplinary action up to and including discharge from County employment.

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 shall document and maintain a log of all incidents related to an expressed or implied threat involving an employee in the workplace, and will take appropriate actions to ensure the safety of the threatened employee. 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, shall be reported to the appropriate licensing, certification, registration, or permit 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.
- Warn potential victim(s).
- Seek personal safety.
- Post-event, the victim or supervisor/manager shall contact the Office of Security Management (OSM) within 24 hours.

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 following the incident.

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

Each patient in a DHS facility has the right to be free from mental, physical, sexual, and verbal abuse, neglect, harassment, and exploitation. Each DHS facility will evaluate all allegation, observations, and suspected cases of abuse, exploitation, neglect, and harassment that occur within the facility and report such incidents in accordance with provisions of this policy and guidance

Sexual contact between a workforce member 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, conducting physical exams not needed or not within the scope of the treatment or complaint, making phone calls or communications not of a patient care or business nature, and any demeaning or undignified treatment.

Sexual conduct that occurs concurrently 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 of resolution. 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.

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 Los Angeles County Sheriff's Department. The reporting party shall report the suspected abuse using a Security Incident Report (SIR) and in the UHC Safety Intelligence Event Reporting 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 discipline. Moreover, reporting a violation does not protect individuals from appropriate disciplinary 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 licensing, certification, registration, or permit board/agency. 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 mandated reporters 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.

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 or Neglect** includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harm or injuring of a child or endangering of the person or health of a child (child endangerment), and unlawful corporal punishment or injury. *Child abuse or neglect does not include a mutual affray between minors or injury caused by reasonable and necessary force used by a peace officer acting in the scope of his or her employment as a peace officer.* A "child" is defined as a person under the age of 18 years of age. Healthcare providers are mandated to report incidents of suspected abuse to the Department of Children and Family Services' Child Abuse Hotline at 1-800-540-4000 immediately or as practically as possible. A written report must be submitted within 36 hours of the telephone report, and may be submitted through their website at http://dcfs.lacounty.gov.
- **Elder or Dependent Adult Abuse** includes physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment resulting in physical harm or pain or mental suffering, deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering of an elder is any person residing in this state 65 years of age or older. A dependent adult is any person between the ages of 18 and 64 who resides in this state and who has a physical or mental limitation that restricts his or her ability to carry out normal activities or to protect his or her rights, including but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age. Healthcare providers are mandated to report incidents of suspected elder/dependent adult abuse immediately or as practically as possible by calling the Elder Abuse Hotline at 1-877-477-3646. A written report must be submitted within two (2) working days of the telephone report.
- Healthcare providers are mandated to report incidents of adult abuse by calling 1-877-477-3646 and submitting a follow-up report immediately or as soon as practically possible.
- **Intimate Partner Abuse** involves the threatened or actual use of physical force against an intimate partner that either results in or has potential to result in death, injury or harm. Intimate partners include current and former spouses, as well as current and former non-marital partners. Intimate abuse partners are those individuals who are currently dating, married, cohabitating, or separated. Abuse includes physical violence and sexual violence, severe psychological or emotional distress and economic coercion. Intimate partner abuse must be reported if there is a current injury. Healthcare providers are mandated to report the violence immediately or as soon as practically possible to local law enforcement by telephone at 1-800-978-3600 and follow up report within 48 hours.

In addition, contact the Social Work Department at (562) 401-7867 for assistance with evaluations, reporting forms and referrals.

Also reference 321.100 the Rancho Administrative Policy and Procedure No. B708, Reporting Known or Suspected Abuse.

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 Los Angeles County Board of Supervisor's (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 (323) 890-5300 or (800) 698-8255, and is located at 4900 S. Eastern Ave., Suite 100, Commerce, CA 90040.

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 or sexual assault investigation 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 patient confidentiality procedures documenting the release of such information.

SAFELY SURRENDERED BABY (SSB) LAW

California law, SB 1368 (Brulte) Chapter 824, Statues of 2000, and Rancho Administrative Policy No. B801, Infant Abandonment provides criminal immunity for any person with lawful custody of a newborn who is less than 72 hours old, if he/she voluntarily surrenders physical custody of the child to the emergency department or to a workforce member at any health facility. Newborn babies may also be safely surrendered at Los Angeles County Fire Department stations designated by the County Board of Supervisors. For a list of Los Angeles County's Safely Surrendered Baby (SSB) Sites visit **www.babysafela.org** or call 1-877-BABY SAFE.

Los Angeles County Department of Children and Family Services (DCFS) must be notified as soon as possible, but no later than 48 hours. Child Protective Services will place the newborn in a pre-adoptive home. The 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 newborn. Parents that have surrendered their baby have 14 days to change their minds if they want their baby back. These parents need to call DCFS at 1-800-540-4000.

Emergency Medical Treatment & Active Labor Act (EMTALA) regulations apply to the care of the newborn. In addition, information regarding the parent or individual surrendering the newborn should not be shared under any circumstances.

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 held or desired, and who, with or without reasonable accommodation can perform the essential functions of a job. Illegal use of drugs is not a disability covered by ADA. The DHS will provide reasonable accommodations that do not impose undue hardship. 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 the ADA Coordinator at (562) 401-7428 for assistance.

PATIENT RIGHTS AND SERVICES

This section explains Rancho's patient rights and services such as patient advocacy, interpreter services, the Chaplaincy Program, advanced directives, ADA, organ/tissue donations, and EMTALA.

PATIENT RIGHTS AND RESPONSIBILITIES

To ensure that our patients' rights are protected, Rancho has a Bioethics Committee. This committee is multi-disciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises Rancho staff concerning such issues related to patient care decisions, and offers consults to Rancho departments. Rancho staff, patients, and families or significant others are encouraged to contact a committee member to review or discuss bioethical issues of concern to them.

Patients of Rancho 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, Rancho has posted these rights and responsibilities throughout the hospital to inform patients and our staff.

PATIENT RIGHTS

Patients have the right to:

1. Considerate and respectful care, and to be made comfortable. They have the right to respect for their cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their admission to the hospital.
3. Know the name and the physician who has primary responsibility for coordinating their care and the names of professional relationships of other physicians and non-physicians who will see them.
4. Receive information about their health status diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms they can understand. They have the right to effective communication and to participate in the development and implementation of their plan of care. They have the right to participate in ethical questions that arise in the course of their care, including issues of conflict resolutions withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure they may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, they do not have the right to demand inappropriate or medically unnecessary treatment or services. They have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure 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.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of their pain, information about pain pail relief measures and to participate in pain management decisions. They may request or reject the use of any or all modalities

to relieve pain, including opiate medication, if they suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but in such case must inform them that there are physicians who specialize in the treatment of pain with methods that include the use of opiates.

10. Formulate advance directive. This includes designating a decision maker if they become incapable of understanding a proposed treatment or become unable to communicate their wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on the patient's behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. They have the right to be told the reason for the presence of any individual. They have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to their care and stay in the hospital. They must be provided with a separate "Notice of Privacy Practices" that explains their privacy rights in detail and how we may use and disclose their protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. They have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician of continuing health care requirements and options following discharge from the hospital. They have the right to be involved in the development and implementation of your discharge plan. Upon request, a friend or family member may also be provided this information.
17. Know which hospital rules and policies apply to their conduct while a patient.
18. Designate a support person as well as visitors of their choosing, if they have decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status unless:

    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - They have told the health facility staff that they no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and the number of visitors. The health facility must inform the patient (or their support person, where appropriate) of their visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender, identity sexual orientation, or disability.
19. Have their wishes considered, if the patient lack's decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in their household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, age, disability, medical condition, marital status, registered domestic partner status or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, they may do so by calling: **Patient Advocate at 562-401-7036.**

Their grievance will be reviewed and they will be provided with a written response. The response will contain the name of a person to contact at the organization, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).

23. File a complaint with the California Department of Public Health regardless of whether they use the hospital's grievance process. The California Department of **Public Health's phone number is: 800-228-5234**

These rights may be applied to another who may have legal responsibility to make decisions for the patient regarding their medical care.

PATIENT RESPONSIBILITIES

1. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health.
2. Patients have the responsibility to report unexpected changes in their condition to the responsible practitioner.
3. Patients are responsible for making known whether they understand contemplated courses of action and what is expected of them.
4. Patients are responsible for their actions if treatment is refused or instructions of their practitioner are not followed.
5. Patients are responsible for following the treatment plan recommended by their practitioner who is primarily responsible for their care. This includes following instructions of allied health staff as they carry out the plan of care and implement the appointments. If the patient is unable to keep an appointment for any reason, the patient must notify the responsible practitioner or Rancho staff member.
6. Patients are responsible for being considerate of the rights of other patients and Rancho personnel, and for assisting in the control of noise, smoking and the number of their visitors. Patients are responsible for being respectful of the property of other persons and of Rancho.
7. Patients are responsible for following Rancho rules and regulations affecting patient care and conduct.
8. Patients are responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.

NOTE

For more information, refer to Rancho Administrative Policy and Procedure No. B509, Patient Rights and Responsibilities.

PATIENT ADVOCATE

The Patient Advocate 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. If the problem cannot be resolved in your department or if the problem is not related to your department, refer them to the Patient Advocate at (562) 401-7036.

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 Patient Advocate will also help resolve the problem. Regular business hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday. During after-hours, weekends, and holidays, please ask for the Charge Nurse or 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. An interpreter is a certified bilingual employee, staff interpreter, contracted interpreter, or designated bilingual volunteer, who is qualified to interpret the information given to a patient and any questions that the patient may have. Family members of the patient are not considered interpreters. If the patient chooses to use a family member for interpretation, document their choice by stating the reason of choice and the name of the person serving as the interpreter. It is important to note the family or friend is over the age of 18. **It is prohibited to use minors as interpreters in any situation.**

- To reach an interpreter for any language (including Sign Language), call the Language and Culture Resource Center at Ext. 7428 during business hours from 8:30 a.m. to 5:00 p.m.
- If the call is urgent and requires immediate interpretation, or to access an "over-the-phone" interpreter for any language at any day or time, dial Ext. 8154 from any in-house phone. The operators of this service will request staff name and client ID number.
- Video Medical Interpretation (VMI) devices can also be utilized to access interpreters (including Sign Language) any day or time. This service will automatically convert to telephone (audio only) if the requested interpreter is not available by video connection.
- For questions concerning interpreting or written translation, call the Language and Culture Resource Center at Ext. 7428.

County of Los Angeles - Department of Health Services

Interpretation Services Available

English: Point to your language. An interpreter will be called.

Amharic	Mandarin 國語
Arabic اللغة العربية	Russian Русский Язык
Armenian Հայերէն	Samoan Gagana Samoa
Cambodian ภาษาไทย	Somali Soomaali
Cantonese 廣東話	Spanish Español
Farsi فارسی	Swahili Kiswahili
French Français	Tagalog Tagalog
Hindi हिन्दी	Thai ภาษาไทย
Italian Italiano	Tongan Tonga
Japanese 日本語	Urdu اردو
Korean 한국말	Vietnamese Tiếng Việt
Lao ภาษาลาว	

SPIRITUAL NEEDS OF PATIENTS (CHAPLAINCY PROGRAM)

The Chaplaincy Program at Rancho provides for the spiritual health and well-being of all patients, their families, friends and hospital staff through active listening, counseling, prayer and administration of the Sacraments. We seek to promote wellness by giving comfort to those desiring the services of our volunteer chaplains who are from various denominations. Our chaplains are available to minister to all patients, their family members, friends and hospital staff, regardless of their religious preference.

Referrals to the Chaplaincy Program may be made by contacting the Social Work Department at (562) 401-7867 and/or Nursing by calling (562) 401-7911, Volunteer Services (562) 401-7651 or directly to the Pastoral Care Department at (562) 401-7256. Rancho chaplains are normally available Monday through Friday from 10:30 a.m. to 2:30 p.m. and can be contacted for emergencies by calling the Rancho operator at (562) 401-7111. For specific Sacramental requests such as Communion, Confession, Anointing, etc., the patient or family should contact their priest or religious leader from the spiritual community. Hospital staff should assist patients who need help in contacting their religious leader. Catholic and Protestant worship services are conducted on Sundays in English and Spanish.

ADVANCE HEALTH CARE DIRECTIVE

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. Rancho 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 Social Work Department at (562) 401-7867, or the patient's physician. Remember patients can change their mind at any time regarding AHCDs.

ORGAN/TISSUE DONATION

Rancho 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 deaths must be communicated to *OneLegacy* 24-hour referral line at 1-800-338-6112 by the nursing staff. *OneLegacy* is nonprofit, federally designated transplant donor network serving 18 million people in seven Southern California counties. It is extremely important to call in a timely manner as defined as within one hour following the identification of a clinical trigger that would identify the patient as a potential donor.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA), establishes specific responsibilities for physicians attending to the Emergency Department patient. EMTALA serves to provide structure to the proper examination, treatment and transfer of Emergency Department patients. A hospital that operates an emergency department must provide a medical screening examination to anyone on whose behalf a request is made for examination or treatment. The purpose of the examination is to determine whether or not the individual is in an **emergency medical condition**. This is defined as a medical attention that could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, this includes the health of the woman or her unborn child.

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. DHS 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 Advocate 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 all 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.

A service animal may not be restricted from its handler who is a patient in the hospital. The hospital staff and the patient with the disability should discuss the possible need for the service animal to be separated from the patient for a period of time during non-emergency care as well as a plan of care for the service animal in the event the patient is unable to provide care. This plan may include family members taking the animal out of the facility several times a day for exercise or elimination, the animal staying with relatives, or boarding off-site. Care of the service animal will remain the responsibility of the patient with the disability and not the hospital staff.

"Facility animals" are used for the purpose of therapy programming only and are not to be considered as Service Animal under the ADA. The primary animal that Rancho uses to conduct an Animal Assisted Therapy (AAT) program are health dogs of various breeds that are under the care of a licensed veterinarian or certified handler.

Violators of the ADA can be required to pay monetary damages and penalties. If you have additional questions concerning ADA and service animals, please call Rancho's ADA Coordinator at (562) 401-7428. Additional information can be obtained by calling DHS Human Resources at (323) 869-7122 or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

ENVIRONMENT OF CARE

This section describes the requirements for a safe patient care environment. Included are descriptions of the Environmental Safety; 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 Rancho to provide a safe environment for our customers and workforce members. Our Environmental Safety Program looks for and identifies hazards through surveillance rounds and data collection. The Environment of Care Committee investigates all identified hazards. This Committee works under Rancho's Safety Officer. Address any concerns you have regarding safety to your supervisor or the Safety Officer at **(562) 401-6672.**

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.
   - Complete an "Employee/Safety and Security Concern Program" form.
   - Use the Safety Suggestion Boxes available throughout the campus.
   - Notify the Safety Officer at Ext. 6672 or the Patient Safety Officer at Ext. 6085 for clinical patient safety issues.

RANCHO HOSPITAL CODES

Emergency overhead paging is used at Rancho to alert staff to potential emergency situations and to summon staff responsible for responding to specific emergency situations, among other things.

Rancho uses the following list of codes to identify specific emergencies:

RANCHO LOS AMIGOS - Emergency Codes

CODE Name	Description	Ext.
CODE ASSIST	Urgent Medical Assistance to Outpatients, Visitors, and Staff	544
CODE BLUE	Adult Medical Emergency	544
CODE GOLD	Mental Health/Behavioral Response	544
CODE GRAY	Combative Person	551
CODE GREEN	Patient Elopement	544
CODE ORANGE	Hazardous Material Spill/Release	7291 "0" after hrs.
CODE PINK	Infant Abduction (Birth to 11 months old)	544
CODE PURPLE	Child Abduction (1 yr. old to 17 yrs. old)	544
CODE RAPID REPONSE	Urgent Medical Attention to Inpatients	544
CODE RED	Fire	522
CODE SILVER	Person with a Weapon and/or Active Shooter and/or Hostage Situation	551
CODE TRIAGE ALERT	Potential Disaster	0
CODE TRIAGE EXTERNAL	External Disaster	0
CODE TRIAGE INTERNAL	Internal Disaster	0
CODE WHITE	Pediatric Medical Emergency	544
CODE YELLOW	Bomb Threat	551

DHS Standardized Emergency Codes – Effective July 1, 2015

SECURITY

The Sheriff's Department provides Rancho with professional police and security services. The Sheriff's Department consists of Deputy Supervisors and Sheriff's Security Officers to provide law enforcement services. Contract security is responsible for basic security needs under the supervision of the Sheriff's Department. They strive to provide a crime free and secure environment for patients, visitors, patrons, and workforce members.

The Role of the Los Angeles Sheriff's Department (LASD)

The LASD enforces the California Penal codes, Federal and State laws, County ordinances, and assists in attaining compliance with hospital policies. The LASD conducts foot and vehicle patrols of Rancho.

The Role of Contract Security

- Observe and report any suspicious activities to the Sheriff's Department.
- Monitor the entrances to Rancho, check workforce member badges, visitor check in, and exterior foot patrol.

SAFETY AWARENESS

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

- Walking in groups when leaving the workplace after dark.
- Reporting any suspicious activities to the Sheriff's Department at Ext. 7042.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.

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 the 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?

Contact the Sheriff's Department immediately at Ext. 551 as well as your supervisor.

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 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 Rancho.

WORKPLACE VIOLENCE

The County and Rancho 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 facility police. Please refer to DHS Policy and Procedure No. 792, Threat Management "Zero Tolerance", and Rancho's Administrative Policy and Procedure No. A258, Violence in the Workplace, Threat Management.

CHILD/INFANT ABDUCTION

When a "Code Pink" or "Code Purple" is called, all available staff members are required to immediately cover exits in their areas and report any suspicious persons to the campus Sheriff 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" or "Code Purple" is initiated.

HAZARDOUS MATERIALS/COMMUNICATIONS

Whenever there is an actual release or spill of a hazardous material and waste, the following emergency procedures shall be placed into effect in accordance with Rancho Administrative Policy No. A405.

1. The Safety Officer or the Hazardous Materials Specialist shall be the Hazardous Materials Spill Response Team Leader and shall coordinate all emergency response measures.
2. The first person at the scene shall immediately **block off the area and** notify the supervisor and all staff in the immediate area that a spill has occurred.
3. The supervisor who is familiar with the material spilled/released through safety training, 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:

a. Eye Contact – Wash the eye with copious amount of water for 15 minutes.
b. Ingestion – Drink a lot of water but do not induce vomiting.
c. Skin Contact – Flush the affected area with water for 15 minutes.
d. Inhalation – Remove victim to fresh air.

The Safety Data Sheet (SDS), formerly known as Material Safety Data Sheet (MSDS) tells what hazards a chemical presents and how to handle spills/exposures. You should know the location of the SDS in your work area. If you do not know where it is kept, ask your supervisor. The master SDS manual is located in the Nursing Resource Office, JPI, Room T1107.

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.**

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.

Keep the length of exposure time to a minimum. If you provide direct care to radioactive patients, plan the care to accommodate minimal exposure to the patient. Keep your distance from the source of radiation. Always maintain an appropriate distance from the patient, except when it is necessary for the patient's care. The farther away you are from the source of radiation, the less radiation you will absorb. Take precautionary safety measures such as wearing a lead apron, as appropriate, while using x-ray/fluoroscopic equipment. Remember: 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

HOSPITAL EMERGENCY PLAN

During an emergency, (for example, a sudden influx of a large number of infectious patients), Rancho will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Preparedness Manual; all departments have copies of the Emergency Preparedness Manual.

The Emergency Preparedness Manual provides instructions on what to do in the event of various disasters. Each nurse's station, clinic and Department Chair and Service Director's office has a copy of the manual.
When Rancho announces a **"Code Triage"** to activate the Emergency Preparedness and Management Plan, you should:

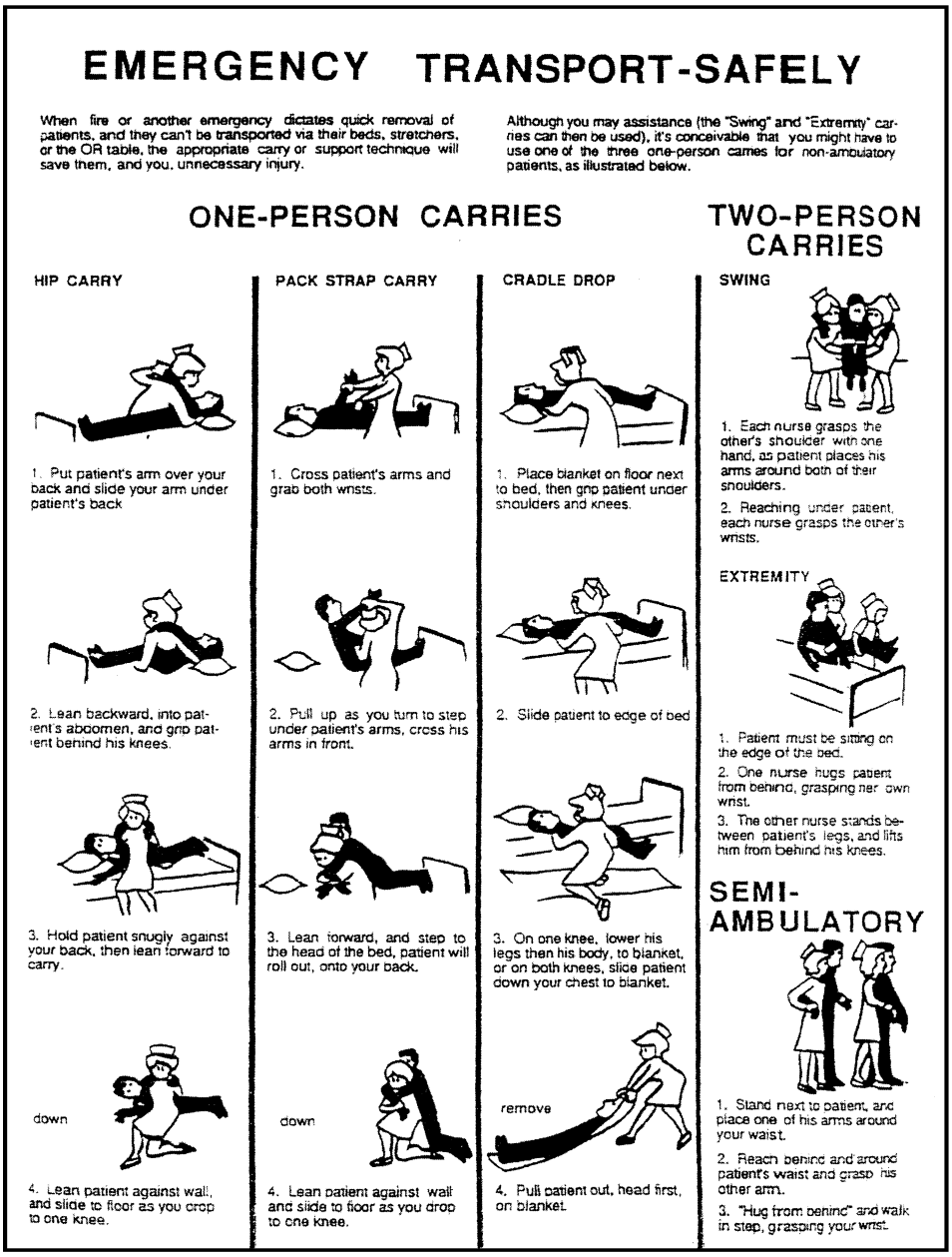
- Remain calm.
- Provide reassurance to patients, visitors, and fellow workforce members.
- Return to your regular assigned workstation, check in with your supervisor or designee, and wait for instructions.

During a **"Code Triage Alert", "Code Triage Internal" or "Code Triage External"** incident, you may be asked to:

- Assess your area for injuries and give first aid.
- Check your area for people who are trapped.
- Check your area for fires, loss of critical systems (i.e., electricity, water, wall oxygen, computer systems, phones), critical equipment (ventilators and laboratory equipment), or critical supplies.
- Provide a status report about your area to the Hospital Command Center. Listen to the overhead page announcement for the Hospital Command Center location.
- Report to the Building Emergency Coordinator (also known as BEC) in your area in order to receive your assignment to a specific disaster-response duty.

EMERGENCY TRANSPORT (CARRIES)

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



FIRE/LIFE SAFETY

FIRE RESPONSE

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

R	**R**emove patients and others from immediate danger.
A	**A**larm – Activate nearest safe fire alarm pull station – call Ext. 522, Code Red, to report smoke or fire to the Downey Fire Department.
C	**C**ontain – Close doors in fire area to prevent the spread of fire and smoke.
E	**E**xtinguish – Use proper extinguisher to fight fire only, if safe to do so.

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 – twist and pull the pin to break the plastic seal. 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.

REMEMBER

5 lb. fire extinguishers will empty in less than one minute.

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.

KEY POINT

You must know where the fire alarm, fire extinguisher, and exits closest to your work area are located. Check with your supervisor, if you are unable to find them.

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

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

In order to ensure the safe operation of medical equipment, the Biomedical Department is responsible for testing all medical equipment according to the hospital's preventative maintenance schedule. This may be annual, semi-annual or quarterly based on the manufacturer recommendations and/or risk associated with its use. You can find the dated green inspection label affix to the device. The medical equipment should not be used if the due date on the green sticker has expired. If the due date has expired immediately contact the Biomedical Department (Ext. 6328). Report all medical equipment and utilities malfunctions to your supervisor and the Facilities Management Department. 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 a serious negative consequence to a patient, you must inform the Patient Safety Officer (Ext. 6085) and Risk Management (Ext. 7475) and submit it in the Safety Intelligence/Event Reporting system as soon as possible (within 24 hours) and immediately impound the device.

ELECTRICAL SAFETY

Before using any piece of electrical equipment check:

- 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).
- Inspection sticker with proper date.

Other points to remember:

- Keep long cords coiled and out of way of traffic.
- Unplug all electrical equipment that is not in use.
- Keep chargeable batteries plugged in.
- 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 emergency generator system. These emergency outlets can be used at all times; **however**; their use is restricted to life support equipment (e.g., ventilators and monitors) only.

MEDICAL GAS OUTLET

Facilities Management should be called in the event of the failure of a gas outlet to shut off or to supply medical gases. Only Facilities Management, Fire Department and Charge Nurse are authorized to shut off medical gas valves.

In order to report a mechanical emergency, mechanical failure, or the need for mechanical repair: **Call Safety Office at Ext. 6672 or Facilities Management at Ext. 7291.**

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 and progressive discipline up to and including discharge from County service or assignment.

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.

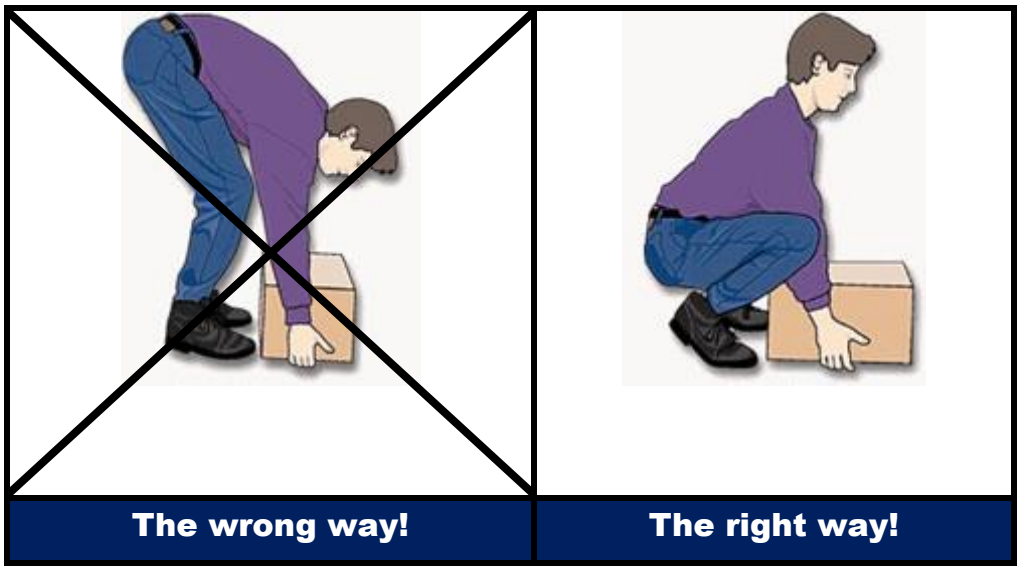
Patient Transfers

- 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, the patient may be able to do the transfer with minimal assistance, if given time.
- Use a lift or transfer device, whenever possible, to move patients to reduce injuries to patient and workforce member.

- Get extra staff to assist, if needed to safely manage necessary handling equipment, 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!



ERGONOMICS

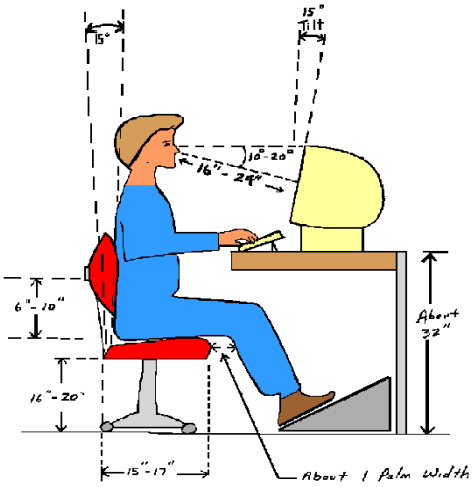
Ergonomic safety is achieved by adapting equipment, procedures and work areas to fit individuals. This helps to prevent injuries – and improve efficiency.

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:



1. **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.
2. **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.
3. **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.
4. **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.

QUALITY IMPROVEMENT

IMPROVING ORGANIZATIONAL PERFORMANCE

Quality Improvement (QI) focuses on outcomes of care, treatment and services. An important aspect of improving quality is our ability to effectively reduce those factors that contribute to unanticipated adverse events and/or outcomes**.** Rancho accomplishes this by:

- Measuring quality (collecting data on important indicators)
- Assessing current performance (How are we doing?)
- Improving performance (What are the opportunities to improve? What have we done to make improvements? How do we know if we have made a difference?)

QUALITY IMPROVEMENT INDICATORS

- ***Data collected:*** Data is collected on various internal processes, e.g., number of do not use abbreviations in orders.
- ***Criteria are identified:*** Criteria are specific measurable events or outcomes used to assess resolution of identified problems. For example, a list of the do not use abbreviations, when writing orders.
- ***Indicators are developed:*** Indicators are measures to document aspects of service performance or care delivery. Example of a performance indicator:

  Use of **"Do Not Use Abbreviations"** in orders
  This rate is calculated by dividing the number of "Do Not Use Abbreviations" by the number of orders.

- ***Problems are identified:*** Aspects of care that do not meet the standard of practice provide opportunities to improve care or services, such as staff using do not use abbreviations.
- ***Corrective actions are taken to address problems that are identified****:* For example, pocket lists of "Do Not Use Abbreviations" provided to all physicians and the "do not use abbreviations" list emphasized at new physician resident, and medical student orientation.
- ***Core measures:*** Core measures were developed by Centers for Medicare and Medicaid Services based on standardized, evidence-based measures, or best practices that have been shown in the medical literature to improve healthcare outcomes.

Currently Rancho is collecting data on all Acute Core Measures:

- Pneumonia
- Heart Failure
- Acute Myocardial Infarction
- Surgical Care Improvement Project

QUALITY IMPROVEMENT MODEL

Rancho's quality improvement model incorporates planned, systematic, organization-wide approaches to process design, performance measurement, analysis and improvement. The organization uses the **FOCUS-PDA** model to guide its quality, performance, and patient safety improvement activities.
FOCUS is an acronym for Find, Organize, Clarify, Uncover, and Start. FOCUS sets the stage for PDSA. FOCUS PDCA is then a nine-step process with five FOCUS steps, and four PDSA steps. Using the FOCUS method with PDSA can help you achieve higher quality results in less time.

THE FOCUS STEPS

F	Find an opportunity or process for improvement. Answer the question: What is wrong?
O	Organize a team that understands the opportunity and related systems or processes. Answer the question: Who knows about this?
C	Clarify the current opportunity or process with Ishikawa ("fishbone") diagrams or other means. Answer the question: What is involved?
U	Understand the causes of the inappropriate activity or results. Answer the question: Why isn't it working?
S	Start the PDSA cycle by choosing a single modification to the process. Answer the question: Where should the change occur?

Using FOCUS helps you focus (pun intended!) on the right things to address using PDSA.

THE FOUR STEPS OF PDSA

Plan	Recognize an opportunity and plan a change. Establish the objectives and processes necessary to deliver results in accordance with the specifications. Use some form of brainstorming or cause and effect diagramming (i.e., Ishikawa "fishbone") to determine the problem.
Do	Implement the processes; test the change, often with a small-scale study.
Study	Monitor and evaluate the processes and results against objectives and specifications and report the outcome. Review the test, analyze results, and identify what you have learned.
Act	Take action based on what you learned in the check step. Apply actions to the outcome for necessary improvement. Review all steps the (Plan-Do-Study-Act) and modify the process to improve it. If the change did not work, go through the cycle again with a different plan. If successful, incorporate what you learned into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

These key elements are the foundation of the model through which Rancho measures its performance. Leaders evaluate the effectiveness of new and redesigned processes, monitor the performance of processes that involve risks or may result in sentinel events, identify opportunities for improvement, identify changes that will lead to improvement, and demonstrate sustained improvement.

EXAMPLES OF PERFORMANCE IMPROVEMENTS MADE AT RANCHO

PROJECT	DEPARTMENTS INVOLVED	STANDARD
Decrease Blood Contamination Rate	Laboratory, Nursing, Infection Prevention and Control	Provision of Care
Increase Hand Hygiene Compliance	Infection Prevention and Control, Nursing, Medicine, Therapies	Infection Prevention and Control
Improve Core Measure Compliance	QI, Medicine, Nursing, HIM, IMS	Performance Improvement
Verbal Order Authentication	QI, Medicine, Nursing	Communication/NPSG
Decrease the use of Unapproved Abbreviations	QI, Medicine, Nursing, Pharmacy, Therapies	Communication/NPSG
Medication Reconciliation	QI, Medicine, Nursing, Pharmacy	Communication/NPSG
Decrease the Delay in Transcription of Medical Imaging	Imaging Department	Communication/Provision of Care

PROJECT	DEPARTMENTS INVOLVED	STANDARD
Improve Turnaround Time for Inpatient Medications	Pharmacy	Medication Management
Improve Turnaround Time for Outpatient Medications	Pharmacy	Medication Management
Improve Patient Safety While Processing Inpatient Medications	Pharmacy	Medication Management
Improve Patient Safety While Processing Outpatient Medications	Pharmacy	Medication Management
Decrease Medication Errors (Medication Error Reduction Plan)	Pharmacy	Medication Management
Transforming Care at the bedside • **Hourly Rounding** • **Improve Patient Experience**	Nursing	Provision of Care
Increase Security of Data and Information Through the Implementation of an Encryption Program such as SAFEND	IMS	Communication
Decrease Medical Record Deficiency Rate	HIM, Medicine	Record of Care
Patient Visit Redesign	Ambulatory Care	Provision of Care
Decrease Hospital Fall Rate	QI, Nursing, Therapies, Medicine	Provision of Care
Decrease the Prevalence of Post Admission Pressure Ulcers	QI, Nursing, Therapies, Medicine	Provision of Care
Improve the Provision of Cultural and Linguistic Sensitive Care • **Video Interpreter**	Language Center	Provision of Care
CARF Adult Brain Injury	Rehab Therapy, Nursing, Rehab Medicine	Provision of Care
CARF CIIRP	Rehab Therapy, Nursing, Rehab Medicine	Provision of Care
CARF Pediatrics	Rehab Therapy, Nursing, Rehab Medicine	Provision of Care
CARF Stroke	Rehab Therapy, Nursing, Rehab Medicine	Provision of Care
CARF Spinal Cord Injury	Rehab Therapy, Nursing, Rehab Medicine	Provision of Care
Acute Stroke	Medicine, Nursing	Provision of Care

ORYX INITIATIVE

WHAT IS ORYX?

ORYX, pronounced (or-iks), is a major initiative that integrates our hospital's data into The Joint Commission accreditation process. The purpose of ORYX is to ensure a continuous, data-driven accreditation process that focuses on improving the actual results/outcomes of patient care. This initiative requires us to collect and electronically submit data each quarter to The Joint Commission. In turn, we receive regular reports that show how well we are doing compared to all other hospitals across the country. By collecting and analyzing data we are able to better understand our performance of providing care to high-risk patients in target areas that need improvement.

The Joint Commission developed the ORYX Core Measures or indicators based on standardized, evidence-based measures or factors that medical literature show positive difference in patient health outcomes. Currently, Rancho is collecting data on the following ORYX Core Measure sets:

- Measure FIM score (patient's ability to perform the activities of daily living independently)
- Measure acute care discharges (limit discharges to acute care settings)
- Community discharges

We base our data collection processes on *your* chart documentation. The Joint Commission surveyors will have access to all our reports of performance at the time of our survey. We also make these reports available to the State surveyors through the Center for Medicare and Medicaid Services (CMS) and to the general public.

How are we doing compared to other rehabilitation hospitals?

Overall, Rancho is doing well in most areas. We do well in maximizing patient's ability to function at a high level upon return to the community, and limit acute care discharges. Our areas of concern include:

- Length of stay.
- Time from onset of injury to rehabilitation admission.

What could a surveyor ask you about ORYX?

When performing tracers, if the patient has a spinal cord injury or brain injury the surveyor may ask you about the related ORYX core measure. Be prepared to speak on how you assure that Rancho provides evidence-based care to your patients. Some examples of evidence-based care include:

- Attaining and improving bowel and bladder function, and
- Retaining and improving mobility.

RISK MANAGEMENT

Rancho's Risk Management Department is an integrated, comprehensive, and proactive system designed to identify, evaluate, and reduce the risk of human injury and financial loss to the facility and the County. The Risk Management Department collaborates with all departments who are ultimately responsible for the health, safety and well-being of the patients and personnel. The Risk Manager in collaboration with County Counsel is available to provide consultation and advice on medico-legal issues.

The effectiveness of Rancho's Risk Management Program is dependent on the information reported by all workforce members. This section provides a guideline on reporting events, the indemnification process, the importance of documentation, and the handling of a subpoena or summons.

THE GOALS OF THE OFFICE OF RISK MANAGEMENT

- Ensure timely identification, investigation, and reporting of unusual occurrences, adverse events, and sentinel events.
- Educate staff in the causation of risk management events to prevent them from recurring and enhance a culture of safety.
- Maintain the repository of Risk Management data including Event Notification Reports for tracking/trending and performance improvement purposes.

INDEMNIFICATION

As a County employee or covered contractor, indemnification or legal protection is provided while you are performing duties within the course and scope of your employment and while on duty at your assigned work station. However, **you <u>are not</u> legally protected from:**

- Liability resulting from willful misconduct, malice, or lack of good faith.
- Fraudulent activity and or intentional infliction of an injury.
- Any acts performed outside the course and scope of employment with Los Angeles County.
- When you rotate to facilities that are not owned or operated by Los Angeles County.
- When you are at your outside employment (non-County facilities).

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

EVENT REPORTING PROCESS

Rancho requires all workforce members to report near misses, unusual occurrences, sentinel events, adverse events, reportable unusual events ("Never 28"), and Provider-Preventable Conditions (PPC) in any healthcare setting or Health Care-Acquired Conditions (HCAC) in acute inpatient settings through the online event notification system. The Patient Safety Net (PSN) has been replaced by Datix Systems Safety Intelligence (SI) Event Reporting System.

Sentinel Events, Unusual Occurrences, Adverse Events, "Never 28 Events," PPC, and HCAC require immediate notification of your Area or Department Supervisor as well as notification of Risk Management. The event should be entered into the online event notification system as soon as possible.

SI- Online event notification system can be accessed by logging onto the Rancho Intranet Home Page, and clicking the mouse on the ***event reporting*** icon on the right upper corner of the page. Then completed electronic event report can be accessed by the Risk Manager, your Manager or Supervisor, Directors and other key staff.

- Event notifications may not be used in litigation against the County as long as certain protections are in place to maintain confidentiality. These include: Do not print or produce copies of Event Notification Reports; do not reference existence of Event Notification Reports in the patient's medical record; do not write Risk Management was notified/contacted in the patient's medical record.

NOTE

See Rancho Administrative Policy & Procedure No. B704, Event Notification Reporting.

DEFINITIONS OF EVENTS

Near Miss or "Close Call" Event is an incident or unsafe condition that could have resulted in an adverse event but did not, either by chance or through timely intervention.

Unusual Occurrence Events include epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety, or health of patients, personnel, or visitors.

Sentinel Events is an adverse event or unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

Adverse Event is any event which is not consistent with routine patient care or the routine operation of the facility or caused by the patient's underlying disease and which adversely affects or has the potential to affect the health, life or comfort of the patient.

Provider Preventable Conditions and Health Care-Acquired Conditions are specific conditions for beneficiaries enrolled in the Medi-Cal program that require reporting to Department of Health Care Services Audits and Investigations Division.

MANAGING THE EVENT

When an unusual event occurs, it is important to provide any immediate care needed by the patient. In addition, the following actions should be taken to prevent complications:

- Designate a trained spokesperson from the treating team to keep the patient/family member informed. If needed, the Risk Manager or QRM Director is available for consultation in disclosing the event with the patient/family.
- Save or sequester any "evidence" such as medical device packaging, equipment, etc. and provide these items to the immediate supervisor. Supervisor shall notify Risk Management within 24 hours of the event.
- Document facts about the event as clearly and objectively in the medical record, including conversations with the patient and family. DO NOT document blame or fault by other providers. DO NOT document or reference the Mortality and Morbidity Conference or Peer Review Process in the medical record.

"NEVER 28" OR REPORTABLE UNUSUAL EVENTS

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. Wrong surgical procedure on a patient.
4. Retention of a foreign object in a patient after surgery or other procedure.
5. Intraoperative or immediately post-operative death in a normal healthy patient.
6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

9. Infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours.
11. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.
12. Patient death or serious disability associated with a medication error.
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products (transfusion of the wrong blood type).
14. Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility.
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
16. Death or serious disability (kernicterus) associated with failure to identify and treat jaundice in newborns.
17. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
18. Patient death or serious disability due to spinal manipulative therapy.
19. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.
22. Patient death associated with a fall while being cared for in a healthcare facility.
23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
25. Abduction of a patient of any age.
26. Sexual assault on a patient within or on the grounds of a healthcare facility.
27. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.
28. Neurological Deficit not present at time of admission including coma, paralysis, nerve damage, blindness, related or unrelated to medical or surgical procedures; medication error/ADR; healthcare acquired infection; birth trauma; unanticipated medical/surgical complication; birth/brain injury unrelated to congenital condition or attempted suicide resulting in serious disability.

PROVIDER PREVENTABLE CONDITIONS IN ANY HEALTHCARE SETTING

1. Wrong Surgery/Invasive Procedure
2. Surgery/invasive procedure on the wrong body part
3. Surgery/invasive procedure on the wrong patient

HEALTH CARE-ACQUIRED CONDITIONS IN ACUTE PATIENT SETTING

1. Air embolism
2. Catheter associated urinary tract infection (Reported by Infection Prevention and Control Department – No need to enter into SI Event Reporting)
3. Falls/trauma
4. Iatrogenic pneumothorax with venous catheterization
5. Manifestations of poor glycemic control
6. Surgical site infection (Reported by Infection Prevention and Control Department – No need to enter into SI Event Reporting System)
7. Blood incompatibility
8. Deep vein thrombosis/pulmonary embolism

9. Foreign object retained after surgery
10. Stage III, IV, unstageable pressure ulcers
11. Vascular Catheter-Associated Infection (Reported by Infection Prevention and Control Department – No need to enter into SI Event Reporting)

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 and prevents the assumption of liability in malpractice cases on the basis that the record is missing key documentation. In addition, a complete and accurate medical record ensures that the facility complies with the accreditation and licensure standards.

Because the medical record is a legal document, it is important to ensure completeness and integrity. **Inaccurate, incomplete, illegible or altered medical records reflect negatively on the writer's credibility.** Documentation in the medical record should be done timely and should reflect factual assessments pertinent to the patient. DO NOT document coverage discussions, disputes among services, clinical/staff behavior, or speculate someone else's involvement in a particular event. As applicable, such issues can be reported to Medical, Nursing or Hospital Administration or recorded through the SI Event Reporting System or Event Notification Report form as appropriate. **Do not make reference to an Online Event Report or Risk Management in the patient's medical record.**

MEDICAL RECORD DOCUMENTATION

- Dates, times, signatures, and titles are required at the time each entry is made.
- Documentation must be objective, clear, legible, relevant, accurate, complete, and sequential.
- Late entries must be identified as such, with reason.
- Include signature of the provider with title and assigned provider or employee number. Printed name must be legible.
- Notes written by residents, interns, PA, NP, students, must reflect attending supervision. In some cases, notes must be co-signed by the attending.
- Correction to the medical record entries shall be made so that the original entry remains readable by drawing one line through the entry and the correction dated, timed, and initialed. **Do not use "white out," erase or otherwise obliterate entries.**
- Pertinent patient care related conversations over the phone must also be documented in the medical record. Include the date and time of the phone call(s) and the person who initiated the call.
- Making entries that are untruthful, altering existing notations, destroying and or replacing portions of the medical record, pre-charting or documenting care before provided are unacceptable and are subject to disciplinary action.

Medical Record Access

- Patients have the legal right to view the information contained within their medical record. The staff should be present during this review.
- Patients or their legal surrogate must provide signed release of information to Health Information Management (HIM) in order to obtain a copy of their medical record.

SUBPOENA AND SUMMONS

Common Types of Subpoena

- Court order directed to an individual to testify before the ordering authority.
- Court order directed to an individual to produce documents in a pending lawsuit.
- Court order directed to an individual for testimony and production of documents.

Types of Summons

- Court order to defendants: A written order to somebody to appear in court to answer a complaint.
- Court order to witness: A written order to a witness or juror to appear in court.
- Order by authority to appear: An authoritative demand to appear in a specific place at a specific time.

Actions Needed When You Receive a Subpoena or Summons

- 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.
- DO NOT ACCEPT SUMONS OR SUBPOENA ON BEHALF OF ANOTHER PERSON. DO NOT ACCEPT ANY LEGAL DOCUMENT THAT IS NOT ADDRESSED TO YOU.

The Risk Management Office is Available for Consultation

- During normal business hours at (562) 401-7842 or (562) 401-7900.
- During after hours, weekends, and holidays, contact the telephone operator at (562) 401-7111 or Ext. “0” to connect to the Risk Manager.

MANAGEMENT OF INFORMATION

CONFIDENTIALITY OF PATIENT INFORMATION (HIPAA)

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, age, 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 (i.e. psychotherapy notes).
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 Rancho 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 only take pictures or video of patients for clinical or medical reasons using a DHS issued device, 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 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 Rancho Public Information Officer at (562) 401-7602 or Rancho Administration at (562) 401-7022 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, Instagram, Twitter, Google+, YouTube*, *Linkedin* 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, 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 should report suspected or actual breaches to your supervisor or the HIPAA Compliance Office at (562) 401-7884.

7. If you feel you need to report it somewhere else, you can report it to any of the hotlines listed below:
   - DHS Compliance Hotline at (800) 711-5366.
   - County Fraud Hotline at (800) 544-6861.
   - Report suspected or actual security breaches to your supervisor or Rancho Information Systems (IS) Help Desk at (562) 401-4357

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, Microsoft Surface, 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 username and 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.

Five primary ways patient confidentiality is most often violated:

- Unencrypted emails containing PHI are sent to wrong patient or business associate.
- 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 - Safety Intelligence (SI) /Event Notification System (ENS) AND by phone to the facility Privacy Coordinator.
- 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 HIPAA Compliance Office at (562) 401-7884.
- 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 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

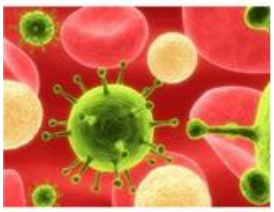
- Don't access information about a patient unless you need it to do your job.
- Don't share confidential patient information with anyone who does not need to know it to do their job.
- Don't share username and/or passwords or your computer while logged on. You are responsible for all information viewed using your username and/or 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, Instagram, Twitter, Google+, YouTube, Linkedin, 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 PREVENTION AND CONTROL

The goal of the Infection Prevention and Control Program is to prevent the spread of infectious diseases between patients, visitors, and workforce members. Infections can be spread through direct or indirect contact or by the airborne route, when infectious organisms enter the body or blood stream through open skin (cut, puncture, rash, wound, burn) or mucous membrane (eyes, nose, mouth). Infections can also spread through frequently touched items, instruments, and articles that come in contact with the patient and/or the environment. Removing the elements of transmission by implementing procedures of cleaning, disinfection, sterilization, hand hygiene, and isolation precautions can interrupt the transmission of infectious diseases. This section will provide you with an overview of Rancho's Infection Prevention and Control Program and how you can prevent the spread of infection.

Rancho has an Infection Prevention and Control Program which consists of Infection Preventionist(s), the Infectious Disease Division, and the Hospital Infection Prevention and Control Committee. The Infection Preventionist(s):

1. Collects and analyzes data from all areas within the hospital to identify and reduce potential sources of infection among patients and staff.
2. Implements surveillance programs to monitor targeted areas for infection prevention and control and report unusual disease trend to the Hospital Infection Prevention and Control Committee with recommendations.
3. Provides in-service education to personnel: (1) annually, (2) when problems are identified, and (3) as requested.
4. Provides consultation to all departments for procedures and use of patient care items as they relate to Infection Prevention and Control.



The Hospital Infection Prevention and Control Committee

1. Reviews all monthly infection reports produced by the Infection Preventionist(s).
2. Makes specific recommendations for the care of all patients as well as those with special infection prevention and control problems.
3. Reviews and approves all sterilization, disinfection and cleaning procedures and all other departmental procedures related to Infection Prevention and Control.

For Infection Prevention and Control Consultation, the Infection Preventionists can be reached at Ext. 7447 and the Infectious Disease Physician can be reached at Ext. 7369.

STANDARD PRECAUTIONS

Standard precautions are precautions designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals. These precautions were introduced in the *Centers for Disease Control and Prevention 1996 Guideline for Isolation Precautions in Hospitals*. Standard Precautions apply to **ALL** patients receiving care in hospitals, regardless of their diagnosis or presumed infection status.

Standard Precautions 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. Standard Precautions are fundamental to patient care and are the standards of practice by every workforce member. You will be trained and will use barrier devices provided for your safety to prevent contact with blood or other potentially infectious materials.

Standard precautions are a system of safeguards or barriers designed to protect workforce members including:

- Work practice controls (hand washing, proper handling of sharps, good hygiene, etc.)
- Personal protective equipment (gloves, gowns, masks, goggles, etc.) for workforce members and patients.
- Engineering controls (autoclave, self-sheathing needles and sharps disposal containers).

- Housekeeping (cleaning equipment and work surfaces, properly handling contaminated linen, laundry, proper disposal of trash, etc.).

STANDARD PRECAUTIONS FOR NON-PATIENT CARE WORKFORCE MEMBERS

1. Consider all blood or body fluid from any person as potentially infectious. Wear latex or vinyl gloves when in contact with blood or body fluids.
2. Avoid contact with blood or body fluids into an open area of your skin or into your mouth, nose and eyes. If this occurs, wash the skin area immediately with soap and water or flush your mouth, nose, and/or eyes liberally with water.
3. Avoid entering specific rooms of the hospital or clinic where you may come in contact with blood or body fluids. If this is not possible, be sure to check with the patient care staff as to the type of protective equipment to wear, if necessary.
4. If you find unsecured needles, scalpels, or other sharp instruments potentially used on patients, notify patient care staff and assist with the disposal of the item per their instructions.
5. Report needle sticks, sharps injuries, or other blood/body fluid exposures to your supervisor and Employee Health Services immediately.

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.

HAND HYGIENE

Practicing good hand hygiene is the most important intervention in preventing the spread of infection. **When hand washing with soap and water, hands must be rubbed together with friction for a minimum of fifteen (15) 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.

Per CDC guidelines, practice hand hygiene:

- When hands are visibly dirty, contaminated, or soiled, wash with non-antimicrobial or antimicrobial soap and water.
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands.

Plain soap and water hand washing is good at reducing bacterial counts, but antimicrobial soap is better, and alcohol-based hand rub is the best.

Exception:
Alcohol is ineffective in killing spore forming agents such as C. difficile or Bacillus anthracis. Wash hands with soap and water after caring for a patient with spore forming agents.

Proper Steps for Performing Hand Hygiene

Washing Hands with Soap and Water	Using Alcohol-based Hand Rub
1. Wet hands with water and apply soap. 2. Rub hands together front and back, using friction for **at least 15 seconds.** 3. Pay particular attention to the area between fingers and fingernails. 4. Turn faucet off using a dry paper towel.	1. Pump sufficient amount of hand rub gel on one palm. 2. Rub hands together, covering all surfaces, until **DRY!!!** 3. Pay particular attention to the area between fingers and fingernails.

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.

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.).

HAND HYGIENE SECRET WORD: CHAMPS

C	H	A	M	P	S
Clean	**Hands**	**Are**	**Making**	**Patients**	**Safer**

Rancho has implemented a Hand Hygiene Secret Word based on a best practice that is cited by The Joint Commission. **CHAMPS** is an acronym for **C**lean **H**ands **A**re **M**aking **P**atients **S**afer. The secret word is to be used in a Just Culture in that any staff member can utter the secret word to any of their fellow staff members to prompt them to conduct hand hygiene regardless of their title in the facility. The staff member that was prompted to conduct hand hygiene will do so without providing negative feedback for the staff member that provided the prompt. For example, a student utters **"CHAMPS"** to a physician or Nurse Manager without any negative repercussions.

RESPIRATORY HYGIENE/COUGH ETIQUETTE

Respiratory hygiene and cough etiquette have been promoted by CDC as a strategy to contain respiratory viruses at the source and to limit the infectious diseases, including the common cold and the flu. Elements of respiratory hygiene/cough etiquette include:

1. Posted signs in language appropriate to the population served with instructions to patients and accompanying family members or friends.
2. Source control measures.
3. Hand hygiene after contact with respiratory secretions.
4. Spatial separation of persons with respiratory infections in common waiting areas when possible.

Individuals with signs and symptoms of a respiratory infection should:

- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
- If tissue is unavailable, cough or sneeze into upper sleeve, not on hands.
- Wash hands or use alcohol-based hand rub after having contact with respiratory secretions and contaminated objects/materials.

Masking and separation of persons with respiratory symptoms

- During periods of increased respiratory infection activity, offer masks to persons who are coughing. Masks are used to contain respiratory secretions.
- Encourage coughing patients to sit apart (at least three (3) feet away, if possible) from others in common waiting areas.

Use precautions to minimize exposure to respiratory droplets

- 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.

GOOD HYGIENE PRACTICES

- Do not eat, drink, apply cosmetics or lip balm or handle contact lenses in work areas where exposure may occur.
- 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.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE 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).

Gloves: 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.
- **DO NOT** wear the same pair of gloves when caring for more than one patient.
- Glove use **DOES NOT** substitute for hand washing.

Masks, goggles, face masks: Protects mucous membranes of eyes, nose and mouth when contact with blood and body fluids is possible.

Respiratory Protection: Use a particulate respirator (i.e., NIOSH-approved N95 respirator) during aerosol-generating procedures when the aerosol is likely to contain M. tuberculosis, SARS-CoV, or avian or pandemic influenza viruses. Clinical staff will be fit-tested for the NIOSH-approved N95 respirator upon hire and annually.

Gowns: Protects skin from blood or body fluids contact and prevents soiling of clothing during procedures that may involve contact with blood or body fluids.

OTHER PRECAUTIONARY MEASURES

Linen: Carefully handle soiled linen to prevent touching skin or mucous membrane. Do not pre-rinse soiled linens in patient care areas.

Patient Care Equipment: Carefully handle soiled equipment in a manner to prevent contact with skin or mucous membranes and to prevent contamination of clothing. Ensure reusable equipment is clean prior to reuse (i.e., Point of Care Devices).

Environmental Cleaning: Ensure area is clean and safe. Routinely care, clean and disinfect equipment and furnishings with hospital-approved disinfectant.

TRANSMISSION-BASED ISOLATION PRECAUTIONS

Transmission-based isolation precautions prevent the transmission of infection between infected patients, health care workers, and visitors. Transmission of infection within a healthcare setting requires three elements: 1) a source of infecting microorganisms; 2) a susceptible host; and 3) a means of transmission for the microorganisms. A variety of infection prevention and control measures are necessary to reduce and prevent the transmission of microorganisms in the health care setting. These measures make up the fundamentals of isolation precautions. When a patient is suspected or diagnosed with having an isolatable process he/she will be placed in the appropriate isolation precautions. Workforce members entering the patient area are to follow posted precautions.

The three transmission-based categories are:

Contact Precautions	For specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms 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. Contact precautions include placing the patient in a private room, if possible, donning gowns and gloves upon entering the room, and dedicated patient care equipment.
	PPE Needed: Gloves and Gowns
Droplet Precautions	For patients known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the patient during coughing, sneezing, talking, or during the performance of cough-inducing procedures. Droplet precautions include putting the patient in a private room or cohort patients with the same infection and wearing a mask.
	PPE Needed: Gloves, Gown, and Mask
Airborne Precautions	For patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance. Airborne precautions include putting the patient in a private room with negative air pressure and wearing an N95 Respirator.
	PPE Needed: N95 Respirator or PAPR (Powered Air Purifying Respirator) hood.

SPECIAL PRECAUTIONS

These precautions are to be used for patients who require neutropenic precautions, which is defined as the absolute neutrophil count <1,000 cells per milliliter. A good example is a patient diagnosed with leukemia.

Guidelines for special precautions are listed below, and include:

- A private room with closed door.
- Hand washing is required upon entering room.
- No gowns or gloves are required.
- No fresh fruits, vegetable or flowers may be taken into the room.
- No visitors or staff with infectious illnesses may enter the room.
- No special precautions must be taken with articles leaving the room.

WAYS TO IDENTIFY A PATIENT IN ISOLATION

You may identify an isolation patient in several ways:

- An isolation cart and isolation sign outside of the patient's room.
- A neon green isolation sticker on the patient's medical record.
- Orange clips on the patient's wrist ID band (call patient unit to verify isolation precaution).
- Patient handoff communication.
- Isolation Status can be found in the medical record.

- Infection Prevention and Control Progress note and updates in the medical record.
- Notify Infection Prevention and Control Department at Ext. 7447.

USE OF PERSONAL PROTECTIVE EQUIPMENT

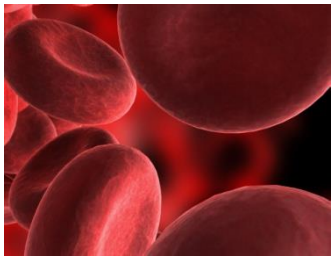
This Isolation system is effective in isolating and containing infectious agents. It is very important to use the required items correctly in order to maintain the effectiveness of the system.

Gloves	Isolation Gowns	Mask
• Free from rips and tears. • Pulled up high on wrist. • Worn covering the cuffs of the isolation gown.	• Free from rips and tears. • Water resistant with long sleeves. • Worn with both the waist and neck ties tied. • Only worn **when in direct contact with the patient in isolation or their environment.**	• Snugly covering the nose and mouth.

ISOLATION GUIDELINES FOR VISITORS

Patients placed on isolation may continue to have visits from family and friends as per hospital and unit-specific policies. Time and number of visitors may need to be limited. All visitors must be instructed and regularly monitored on how to carry out proper isolation technique to ensure adherence.

BLOODBORNE PATHOGENS CONTROL PLAN



The purpose of this plan is to minimize, if not prevent occupational exposure to blood or other potentially infectious materials (OPIM). All workforce members, who have the potential of occupational exposure to blood or body fluids, must practice Standard Precautions.

Bloodborne pathogens may be acquired through percutaneous (needle stick, puncture), mucous membrane (splash to eyes, mouth, nose) and cutaneous (exposure to intact skin) route. It is impossible for you to know who is or is not infected. Therefore, consider ALL blood and OPIM from ALL persons as potentially infectious. Appropriate personal protective equipment must be used when there is a likelihood for blood or OPIM exposure.

BLOODBORNE PATHOGENS

The three most commonly exposed viruses in a health care setting are Hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). These are the primary bloodborne pathogens that are of concern to healthcare workers. Bloodborne pathogens may be found in blood or other potentially infectious material (OPIM) and body fluids such as:

- Blood products.
- Semen.
- Vaginal secretions.
- Fluid in the uterus of a pregnant woman.
- Fluids surrounding the brain, spine, heart and joints.
- Fluids in the chest and abdomen.
- Saliva in dental procedures.
- Any other body fluid that is visibly contaminated with blood (e.g., urine).

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 (there are blood screening programs).

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. HCV poses a greater risk to healthcare workers than HBV and HIV, since it is more easily transmitted.

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.

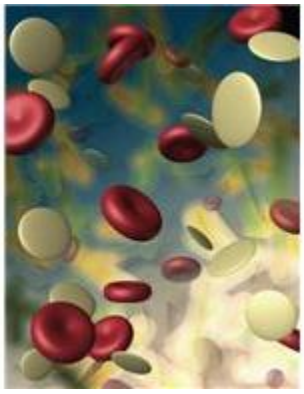
HIV is transmitted in four primary ways:

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 are blood screening programs).

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

HANDLING AND TRANSPORTING SPECIMENS OF BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS

1. Specimens of blood or body fluids are placed in a leak-proof container, placed in a plastic bag and transported to the laboratory in a tote box.
2. Specimens to be transported out of the hospital are placed in a leak proof container clearly marked with a “Biohazard” label.



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 lining (eyes, nose or mouth).

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

- Wash wound or skin with soap and water.
- Flush mucous membranes with water.
- Report the exposure to your supervisor and Employee Health Services at Ext. 6016, to ensure timely evaluation and maximum post-exposure prophylaxis benefit.
- The medical evaluation should be initiated immediately since prophylaxis, if indicted, may need to be started within 1-2 hours of the exposure.
- On weekends or during after-hours, you should report exposure to the Administrative Nursing Supervisor via the hospital operator.

NOTE

The most effective treatment is treatment that is started immediately after the exposure. Initial HIV prophylactic medications, if indicated, should be administered within two (2) to four (4) hours of exposure.

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

DO

- Use and activate needle/sharps safety devices.
- Get help with uncooperative patients.
- Let falling objects fall.
- Dispose of sharps into covered, labeled, and rigid puncture resistant sharps container.
- Use tongs or brush & dustpan to pick up broken glass.
- Practice safe handling techniques.

DO NOT

- Bend, break or recap needles.
- 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.

SAFE INJECTION 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 of them 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 Prevention and 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 for County workforce members at risk of exposure to blood and body fluids per their job duties. Varicella (Chickenpox), MMR (measles, mumps and rubella), Tdap (tetanus, diphtheria, and acellular pertussis),

Workforce members may decline to accept a recommended vaccination by completing a mandatory vaccination declination form. If the workforce member later decides to accept the vaccination, 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 their 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 when working in a health care area that provides patient care. 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.

TUBERCULOSIS (TB) CONTROL PLAN

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 a person with active TB to others through close, prolonged, intense and unprotected contact indoors.

TB precautions include the following:

- Annual TB Screening for all workforce members.
- Early triage and identification of TB suspects.
- Isolation of suspect and confirmed TB patients.
- Proper engineering and maintenance of TB isolation rooms (door is to be kept closed at all times).
- TB patient wears barrier (surgical) mask when outside of isolation room and in an enclosed area.
- Any workforce member providing direct patient care to respiratory isolation patients are to be fit tested for the NIOSH-approved N95 mask on an annual basis.
- Workforce members must wear the NIOSH-approved N95 mask or HEPA respirator:
  - 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 patient(s).

Notify Infection Prevention and Control Department when a patient is diagnosed as suspected or confirmed TB:

a. Communicate the patient's name, file number, unit, and bed number to Infection Prevention and Control (Ext. 7447).
b. The Infection Preventionist(s), upon notification from the Physician, Nurse Manager/designee, Central Admission and Referral Office, and Pharmacy, will initiate the Confidential Tuberculosis Suspect Case Report – Hospitalized Patient Report (Form H803) within twenty-four (24) hours of admission, under the Gotch Bill requirement.
c. Fax the completed H803 to TB Control at (213) 749-0926; or report by phone at (213) 744-6271.
d. Before patient is discharged, complete and fax the Tuberculosis Discharge Care Plan (Form H804) 24 hours prior to discharge at (213) 749-0926; or report by phone at (213) 744-6271.
    - TB Control staff will review the discharge plan and notify the provider within 24 hours of approval plan or inform the provider of additional information/action that is required for approval prior to discharge.
    - All arrangement for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the TB Control Physician on call. Response will usually occur within one hour. If the discharge cannot be approved, the patient must be held until the next business day for appropriate arrangements to be made.
    - Both H803 and H804 forms can be obtained from the Rancho Intranet (Forms/Nursing/TB Suspect Case Report [H803] or TB Suspect Discharge Care Plan Approval Request [H804]).

Instruct and ensure that all visitors check with patient care staff before entering a patient room identified as Airborne Precautions Isolation.

Remember: The key to preventing TB infection is to complete your annual health assessment, which includes screening for TB infection/disease. All employees who convert to a positive TB skin test will be evaluated through a Pulmonary Medicine consult via Employee Health Services for further testing and possible treatment. For further information on TB, refer to Rancho Tuberculosis Exposure Control Plan in the Infection Prevention and Control Manual.

AEROSOL TRANSMISSIBLE DISEASE PLAN

On August 5, 2009 State of California adopted section 5199 to California Code of Regulations, Title 8, Chapter 4 requiring hospitals, clinics, and areas where high hazard procedures are performed to follow the Aerosol Transmissible Disease requirements.

The Aerosol Transmissible Disease Plan was developed to prevent the transmission of respiratory infections in healthcare settings, including seasonal influenza, pandemic influenza, severe acute respiratory syndrome (SARS) and other respiratory viral pathogens that potentially can be transmitted via aerosol, small particles (airborne transmission). If there is evidence of Pandemic Flu present in the community, refer to Rancho Los Amigos Pandemic Influenza Response Plan. The facility Safety Officer and Infection Preventionist will administer the Aerosol Transmissible Disease Program.

Infection Prevention and Control measures should be implemented at the first point of contact with a person who is potentially infected with a respiratory illness. The recommendations are based on the Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings and recommendations of the Healthcare Infection Prevention and Control Practices Advisory Committee (HICPAC), Centers for Disease Control and Prevention (CDC) and Cal/OSHA Aerosol Transmissible Disease Protections (2009).

PANDEMIC INFLUENZA PLAN

Influenza that is a novel or new virus strain that is different from commonly occurring seasonal influenza can easily cause a pandemic. Since there is little immunity, it can spread quickly and easily from person to person, potentially affecting millions of people. Therefore, information and guidelines in this handbook are based on generalities and may change depending on the novel stain. Once a novel virus is identified and a case definition is developed, it will be communicated by public health officials.

Flu Terms Defined

- H_1N_1 (referred to as “swine flu” early on) is a new influenza virus causing illness in people. This new virus was first detected in people in the United States in April 2009. Other countries, including Mexico and Canada, have reported people sick with this new virus. This virus is spreading from person-to-person, probably in much the same way that regular seasonal influenza viruses spread.
- Seasonal (or common) flu is a respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available.
- Avian (or bird) flu is caused by influenza viruses that occur naturally among wild birds.
- H_5N_1 variant is deadly to domestic fowl and can be transmitted from birds to humans. There is no human immunity and no vaccine is available.
- Pandemic flu is a virulent human flu that causes a global outbreak, or pandemic, of serious illness. An influenza pandemic occurs when a new influenza virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads easily person-to-person worldwide. Currently, there is no pandemic flu.

Clinical Information

1. Affects people of all ages. Infants, young children, elderly adults, pregnant women, and individuals with chronic disease are at greatest risk.
2. Incubation period and duration of viral shedding may vary depending on the novel strain.

3. The period of communicability (duration of viral shedding) continues for up to 7 days after the onset of illness: probably 3-5 days from clinical onset in adults and up to 7 days in children. Young children can also shed the virus before their illness onset. Severely immunocompromised persons can shed the virus for weeks or months.

SYMPTOMS OF FLU INCLUDE:

- Fever (usually high).
- Headache.
- Extreme tiredness.
- Dry cough.
- Sore throat.
- Runny or stuffy nose.
- Muscle aches.
- Stomach symptoms, such as nausea, vomiting, and diarrhea, also can occur but are more common in children than adults.

TRANSMISSION

- Direct and indirect contact.
- Droplet transmission of droplets through coughing or sneezing (droplet > 5 micron in diameter).

DIAGNOSIS

- Influenza surveillance information and diagnostic testing can aid clinical judgment and help guide treatment decisions.
- Diagnostic tests available for influenza include viral culture, serology, rapid antigen testing, polymerase chain reaction (PCR), and immunofluorescence assays.

INFECTION PREVENTION AND CONTROL

Use of containment measures will be critical to reducing the spread of pandemic influenza:

- Respiratory hygiene and cough etiquette.
- Standard precautions and personal protective equipment.
- Droplet/Airborne Precautions, negative pressure room if available.

Guidelines may be amended as more is learned about the infectivity of the pandemic virus. Refer to Infection Prevention and Control: Pandemic Flu Plan.

BIOHAZARD WASTE DISPOSAL

Biohazard waste is defined as fluid blood; blood caked waste or contaminated sharps. Keep regular, biohazard, chemotherapy, pharmaceutical or other hazardous waste separate from each other.

INFECTION PREVENTION AND CONTROL MANUAL

Rancho's Infection Prevention and Control Manual contain:

- Infection Prevention and Control Plan
- Reporting of Reportable Communicable Diseases
- Outbreak Policy
- Hand Hygiene Policy
- Bloodborne Pathogen Exposure Control Plan
- Tuberculosis Exposure Control Plan
- Respiratory Etiquette

REMEMBER

Practicing good hand hygiene is the most important intervention in preventing the spread of infection!

- Pandemic Influenza Control Plan
- Bio-Terrorism & Infectious Disease Disaster Readiness Infection Prevention and Control Plan
- Construction and Maintenance Risk Assessment Policies and Procedures: Infection Prevention and Control Risk Assessment (ICRA)
- Vaccination Program
- Airborne Transmissible Disease Control Plan
- High Level Disinfectant Solutions Preparation, Use, Monitoring and Disposal

For additional information, contact:

- Your Supervisor or Manager.
- Infection Prevention and Control Department at Ext. 7447.
- Employee Health Services at Ext. 6016.
- Facility Safety Officer at Ext. 6672.
- Patient Safety Officer at Ext. 6085.

Remember
Infection Prevention & Control – It's in Your Hands!

KEY POINTS TO REMEMBER

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.
- All licensed medical 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 must report it to the appropriate office.
- 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 provide each patient with superior medical and rehabilitation services in a culturally sensitive and safe environment.

THE JOINT COMMISSION

- 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.

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.

Report events in one of the following ways:

- Safety Intelligence (SI) Event Report
- Communication of Concern Form (available on the intranet) – for near miss events and other concerns not related to SI: complete page 1 and submit the hard copy or electronically to Administration (QRM).

Or call:

- Hospital Risk Manager's Office (Ext. 7842) or (Ext. 7900)
- Pharmacy Hotline (Ext. 6129) to report Adverse Drug Events
- Medical Administration (Ext. 7161)
- Employee Health Services (Ext. 6016)
- Hospital Administration (Ext. 7022)
- Patient Safety Officer (Ext. 6085)

- A **sentinel event** is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, not related to the natural course of the patient's illness or underlying condition.

- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
- Before you administer medication to patients, identify the patient using two identifiers per hospital policy.
    - **Inpatient: Patient Name and Rancho Number**
    - **Outpatient: Patient Name and Rancho Number OR Patient Name and Date of Birth**
- The Joint Commission annually establishes National Patient Safety Goals (NPSG) which Rancho workforce members must follow. You are responsible for reviewing and complying with the NPSG that are applicable to your duties.

STAFF RIGHTS AND RESPONSIBILITIES

Human Resources

- All Rancho staff must complete all mandatory training and competency validation requirements for their respective positions (e.g., orientation, compliance awareness, infection prevention and control, fire/life safety, emergency management, CPR and other core competencies)
- All Rancho staff is required to complete initial and annual health screening/evaluation on time as required by departmental policy and regulatory agencies. You are responsible to obtain a health screening annually.
- All Rancho staff is required to ensure their professional credential, as applicable, is kept current and in good standing with the appropriate licensing board/agency. Professional staff that must maintain a current professional credential to perform the duties will not be allowed to work with an expired professional credential.

PATIENT RIGHTS, RESPONSIBILITIES, AND SERVICES

Patient Rights

- Rancho Patient Rights and Responsibilities are posted throughout the facility for reference.
- 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 (such as admission by ambulance).
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Patient Advocate at (562) 401-7036.
- It is our responsibility to provide interpreter services free of charge for our Limited English Proficient and non-English speaking patients.
- It is prohibited to use minors as interpreter in any situation.
- 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 patients to determine 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.
- Rancho admissions staff and social workers inform 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 and a physician order set (Advance Directive/Resuscitation Status) will be initiated. Appropriate documentation(s) will be completed.
- Service animals must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.

ENVIRONMENT OF CARE

- The Environmental Safety Program and Environment of Care Committee identify and investigate all recognized hazards to patient safety.
- Safety concerns must be reported to your supervisor and the Safety Officer at Ext. 6672 or Patient Safety Officer at Ext. 6085 for clinical patient safety concerns.
- Completion of the "Employee/Safety and Security Concern Program" form is also required.
- You can report safety concerns anonymously.
- Know what all emergency codes mean and how you should respond to each:
  - 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 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 Material Spill/Release.
  - 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 Emergency/Disaster Plan.
  - Code Triage Internal means internal disaster situation.
  - Code Triage External means external disaster situation.
  - Code Police Emergency means Emergency Police Response.
- The Safety Data Sheet (SDS) tells 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 it is kept, ask your supervisor. The master SDS manual for Nursing Units is located in the Nursing Resource Office, JPI. Room T1107.
- In the event of a fire, follow the RACE 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.

PERFORMANCE IMPROVEMENT

- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
- Ask yourself "How have you been involved in the improvements made in your department in the past 12 months?"
- Know what our hospital Quality/Performance Improvement Program: Participate in our Quality/Performance Improvement Program.
- How can you work with other departments to improve care/services? If you don't know, speak to your supervisor.
- Rancho's performance improvement (PI) model is FOCUS-PDCA, based on the four key elements of Design, Data Collection, Aggregation/Analysis, and Improve.
- We measure our performance using our PI model to assess how well we are doing, seek opportunities to improve, and look for evidence that we are making a difference.

RISK MANAGEMENT

- The success and effectiveness of Rancho's Risk Management Program is dependent on the participation and information reported by all workforce members.
- All workforce members are expected to complete the Safety Intelligence (SI) event reporting system by clicking on the event reporting icon on the Rancho intranet. The expectation is to complete an event report within 24-hours of a near miss, adverse, or sentinel event. Incidents that resulted in unexpected serious injury, permanent disability, or death should also be reported verbally to the Risk Manager in addition to completing the SI report.
  - A near miss is an incident or unsafe condition with the potential for injury or damage.
  - An adverse event is an incident in which a person receiving care is harmed. The event may also meet the criteria for reporting to an outside agency as a "Never 28" even, "Provider Preventable Condition" or a Joint Commission Sentinel event.
- If you are in doubt if an event qualifies as a "near miss" or an adverse event, complete an SI report. You may also enter an event anonymously.

INFECTION PREVENTION AND 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 and after eating, drinking, smoking, after using the toilet, whenever there is any doubt about contamination, and when hands are visibly soiled.
- 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 washing.
- In the event of a sudden influx of a large number of infectious patients, Rancho will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Preparedness Manual; all departments have copies of the Emergency Preparedness Manual.

MANAGEMENT OF INFORMATION

- Protecting Patients' Rights 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 uview.
- Position computer workstations and monitors away from 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 patient information as if it were your own.
- Cover carts when transporting medical records, so that the patient names are not visible.
- Report suspected patient privacy violations through the Safety Intelligence (SI) Event Reporting system AND by phone to the facility Information Security Office at (562) 401-7884.
- Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside of 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.
- Wear your identification badge at all times while on duty.
- Access to computers or computer systems containing e-PHI must be restricted to authorized users.
- Log off the computer when you are away from the work area or when the computer is not in use.
- Encrypted and password-protect PHI and other confidential information stored on laptops, portable devices, and removable media (e.g., USB thumb/flash drives and handheld digital equipment such as cameras, PDA, tablets, and cellular phones).
- It is the responsibility of every workforce 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, and 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.
- In the event of a disaster, Rancho ensures against loss of data by activating the Information Technology (IT) Disaster Recovery Plan. Additionally, IT performs daily data backup on all servers and stores the backed-up information at an off-site location.
- Rancho 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.
- Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.
- Rancho provides "knowledge-based data and information" through the Medical Library, located in the 500 Building. Leaders and care providers can access journals, text books, audio visual materials, etc. The library is accessible online.

CLINICAL ORIENTATION (FOR CLINICAL STAFF)

This section of the Orientation Handbook should be reviewed by all clinical workforce members who provide care, treatment or services to patients. 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	Social Workers
Rehabilitation Therapy Technicians	Surgical Technicians
Licensed Physical Therapy Assistants	Dental Assistants
Nurse-Midwives	Dental Hygienists
CRNA'S	Registered Dietitians
Physician Assistants	Certified Occupational Therapy Assistants
Nurse Practitioners	Cardiac Monitor Technicians
Certified Medical Assistants	

* Also anyone with a degree as required by their classification, and/or who provides patient care.

PATIENT CARE PRACTICES

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

Workforce members with direct patient care responsibilities are trained in working with the appropriate population groups (neonate, infant, and 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/age 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)

- 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.

PEDIATRICS (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 5-12).
- 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.
- Allow for peer visits.

ADULTS (18 YEARS THROUGH 64 YEARS)

- Be supportive and honest.
- Respect the patient's personal values.
- Avoid labeling.
- Support the person in making healthcare decisions.

- Recognize commitments to family, career and community.
- Address age-related changes.
- Offer information about support groups.

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. Decline in physical strength.
  d. Loss of ability to discriminate sounds.
  e. Decreased visual acuity.
  f. Slowed cognitive function (understanding).
  g. Decreased heat regulation of the body
  h. Decreased 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.
- Inspect environment for safety after discharge.

PAIN ASSESSMENT AND REASSESSMENT

Our approach to pain management includes the use of pharmacologic as well as non-pharmacologic interventions. We educate our patients and families about their right to have their pain managed appropriately and the purpose for frequent reassessment using the pain tools.

VISUAL ANALOG/NUMERIC SCALE (VAS/N)

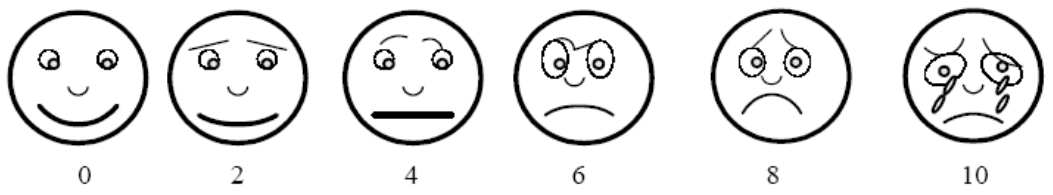
Adults and children able to understand the scale respond verbally or by pointing at a number.

0	1	2	3	4	5	6	7	8	9	10
Instruction: "Choose a number between 0 – 10 that matches how much pain you are feeling right now. ZERO means you have NO pain and TEN is the WORST pain possible."										

OUCHER SCALE

Used for patient population over the age of 5 when VAS is not appropriate, including adults with cognitive problems who can understand the scale.

a. Children old enough to understand the scale.
b. Adults with cognitive problems who can understand the scale.



Instruction: Choose the face that matches how much pain you are feeling right now.

CPOT CRITICAL CARE PAIN OBSERVATION TOOL

Used for adult patients who are unable to communicate verbally secondary to mechanical ventilation, sedation and changes in LOC.

Critical Care Pain Observation Tool (CPOT)

Use for adult patients who are unable to communicate verbally due to mechanical ventilation, sedation and changes in LOC.

Indicator	Score		Description
Facial Expression	Relaxed, Neutral	0	No muscle tension observed
	Tense	1	Frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)
	Grimacing	2	All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the ET tube)
Body Movements	Absence of movements or normal position	0	Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness/ Agitation	2	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Compliance with the Ventilator (Intubated Patient)	Tolerating ventilator or movement	0	Alarm not activated, easy ventilation
	Coughing but tolerating	1	Coughing, alarms might be activated but stop spontaneously
	Fighting ventilator	2	Asynchrony: blocking ventilation, alarms frequently activated
OR			
Vocalization (Extubated patients)	Talking in normal tone or no sound	0	Talking in normal tone or no sound
	Sighing or moaning	1	Sighing or moaning
	Crying out, sobbing	2	Crying out, sobbing
Muscle Tension	Relaxed	0	No resistance to passive movements
	Tense, rigid	1	Resistance to passive movements
	Very tense or rigid	2	Strong resistance to passive movements or incapacity to complete them

Instructions: Observe the patient for 1 minute at rest for baseline score, then during nociceptive procedures. Rate the patient in each of the 4 categories, add together and document total pain score. Highest possible pain level = 8 **Provide pain relief measures for score 2 or higher

FLACC SCALE

FLACC SCALE

CATEGORIES	SCORING		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn	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 whimpers, 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
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten. **USED TO EVALUATE PAIN FOR CHILDREN 0 TO 5 YEARS**			

Malviya, S., Merkel, S., Shayevitz, J. & Voepel-Lewis, T. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3) p. 293-297

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

The FLACC Pain Scale can be used with infant and pediatric patients' age 0-5 years, cognitively impaired patients, and those patients unable to use other scales. Assess the patients in each area – total the score – evaluate the total using the 0-10 pain scale.

ASSUMED PAIN PRESENT (APP)

APP is a culmination of a pain assessment of a non-verbal patient, usually when there is no appropriate behavior assessment instrument to quantify behaviors systematically (Quinn, 2006). It is used for patients in vegetative state who are unable to elicit a behavioral response due to traumatic brain injury, pharmacologically induced coma, or those receiving neuromuscular blockers for disease management. Pain is assumed to be present in these patients. Analgesics will be administered when clinically indicated.

FOOD AND NUTRITION SERVICES

The Food and Nutrition Services Department at Rancho is a county contracted service (Prop A). The contractor since 1995 has been Sodexo. The Food and Nutrition Services Department provides the following services:

- Prepare and serve all patient meals and snacks.
- Provide clinical nutrition programs for inpatients and outpatients.
- Prepare all food served in the Café Amigos, the employee and visitor cafeteria in the Support Services Annex (SSA).
- Operate the Amigos Snack Bar in the 500 Building.
- Provide catering services for special functions and meetings.
- Provide meals for ordinance employees and volunteers.

The Clinical Nutrition Department consists of registered dietitians and dietetic technicians. They provide nutrition therapy services to all patients.

The manager of food services is located in the SSA 1131 (Ext. 7151).

Hours of operations are Monday through Friday at the following times and location:

Location	Open	Closed
Café Amigos	6:30 a.m.	3:00 p.m.
500 Snack Bar	7:30 a.m.	3:00 p.m.
JPI Hallway food cart	7:30 a.m.	7:30 p.m.

In addition to the above contract services, a food cart is frequently in the 900 Building lobby, Monday through Friday mornings.

PATIENT SAFETY

This section addresses general patient care principles related to patient safety including "Read-Back" requirements, fall reduction, deteriorating patient condition, Speak Up program, medication management, unapproved abbreviations, behavioral restraints, medical record requirements for physicians/licensed independent practitioners (LIP), and medical review checklist.

"READ BACK", "REPEAT BACK" REQUIREMENTS

In an effort to improve communication among care providers, Rancho has several processes in place to confirm the accuracy of orders issued over the telephone, verbal orders issued in an urgent or emergent situation, verbal orders issued in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

- ***Telephone Orders (TO)*** – While the physician issues the order, the RN, in direct communication with the physician, writes the order on the Physician's Medication Non-Medication Order Form. Before ending the telephone call, the RN "reads back" the order to the prescriber to confirm that he/she understood and transcribed it correctly. The physician must indicate whether the order was written correctly. The RN will check the TO box on the Physician's Medication Non-Medication Order Form and circle TO, print the name of the physician who gave the order, check the Write/Read Back box, sign their name, and document the date. The RN will flag the order to be co-signed by the physician. The physician must co-sign within 48 hours. Physician assistants may not provide TOs.
- ***Verbal Orders (VO)*** – 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. When able, the RN will write the order on the Physician Medication Non-Medication Orders Form. The RN will check the VO box, circle VO, print the name of the physician who gave the order, check the Write/Read Back box, sign their name, and document the date. The RN will flag the order to be co-signed by the physician. The physician must co-sign within 48 hours. Physician assistants may not provide VOs.
-
- ***Critical Test Results*** – Rancho uses the *VOCADA VERIPHY* System for reporting of critical laboratory values, and significant medical imaging diagnostic findings.
  - ***For Critical Diagnostic Laboratory Values***
    - The laboratory personnel enters the value, the ordering practitioner or designee, and the location at which the specimen was collected into the *Vocada* system. *Vocada* will page or call the ordering practitioner, and at the same time, will call and fax to the ordering location (unit or clinic) to notify. After 5:00 p.m. or on weekends and holidays, the B-physician will be paged, except for Units 101 and 102 for which the Intensivist will be paged.
    - For a clinic patient: If the critical value is identified after 5:00 p.m., before 8:00 a.m., or on a weekend or holiday, Vocada will call and fax a notification to the Telephone Operator Office, which then notifies and provides the Administrative Nursing Supervisor (ANS) with the fax notification. The ANS, then, contacts the on-call B physician or Intensivist.
    - Once called/paged by *Vocada*, the ordering practitioner/designee or the on-call physician or intensivist, and the RN on the ordering unit will call the Vocada telephone number within 30 minutes, and using the six (6) digit message number, will retrieve the critical value and close the report.
    - All critical values will be verified through a read back process.

  For Medical Imaging significant findings

  The Medical Imaging Department reports all critical findings to the Vocada system. The system notifies the physician or designee via telephone, page or fax, and maintains record of when this communications occur.

DETERIORATING PATIENT CONDITION

As patient caregivers, you need to know the signs and symptoms of a 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 our 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. It is every member of the health care team's responsibility to ensure that they give the highest level of care, and to immediately react to emergencies, potential emergencies and/or incidents.

Signs and Symptoms:

Depending upon your scope and/or level of practice, these are some of the warning signs that a patient is deteriorating:

- Acute change in mental status.
- Acute change in heart rate.
- Acute change in respiratory rate or effort.
- Acute decrease in oxygen saturation.
- Acute decrease in systolic blood pressure.
- Acute decrease in urinary output.
- Uncontrolled bleeding.
- Any staff member's significant concern about a patient's status
- Pediatric patients under 5 years of age hypo-perfusion may often present with altered mental status, the patient feels clammy, he/she has poor capillary refill >3 seconds, may be unable to obtain blood pressure.

If you are concerned that a patient is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. That patient's nurse will assess the situation and call for additional assistance if needed. Rancho has a Rapid Response Team set up to evaluate and stabilize patients or visitors who are deteriorating. The Rapid Response Team is not intended to take the place of the Code Blue Team or urgent/immediate consultation. A Code Blue should be called when appropriate. Anyone can call a Code Blue for respiratory or cardiac arrest or Rapid Response Team by dialing Ext. 544 from a hospital phone.

FALL REDUCTION AND PREVENTION

The Department of Health Services has a Fall Management Program policy 311.101 that outlines our system-wide fall management program. The purpose of having a system wide program is to ensure continuity throughout our facilities both inpatient and outpatient. This policy was recently revised and is going through the approval process. If approved, changes will be made to our DHS Fall Management Program.

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.

Selection of System Wide Fall Assessment Tools

All DHS inpatient facilities assess patients for their fall risk using the same tools. The Morse Risk Assessment Tool is used for the assessment of our adult inpatients. The Humpty Dumpty Risk Assessment Tool is used for the assessment of our pediatric patients. In the outpatient settings, patients are screened for their fall risk utilizing either an adult or pediatric screening tool.

Definition of a 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.

Interventions

Standardized interventions are established for each level of risk using both the Morse Tool and the Humpty Dumpty Tool. The interventions were designed as a build-upon system. Patients at a moderate or high risk for falls will have the interventions for each lower risk level implemented. For example, patients at a moderate risk will have both the low and moderate interventions implemented. The option of selecting interventions from a higher level of risk and/ or a higher level of risk is provided.

Assessment Times

Standardized assessment and re-assessment times were established. Patients will be assessed on admission, upon transfer, daily, and immediately after a fall.

System Wide Initiatives

- Yellow is the DHS fall program color. All fall management items are to be yellow as much as possible.
- A logo was selected.
- Armbands were selected for both the outpatient and inpatient areas.
- Doorway signs and stickers designed.
- A standardized post fall procedure was created defining the duties of the first responder, nurse, and practitioner after a fall is available.
- The Fall Management Program is included in Interdisciplinary Orientation.

Rancho's Fall Management Program

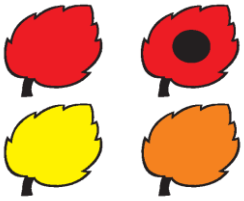
- Rancho's patient population is at a high risk for falls. Rancho's patient population is unique within the DHS system.
- The Humpty Dumpty Fall Risk Assessment tool is used to assess all Pediatric Service patients regardless of age.
- Rancho posts Morse Fall Signs at the bedside of each adult patient to communicate their fall risk and interventions.
- Hand-off communication between caregivers is a low risk intervention.
- Rancho RNs make the notification call to the next of kin versus the physician.

Rancho's Fall Management Initiatives

Falling Leaves Program

A colored leaf representative of the patient's level of fall risk will be attached to the nameplate outside of the patient's room.

Yellow – low risk
Orange – moderate risk
Red – high risk
Red with a black dot – has fallen



The leaf is to be checked minimally every 8 hours to ensure the correct one is posted. The leaf communicates the patient's risk level to all who enter the room.

Fall Dashboard

The dashboard communicates the fall rate for the week and month. It allows all caregivers to know how the unit is doing. The dashboard is updated each time there is a fall. There are laminated leaves attached to the tree. They represent all fall risk levels and if the patient has fallen. The correct colored leaf for the risk level of the patient who fell is to be removed from the tree and attached to the Velcro on the ground. At a glance, staff will know by looking at the leaves on the ground how many patients have fallen and what risk level they were at the time of the fall.

Intentional Rounding

Intentional rounding is done hourly or more frequently if the patient's situation warrants. Two employees are to round the patient at the change of each shift, an off-going and an on-coming. Therapies round their patients when leaving at the end of each session. Before leaving the room, the patient is to be asked if there is anything else they need that may not have already been addressed. Patient satisfaction surveys have improved since we began to indicate to patients that we are rounding so they know their concerns are addressed and needs met on an hourly basis.

Bed Alarms

Bed alarms are to be on at all times when moderate and high risk patients are in bed. All patients on Units 1 North, 2 North, and 2 South will have the bed alarm on at all times regardless of level of risk. If the patient is in a specialty bed and does not have an alarm, it is to be reported to the Nurse Manager. If the alarm is not working, a different bed is to be used. We are not to leave the patient in the bed while awaiting the repair. The alarm is to be checked hourly during intentional rounds. The alarm should be set on the #2 setting so as to not be too sensitive or not sensitive enough.

Safety at the Bedside

The #2 most frequent activity associated with a fall is reaching for items. Bedside stands with many items place patients at risk for having items fall from the table that they may reach for. Only a small number of specific items are to be on the bedside table. They are:

Telephone – is time sensitive and placed closest

Water bottle or other hydration items

Food items

Aids such as glasses, hearing aids, dentures

Leisure items

A trash bag

Reacher if issued by OT

The urinal is to be placed within easy reach of the patient. If the patient has a strong side, the table is to be placed on their strong side. Side rails are to be in position to ensure the patient's safety. For example, if the patient has experienced a right sided stroke and is not impulsive, the right lower rail is lowered. If the patient has experienced a right sided stroke and is impulsive, the left lower rail is lowered.

Bedside Communication Tool

The Bedside Communication Tool is at the patient's bedside. It is used to communicate key patient care information between caregivers such as transfers, toileting, and eating drinking. It is updated when there is a change and checked daily. It communicates to the patient and family how the patient is progressing.

The Loaner Reacher Program

The reachers provide a safer environment for patients who are assessed by OT as candidates for their use. If the patient would have a false sense of security associated with its use, they would not be a candidate. If they do not have the dexterity to safely use the reacher, they would not be a candidate. If they may use the reacher as a weapon or for any other inappropriate activity, they would not be a candidate. Any ID team member can request an OT assessment. They are loaner reachers and are for hospital use only. They are painted yellow, the fall color. A reacher may be provided on discharge if warranted.

Wheelchair Seatbelt Alarms

An alarmed W/C seatbelt is attached to all W/Cs in our high risk areas, units 1 North, 2 North, and 2 South and to some on the other units. They are attached to the bottom of the chair to prevent the patient from removing the belt from their chair. We have ones that are both alarm and voice activated. They can be doubled for patients if the additional time it would take to release two belts would allow staff to respond in time to keep them safe. They are not used for patients who cannot release them as it would then be a restraint.

The Second Floor Safe Zone

On JPI second floor, when the patient is not in therapy, at an appointment, or in bed, they are to be in the Safe Zone. If they have been in therapy or at an appointment, they will be returned to the Safe Zone. The Safe Zone is in the Activity Dining Room where there is an hourly schedule of events. Patient education, TIGR, crafts, Wii, games, exercise is provided. ID patient education classes are held at 1000 and 1600. The program schedule is posted. We invite the families and other visitors to attend. Patients, family, and other visitors can attend as many as they choose and attend the same class more than once. Patient education videos are viewed. Many are available for the patient population. The Wii gaming system is available and enjoyed by those in chairs and those that can stand. A combination of therapies can be provided such as PT and Recreational Therapy. If a patient wants the freedom to come and go from the safe zone, they will be discussed at Patient Centered Rounds. If all team members agree that the patient is safe in their room while in their chair, the physician will write a note indicating this in the patient's chart. The patient will have a small yellow happy face sign attached to their W/C and another larger one attached to their room nameplate.

Care Companion Badges

Staff assigned as a Care Companion will wear a Care Companion badge. The badge will be passed between all ID caregivers. It is a tangible indicator that the patient has been handed off and they need 1:1 or 1:2 supervision. The badge is not to be handed off to a family member or other visitor even if they are a trained Care Companion. The badge can be attached with a clip or a lanyard.

Post Fall Huddle

As soon as reasonable after a patient falls, an ID group of leadership staff will conduct a post fall huddle. The circumstances surrounding the fall will be evaluated. Any interventions that should be in place that are not will be noted. If an additional intervention is indicated to keep the patient safe, it will be discussed. Once the situation is analyzed, the staff and patient will be included in the huddle as indicated. Corrective actions are done and staff/ patient/ family education provided. There are Post Fall Huddle Champions assigned to each unit.

SAFE PATIENT HANDLING (SPH)

Effective October 1, 2014, every general acute care hospital was required to adopt Cal/OSHA Safe Patient Handling Regulation AB 1136. This regulation requires hospitals to have a program and policy that enables nurses and other caregivers to move patients utilizing equipment in a way that does not cause strain or injury while preserving the patient's dignity.

Department of Health Services policy 311.003, and Rancho Los Amigos National Rehabilitation Center policy B873, addresses Safe Patient Handling. These policies require workforce members, except in an emergency, to perform patient transfers/complex lifts with mechanical assistive devices as appropriate for the specific patient and consistent with the professional judgment and clinical assessment of the registered nurse, who is the coordinator of care. Rancho has developed a Musculoskeletal Injury Prevention Plan (MIPP) which describes the elements of the Safe Patient Handling Program.

Patient handling activities include:

1. Repositioning in bed
2. Bed to chair/wheelchair
3. Bed to gurney and return
4. Gurney to treatment table and return
5. Bed to toilet
6. Floor to bed
7. Any other lift where total body movement of the non-ambulatory patient is required

During an emergency in a nursing unit, contact a registered nurse to get help for the patient.

UNIVERSAL PROTOCOL

Rancho has adopted all components of The Joint Commission's Universal Protocol intended to prevent wrong site, wrong surgery/procedure and wrong person. The Protocol establishes a process for a defined series of pre-procedure verifications designed to maximize patient safety and well-being. It applies to all surgical and non-surgical invasive procedures. Healthcare providers facility-wide share in the responsibility of conducting this verification process in cooperation with the patient. Universal Protocol must be used on all procedures, which are not only invasive, but that present more than minimal risk to the patient vs. what follows: is required across the campus anywhere that an invasive procedure occurs.

The three main components are:

1. **Pre-Procedure Verification** – Rancho uses a standardized list for verifying that all relevant documents are available and correct before sending a patient for all surgical and non-surgical invasive procedures. Verification that the patient's history and physical is present and current, that we obtained the patient's informed consent, and that the patient is included in the process and agrees to the planned surgery/procedure. If any information is missing or any discrepancy found, the procedure is postponed until the information is clarified and/or corrected. This standardized list also addresses marking of the correct surgical site, verification of the correct procedure, verification of the correct patient and the time out processes required. The documentation of the use of the standardized list on a per patient basis is not required.

2. **Site marking** – The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs). However, the licensed independent practitioner who delegates responsibility is ultimately accountable for the procedure. This option takes into account the current position of The Joint Commission, National Quality Forum, World Health Organization, and American Academy of Orthopedic Surgeons and the concern raised by the field that the current requirement is impractical under some circumstances. The Joint Commission will continue to gather input and data on this issue.

3. **"Time Out"** – The "time out" process will occur prior to incision or start of the procedure. All members of the service delivery team conduct a final verbal verification to confirm the correct identity of the patient, planned procedure, operative site, side, and level. A member of the Health Care Team (the circulating nurse, as in the case of the operating room or the person assisting with the procedure, as in the case elsewhere in the hospital) will initiate the verbal "time out", and document the confirmations. The discussion should involve all team members regarding the type of anesthesia, availability of blood, any relevant heath conditions or risks, presence of x-rays or other relevant testing, presence of all surgical instruments, and any intended surgical implants. For procedures performed outside of the OR, the physician documents the occurrence of the "time out" process, surgical site marking and other information on the Time Out Procedure form.

MEDICATION MANAGEMENT

MEDICATION USE

The medication use process involves multiple steps in order to ensure the delivery and right documentation of the right medication to the right patient, at the right dose, at the right time, using the right route, for the right reason, and response. The following are several important medication use practices to ensure medication safety and reduce the potential for medication-related events.

MEDICATION RECONCILIATION

It is Rancho's policy to accurately and completely reconcile medications across the continuum of care. The practitioner or provider is responsible for the medication reconciliation process in collaboration with nursing, pharmacy, and other members of the interdisciplinary team.

All admissions, intra-facility transfers, transfers to another facility, discharges and encounters in the Ambulatory Care Center require the practitioner or provider to reconcile medications, surgeries, and document that the medication reconciliation process was completed. This entails obtaining a current medication history, including prescription and non-prescription medications, such as over-the-counter medications, supplements, herbals, and alternative medications from all patients admitted to the facility or seen in the Ambulatory Care setting.

Tools and resources that are available to the practitioner include, but are not limited to:

- Medication list from the module in the electronic health record (Ambulatory Care).
- Medication Administration Records (MARs) from the previous health care facility.
- Current MARs for intra-facility transfers and discharges to another health care facility.
- Medication Reconciliation Worksheet.
- Interviews with previous caregivers, patient, family, and significant others.
- Any records received from the patient, e.g.., discharge instructions, prescriptions, patient's personal record, list of medications.
- Actual bottles or packages of medications, supplements, etc.
- Prescription Profile.

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, frequency, contraindications, and the pharmacological effects of each medication that you prescribe to avoid adverse drug events. Rancho 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, and any instructions/parameters. Make your medication orders clear and complete by:

- Identifying your patient with **TWO** identifiers:
  - Inpatient: Name and Rancho Number
  - Outpatient: Name and Rancho Number OR Name and Date of Birth
- Placing the date and time on all orders.
- Using generic drug names on all medication orders, except for combination products which can be expressed by their respective trade names.
- Including specific drug name, dose, route, frequency, and any instructions/parameters.
- 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 for pain) with indications.
- Signing all orders and printing your name and provider number or identification so that you may be located for any questions as well as the date and time.
- Entering the patient's diagnosis, allergies, and height/weight (in kilograms) on all admitting orders to avoid delay in dispensing.
- Entering the patient's pregnancy and lactation status, and any other information required for safe medication management.
- Using weight-based dosing on all pediatric patients until the adult weight is reached or the pediatric dose equals the normal adult dose.
- Notifying that hold orders will be interpreted as a discontinuation order, if no parameters were provided at the time the order was written and that medications held due to parameters provided at the time the order was written will not discontinue the order
- Using patient identification labels or computer generated patient identification on ALL patient orders. Do not write out patient names, Rancho# or birthdate. You **must** list unit location on ALL patient medication orders.
- Avoiding the use of "Do Not Use" abbreviations. When in doubt, do not abbreviate! To prevent any confusion, spell out the entire name of the drug.
- Not using trailing zeros after decimal point.
- Always using a zero before a decimal when dose is less than a whole unit.

DO NOT USE ABBREVIATIONS LIST

"DO NOT USE" ABBREVIATIONS/DOSE EXPRESSION	APPROVED ABBREVIATION/CORRECTION
U	Use **unit**
i.u., I.U.	Use **international unit**
Q.D., QD, q.d., qd	Use **daily**
Q.O.D.,QOD, q.o.d, qod	Use **every other day**
zero after decimal point (e.g. 1.0) (Trailing zero)	**Do not** use terminal zeros for doses expressed in whole numbers (e.g., 1.0 mg should be 1 mg instead)
Lack of a leading zero (e.g., **.1** mg)	Always use zero before a decimal point **(0.1** mg).
MgS04	Use **magnesium sulfate**
MS or MS04	Use **morphine sulfate**

When in doubt, DO NOT ABBREVIATE!

SPELL OUT THE ENTIRE NAME OF THE DRUG TO PREVENT ANY CONFUSION

LOOK-ALIKE/SOUND-ALIKE LIST

epHEDrine	and	epINEPHrine
lamIVUDine	and	lamOTRIGine
HumULIN	and	HumALOG
LantUS	and	LentE
CeLebREx	and	CeRebYx and CeLeXA
KlonOPin	and	ClonIDinE
LamiSIL	and	LamiCTAL
foliC acid	and	foliNIC acid
hydOXYzine	and	hydRALAzine
traMAdoL	and	traZOdoNE

PLEASE USE ENHANCED CAUTION
WHEN PRESCRIBING, DISPENSING, AND ADMINISTERING THESE MEDICATIONS

MEDICATION DISPENSING

Before dispensing medications, the pharmacists must review all medication orders for appropriate indication, dose, route, frequency, drug-drug interactions, and allergies. The pharmacist utilizes the patient's age, height, weight, and diagnosis provided to determine appropriateness of orders, and reviews the patient medication profile to avoid therapeutic duplication and drug-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 proper patient identification (using two identifiers per hospital policy: If the patient is unable to state his/her full name, a picture identifying the patient will be used for identification. If there are two patients with the same name; the two patient identifiers would then be the patient's Rancho number and birthdate.

For the outpatient area, the two identifiers are: Patient Name and Date of Birth OR Rancho Number. Take the Medication Administration Record (MAR) with you into the patient's room to verify and document the medication administered. The Pharmacy provides a daily printed MARs, generated from the pharmacy information system. The nurse reviews all physician orders, and reconciles the pharmacy-generated MAR on a daily basis before use. Orders in question will be designated by an asterisk to the right of the medication on the physician order form and scanned to the Pharmacy. Errors on the computer generated MAR will be corrected prior to its use.

Patient's Own Medications

Medications brought into the hospital by the patient should be sent home with the patient's family. Rancho 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 Rancho drug formulary or available.
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. Pharmacy must ensure that the medication has not been contaminated. Rancho 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 (ADR) HOTLINE

Report all adverse drug reactions into the UHC Safety Intelligence Event Reporting System and/or to the ADR hotline (562) 401-6129. Provide the patient's name, Rancho number, location, date of occurrence, name of the suspected medication, dose, route, and type of reaction. Sign and print your name. Save all items associated with the administration of the medication, e.g., package, tubing, syringe, infusion bag.

MEDICATION ERRORS

A medication error is any preventable event that may cause or lead to inappropriate medication administration 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 medication error, through the UHC Safety Intelligence Event Reporting Process.

NON-VIOLENT (NON-SELF DESTRICTIVE) & VIOLENT (SELF-DESTRUCTIVE) RESTRAINTS

Rancho is dedicated to preserving the dignity, safety, and rights of each individual. Our goal is to minimize the use of restraints through comprehensive on-going assessments and the use of de-escalation techniques and the lease restrictive alternatives. We are committed to using interventions to control and prevent emergencies that have the potential to lead to the use of restraints. When used for behavior management, limit restraints to those emergency situations in which patient is assaultive, threatening or self-destructive goal-directed behavior poses an imminent risk of physical harm to him/herself, staff, or others and non-physical interventions would not be effective. We have defined a "**Code Gold**" as such an inpatient emergency.

To ensure that there is a system in place to provide for rapid response to significant potential or actual hostile or violent behavior, Rancho will dispatch a Behavioral Response Team (BRT) to diffuse crises and maintain safety. The BRT (Code Gold Team) consists of specially trained licensed and non-licensed workforce members who will provide 24 hour coverage to assist patient in regaining control when exhibiting violent or aggressive behavior toward staff, patients, or others. The BRT members should have appropriate, mandatory training and have demonstrated competency in the use of less restrictive methods of behavior management.

Refer to Rancho Administrative Policy and Procedure Nos. B814, Use of Restraints and B814.3, Code Gold and Behavior Response Team, for additional information on the use of restraints at Rancho. Issues of concern related to restraints or patient falls can be referred to the Risk Manager at Ext. 7842.

MEDICAL RECORD REQUIREMENTS FOR PHYSICIAN AND LICENSED INDEPENDENT PRACTITIONERS (LIPS)

- Begin medical record entry with an identifier (e.g., Attending note, Internal Medicine Fellow note).
- Legibly sign and indicate identification number and degree on all entries. Must use a four (4) digit stamp on all medical record entries. If a provider identification stamp is not available at the time of signing documents, then it is required to print complete name and title in large uppercase letters with provider quality improvement number next to signature (e.g., JOHN DOE, M.D. ID # 9999).
- All verbal and telephone orders must be signed within 48 hours. Rancho accepts verbal orders from a prescribing physician in an emergent or urgent situation in which harm to the patient would be imminent if the order is not implemented immediately and for which the physician is not able to write the order. No verbal orders for high alert medications are allowed except for cases of code blue, rapid response, and rapid sequence intubation.
- Specify reason(s) for prescribing medication(s) on all as needed (PRN) orders (i.e., conditions/symptoms, etc.).
- Failure to rewrite the following orders will cause the pharmacy to stop dispensing the medication.

TYPE OF ORDER	RENEWAL TIME
Oral antibiotics, anti-infective (exceptions: anti-TB, urinary tract "antiseptics")	Every 14 days
I.V. antibiotic piggybacks	Every 14 days
Anticonvulsants (except long-acting barbiturates	Every 28 days
Controlled substances (Schedule II) (Schedules III, IV, V)	Every 3 days, except practitioner may write for an exact period of time which may not exceed 7 days. Every 14 days
Intravenous solution without additives	Every 28 days
Intravenous solutions with additive(s), IV drips, TPN/PPN	Every 24 hours. (Exception: practitioner may write for an exact period of time, which may not exceed 3 days for parenteral nutrition.)
Respiratory treatment medications	Every 7 days
Heparin treatment Heparin and warfarin prophylaxis Low molecular weight heparin treatment Low molecular weight heparin prophylaxis	Daily Every 28 days Every 7 days Every 28 days
Darbepoetin	Every 7 days
Hypertonic I.V. solutions (3% NaCl, mannitol 20%, etc.) I.V. Steroids	Every 24 hours Every 7 days
All other medications	Every 28 days

Corrections and Amendments to Records

- When an error is made in a medical record entry, the original entry must not be obliterated and the inaccurate information should still be readable. The correction must indicate the reason for the correction, and the correction entry must be dated, and signed by the person making the revision. An examples of a reason to correct an entry may include "wrong patient". The contents of medical records must not otherwise be edited, altered or removed.
- **Do not document the word "ERROR."** You are not allowed to make any erasures nor use "white out" in a patient's medical record.

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, Provider number (orders only), and the actual date and time written.
- ☐ Did the patient sign the consent for treatment?
- ☐ 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?
- ☐ For telephone orders in the record, is "write/read back" verification documented? Did the physician sign 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 the least restrictive measures before applying restraints?
- ☐ Are the H&P and progress notes legible and informative?
- ☐ Are all orders dated, timed, signed and include the prescriber's provider number?
- ☐ Are allergies identified in the admission orders?
- ☐ Are there any "Do Not Use" abbreviations used? If so, was the order clarified?
- ☐ Are the resident's orders and notes cosigned by the attending physician?
- ☐ Did the attending physician write notes documenting his/her supervision of the resident?
- ☐ Is there evidence of intradisciplinary care planning?
- ☐ Is pain management well documented?
- ☐ Does the patient have an Advance Directive? If so, is there a copy in the medical record? If not, is there evidence of the provision of information regarding Advance Directives?
- ☐ 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 post-operative report noted in the medical record immediately after a surgical procedure providing information until the dictated operative report reaches the medical record?
- ☐ Were written post-discharge instructions completed at the time of discharge? (The written post-discharge instructions should not include any abbreviations, must contain the final diagnosis, and be signed by the attending physician).
- ☐ 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).

KEY POINTS TO REMEMBER (CLINICAL STAFF)

PATIENT CARE PRACTICES

Provision of Care

- Know the characteristics of each population group that you serve.
- Rancho supports every patient's rights to have his/her pain assessed and treated promptly, effectively, and for as long as the pain persists.

Patient Safety

- Use "Write/Read-Back" procedures to ensure important information is accurately communicated and recorded.
- You must know how to seek medical assistance when there is a decline in a patient's condition.
- Prevention of patient falls is the responsibility of EVERY workforce member. Become familiar with Rancho Fall Prevention Program.
- Universal Protocol applies to all surgical and non-surgical invasive procedures and establishes a process for preventing wrong site, wrong surgery/procedure and wrong person.
- 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.
- Identify the patient by two identifiers:
  - **Inpatient: Patient Name and Rancho Number**
  - **Outpatient: Patient Name and Date of Birth <u>OR</u> Patient Name and Rancho Number**
- 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, for the right reason, with the right response, and the right documentation is completed.
- Do not use "Do Not Use" abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire name of the drug.
- Report all adverse drug reactions into the UHC Safety Intelligence Reporting System) and/or to the ADR hotline at (562) 401-6129.
- Report all medication events, whether an actual medication error or an identified potential to lead to a medication error, through Rancho's Safety Intelligence process.
- Rancho is committed to using non-violent interventions to prevent and control emergencies that have the potential to lead to the use of restraints.
- Use of restraints should be limited to those emergency situations, e.g. "Code Gold", 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.
- Rancho will dispatch the Behavior Response Team (BRT) for a "Code Gold" emergency.
- All medication orders must contain the name of the medication, close, route, frequency, and any parameters. Medication orders need to be signed by the provider with provider number, dated, and timed.
- All verbal and telephone orders must be signed within 48 hours.

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.

NOTE

See DHS – Human Resources Operational Procedure No. 780.000, Performance Evaluations, for detailed guidelines.

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.

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 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 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 licensure, certification, registration or permit.

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

  and
- Has worked at least 1,250 hours during the 12-month period immediately preceeding 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.

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.

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 which could include 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, 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, payroll publishes a calendar for submission and approval of time-sheets. Employees are reminded to be diligent in submitting their time-sheets on time to avoid delayed paychecks, bonuses and/or accrued compensatory time such as 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 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 falls 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 holiday time based on their Sub Title (to a maximum of 8 hours). For 40-hour a 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 codes them on the online timesheet. Coding of the time worked on a County holiday requires a 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. The accrued Holiday time can be requested as time off at a later date. 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 Title/SubTitle. 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 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

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 some 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.; and
- Industrial Accident Leave covered by County Code or California Labor Code 4850 benefits.

The total amount of Full-Pay Sick Leave earned by each eligible full-time employee each year is defined in the 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; and
- 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 practicable 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

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 or 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

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 or 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); for 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/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, 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 10 days of Non-Elective Leave per year, periods of absence without pay will affect the accrual of this leave. MegaFlex employees will earn four hours of Non-Elective Leave each pay period, to a maximum of 80 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 that they earned before they entered MegaFlex when they are sick, but they cannot use that Full-Pay Sick Leave for "Personal Leave" as 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 Elective Leave (with supervisory 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.

SALARIES

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 paycheck stubs online.

EMPLOYEE PAY STATEMENTS (PAYSTUBS)

Paystubs are online through the eHR application. Paystubs can be printed or saved to an approved USB thumb drive. To view paystubs online the employee must log into 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 and downloaded. 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 the 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 and whether or not they are represented by a labor union and whether FLSA covered or not. 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 1, 2012 retain the current 1st 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

To be eligible to earn Vacation 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).

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 some 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.; and
- 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 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 in 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.

BEREAVEMENT LEAVE

Any person employed in a full-time, permanent position who is compelled to be absent from duty because of death of his 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 working days, 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 has to travel over 500 miles.

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 Title Sub 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 working days for each qualifying family member.

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 should not 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: Destination must be most direct from point A to point B.

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.

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.

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.

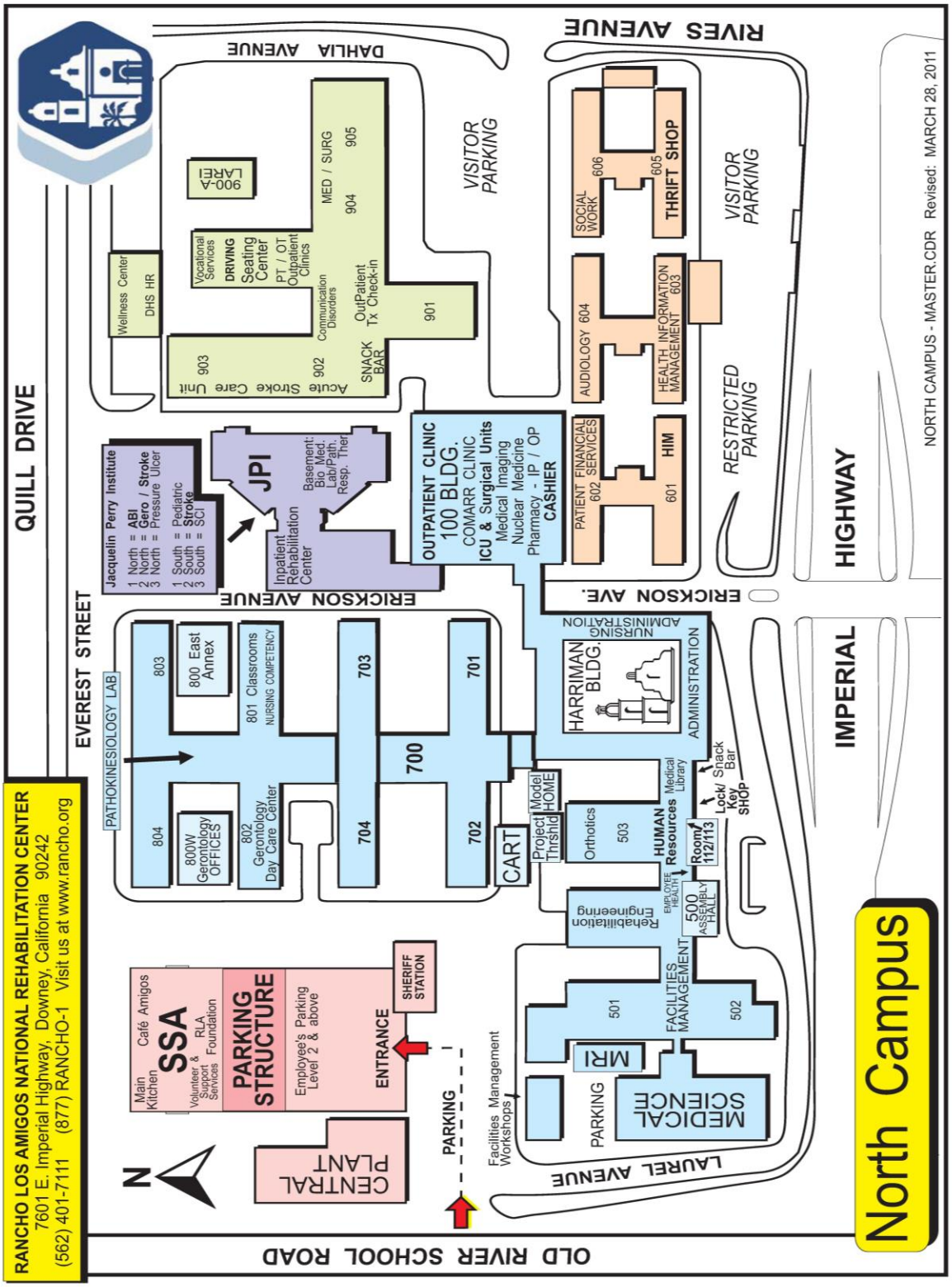
Vehicle Purchasing Services Program: The County has arranged for employees to receive a discount on the purchase of a "green" vehicle from various car dealerships. Many sites have charging stations to accommodate electric vehicles. Refer to the CEO Rideshare Website for more information.

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!

FACILITY MAP



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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