

2016



Harbor-UCLA
M E D I C A L C E N T E R

Orientation/Reorientation Handbook

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Interim Chief Executive Officer



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

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Performance Management		(310) 222-3190
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Information		
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Medical Records	Alma Smith	(310) 222-2045
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Vital Statistics		(310) 222-2083
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STD Control		(310) 222-2254
TB Control		(310) 222-3443
Volunteer Services	Bernice Hill-Shepherd	(310) 222-3258

HOTLINES

Child Abuse	(800) 540-4000
DHS Compliance	(800) 711-5366
DHS Quality Improvement.....	(800) 611-4365
Domestic Violence/Intimate Partner	(800) 978-3600
Elder Abuse/Adult Abuse.....	(877) 477-3646
Fraud	(800) 544-6861
The Joint Commission	(800) 994-6610
Patient Safety	(213) 989-7233
Poison Center	(800) 411-8080
Safely Surrender Baby (SSB).....	(877) 222-9723
Suicide Prevention.....	(877) 727-4747

TABLE OF CONTENTS

INTRODUCTION **1**

History and Highlights.....	1
Facility Profile	1
Vision, Mission, and Values.....	4
Los Angeles County Strategic Plan.....	4

CUSTOMER SERVICE **6**

Teamwork	7
Effective Workplace Communication	7
Coordination of Care.....	8
Conflict Resolution through Team Building.....	9

THE JOINT COMMISSION **10**

The Joint Commission’s “Shared Vision, New Pathways”.....	10
Survey Process – (Tracer Methodology).....	10
Accreditation Participation Requirements (APR 09.02.01)	11

PATIENT SAFETY **12**

Patient Safety Program.....	12
Safe and Just Culture	13
National Patient Safety Goals.....	13
Deteriorating Patient Condition	16
Fall Prevention and Response	16

STAFF RIGHTS AND RESPONSIBILITIES **20**

DHS County Workforce Member Emergency Protocol	20
Staff Rights.....	21
DHS Compliance Program and Code of Conduct	21
Procurement Process.....	25
Training and Competency.....	26
Professional Credentials (License/Certification/Registration/Permit)	26
Criminal Background Checks.....	27
Professional Appearance	28
Attendance/Tardiness.....	28
Health Screening	29
Smoking Policy.....	29
County Policy of Equity	29
Cultural and Linguistic Competence	32
Workforce Behavioral Expectations	36
Threat Management “Zero Tolerance”.....	36
Abuse Prevention, Sexual Abuse, Sexual Coercion (Inappropriate Behavior Toward a Patient)	38
Reporting of Abuse/Neglect Incidents	39

Reporting Suspicious Injuries.....	40
Safe Haven/Safely Surrendered Baby Law	40
Americans with Disabilities Act (ADA)	41

PATIENTS’ RIGHTS AND SERVICES 42

Patients’ Rights	42
Patients’ Responsibilities	45
Patient Advocates	45
Interpreter Services.....	46
Spiritual Needs of Patients	46
Advance Health Care Directives	47
Americans with Disabilities Act (ADA)	47
Service Animals	47
Organ/Tissue Donation	48
Emergency Medical Treatment and Active Labor Act (EMTALA).....	49

CLINICAL SOCIAL WORK 50

Scope of Services.....	50
------------------------	----

PERFORMANCE IMPROVEMENT 52

Improving Organizational Performance (IOP)	52
Performance Improvement	53
Publicly Reported Data.....	54

RISK MANAGEMENT 55

Reporting Near Miss, Adverse and Sentinel Events.....	55
Reportable Unusual Occurrences.....	58
Timely Reporting	58
Documentation – A Key Defense	58
Subpoena and Summons.....	59

ENVIRONMENT OF CARE 60

Workforce Safety Program	60
Emergency Codes	60
Security.....	61
Safety Awareness	62
Infant/Child Abduction (Code Pink/code purple).....	62
Bomb Threats (Code Yellow).....	62
Weapons.....	63
Workplace Violence	63
Hazardous Materials/Hazard Communications	63
Radiation Exposure.....	64
Emergency Preparedness and Management	64
Fire/Life Safety.....	67
Medical Equipment and Utilities	68

Reporting Work-Related Injuries/Illness.....	69
Injury and Illness Prevention Program (IIPP).....	69
Body Mechanics	70
Ergonomics	72

INFECTION PREVENTION & CONTROL 74

Infection Prevention and Control.....	74
Hand Hygiene	75
Fingernails	75
Respiratory Hygiene/Cough Etiquette.....	76
Standard Precautions	77
Transmission-based Isolation Precautions	77
Bloodborne Pathogen Exposure Prevention & Control Plan.....	78
Personal Protective Equipment (PPE).....	79
BloodBorne Pathogens	79
Central Line Associated Bloodstream Infections.....	80
Surgical Site Infections.....	80
Ventilator Associated Pneumonia (VAP)	81
Catheter Associated Urinary Tract Infection (CAUTI).....	81
Multi Drug Resistant Organisms (MDROs)	81
Methicillin-Resistant Staphylococcus Aureus (MRSA).....	82
Vancomycin-Resistant Enterococci (VRE)	82
Clostridium Difficile (C. Difficile).....	82
Preventing Sharp Injuries.....	83
Safe Injections Practices	83
Injection Safety Tips for Providers.....	84
Vaccinations	84
Seasonal Influenza.....	84
Tuberculosis (TB) Control Plan	85
Aerosol Transmissible Disease (ATD) Plan.....	86
Pandemic Influenza Plan	86
Waste Disposal.....	87

MANAGEMENT OF INFORMATION 89

Confidentiality of Patient Information (HIPAA).....	89
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KEY POINTS TO REMEMBER – ALL STAFF 95

PATIENT CARE PRACTICES 101

Population-Specific Guidelines and Care of Special Patient Populations.....	101
Pain Assessment and Reassessment.....	102
Patient Food Services/Nutrition Services.....	104

PATIENT SAFETY 106

“READ-BACK” Requirements	106
Universal Protocol	106

Deteriorating Patient Condition	107
Fall Reduction and Prevention.....	108
Medication Management.....	117
Medication Use.....	117
Medication Prescribing	117
Dangerous Abbreviations: DO NOT USE.....	119
“Look-Alike/Sound-Alike” Medications.....	120
Medication Dispensing	120
Medication Administration	121
Adverse Drug Reaction (ADR) Reporting.....	121
Medication Errors	121
Reduce the Risk of Health Care-Associated Infections.....	121
Non-Violent (non-self destructive) & Violent (self-destructive) Restraints.....	122
Use of Restraints and Seclusion.....	123

KEY POINTS TO REMEMBER (CLINICAL STAFF) 125

HUMAN RESOURCES 126

Performance Evaluation.....	126
Competency Assessment	126
Employee Assistance Program (County Employees).....	128
Family and Medical Leave Act (County Employees).....	128

PAYROLL (COUNTY EMPLOYEES) 130

Time Reporting.....	130
Holidays.....	130
Time Off Requests	131
Sick Leave.....	132
Salaries	135
Employee Pay Statements (PayStubs).....	136
Work Hours/Work Week.....	136
Overtime	136
Salary Increases.....	137
Vacations.....	138
Bereavement Leave	139
Jury Duty.....	141
VEHICLE TRIP REDUCTION – RIDESHARING.....	142

Post-Test 144

Facility Map 152



Harbor-UCLA
MEDICAL CENTER



Welcome to Harbor-UCLA Medical Center!

On behalf of all of your colleagues here, I want you to know how excited we are to have you on our team. You are joining a diverse and dynamic group of over 4,000 professionals who are committed to our mission of ***providing high-quality, cost-effective, patient-centered care through leadership in medical practice, education, and research.***

This is a particularly exciting time at Harbor, as we are continuing our work on initiatives to increase access to ambulatory care and improve the patient experience. We also have begun implementation of the hospital campus master plan, which will result in the construction of new ambulatory care facilities and a new hospital tower. Through these efforts, we will strengthen our reputation as a provider of choice, as well as continue to serve the health care needs of those in need of a health care safety net.

Harbor-UCLA Medical Center includes a tertiary-care teaching hospital, a Level 1 trauma center, and host of primary and specialty clinics situated mainly on a 72-acre campus. Collectively, we provide care and services to approximately 20,000 inpatients, 80,000 emergency room patients, and 300,000 outpatient visits each year. We also play a major role in the training of future physicians, nurses, and other health care providers in our more than 40 accredited medical and surgical physician training programs, our radiologic technologist training programs, and our collaborations with local nursing schools. Finally, through our affiliation of the Los Angeles Biomedical Research Institute (or LA Biomed), located on our campus, we continue to explore and create novel treatments and therapies that are advancing health care delivery not just locally, but worldwide.

I am pleased that you have chosen to join our team and made the commitment to provide quality health care services to our family, friends, neighbors and everyone who comes to us for care in their time of need. We are most successful in achieving our collective mission when we emphasize ***trust, teamwork, and respect.*** These principles are not just important for our patients and visitors, but for our colleagues, as well. They are important components in our journey from currently being a great place to work to one of the best places to work.

This handbook provides you information regarding the Harbor-UCLA, Department of Health Services, and Los Angeles County policies. Please take the time to thoroughly read and review these policies. If you have any questions or need additional information, you may discuss them with your supervisor or contact Human Resources for assistance.

Sincerely,

Kimberly McKenzie, RN, MSN, CPHQ
Interim Chief Executive Officer

INTRODUCTION

This section provides a broad organizational overview of Harbor-UCLA Medical Center's service delivery. Included is the history, its Mission, Vision, Values and customer-service philosophy.

As a vital resource for the delivery of health care, Harbor-UCLA Medical Center and its affiliated Ambulatory Care Network health centers are committed to achieving the goals and objectives of the Los Angeles County Department of Health Services (DHS), improving service-delivery systems to our community and enhancing the quality of patient care provided by the Cluster's health care facilities. We also are 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 that together we can achieve excellence by meeting regulatory standards and the health care needs of our patients. It is important that you understand whether you are a health care practitioner, technician, clerical or housekeeping member of our team, that you make an important contribution to the delivery of quality health care.

We have designed this handbook so that important information is readily available. It provides you with general information about Harbor-UCLA and can be used as a quick reference guide to key policies and procedures. You are expected to know the material in this handbook and you may be tested on the information contained herein.

HISTORY AND HIGHLIGHTS

Since 1946, Harbor-UCLA Medical Center has been a prime provider of high-quality, cost-effective health care to insured and uninsured Los Angeles County residents, alike. Harbor-UCLA is an integral part of the County's health care safety net, a world-class academic medical center, and a major medical research site.

The medical center began as a military station hospital for the Los Angeles Port of Embarkation. In June 1946, the US Army sold the facility as war surplus to the County's Department of Charities. Opening one month later, Harbor General Hospital - as it was then known -- had 60 beds and a 70-person staff.

Since then, Harbor-UCLA's physical plant has evolved. Following the passage of a bond issue in the mid 1950's, an 8-story replacement facility opened in 1963. In 1994, the 50,000-square-foot Edward J. Foley Primary Care and Diagnostic Center was opened. A new 190,000-square-foot Operating Room and Emergency Department Building opened in 2014. Planning is underway for the campus master plan, which will result in construction of a new hospital tower to meet 2030 seismic requirements, as well as new outpatient ambulatory care facilities.



FACILITY PROFILE

Today, Harbor-UCLA is a tertiary medical center, licensed for 453-beds. The hospital is owned and operated by the County of Los Angeles and is affiliated with the David Geffen School of Medicine at UCLA, as well as the UCLA Schools of Nursing and Dentistry. It is a key part of Los Angeles County's 4,000-square-mile health care safety net for its 10.3 million residents, many thousands of whom are uninsured or underinsured and dependent on the County's Department of Health Services.

The medical center also provides 24-hour emergency services for acute medical, surgical, pediatric, obstetrics/gynecology, and psychiatric problems. The hospital is designated as a Level I Trauma Center, Emergency Department Approved for Pediatrics (EDAP), and a ST-Elevation Myocardial Infarction (STEMI) Receiving Center.

2016 Orientation/Reorientation

Additionally, the medical center provides a wide range of primary and specialty ambulatory care, as well as support services including physical and occupational therapy, nutritional counseling, health education and psychosocial intervention.

HOURS OF OPERATIONS

EMERGENCY AND OUTPATIENT TREATMENT

- Emergency Department: Daily round the clock
- Urgent Care: Weekdays, 8:00 a.m. to 11:00 p.m. and weekends, 8:00 a.m. to 5:00 p.m.
- Outpatient Clinics: Weekdays, 8:00 a.m. to 5:00 p.m.

PHARMACY LOCATIONS/HOURS

Outpatient Pharmacy

- Location: 1st Floor, by the Vermont Avenue public entrance
- Hours of Operation:
Weekdays – 8:00 a.m. to 8:00 p.m.
Weekends and Holidays – 8:00 a.m. to 6:00 p.m.
- Telephone: (310) 222-1977
- New prescriptions only for ambulatory care clinics, emergency rooms, and hospital discharge medication orders.

Outpatient Pharmacy Satellite

- Location: Building N-22
- Hours of Operation: Weekdays – 9:00 a.m. to 5:00 p.m. (Closed weekends & holidays.)
- Telephone: (310) 222-5663
- Refill prescriptions only.

INPATIENT VISITING HOURS

Visiting hours are established to ensure patients get the rest they need and to allow hospital staff to do their work efficiently. Visiting hours may be suspended or changed during procedures or when the patient's condition warrants it.

- General visiting hours are 9:00 a.m. to 9:00 p.m. daily.
- Different hours for individual units may be posted.
- Children must be under the supervision of an adult other than the patient throughout the visit.

For general information, please call (310) 222-2345. For TDD (Telecommunication Device for the Deaf), call (310) 212-5369 for appointments; (310) 533-9958 for the Emergency Department. Relay Services (blind/deaf/hard of hearing): (800) 855-7100 or "7-1-1" for English; (800) 855-7200 for Spanish; and (800) 855-2883 for Telebraille.



DEPARTMENTS AND CLINICS

- Anesthesiology
- Emergency Medicine
- Family Medicine
- Internal Medicine
 - Anti-coagulation
 - Cardiology
 - Chest/Pulmonary
 - Continuity of Care
 - Dermatology
 - Diabetes
 - Endocrine
 - Endoscopy
 - Gastroenterology
 - Genetics
 - Hematology
 - Immunology
 - Infectious Disease
- Infusion
- Nephrology/Hypertension
- Neurology Oncology
- Pituitary
- Renal Transplant
- Rheumatology/Arthritis
- Urgent Care
- Neurology
- Obstetrics/Gynecology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Psychiatry
- Radiology
- Surgery
- Women's Health Center

SERVICES

- Audiology
- Blood Donor Center
- Clinical Social Work
- Food and Nutrition Services
- Health Information Management
- Laboratory Information
- Language Center
- Managed Care Member Services
- Patient Advocate
- Patient Financial Services – Ability to Pay (ATP)
- Patient Financial Services – Billing Information
- Patient Financial Services – Medi-Cal
- Patient Relations Center
- Pharmacy – Outpatient Pharmacy
- Pharmacy – Outpatient Satellite Pharmacy
- Radiation Therapy
- Radiology (X-ray, CT, MRI, Nuclear Medicine)
- Respiratory Therapy
- Rehabilitation Services (Physical/Occupational Therapy)
- Sleep Studies
- Speech Pathology
- TDD (Telecommunication Device for the Deaf)
- Volunteer Services

VISION, MISSION, AND VALUES

VISION

Harbor-UCLA Medical Center..... an integrated, regional health care delivery system which excels in patient-centered care, medical education, and research.

MISSION

To provide high quality, cost-effective, patient-centered care through leadership in medical practice, education, and research. Services are provided through an integrated health care delivery to residents of Los Angeles County regardless of ability to pay.

VALUES

We are a community that cares about people and their health.

Each of us is a leader as well as a team player in our campus community.

Community means caring, belonging, trusting and sharing pride in our achievements.

All members choose to be active learners, listeners and innovators.

Recognition and commitment to excellence are values we cherish.

Energy is focused on patient care, education and research.

LOS ANGELES COUNTY STRATEGIC PLAN

COUNTY MISSION

- To enrich lives through effective and caring service.



COUNTY 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

1. **Operational Effectiveness/Fiscal Sustainability:** Maximize the effectiveness of processes, structure, operations, and strong fiscal management to support timely delivery of customer-oriented and efficient public services.
2. **Community Support and Responsiveness:** Enrich lives of Los Angeles County residents by providing enhanced services, and effectively planning and responding to economic, social, and environmental challenges.
3. **Integrated Services Delivery:** Maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

CUSTOMER SERVICE

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

- Personal Service Delivery
- Service Access
- Service Environment



PERSONAL SERVICE DELIVERY

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

Always:

- Introduce yourself by name and, when appropriate, **SMILE**.
- Treat our customers with courtesy and respect.
- Listen carefully and patiently to them.
- Be responsive to their cultural and linguistic needs.
- Explain procedures clearly.
- 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 patients' families in their service plan development.
- Following-up to ensure appropriate delivery of services.
- Responding to customer concerns immediately and following up within 24 hours.

SERVICE ENVIRONMENT

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

- Report any unsafe conditions to your supervisor or Harbor-UCLA Environmental Safety Officer at (310) 222-2835.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers' health information.

TEAMWORK

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



EFFECTIVE WORKPLACE COMMUNICATION

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

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

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

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

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

- Be clear and accurate in speech and make sure the other party(ies) understands you.
 - 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 communications such as facial expressions, tone of voice, body language and movements, and hand gestures express messages (both negative and positive), intended and unintended.

KEY POINT

Team members need to learn what information other team members need to make decisions about treatment and/or to have positive outcomes in the workplace.

- Remember to follow patient privacy and confidentiality laws and regulations when dealing with patient information in any information format.

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.

KEY POINT

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

Communication and accurate documentation of services between disciplines is 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.

CONFLICT RESOLUTION THROUGH TEAM BUILDING



It is not unusual for conflict to arise in the workplace. Conflict in the workplace can lead to positive outcomes for team members as well as patients. Effective problem resolution can lead to a better understanding of processes, systems, and procedures. It allows team members to better understand how other team members' responsibilities and views fit into the scheme of things. Addressing conflict openly and constructively can generate new ideas, approaches and process improvements; promote increased respect for each team member and improve team cohesion. Workforce members should remember these strategies when dealing with conflicts in the workplace:

- Learn to respect the ideas, suggestions, processes, and contributions of all members of the team, however varied and diverse. For example, physicians, pharmacists, nurses, social workers, and psychologists have been educated to view and process problems in various ways. Each one may have a unique and different perspective on the problem.
- Acknowledge and appreciate other disciplines' processes and contributions to ensure that thorough and complete care planning is patient and family-focused and outcome oriented.
- Minimize competition. Each party should feel a sense of contribution to the care plan and the resolution of patient care issues.
- Ask and respond to questions in a respectful manner, based on the premise that additional exploration of issues is an important method to enhance knowledge and foster collaboration between team members to provide the best possible patient care.
- Evaluate the facts of the situation and make a determination of the problem.
- Promote open dialogue and allow all voices to be heard in the exploration of appropriate methods to resolve problems and issues.
- Keep an open mind and listen to the idea or suggestion being presented. Explore all options before discarding them.
- When discussing problems remember, the problem is not the person, separate the person from the equation so that the problem is the focus.

KEY POINT

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



THE JOINT COMMISSION

This section describes The Joint Commission's accreditation process. This includes a description of The Joint Commission's Shared Vision, New Pathways, the System Tracer Methodology, other survey activities and The Joint Commission Accreditation Participation Requirement (APR) standard 09.02.01.

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

"Shared Visions, New Pathways" is one of various initiatives 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, standards related to TJC identified risk areas, direct impact standards, and standards listed as requirements for improvement from our triennial survey event.
- **Priority Focus Process (PFP)** – 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.
- **System Tracer** – Sessions devoted to evaluating high-priority safety and quality-of-care issues on a system-wide basis: Environment of Care, Emergency Management, Human Resources, Infection Control & Prevention, Information Management, Leadership, Life Safety, Medication Management, Medical Staff, National Patient Safety Goals, Nursing, Provision of Care, Performance Improvement, Record of Care, Patient's Rights and Responsibilities, Transplant Safety, and Waived Testing.
- **Elements of Performance (EP)** – Specific performance expectations in place for each of the standards.
- **Measure of Success (MOS)** – A quantifiable measure, usually related to an audit that can be used to determine whether an action has been effective and is being sustained.
- **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.

SURVEY PROCESS – (TRACER METHODOLOGY)

When The Joint Commission surveyors visit our facility, they will spend 70% – 80% of their time in patient care areas conducting tracers. This means the surveyors will select specific inpatients and review their medical records to determine the services each patient received during their hospitalization. By tracing the course of care and services experienced by the patient (a real time review), the surveyors will interact with direct care providers and/or other applicable workforce members to determine the relationship among departments involved in the care, the integration and coordination of important processes, opportunities for improvement and education (as appropriate) and validation of findings through review of additional records. The surveyors will observe:

- Direct patient care
- Medication administration
- Care planning processes

- Environment of care (including security)
- Medical record documentation

OTHER SURVEY ACTIVITIES

- System Tracers
 - Medication Management
 - Data Management
 - Infection Prevention and Control
 - Medical Staff Functions/CDPH Regulatory Review
 - Medical Staff Leadership Session
 - Dietetic Service and Food Service Visit
 - Pharmaceutical Services and Clinical Unit Inspection
- Life Safety Building Code Tour
- Environment of Care Review and Facility Tour
- Environment of Care Session with Emergency Management Tracer
- Program Tracers – Patient Flow and Laboratory Integration
- Leadership Session
- Human Resources Interview
- Medical Staff Credentialing and Privileging
- Competence Assessment Process

KEY POINT

All triennial surveys are unannounced. It is important to maintain continuous compliance with all Joint Commission's Standards.

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, Patient Safety, and Risk Management 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 report those concerns directly to The Joint Commission as follows:

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

PATIENT SAFETY

PATIENT SAFETY PROGRAM

We are committed to providing safe and quality health care to all patients. The primary objective of the Patient Safety Plan is to create a safe environment for patients, visitors and workforce members by:

- Improving patient safety, patient safety awareness, and reducing the risk of harm to patients.
- Ensuring that leadership and staff demonstrate a consistent effort to evaluate, monitor, improve, and document patient safety activities.
- Establishing systems to assess and improve institutional compliance with The Joint Commission's (TJC) current National Patient Safety Goals (NPSGs).
- Promoting a "Just Culture" which encourages the reporting of errors and near misses. After an incident occurs, there is an emphasis on learning and improving systems, not on finding someone to blame.

Patient Safety Council

The Patient Safety Council is a multi-disciplinary committee established to manage the organization-wide Patient Safety Plan and ensure compliance with The Joint Commission's current National Patient Safety Goals. The Patient Safety Council is chaired by the Patient Safety Officer. The Patient Safety Council also provides leadership and direction for patient safety initiatives and activities.

Patient Safety Brochures

Harbor-UCLA provides inpatients with a DHS Patient Safety "Tips for Patients" pamphlet; surgery patients with an "If You Need Surgery" pamphlet; and outpatients with a "Living Healthy Staying Safe" pamphlet. We encourage each patient to review the pamphlet and apply the safety tips to their care. *Encouraging a patient's active involvement in their own care will provide a better means of communication between patients and staff; and ultimately a safer environment.*

KEY POINT

Know that we have a proactive, multifaceted, and integrated Patient Safety Program. The purpose of the Program is to ensure that Harbor-UCLA complies with current patient safety standards as required by The Joint Commission's National Patient Safety Goals and standards.

Ways to Report Patient Safety Issues/Concerns/Suggestions

- Via the Safety Intelligence (a web-based DHS-wide system).
- Discuss your concerns or issues/suggestions with your supervisor.
- Patient Safety Hotline at (213) 989-SAFE or e-mail at patientsafety@dhs.lacounty.gov.
- Executive Leadership Rounds.
- The Joint Commission at (800) 994-6610 or by e-mail at complaint@jointcommission.org.
- Submit patient safety issues/concerns/suggestions in the suggestion boxes.
- **See Risk Management Section for additional reporting procedures.**

Ways to Stay Updated on Patient Safety Initiatives

- Participate in patient safety discussions in your unit staff meetings.
- Speak up during Patient Safety Rounds in your department.
- Review the Patient Safety Committee webpage on the intranet.
- Attend sponsored educational presentations.

2016 Orientation/Reorientation

- Attend the annual DHS Patient Safety seminar.
- Read the Employee Patient Safety Handbook.
- Read the Patient Safety Newsletter.

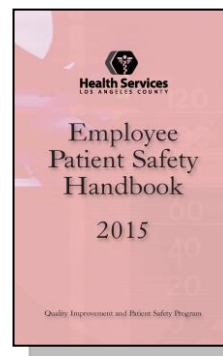
SAFE AND JUST CULTURE

A safe and just culture is one in which safety is a personal and organizational priority, where frontline staff feel comfortable reporting errors, including their own, while maintaining professional accountability and knowing that they will not be subject to retaliation. 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.

KEY POINT

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. The Safety Intelligence web-based reporting system is the best way to report an unsafe event or condition. Additionally, an incident may be reported directly to the Patient Safety Officer, Patient Safety Hotline at (213) 989-SAFE, or e-mailing patientsafety@dhs.lacounty.gov, or *The Joint Commission*.

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 on how we can improve.
- Acknowledging that errors in health care 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.
- Staff is held accountable for reckless, dangerous behaviors even if no patient has been harmed.

NATIONAL PATIENT SAFETY GOALS

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

KEY POINT

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

See 2016 National Patient Safety Goals on Next Page

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.

2016 Hospital National Patient Safety Goals

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

Identify patients correctly

NPSG.01.01.01

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

NPSG.01.03.01

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

Improve staff communication

NPSG.02.03.01

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

Use medicines safely

NPSG.03.04.01

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

NPSG.03.05.01

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

NPSG.03.06.01

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

Use alarms safely

NPSG.06.01.01

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

Prevent infection

NPSG.07.01.01

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

NPSG.07.03.01

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

NPSG.07.04.01

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

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

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

Identify patient safety risks

NPSG.15.01.01

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

Prevent mistakes in surgery

UP.01.01.01

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

UP.01.02.01

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

UP.01.03.01

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



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.

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

2016 Ambulatory Care National Patient Safety Goals

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

Identify patients correctly

- NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- NPSG.01.03.01 Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use medicines safely

- NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.
- NPSG.03.06.01 Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

- NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- NPSG.07.05.01 Use proven guidelines to prevent infection after surgery.

Prevent mistakes in surgery

- UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
- UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done.
- UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.



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

DETERIORATING PATIENT CONDITION

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. Perhaps 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 hospital are covered by Harbor-UCLA's Rapid Response Teams. Registered nurses in the areas covered by Rapid Response Teams 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 code white, 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 to seeking medical attention for a patient/visitor in distress. At Harbor-UCLA Medical Center it is important that you know that anyone can call for emergency medical assistance by dialing Ext. 112 from a hospital phone.

If you are outside the main hospital building, you should call 9-1-1 for any medical emergency, (e.g. buildings other than the main hospital, parking lots or parking structures, adjacent streets or areas near the facility, etc.). Please note that 1 South CRU is considered part of the main hospital, dial Ext. 112. If you encounter a situation that you feel requires emergency assistance, then you should always act on it by calling for help!

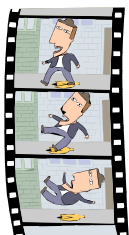
HARBOR-UCLA MEDICAL CENTER:

Cardiac or Respiratory Arrest <ul style="list-style-type: none"> ○ Adult patient: Code Blue ○ Pediatric patient: Code White 	Inside the main hospital, including 1 South CRU: Call Ext. 112
	Outside the main hospital: Call 9-1-1

AMBULATORY CARE NETWORK HEALTH CENTERS:

- ◆ Call 9-1-1 for ALL medical emergencies

FALL PREVENTION AND RESPONSE



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

A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, such as a trash can or other piece of equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

You may encounter visitors, registered or unregistered patients, and staff who may have fallen and who may be in need of assistance.

Prevention is the key factor to reduce injury from falls. It is crucial to know how to respond to a fall situation at your facility or in your work environment.

PREVENTION

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



- **Identifying and Eliminating Hazards:** If you see a hazard and you can fix the hazard (e.g. a water/liquid spill), do so. If you can't fix the hazard, promptly notify the proper department, maintenance worker, clinician, and/or area supervisor; according to your facility protocols. Try to secure the area to avoid a potential fall victim.
- **Environmental risks and hazards** include: Wet or slippery floors, spills, debris, clutter, obstructions, stairs, change in surfaces, rugs/floor mats, extension cords, power cords of equipment in use or not in use, ladders, etc.
- **Physical/Cognitive Risks:** The elderly and the very young make up the highest percentage of fall victims. Some factors that contribute to fall risk for elderly are: medication usage, confusion, unsteady gait, declined hearing and vision. Some factors that contribute to fall risk for children are: running, climbing, jumping, illness or injury.
- **Fall Risk Communication:** Communicating potential hazards anywhere on campus to the correct people in a timely manner can keep staff, visitors, and patients safe from falls and injuries and provide a safer, healthier environment. When a patient is identified as high risk for falls, the nursing staff will place them on "fall risk" alert. Nursing staff might place a sign on the door or wall alerting staff to the patient's fall risk, and have the patient wear a wristband or some other modality based on the facility protocols. We must use precautions to prevent patient falls.

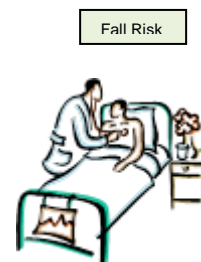
TIPS FOR PREVENTING FALLS

Environmental

- ◆ Identify and eliminate environmental hazards throughout the facility, parking lots, waiting rooms, clinic areas, and patient's rooms.
 - Maintain adequate levels of lighting.
 - Report wet floors, spills, blocked passageways immediately.
 - Remove obstacles and trash on the ground or in passageways/hallways.

Inpatients

- ◆ Check for "Fall Alerts" for inpatients such as "fall risk" wristband, fall precaution sticker on patient's chart, signage, etc.
- ◆ 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.



Process for obtaining medical assistance:

- Notify your supervisor/manager.
- Dial Ext. 112.
- Document the incident via Safety Intelligence and follow other facility reporting procedures.

Report environmental hazards to the Facility Management or the Environmental Safety Officer. Safety concerns/complaints may be made through the workforce member's supervisor, the facility Risk Manager, and/or the DHS Quality, Patient Safety, and Risk Management 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 notify your supervisor immediately) so conditions associated with falls can be corrected and documented. Falls are to be reported in the Safety Intelligence (SI) 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 SI 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 in apparent need of assistance, you should respectfully offer to help. The County's mission is:

“To enrich lives through effective and caring service”

STAFF RIGHTS AND RESPONSIBILITIES

This section discusses your rights and responsibilities as a workforce member. Included in this section are the DHS emergency protocol, your rights with respect to the delivery of patient care; compliance awareness and Code of Conduct; procurement process; your responsibilities for attending training and demonstrating competence; policies on attendance/tardiness, health screening, the Employee Assistance Program, sexual harassment prevention, cultural competence and sensitivity, preventing and reporting of abuse/neglect, Workforce Behavioral Expectations, Safe Haven/Safely Surrender Baby Law, and Americans with Disabilities Act (ADA).

DHS COUNTY 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 County 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 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 earthquake, fire, flood, or other natural or man-made disasters). This is mandatory for all eligible County employees and requires DSWs to receive training on basic emergency management principles, take the oath, and sign an affirmation of allegiance (also referred as the affirmation of loyalty) card and document specialized skills.

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



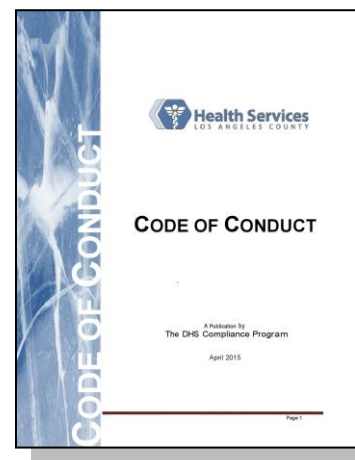
STAFF RIGHTS

Harbor-UCLA seeks to provide high quality patient care in an environment that protects all members of our service delivery team and respects their cultural values, ethics, and religious beliefs. Network leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious beliefs conflict with the rendering of patient care. The policy titled “Staff Rights in 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 administrator for terms and conditions of their contract.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

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

The Chief Compliance Officer located at DHS headquarters is responsible for directing the DHS Compliance Program. Each hospital has a Local Compliance Officer who is responsible for implementing compliance-related activities at each of their respective facilities. The Local Compliance Officer for Harbor-UCLA can be reached at (310) 222-2106.



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 that they will abide by the Code of Conduct and understand that non-compliance with the Code of Conduct can subject them to disciplinary action up to and including discharge from County service or termination of assignment.

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

- Your supervisor or manager
- Local Compliance Officer
- DHS Audit and Compliance Division:
313 North Figueroa Street, Room 801
Los Angeles, CA 90012
Telephone: (213) 240-7901
Fax: (213) 481-8460
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 (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, release, demote, suspend, threaten, harass, or in any manner discriminate against workforce members who exercise their rights under any federal or state whistleblower laws.

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

FALSE CLAIMS ACT

It is the policy of the Department of Health Services (DHS) to ensure compliance with all state and federal laws, rules, and regulations and to establish, maintain, and enforce policies and procedures to detect and prevent fraud, waste and abuse regarding claims to the federal government. DHS is compelled, by Section 6032 of the federal Deficit Reduction Act 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 protections 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 health care programs by giving certain governmental agencies the authority to seek out and investigate violations and prosecute violators.

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

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

The policy also describes the following state law provisions:

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

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

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

Actions that violate the federal FCA include:

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

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

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

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

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

Administrative Remedies for False Claims

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

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

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

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

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

The State of California has also enacted the California False Claims Act (CFCA), which applies to fraud involving state, city, county or other local government funds. It is similar to that of the Federal False Claims Act in which 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, county government, or to an entity that will use State or county funds in whole or in part to pay the claim, a false or fraudulent claim for payment;
2. Making or using, or causing to be made or used, a false record or statement that is material to a false or fraudulent claim. A statement is “material” if it has a natural tendency to influence the payment;
3. Conspiring to violate the CFCA;
4. Making, using, or causing to be made or used, a false document material to an obligation to pay the State or county government;
5. Concealing, or improperly avoiding or decreasing an obligation to pay the State or county government; and
6. Failing to inform the State or county government within a reasonable period after discovery, that it is the beneficiary of an inadvertent submission to the State or county government of a false claim. In essence, this provision makes individuals responsible for telling the State or county government about a payment they received which they should not have received, even when they did not intend to get the incorrect payment.

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

Individuals acting as whistleblowers can sue for violations of the CFCA. However, if the whistleblower is a government employee who discovers the fraud in the course of his/her job, he or she must use, to the fullest

extent possible, internal agency processes for reporting the fraud and seeking recovery through official channels, and the agency must have failed to act on the information within a reasonable time period, before the employee has a right to file the action.

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

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

Such as with the federal FCA, the CFCA bars employers from interfering with an individual's ability to bring or cooperate with the government's action under CFCA. Workforce members 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) to 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 on obtaining essential supplies, equipment and services. Workforce Members are to refer any unauthorized or unsolicited contact from vendors to their facility Supply Chain Division.



Unauthorized Purchases

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

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

TRAINING AND COMPETENCY

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



PROFESSIONAL CREDENTIALS (LICENSE/CERTIFICATION/REGISTRATION/PERMIT)



Any workforce member whose position requires a current valid professional credential to perform the duties of his/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. It is the responsibility of the applicable workforce member 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 the person 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, licensing 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 professional credential to perform your job, it is your responsibility to provide a copy of a renewal professional credential to your supervisor prior to the expiration date.

REMEMBER

It is your responsibility to renew all required professional credentials or other requirements with the appropriate issuing board or agency before the expiration date.

2016 Orientation/Reorientation

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 the professional credential.

Persons recruited for positions requiring a professional credential may be appointed to that classification on a temporary basis. Such 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 professional credential within the applicable time specifications will result in corrective action, which may include discharge from County service or immediate release from assignment.

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

If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report the behavior by notifying your immediate supervisor or the House Supervisor at Ext. 3434 during after-hours.

Medical Staff.....Medical Administration – (310) 222-2901

Nursing StaffNursing Administration – (310) 222-3434

Non-Physician/Nurse Clinical Staff.....Hospital Administration – (310) 222-2106

OR contact:

DHS Human ResourcesPerformance Management – (323) 890-8428

CRIMINAL BACKGROUND CHECKS

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



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

- Office of Inspector General (OIG) exclusions list on the OIG Internet website to ensure the workforce member has not violated any federal regulations pertaining to Medicaid or Medicare or any other health care related regulations.
- General Services Administration/Excluded Parties List System (GSA/EPLS) exclusions list to ensure the workforce member has not violated any administrative or statutory federal regulations, or is listed as a suspected terrorist or person barred from entering the United States.
- Medi-Cal Suspended and Ineligible Provider List (S&I List) to ensure eligibility to participate in Medi-Cal programs.

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

2016 Orientation/Reorientation

In accordance with Civil Service Rule 6.04, the Department may refuse to accept an application for a position if the candidate has been convicted of a crime or who is guilty of conduct incompatible with County employment/assignment, whether or not it amounts to a crime. The conviction may not be disqualifying if it is determined that there were mitigating circumstances or that the conviction is not related to the position and poses no threat to the County or the public. Prospective workforce members with criminal convictions may still be accepted and placed in a position for which they qualify and in which their previous conviction does not pose a risk.

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

If you are arrested or charged with a crime (including traffic violations, if position requires driving on County business) you must report being 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 Harbor-UCLA. All workforce members are expected to comply with DHS and Harbor-UCLA’s 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. DHS photo identification badge must be worn at all times while on duty and in County facilities. Do not obscure your name, title, and photo on your identification badge.

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

NOTE

Refer to Harbor-UCLA Policy No. 202, Personal Appearance.

ATTENDANCE/TARDINESS



You are expected to report to work each day, and arrive on time in accordance with your work schedule. You are required to notify your supervisor if you’re going to be late or absent as established by DHS, facility and/or departmental policy. You must follow your work schedule, including observing your lunch and break times. Your supervisor will explain the attendance requirements for your work area. Lunch and break times cannot be combined.

HEALTH SCREENING

All workforce members within Harbor-UCLA's service delivery team as well as all students, volunteers, and non-DHS/non-County workforce members must have an initial and annual health screening, including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease status, and/or any other medical tests, as required. It is your responsibility to obtain a health screening annually as a condition of continued employment/assignment. Documentation of your annual health clearance certificate must be kept up-to-date in your area file. You may contact Employee Health at (310) 222-2360 to find out when your health screening is due.



IMPORTANT!

You must complete your health screening annually.

You will not be allowed to work inside a County medical facility without appropriate documentation of health clearance or required health evaluation. It is a violation of Joint Commission, Title 22, and CMS standards for a workforce member to work without appropriate health clearance and will subject the facility to possible fine and/or loss of accreditation.

Workforce members evidencing symptoms of infectious disease or reasonably suspected of evidencing symptoms of infectious disease shall be medically screened prior to providing patient care or performing work duties. Workforce members determined to have infectious potential shall be denied or removed from patient contact and work duties as deemed necessary to protect the safety of patients and workforce members.

SMOKING POLICY



Harbor-UCLA is a smoke-free campus in accordance with hospital policy No. 458, Smoke/Tobacco Free Environment. Smoking/tobacco use is not permitted by any workforce member including a volunteer, patient, visitor, vendor, contractor, or anyone else within the boundaries of the facility. This includes anywhere on the campus grounds, including parking lots and cars parked in the parking lots, etc.

It is the responsibility of all workforce members to support the Medical Center's smoke/tobacco free environment policy by encouraging their colleagues, patients, visitors and others to comply with this policy. Supervisors, managers or designees are responsible for implementing and enforcing the smoke/tobacco free policy.

COUNTY POLICY OF EQUITY

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

DISCRIMINATION

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

SEXUAL HARASSMENT

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

Facts about Sexual Harassment

1. Sexual harassment has consequences. Anyone who chooses to harass another in the workplace is subject to appropriate corrective action, which can range from a warning to termination.
2. Sexual harassment can occur anywhere in our facility and at any activity sponsored by Harbor-UCLA, 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, gender/gender identity, 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, gender/gender identity, marital status, medical condition or any other characteristic protected by state or federal employment law when such conduct reasonably would be considered inappropriate for the workplace.

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

RETALIATION

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

Examples of Prohibited Activities (not a complete list):

- ◆ Sexual propositions, stating or implying that sexual favors may be required as a condition of employment/assignment or continued employment/assignment, preferential treatment or promises of preferential treatment to a workforce member for submitting to sexual conduct; repeated unwanted sexual flirtations, advances, or invitations; unwanted physical conduct, such as touching, pinching, grabbing, kissing, patting, or brushing against another's body;
- ◆ Sexually oriented or suggestive jokes, comments, teasing, or sounds such as whistling or cat calls; unwelcome comments about a person's body or questions about or discussions of another person's or one's own sexual experiences/preferences or desires; sexually derogatory or stereotypical comments; verbal abuse of a sexual nature or based on sex/gender; sex/gender-based hostility; sexual orientation/preference;
- ◆ Offensive leering, unwelcome flirtatious eye contact, staring at parts of a person's body, sexually oriented gestures;
- ◆ Verbal conduct such as comments or gestures about a person's physical appearance which have a racial, sexual, disability-related, religious, age or ethnic connotation or derogatory comments about religious differences and practices;
- ◆ Posting, sending, forwarding, soliciting or displaying in the workplace any materials, documents, or images that are, including but not limited to, sexually suggestive, racist, "hate-site" related, letters, notes, invitations, cartoons, posters, facsimiles, electronic mail or web links;
- ◆ Inappropriate e-mail usage and transmissions containing sexually explicit messages, cartoons, jokes, and unwelcome propositions; as well as accessing or viewing pornographic websites, computer/video games depicting sexual situations or behaviors;
- ◆ Adverse employment actions like discharge and/or demotion.

Preventing and Reporting Harassment or Inappropriate Behavior

It is the responsibility of all workforce members to ensure sexual harassment does not occur in the workplace. Any workforce member who believes that he or she has been the object of, has witnessed, or has been affected by sexual harassment shall report the action or incident to his/her manager/supervisor, hospital or Comprehensive Health Care Center Chief Executive Officer, facility Human Resources office, or 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.

CULTURAL AND LINGUISTIC COMPETENCE

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

WHAT IS CULTURAL AND LINGUISTIC COMPETENCE?

Cultural and Linguistic Competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

(Source: <http://www.innovations.ahrq.gov/CulturalCompetence.aspx>)



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

(Source: <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>)

WHY IS CULTURAL COMPETENCY IMPORTANT?

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

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

(Source: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

CULTURAL COMPETENCE

Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social

groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. (Source: <http://www.nih.gov/clearcommunication/culturalcompetency.htm>)

Culture and language may influence:

- Accurate communication with providers and the health care system;
- Health, healing, and wellness belief systems;
- How illness, disease, and their causes are perceived; both by the patient/consumer;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; and as well as
- The delivery of services by the provider who looks at the world through his /her own limited set of values, which can compromise access for patients from other cultures.

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

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

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

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



Cultural and linguistic competence in health care – 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.

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

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' SERVICE DELIVERY

Cultural and Linguistic Competency plays a key role in DHS' system transformation to a managed care model.

Cultural and Linguistic Competency results in improved outcomes in delivery of health care 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.
- ✓ Patient safety compliance.
- ✓ Improved patient adherence with the medical regimen.
- ✓ Improved patient experience and customer satisfaction.
- ✓ Last, and equally important as each of the elements mentioned above, by ensuring cultural and linguistic competency, DHS puts itself in a much better position in our efforts to become the **"Provider of Choice"** to patients and their families.

DHS-wide Language Data Report

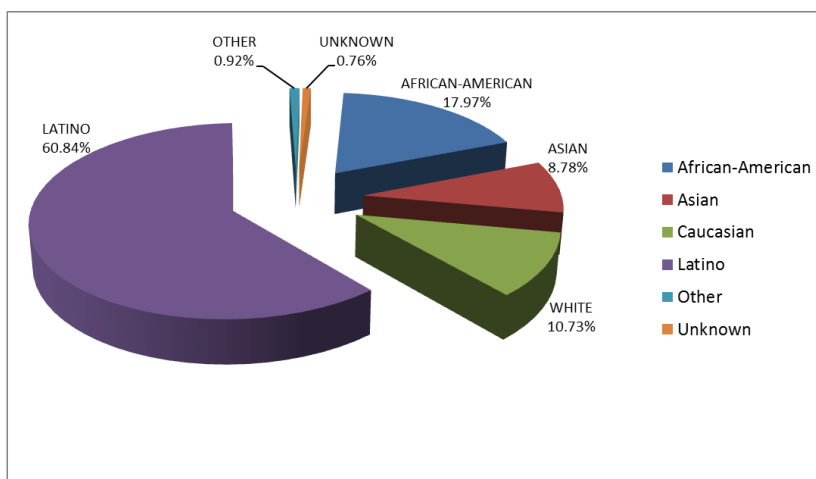
All DHS hospitals, multi-service ambulatory care centers, and comprehensive health center facilities capture the **"preferred language"** of the limited English-proficient (LEP) patients. According to DHS' "Language Report" database for FY '11 – '12, DHS facilities provided health care services to a total of 1,335,133 patient visits with LEP skills, representing 53% of our total patient visits (2,517,319). During the same time period, a total of 678,309 unique patients sought health care services throughout DHS facilities, 349,933 (51.6%) of whom spoke English and 328,376 (48.4%) spoke other than English. Furthermore, our patient utilization data indicated that over 86 languages were spoken by our LEP patients, including the top 12 languages that are heavily utilized, and therefore, are in much greater need for interpreter (voice/verbal) and translation (written) services. The top 12 languages are Spanish, Korean, Armenian, Tagalog, Mandarin, Cantonese, Vietnamese, Russian, Farsi, Thai, Arabic, and Khmer (Cambodian).

HARBOR-UCLA PATIENT POPULATION

Culturally competent patient care is not just a right; it's also a key factor in the safety and quality of patient care. Our 2014 patient ethnicity is as follows:

2014 Patient Population

ETHNICITY	TOTAL	PERCENTAGE
African-American	86748	17.97%
Asian	42408	8.78%
Caucasian	51785	10.73%
Latino	293720	60.84%
Other	4458	0.92%
Unknown	3663	0.76%
TOTAL	482782	100%



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 Harbor-UCLA 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.

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.

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

Any workforce member, including medical or professional staff, who engage in inappropriate conduct, or exhibit disruptive or unprofessional behavior, or who fail to exercise sound judgment in dealing with other workforce members, patients, or the public may be subject to appropriate corrective action, up to and including discharge or dismissal from assignment.

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

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

- Verbal and/or written threats, including bomb threats, to a County facility or toward any workforce member and/or member of that person’s family.
- Psychological violence such as: bullying, verbal and/or written threats, threats against any property of the workforce member.
- 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 of local law enforcement.

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

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

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

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

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

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

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

IMMEDIATE DANGER OR IMMINENT THREAT OF VIOLENCE

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

- Immediately notify on-site security personnel/L.A. County Sheriff's Department.
- 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 in which the incident occurred.

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

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

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

Sexual conduct that occurs concurrent with the patient-physician/health care provider relationship constitutes sexual misconduct. If a physician/health care 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 health care provider's ethical duties include terminating the physician or health care 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 health care 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 health care worker, another patient, contract staff, unknown perpetrator or spouse/significant other, while being treated or occurring on the premises of a DHS facility may constitute a criminal act punishable by law.

Each patient, his/her family member, or legal representative has the right to file a complaint or grievance, without fear of retaliation, with the patient advocate, patient relations, or other designated section of the hospital and to have timely review and notification. Each DHS facility shall provide the patient, his/her family member, and/or legal representative with information on how to file a patient complaint/grievance.

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/her supervisor and to the facility Los Angeles County Sheriff's Department. The supervisor is responsible for notifying the facility administrator or designee before the end of the shift during which the supervisor was notified of the incident. The reporting party shall report the suspected abuse using a Security Incident Report (SIR) and in the Safety Intelligence in accordance with Departmental policy.

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

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

A workforce member determined to have violated this policy shall be subject to appropriate corrective action which may lead up to termination. The workforce member may also be subject to criminal and/or civil prosecution and reporting to the appropriate 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 mandates that health care practitioners report incidents of suspected or identified child abuse/neglect, and elder or dependent adult abuse/neglect. Any mandated reporter (any workforce member) 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 includes emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years, including a newborn child where either mother or child has a positive toxicology screen as a result of mother's substance use/abuse. Workforce members are mandated to report incidents of suspected abuse to Department of Children and Family Services Child Abuse Hotline at (800) 540-4000 immediately or as practicably 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>. Abuse that is sexual in nature also must be reported to law enforcement by calling the Los Angeles County Sheriff's Department at (310) 222-3311 or other local law enforcement agency within the jurisdiction of the incident.
- Elder Abuse includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Health care providers are mandated to report incidents of suspected elder abuse immediately or as practicably possible by calling the Elder Abuse Hotline at (877) 477-3646. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at <https://apslive.lacss.harmonyis.net/LACSSLiveIntake/>.
- Dependent Adult Abuse includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals between the ages of 18-64. This includes individuals who are mentally or physically challenged. Workforce members are mandated to report incidents of dependent adult abuse by calling the Adult Abuse Hotline at (877) 477-3646 a written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website <https://apslive.lacss.harmonyis.net/LACSSLiveIntake/>.
- Domestic/Intimate Partner Abuse involves any individual who has been abused by their domestic/intimate partner. Domestic/intimate partners are those individuals who are currently dating, married, cohabitating, or separated. The abuse includes physical violence, sexual assault, severe emotional distress and economic coercion. Domestic/intimate partner abuse must be reported if the patient is presenting to the facility for treatment of a current injury sustained through domestic/intimate partner abuse. Workforce members are mandated to report the violence as soon as practicably possible to local law enforcement or the Sheriff's Department at (310) 222-3311.

NOTE

Contact the Clinical Social Work Department at (310) 222-3278 for assistance with evaluations, reporting forms and referrals.

REPORTING SUSPICIOUS INJURIES

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

- Inflicted by the injured person's own act or by another where the injury was by means of a firearm; or
- Is suspected to be the result of assault 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/her professional capacity or within the scope of his/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 investigation or sexual assault may be asked to release the report to local law enforcement and other agencies, the reports must be prepared on specific forms as required by statute. Health practitioners must follow DHS HIPAA procedures documenting the release of such information.

SAFE HAVEN/SAFELY SURRENDERED BABY LAW

In compliance with Senate Bill 1368 (Brulte) Chapter 824, Statutes of 2000, per Harbor-UCLA's Newborn Abandonment Policy No. 376, it is the hospital's policy to take physical custody of an infant 72 hours old or younger when surrendered to the Emergency Department by the parent or other person having lawful custody. The Emergency Department assesses the baby and provides necessary medical care (consent of parent/surrendering party is not required to provide care). EMTALA regulations apply to the care of the infant.

Actions taken when a baby is surrendered:

- A band with a unique, coded, confidential identification number is placed on the baby's ankle and a duplicate band is given to the surrendering party for reclaiming the baby within 14 days if they should change their mind.
- A good faith effort is made to get information about the baby and the birth, along with a completed Newborn Family Medical Questionnaire from the surrendering party.
- The Pediatric Emergency Department Attending Physician shall arrange admission of the newborn based on the appropriate level of medical care required.
- The Department of Children and Family Services is notified by the Clinical Social Work Department or by the Emergency Department during after-hours and weekends by calling (800) 540-4000.



The Department of Children and Family Services assumes custody of the baby upon notification. If the surrendering party returns to reclaim the baby, contact the Clinical Social Work Department at (310) 222-3278, or during after-hours contact the Shift Nurse Manager at (310) 222-3434.

The Emergency Department staff documents the abandonment on the infant's medical record, along with the baby's identification number on the band. All information pertinent to the abandonment and all related telephone calls are documented in the medical record. An Event Notification Report is completed. In addition, information regarding the parent or individual surrendering the infant should not be shared under any circumstances.

Newborn babies may also be safely surrendered at hospitals with emergency rooms and fire stations designated by the County Board of Supervisors. For a list of Los Angeles County's Safely Surrender Baby (SSB) Sites visit www.babysafela.org or call 1-877-BABY SAFE.

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

If you have a disability that is covered under the ADA and you are a qualified individual, you are entitled to reasonable accommodation. Please contact DHS Risk Management at (323) 869-7122 for assistance.

PATIENTS' RIGHTS AND SERVICES



This section explains Harbor-UCLA's patients' rights and services such as patient advocacy, interpreter services, the Chaplaincy Program, advance directives, Americans with Disabilities Act (ADA), Service Animals, organ/tissue donation, and Emergency Medical Treatment and Active Labor Act (EMTALA).

To ensure that you are protecting our patients' rights, Harbor-UCLA has a Bioethics Committee. This committee is multidisciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises staff concerning such issues related to patient care decisions and offers consultation to Harbor-UCLA departments.

If you, your patient or the patient's family are facing a difficult choice or are struggling with decisions that involve ethical, moral or spiritual concerns, help is available. Contact the Clinical Social Work Department at (310) 222-3278, or during after-hours, contact the Shift Nurse Manager at (310) 222-3434.

Patients of Harbor-UCLA have both rights and responsibilities. Upon admission, each inpatient receives a *Harbor-UCLA Medical Center Admission Pamphlet* that provides information about patients' rights and responsibilities. Additionally, Harbor-UCLA has posted these rights and responsibilities for easy reference.

If a patient comes to you with a complaint about any part of his/her medical care or treatment, refer the patient to the accountable supervisory staff to resolve the complaint at the first level whenever possible. Complaints that cannot be resolved at the first level will be referred to the Administrative Patient Advocate at (310) 222-2151. Patients may contact Patient Relations Department directly with a complaint at (310) 222-5350.

PATIENTS' RIGHTS

Source: The Federal Register, Patients' Rights; The California Code of Regulations, Section 70707; and the Joint Commission describe the following rights: Patients may exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, disability, age, or the source of payment for their care. These rights will also apply to any legally authorized patient representative.

1. Patients have the right to impartial access to available medically indicated treatment, regardless of sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender, gender identity, or marital status, disability, age or the source of payment for care.
2. Patients have the right to know the name of the physician who has the primary responsibility for coordinating their care, as well as the name, professional relationships, and responsibilities of other health care providers who will see them.
3. Patients have the right to receive information in a manner tailored to the patient's age, language, and ability to understand. This right for effective communication includes providing interpreting and translation services, as necessary, at no cost to the patient and is inclusive of meeting the needs of those patients who have vision, speech, hearing, or cognitive impairments.
4. Patients have the right to receive information from their physician concerning their illness, their course of treatment, and prospects for recovery in terms they are able to understand and in a culturally sensitive manner. If it is medically inadvisable to give such information to the patient, the information should be made available to a legally authorized individual.
5. Patients have the right to be informed of consent to and participate in decisions involving their health care. Whenever possible, the participation is based on a clear explanation of the patient's condition and of a proposed treatment or procedure the patient may need in order to give informed consent or refusal to a course of treatment. The patient has the right to participate in the development and implementation of their

plan of care. The information shall include the possibility of any risk of mortality or serious side effects, alternate courses of treatment or non-treatment and the risks involved in each, problems related to recuperation, probability of success, and the name of the person who will carry out the procedure. Patients shall be given information concerning the risks of their failure to comply with the advice of their physician, and their right to refuse such treatment and/or hospitalization to the extent permitted by law. Patients shall be informed that the refusal of treatment by patients or their legally authorized representatives might prevent the provision of appropriate care in accordance with professional standards and can result in the termination of the physician/patient relationship.

6. Patients have the right to formulate advance directives and appoint a person to make health care decisions on their behalf, to the extent permitted by law. The person selected to make the decisions for the patient may be the patient's guardian, next of kin, or legally authorized responsible person. The legally authorized representative shall have the same rights as the patient if a physician finds the patient to be incompetent and medically incapable of understanding or providing an informed consent to proposed treatments or procedures. Health care providers who provide care in the hospital shall comply with these directives.
7. Patients have the right to request or refuse treatment, to the extent permitted by the law. This right must not be interpreted as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. Patients have the right to leave the hospital against the advice of health care providers, to the extent permitted by the law.
8. Patients have the right to participate in ethical issues that arise in the course of their care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
9. Patients have the right to be informed of any continuing health care requirements following their discharge from the hospital. This includes the right to reasonable continuity of care and to know in advance the time and location of medical appointments.
10. Patients have the right to privacy concerning their medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Patients have the right to know the reason for the presence of any individual and may also choose to exercise the following:
 - a. to refuse to talk with or see anyone not officially connected with the facility, or with those persons officially connected with the hospital but not directly involved with their care;
 - b. to be interviewed and examined in surroundings designed to assure privacy. This includes the right to have someone of the same sex present when a gender specific medical examination and/or procedure is performed by a health professional of the opposite sex and the right to be disrobed only for the period necessary to accomplish the medical purpose for which patients are asked to disrobe;
 - c. to expect all communications and other records pertaining to the patient's care, including the source of payment for treatment, to be treated as confidential;
 - d. to request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing, and/or
 - e. to have visitors leave prior to an examination and when treatment issues are being discussed. [Privacy curtains will be used to maximize privacy.]
11. Patients have the right to designate visitors of their choosing, if they have decision-making capability, whether or not the visitor is related by blood or marriage, unless:
 - a. no visitors are allowed,
 - b. the hospital reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a health care provider, or other visitor to the hospital, or would significantly disrupt the operations of the hospital, or
 - c. the patient has told the health care provider s/he no longer wants a particular person to visit.

Health care providers will determine who may visit a patient that lacks a decision-making capability, which shall include, at a minimum, persons living in the patient's household. Visitors may only be denied for good cause and supported by documentation in the medical record. The hospital may not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

A hospital may establish reasonable restrictions on visitation, including restrictions upon the hours of visitation and number of visitors.

12. Patients have the right to receive care in a reasonably safe setting where they are free from neglect, exploitation, harassment, and abuse (verbal, mental, physical, or sexual). They have the right to access protective services, including notifying government agencies of neglect or abuse.
13. Patients have the right of access to persons outside of the hospital by means of visitors and/or by verbal and written communication (i.e. telephone and mail) with others.
14. Patients have the right of access to the contents in their medical record within a reasonable time frame, to the extent permitted by law. Patients have the right to receive a copy of their records in accordance with the hospital's policy and procedure on access to health information. They also have the right to expect confidential treatment of all communications and records pertaining to their medical care and health care providers in the hospital and must give written permission if records are to be made available to anyone not directly concerned with their care. Basic information may be released to the public, unless specifically prohibited in writing by the patient.
15. Patients have the right to be informed of a pending transfer to another facility or organization, the need for such a transfer, the alternatives to the transfer and assurance the transfer is acceptable to the receiving facility or organization.
16. Patients have the right to be informed if the hospital or physician proposes to engage in or perform human experimentation affecting their care or treatment, and the right to refuse to participate in such research projects.
17. Patients have the right to be free from restraints and seclusions of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
18. Patients have the right to prompt notification of a family member (or other representative of their choosing) and their own physician of their admission to the hospital.
19. Patients have the right to considerate and respectful care that supports his/her dignity and to be made comfortable. Patients have the right for their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences to be respected. The hospital accommodates the patient's need for religious and other spiritual services in support of this right.
20. Patients have the right to appropriate pain management that includes care by concerned staff members committed to pain relief and prevention, information about pain and pain relief measures, timely response to their reports of pain, and informed participation in decisions regarding their care.
21. Patients have the right to be informed about the outcomes of care, including unanticipated outcomes.
22. Patients have the right to reasonable responses to any reasonable request for services.
23. Patients have the right to examine and receive explanation of their bills, regardless of the source of payment.
24. Patients have the right to file a grievance concerning these rights or any other policy or procedure of the hospital to the attention of the hospital's Patient Advocate or the Office of Quality Improvement and Patient Safety for the Los Angeles County Department of Health Services and to be informed of the action taken.

Grievances are handled through the administrative Patient Advocate Office, located on the 8th Floor East, Room 5. The Patient Advocate can be reached at (310) 222-2151. Patients unable to call or go to the 8th floor have the right to request hospital staff to assist them in contacting the Patient Advocate Office.
25. Patients have the right to file a complaint with the State Department of Public Health and to be informed of the action taken regardless of whether the patient uses the hospital grievance process. Patients may contact the California Department of Public Health, Licensing and Certification Office, in the Orange County District. This office is located at 681 South Parker Street, Suite 200, Orange, California, 92868. Telephone numbers are (714) 567-2906 or (800) 228-5234. For Relay Services (blind/deaf/hard of hearing), call (800) 855-7100 or "7-1-1" (English) or (800) 855-7200 (Spanish) or (800) 855-2883 (Telebraille).

PATIENTS' RESPONSIBILITIES

1. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible health care provider.
2. Patients are responsible for making known whether they understand contemplated courses of action and what is expected of them. This includes the responsibility of requesting interpreting services to ensure that they understand the language in which the information is being provided.
3. Patients are responsible for their actions if treatment is refused or instructions of the physician are not followed.
4. Patients are responsible for the treatment plan recommended by the health care provider primarily responsible for their care. This includes following instructions of allied health staff as they carry out the plan of care and implement the physician's orders, and as they enforce applicable hospital rules and regulations.
5. Patients are responsible for keeping appointments and, when unable to do so for any reason, for notifying the appropriate service.
6. Patients are responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking, and the number of visitors.
7. Patients are responsible for being respectful of the property of other persons and of the hospital.
8. Patients are responsible for following hospital rules and regulations affecting patient care and conduct.
9. Patients are responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.
10. Patients have the responsibility to request treatment when they experience pain, to cooperate with health care providers in measuring their pain, developing a pain relief plan, and communicating the effectiveness or ineffectiveness of pain management interventions.
11. Patients have the responsibility to know which hospital rules and policies apply to their conduct regarding smoking, safety, and visiting hours, while a patient.

PATIENT ADVOCATES

Patient Advocates are available at Harbor-UCLA and can provide assistance to ensure that patient rights are protected. If a patient, family member or visitor comes to you with a complaint about any part of his/her hospital visit or clinic appointment, make every attempt to resolve the issue or refer them to your supervisor. If the problem cannot be resolved in your department or is not related to your department, the Patient Advocate is available to assist to resolve the problem.

The Patient Advocate will assist in a wide range of issues from billing conflicts and difficulty making appointments, to general complaints and allegations of patient rights violations. Every attempt will be made to immediately resolve the verbal and/or written complaints made by patients, and their family and friends. Patient complaints are assessed and used to identify, resolve and prevent risk exposure and problems that have a negative impact on patient satisfaction and delivery of services.

At Harbor-UCLA, the Patient Advocate is located at Room 8, East-5 or can be contacted by phone at (310) 222-2151. Patients may contact the Patient Relations Department directly with LA Care and Healthy Way LA complaints at (310) 222-5350.

INTERPRETER SERVICES

It is our responsibility to provide interpreter services, free of charge, for our Limited English Proficient (LEP) and non-English speaking patients. The patient's family, friends or other non-Network personnel may not be used as interpreters unless expressly requested by the patient or in an emergency. It is prohibited to use minors as interpreters in any situation and overhead interpreter paging is not allowed.

TO REQUEST AN INTERPRETER:



Use local area certified bilingual staff for interpreters or refer to the Interpreter Staff or Bilingual Bonus list for assistance. If an appropriate bilingual staff person cannot be located in your area, use the Video Medical Interpreter (VMI) equipment to call (310) 222-5405. This telephone number will automatically link you to Health Care Information Network and contract language interpreters. Refer to the laminated cards on the VMI and other interpreter equipment for details regarding VMI and telephone interpreter services.

City of Los Angeles - Department of Health Services	
Interpretation Services Available	
English: Patient to your language	An interpreter will be called:
American Sign Language 美國手語	Handicapped 殘障人士
Arabic 阿拉伯語	Hebrew 希伯來語
Armenian 亞美尼亞語	Hmong 哈蒙語
Chinese 中文	Japanese 日語
Creole 克里奧爾語	Korean 韓語
Dominican 多明尼加語	Laotian 寮語
French 法語	Portuguese 葡萄牙語
German 德語	Russian 俄語
Haitian 海地語	Spanish 西班牙語
Hindi 印地安語	Tamil 泰米爾語
Italian 義大利語	Tagalog 他加路語
Japanese 日語	Thai 泰語
Korean 韓語	Vietnamese 越南語
Laotian 寮語	

For further language assistance at Harbor-UCLA Medical Center: call the Language Center at (310) 222-6557.

- TTY (teletypewriter) Devices or the California Relay Service is available for the deaf, hard of hearing or speech disabled patients. Numbers can be obtained from the Patient Relations Office at (310) 222-5350 or Hospital Administration.
- Speech to Speech (STS) for patients with speech disabilities can be reached at (800) 854-7784.
- Remember the HIPAA Privacy rules and be careful not to break patient confidentiality.

REMEMBER

Speak directly to the patient, not to the interpreter.

SPIRITUAL NEEDS OF PATIENTS

The Pastoral Care Service provides for the spiritual health and wellbeing of the patients, their families, friends and staff through active listening, prayer, sacred texts (e.g. Bible, Koran) and administration of sacred rituals such as Sacraments. We seek to promote wellness by giving comfort to those desiring the services of our interfaith along with our staff Christian chaplains. Our chaplains are available to minister to all patients, their family members, friends and hospital staff, regardless of their religious preference.

Emergency chaplains are available 24 hours a day through referrals by nurses at any unit. Referrals to the Pastoral Care Service may be made by having a nurse contact (310) 222-2166 Monday – Friday, by requesting a Consult to Pastoral Care in the EHR, or by calling the Nursing Supervisor after hours and on the weekends at (310) 222-3434. .

Chaplaincy services offered include: Pastoral care visits, spiritual and grief support, Holy Communion/Anointing of the Sick/Confession, spiritual literature, Sunday worship services, Bible study (staff), prayer and spiritual support groups. The Chapel is located on the medical center's first floor across from the Gift Shop.

ADVANCE HEALTH CARE DIRECTIVES

The Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give directives regarding health care 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 health care, when they are unable to do so. Harbor-UCLA Admissions Staff are 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. The Advanced Health Care Directive form is available on Harbor-UCLA intranet.

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 Clinical Social Work Department at (310) 222-3278, request a Consult to Clinical Social Work for Advance Directive or contact the patient's physician. Remember patients can change their mind at any time regarding AHCDs.

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

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

A patient has the right to not participate in any program or service designed specifically for persons with disabilities. 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, if it is not obvious, but cannot require special ID cards for the animal or ask about the person's disability.
- The service animal must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.
- People with disabilities who use service animals cannot be charged extra fees, isolated from other patrons or treated less favorably than other patrons. However, if a business normally charges guests for damage that they cause, a customer with a disability may be charged for damage caused by his/her service animal.
- A person with a disability cannot be asked to remove his/her service animal from the premises unless:
 1. The animal is out of control and the animal's owner does not take effective action to control it; or
 2. The animal poses a direct threat to the health and safety of others.

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

- Businesses that sell or prepare food must allow service animals in public areas, even if state and local health codes prohibit animals on premises.
- Businesses are not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

If you have additional questions concerning ADA and service animals, please call DHS Risk Management at (323) 869-7122. Additional information can be obtained by calling the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

ORGAN/TISSUE DONATION

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

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

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

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA) prohibits discrimination in the provision of emergency services to persons presenting with similar types of conditions regardless of financial or insurance status. EMTALA is also referred to as the anti-dumping law. The current definition of EMTALA includes patients anywhere on the campus. This includes the outpatient clinics, emergency department, labor and delivery, psychiatric emergency department and any port of entry to the hospital or grounds.

Although there are many components of the EMTALA law, some basic requirements include: providing a medical screening examination to all patients seeking examination or treatment for a medical condition, providing stabilizing treatment within the capabilities of the hospital to those patients with emergency medical conditions and maintaining logs of all patients that present for care, and transfers in and out of the facility. Compliance with all portions of EMTALA is mandatory for any hospital receiving Medicare reimbursement. Failure to comply with the EMTALA regulations may subject the medical facility to monetary penalties and risks termination of its Medicare provider status.

A central log must be kept in each area that receives walk-in or emergency patients. If a patient presents for medical care, the log must include the patient's name and whether the person was transferred and where the patient was transferred. A medical screening examination must be provided to all patients who request examination or treatment within the capability of the hospital's emergency department, to determine if a medical condition exists regardless of ability to pay. This applies to patients who present at clinics requesting services. The medical screening examination cannot be delayed to determine the patient's ability to pay or insurance coverage.

EMTALA also applies to emergency patients transferred into or out of Harbor-UCLA Medical Center. Caring for patients transferred into the facility requires knowledge of previous treatment. Adequate documentation and information must be received from the hospital sending the patient. EMTALA requires notification of the receiving hospital and copies of the patient's chart, X-rays, EKGs, laboratory work and any other necessary information to be sent with the patient. Requests from other hospitals to transfer a patient should always be accepted when the patient is requiring higher level of care.

Patients transferred out of Harbor-UCLA must be sent with all documents listed above that would aid the receiving facility. The patient must be informed of the risks and benefits of transfer. The benefits of transfer should outweigh the possible risks. Consent to transfer must be evident. The patient must be stabilized prior to transfer. All transferred patients must be transferred with appropriate equipment and personnel for the medical condition for which the transfer is initiated by the appropriate mode. Transfer patients must have evidence of EMTALA requirements documented by both the sending and receiving hospitals.

Failure of a hospital to comply constitutes a violation. The hospital noting the failure is mandated to report the violation within 72 hours. Failure to report a violation can result in a fine. Violations of EMTALA regulations are investigated by the Center for Medicare & Medicaid Services (CMS). Hospitals and physicians that are found to be in violation of EMTALA can be fined up to \$50,000 per violation and the hospital's Medicare participation agreement can be terminated. EMTALA violations can be detrimental to a facility. In order to avoid citations, staff members must be informed and comply with EMTALA regulations.

CLINICAL SOCIAL WORK

SCOPE OF SERVICES

The Department of Clinical Social Work provides recognition of and attention to the psychosocial needs of patients and their families consistent with Federal, State and County regulations and The Joint Commission standards. Psychosocial needs are defined as the biological/medical, psychological, social, economic, cultural and spiritual factors that influence the patient/family wellbeing. Services are available to all inpatients, outpatients and staff. Priority is given to high-risk patients as defined by those patients who, because of their severe medical diagnosis and/or treatment combined with their psychosocial situation, are at risk for a maladaptive response.

The Department of Clinical Social Work provides services in five major domains and administrates the division of Pastoral Care:

1. Patient/Family Counseling

- a. Assess and address safety issues: suicidal/homicidal ideation or child, elder and partner abuse, sexual assault.
- b. Provide bereavement support for sudden loss.
- c. Conduct psychosocial evaluation to assess psychological, social, and economic factors and determine their bearing on the patient's illness, medical care, and maintenance of health or rehabilitation. Determine if the patient and/or family are in crisis and appropriately prioritize interventions.
- d. Determine the need for further assessment/intervention in relation to patient's diagnosis, treatment, home environment, the patient's motivation for treatment (including capacity for change), and patient's responses to any previous treatment. Interventions may include the practice of individual, group, marital, family and educational counseling. Modalities of service range from crisis intervention and brief problem-focused therapy to brief or on-going case management.
- e. Provide consultation and staff development services to hospital personnel.
- f. Act as a consultant to community groups, organizations and institutions.

2. Discharge Planning and Coordination

- a. Develop, coordinate and implement discharge plans to lower-level of care facilities.
- b. Provide linkage to community resources to address unmet needs.
- c. Confer with representatives of appropriate community agencies.

3. Communication regarding Patient Needs

- a. Advocate for the patient within the health care system or the community.
- b. Assist the patient and family with ethical issues: Advance Directive, right to self-determination, informed consent.
- c. Establish lines of communication and a working relationship between the hospital, the community health care system (including psychiatric), community groups, organizations and institutions.

4. Education and Research

- a. Provide field instruction to social work graduate students from UCLA, USC, CSULB, CSUDH and CSULA.

5. Pastoral Care

- a. Recognize and provide spiritual and emotional support for the sick and recovering and/or the dying patient.
- b. Maintain a pool of spiritual leaders in the community who will respond when called to meet the needs of patients with diverse religious backgrounds.
- c. Coordinate worship services available to patients, families and staff.
- d. Supervise and conduct ongoing training for all pastoral care volunteers.

PERFORMANCE IMPROVEMENT

This section includes a description of organizational performance improvement, Harbor’s Model for Improvement, and publicly reported data initiatives.

IMPROVING ORGANIZATIONAL PERFORMANCE (IOP)

According to the National Academy of Science’s Institute of Medicine, between 44,000 and 98,000 Americans die in hospitals each year due to mistakes in their care. In their reports, the Institute highlighted specific aims for health care and defined the six dimensions of care noting that health care should be:



Safe * Effective * Patient Centered * Timely * Efficient * Equitable

Our patients and their families are the highest priority at Harbor-UCLA Medical Center. Providing them with safe, high-quality health care and excellent service is their right and our responsibility. Excellent quality and service doesn’t just happen, but it is a result of purposeful commitment, shared vision, accountability, and a sound systematic approach with effective oversight, and support. We are committed to improving how we deliver health care in a way that promotes “high reliability”, meaning we strive to perform consistently at high levels of safety over long periods of time.

To assure alignment with the County’s Strategic Plan, the Department of Health Services goals, and the organization’s mission, vision and values, the clinical and administrative leadership at Harbor-UCLA has adopted five pillars to support the foundation for all quality improvement and patient safety activities at the Medical Center.

HARBOR-UCLA’S FIVE ORGANIZATIONAL PILLARS	
Quality & Safety	Transform and sustain an infrastructure that: 1) promotes unwavering commitment to provide the safest, highest quality care to every patient we serve; 2) is inclusive of and responsive to input from patients, their families and staff and; 3) engages, empowers and inspires staff to seek opportunities to improve care/services within their unit and across the facility and; 4) is data driven and aimed at improving outcomes and reducing harm.
Service	Create a culture of “service excellence” where patients come first and a corresponding organizational structure that empowers staff to “own” the patient visit experience striving to exceed patient expectations by providing care/service that is seamless and coordinated across services and departments.
People & Community	Create expectation of excellence by ensuring a united and talented workforce driven by our mission, mutual trust, teamwork and respect; enhance the health of patients and staff through a wellness initiative that promotes healthy life styles, and emotional, physical, and spiritual well-being.
Education & Research	Excel in education and research that is linked to improving quality and safety outcomes for all.
Infrastructure & Financial	Adopt an operational efficiency framework that embraces integrity, accountability, innovation and maximization of available resources; support the workforce through identification and effective use of available technology and other resources; create an infrastructure to promote an effective transition to E-HR and other new technologies; ensure fiscal responsibility while never compromising high quality standards of care.

On an annual basis, the leadership of Harbor-UCLA develops an Improving Organizational Performance (IOP) Plan and selects measures that are meaningful to the organization for each pillar giving priority to high-volume, high-risk, or problem-prone processes for performance improvement with thoughtful attention given to our setting, scope, services, the needs of our patients and our available resources.

Additionally, each medical department and clinical service is responsible for developing a specific department/service quality plan using a standardized template and adopting one or more of the organization's goals or developing ones that are congruent with the pillars. **If you do not know what your department is working on, ask your supervisor. You must be able to speak to what your department or service is working on to improve care or service.**

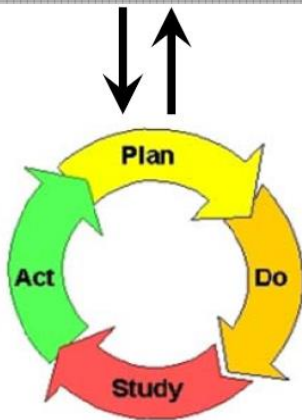
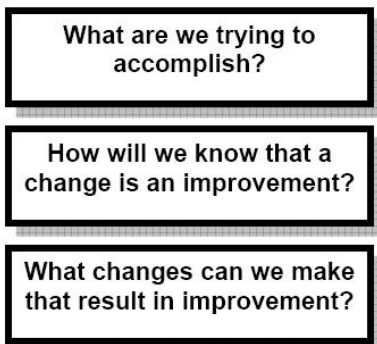
KEY POINT

Know what your department/ service or unit is working on to improve care or service- if you don't know, ask your supervisor.

One example of an organizational goal is to reduce patient harm from catheter-associated urinary tract infections; ventilator associated pneumonias; surgical site infection; falls, pressure ulcers and adverse drug events by 40% by December 2015. To meet this goal, which is part of the Quality & Safety Pillar, multidisciplinary teams have been formed and are developing and testing strategies to improve using the PDSA model (see below). **To learn more about the organization's efforts to reduce harm, go to the Harbor Intranet Quality page and click on "Reducing Harm".**

PERFORMANCE IMPROVEMENT

Teams, whether formal or informal, can utilize the Plan-Do-Study-Act (PDSA) improvement model to guide their efforts to improve. By asking the key questions: "*What are we trying to accomplish?*", "*How will we know that a change is an improvement?*" and "*What changes can we make that result in improvement?*" followed by the PDSA cycle, teams are able to improve processes and patient care outcomes. The following is an example from a multidisciplinary team that worked to reduce 30-day readmissions for heart failure patients, a high risk patient population.



PDSA EXAMPLE FROM THE HEART FAILURE READMISSION REDUCTION TEAM

The team analyzed readmission data and found that while heart failure patients who were readmitted within 30 days post discharge did have a follow-up appointment within 7 days, about half were being readmitted on post discharge day 3. The team worked through these questions:

What are we trying to accomplish? High risk heart failure patients need to be seen prior to 3 days post discharge to reduce an avoidable readmission.

How will we know that a change is an improvement? Track the number of home health referrals for heart failure patients do determine if referrals are going up: track monthly 30-day readmissions for heart failure patients to determine if readmission rates go down.

What changes can we make that result in improvement?

- Home Health representative was added to the team;
- Streamline the Home Health referral process for high-risk heart failure patients so that patients are seen within 24 hours post-discharge.

Plan: Revise the Home Health referral forms; educate staff on new form.

Do: Implement the revised form: start small with one patient and one physician. Make changes to be more user-friendly based on staff feedback; then expand to 3 patients with 3 physicians; then 5 patients with 5 physicians, then implement the new form throughout the organization.

Study: In the first quarter after implementation, referrals to home health increased from zero to 14 and the number of referrals has remained consistent. 30-day heart failure readmissions have been reduced by 42% as a result of this initiative and other ones implemented by the team.

Act: Revised home health referral process is now incorporated into "daily work" processes.

PUBLICLY REPORTED DATA

Harbor's quality is judged by how we perform on publicly reported data measures. There are several web sites that post hospital-specific quality data, including data from our hospital. Harbor's performance is compared to other organizations across the country. Hospital reimbursement is now tied to how well we perform in selected measures.

One example of publicly reported data is The Joint Commission's ORYX/Core Measures. The indicators are based on standardized, evidence-based measures, or factors that medical literature showed to make a positive difference in patient health outcomes.

Currently, Harbor is collecting data on the following:

- Acute Myocardial Infarction (AMI)
- Heart Failure (HF)
- Pneumonia (PN)
- Surgical Infection Prevention (SIP)

KEY POINT

Most of the publicly reported data collection is based on your chart documentation. Document accurately and completely.

Another example of publicly reported data is HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is a national, standardized survey of hospital patients. HCAHPS (pronounced "H-caps") was created to publicly report the patient's perspective of hospital care. Patients who have had an overnight stay in the hospital are randomly chosen to complete a survey that rates their hospital experiences in various areas. The following areas have been chosen by the federal government to compare patients' perception of care across health care organizations:

- Patients who reported that their nurses "Always" communicated well.
- Patients who reported that their doctors "Always" communicated well.
- Patients who reported that their pain was "Always" well controlled.
- Patients who reported that the area around their room was "Always" quiet at night.
- Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.

Physicians:

Remember to document contra-indications for evidence-based practices (e.g. for AMI patient: "patient allergic to Aspirin- not ordered".)

How are we doing compared to other hospitals?

Improving patient's perception of our care and service is a top priority for our organization. While we do well in some indicators, we have significant opportunities to improve. **To view the most recent reports for the ORYX/Core Measures, HCAHPS and other publicly reported data, go to www.medicare.gov/hospitalcompare or www.qualitycheck.org/consumer/searchQCR.aspx web sites.**

We value...

TRUST TEAMWORK RESPECT

GET INVOLVED AND STAY INVOLVED!

No one knows better of what can be improved in an area than the staff that works there day in and day out. If you have an idea on how to improve something- share it during staff meeting. Work with your supervisor and co-workers to come up with solutions to try. Think of ways to include patients and their families as we partner with them to provide them with the highest quality care and services.



Be an informed advocate for quality, safety and service! Ask your supervisor if you can attend a scheduled "Quality & Safety Town Hall" meeting or go to the **Quality page on the Harbor Intranet to read more about quality initiatives, and upcoming educational opportunities to learn more.** Speak to your supervisor about other ways you can be involved! Our patients are depending on **YOU!**

RISK MANAGEMENT

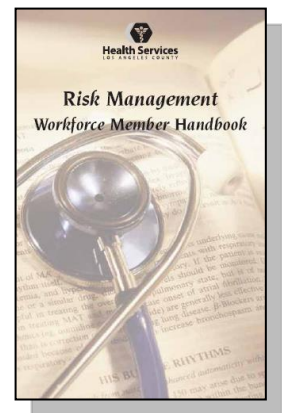
Risk Management involves the identification, evaluation, and reduction of the risk of injury to patients, visitors, and workforce members. This section provides policies and procedures on how to report adverse events, sentinel events and near miss incidents, documentation of all care and treatment, and responding to subpoenas and 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 reoccurring and enhance a culture of safety.
- Maintain a repository of Risk Management data including Event Notification Reports for tracking/trending and performance improvement purposes.

As a County workforce member, indemnification (legal protection) is provided while you are performing duties within the course and scope of your employment/assignment, while on duty at your assigned workstation. However, you are not legally protected from:

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



REPORTING NEAR MISS, ADVERSE AND SENTINEL EVENTS

DEFINITIONS OF EVENTS

Patient Safety event: An event, incident or unsafe condition that could have resulted or did not result IN harm to a patient.

Near Miss or Close Call: A patient safety event, situation or unsafe condition that did not reach the patient.

No-Harm Event: A patient safety event that reaches the patient but does not cause harm.

Hazardous (or "unsafe") Condition(s): A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event.

Adverse Event: A patient safety event that resulted in harm to a patient. Identifying something as an adverse event does not imply "error," "negligence" or poor quality of care. It simply indicates that an undesirable clinical outcome resulted from aspect of diagnosis or therapy, not an underlying disease process. The California Health and Safety Code identifies 28 specific adverse events that must be reported to the California Department of Public Health (CDPH). Reportable adverse events are:

1. Surgery performed on the wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability from contaminated drug/device/or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product..
7. Patient death or serious disability associated with use/function of device in a way other than as intended. "Device," includes but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Death or serious disability associated with patient disappearance for more than 4 hours (excludes adults who have competency or decision-making capacity.).
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. Patient death or serious disability associated with medication error including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient Death or serious disability related to hypoglycemia, the onset of which occurs while the patient is being cared for in a hospital.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. Stage 3 and 4 ulcers acquired after admission to a health facility, excluding progression from State 2 to Stage 3 if Stage 2 was recognized upon admission.
18. Patient death or serious disability from spinal manipulation therapy performed at the health facility.
19. Patient death or serious disability associated with electrical shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
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 a toxic substance.
21. A patient death or serious disability associated with burn incurred from any source while being cared for in facility health facility.

22. A patient death associated with fall while being cared for in the health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in the health facility.
24. Any instance of care ordered or provided by someone impersonating a physician, nurse, pharmacist, or licensed health care provider.
25. Abduction of a patient of any age.
26. Sexual assault of a patient within or on the facility grounds.
27. Death or significant injury of patient or staff from physical assault that occurs within or on the grounds of the facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

California Department of Public Health Reportable Adverse Events must be immediately reported to your direct supervisor and entered into the Safety Intelligence (SI), a web-based, DHS-wide system accessible from the Harbor-UCLA Intranet Webpage.

Sentinel Event: A subcategory of Adverse Events, a Sentinel Event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, or permanent or severe temporary harm.

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

- Suicide of any patient in a setting where the patient receives around-the-clock care or suicide of a patient within 72 hours of discharge.
- Unanticipated death of a full-term infant.
- Abduction of any patient receiving care, treatment or services.
- Discharge of infant to the wrong family.
- Patient elopement from a staffed around-the-clock care setting, including the ED, leading to death, permanent harm, or severe temporary harm to the patient.
- Rape, assault (leading to death, permanent harm, or severe temporary harm) or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups).
- Surgery or invasive procedure performed on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure.
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.
- Severe neonatal hyperbilirubinemia (bilirubin >39 milligrams/deciliter).
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

If you become aware of an Adverse Event or Sentinel Event or any other incident, event, or injury involving a patient, visitor, vendor, contract staff, or workforce member, you must report it within 4 hours of discovery to:

- Your Direct Supervisor; and
- Safety Intelligence (SI) – a web-based, DHS-wide system accessible on the Harbor-UCLA intranet.

Submission of SI report ensures that Risk Management is notified when an Adverse Event or a Sentinel Event occurs. Please review Harbor-UCLA Medical Center Policy No. 612 B for information regarding adverse and

REMEMBER

You must report all adverse events and sentinel events to your direct supervisor or the House Supervisor and enter a report in the Safety Intelligence system within 4 hours of discovery of the event.

sentinel event notification, reporting and documentation. “Near Miss” event, situation or unsafe condition, should be similarly reported.

REPORTABLE UNUSUAL OCCURRENCES

Title 22 requires the reporting of occurrences such as an epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe, or unusual occurrence which threatens the welfare, safety, or health of patients, staff, or visitors to the California Department of Public Health.

A workforce member who encounters such an occurrence must immediately notify his/her direct supervisor and submit a SI report.

TIMELY REPORTING

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

- Submit a SI report via the Harbor-UCLA intranet within 4 hours of discovery of the event.
- Immediately report Adverse and Sentinel events (as defined above) to your Department Supervisor; during after hours, report to the House Supervisor at Ext. 3434.
- Your Department Supervisor is responsible for appropriate follow up (e.g., prompt notification of the facility administrator/designee).
- The Risk Management Office can be reached by calling (310) 222-2168 during business hours or through the Telephone Operator during after-hours.
- When in doubt, call the Risk Manager at (310) 222-2168.
- Follow-up with all calls by submitting a SI report.

Note: You cannot be disciplined for the act of reporting an event. However, if you have knowledge of an event and fail to report it, which is against Harbor-UCLA policy, there is a possibility that you may be disciplined for failure to report.

REMEMBER

Notify your Department Supervisor whenever possible when reporting a case to the Risk Management Office. **Do not make copies of the SI Report.** In addition, keeping separate notes regarding events may not be protected under the attorney/client privilege. Therefore, you are discouraged from keeping separate notes regarding events. All information related to the event should be included in the SI report.

DOCUMENTATION – A KEY DEFENSE



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

Document all care and treatment given and changes in the patient’s condition in a timely manner in his/her medical record. **Do NOT make reference to a SI Report or Risk Management in the patient’s medical record. Do NOT make copies of the SI Report.**

Please also note that comments regarding coverage discussions, disputes among services, or clinician/staff behavior, etc. should not be recorded in the medical record, which is a document with the sole purpose to accurately record the care provided to a patient. As applicable, such issues can be reported to Medical, Nursing or Hospital Administration or recorded on a SI Report or Statement of Concern form, as appropriate.

Your Documentation Must Include:

- Care, treatment provided and patient family education.

Make Your Documentation:

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

Correct Errors in the Medical Record By:

- Follow established protocol in ORCHID for correcting errors in the medical record.

SUBPOENA AND SUMMONS

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

If you receive a subpoena or summons relative to County business, immediately contact Risk Management at (310) 222-2168. Also:

- 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 or fax them to (310) 320-3084.

ENVIRONMENT OF CARE

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

WORKFORCE SAFETY PROGRAM

It is an ongoing priority 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. All identified hazards are investigated and acted upon by the Environment of Care Committee, Environmental Safety Officer and the department/service managers. Address any concerns you have regarding safety to your supervisor or the Environmental Safety Officer at (310) 222-2835.

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.
- Notify the Environmental Safety Officer at (310) 222-2835. (*Calls can be anonymous.*)
- Submit a Safety Intelligence report via the Harbor-UCLA intranet.

EMERGENCY CODES

Emergency overhead paging is used to alert staff of potential emergency situations, announce codes and to summon staff responsible for responding to specific emergency situations.

[See Emergency Codes on Next Page](#)

2016 Orientation/Reorientation

HARBOR-UCLA MEDICAL CENTER CODES

INCIDENT	# TO CALL	PAGING CODE
Fire	Ext. 113	Code Red
Potential Disaster	Ext. 111	Code Triage Alert
External Disaster	Ext. 111	Code Triage External
Internal Disaster	Ext. 111	Code Triage Internal
Hazardous Material Spill/Radiation Incident	Ext. 111	Code Orange
Infant Abduction	Ext. 111 or 3311	Code Pink
Child Abduction	Ext. 111 or 3311	Code Purple
Cardiopulmonary Arrest – Adult	Ext. 112	Code Blue
Cardiac or Pulmonary Arrest – Pediatric	Ext. 112	Code White
Bomb Threat	Ext. 111	Code Yellow
Mental Health/Behavioral Response Team	Ext. 111	Code Gold
Patient Elopement	Ext. 3311	Code Green
Combative Person	Ext. 3311	Code Gray
Person with a weapon/Active Shooter/Hostage Situation	Ext. 111	Code Silver
Urgent Medical Assistance to Outpatients, Visitors, and Staff	Ext. 112	Code Assist
Rapid Response Team – Medicine	Ext. 111	Code Rapid Response
Rapid Response Team – Obstetrics	Ext. 111	Code Rapid Response
Rapid Response Team – Pediatrics	Ext. 111	Code Rapid Response
Rapid Response Team -- Surgery	Ext. 111	Code Rapid Response
Poison Control	(800) 876-4766	

SECURITY



Harbor-UCLA has on-site sworn law enforcement and professional security services at all times while the facility is open to the public. The Los Angeles County Sheriff's Department provides law enforcement and the protective services of deputy sheriffs and security officers at the Medical Center, and oversees and supervises the contract security guards who are responsible for basic security needs at the Ambulatory Care Network health centers. Combined, these personnel strive to provide a crime-free and secure environment for patients, visitors, patrons, and workforce members at Harbor-UCLA. The facility security contact number is (310) 222-3311.

THE ROLE OF THE LOS ANGELES SHERIFF'S DEPARTMENT (LASD)

As full-time, State-certified peace officers, the on-site deputy sheriffs enforce California Penal codes, Federal and State laws, County ordinances, and assist in attaining compliance with the medical center policies. The deputy sheriffs and LASD security officers conduct foot and vehicle patrols of the medical center. They are on-site and available to respond and assist workforce members and the public.

THE ROLE OF CONTRACT SECURITY GUARDS

- Observe/report any suspicious activities to the LASD or other appropriate local law enforcement agency.
- Perform security/weapon screening at the public entrances to Harbor-UCLA
- Conduct workforce member badge checks.

SAFETY AWARENESS

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

- Walking in groups when leaving the workplace after dark.
- Reporting suspicious activities to the facility security.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.

INFANT/CHILD ABDUCTION (CODE PINK/CODE PURPLE)

When a Code Pink or Code Purple is called, all available staff members are required to immediately cover exits in their areas and report suspicious persons to the Sheriff's Department at Ext. 3311. All workforce members should be aware that the Sheriff's Department will temporarily lock down the entrances and prevent anyone from entering or leaving the facility when a Code Pink or Code Purple is initiated. Persons leaving the Medical Center will be routed to a single exit by the Outpatient Pharmacy/Gift Shop lobby exit. If abduction was observed, it is important to obtain a description of the infant/child and abductor. Attempt to note the sex, hair, skin color, height, weight, clothing, and any distinguishing characteristics (e.g., glasses, tattoos, hat, etc.)

BOMB THREATS (CODE YELLOW)

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 Code Yellow.

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

- What kind of bomb is it?
- When is bomb going to explode?
- Where is the bomb?
- What does the bomb look like?
- What will cause the bomb to explode?



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 facility security immediately as well as notifying 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 and contract security guards will strictly enforce all weapons related laws.

WORKPLACE VIOLENCE

The County and Harbor-UCLA will not tolerate any form of violence (for example: threatening gestures, intimidating behaviors or verbal/written 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 security. Please refer to Threat Management "Zero Tolerance" in this handbook or DHS policy on workplace violence for further information.

HAZARDOUS MATERIALS/HAZARD COMMUNICATIONS



Whenever there is an actual release or spill of a hazardous material/waste, the following emergency procedures shall be placed into effect:

1. Remove all individuals from immediate danger if condition permits safe removal. Block off contaminated area and deny entry.
2. Report the incident by calling for a "Code Orange" by dialing Ext. 112. Provide your location, name, hazardous material and quantity, if known.
3. The operator will notify the Environmental Safety Officer and announced "Code Orange" over the public address system giving location and room number. The Fire Department will be notified, if necessary.
4. Obtain the Safety Data Sheet (SDS) for the spilled hazardous material.
5. Report the incident to the area supervisor/manager and complete an online Safety Intelligence (SI) and HAZMAT Spill report.

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

1. **Eye Contact** – Wash the eye with copious amount of water for 15 minutes or use eye wash station.
2. **Ingestion** – Drink a lot of water but do not induce vomiting.
3. **Skin Contact** – Flush the affected area with water for 15 minutes.
4. **Inhalation** – Remove victim to fresh air.

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.

The LABEL on a container holding hazardous material must be marked with the CHEMICAL IDENTITY and HAZARD CLASS of the most dangerous components. There must be a Safety Data Sheet (SDS) available at the location where a hazardous chemical is present. The SDS tells what hazards a chemical presents and how to handle spills and exposures. You should know the location of the SDS in your work area. If you do not know where they are kept, ask your supervisor. The master SDS listing is located on the Harbor-UCLA intranet.

You must know the names of the hazardous materials that you work with and that you may come in contact with in your area. You have the “Right to Know” this information.

RADIATION EXPOSURE

Use precautionary measures in caring for radioactive patients. All signs and safety measures are placed and removed by the Radiation Safety Office staff. A sign indicating "Caution-Radioactive Material" is placed on the patient's door and may also be placed on the patient's bed, chart, and wristband. Anyone providing direct care to patients who have or will receive radiation therapy using radionuclides must read and be familiar with the information on the “Radiation Protection Guide for Hospital Staff”. This guide is available at the Nurse's station, typically in the back of the Radiation Safety Manual. Additional copies can be obtained by contacting the Radiation Safety Officer.

Anyone who is likely to be exposed to a radiation source (i.e., a radiation producing machine or a radioactive material) can use the following basic radiation safety precautions to maintain their exposure As Low As Reasonably Achievable (ALARA).

1. SHIELDING – in addition to portable (e.g., movable lead barriers) and fixed (e.g., construction materials and lead sheets that are added to the walls of the room); lead equivalent aprons and thyroid collars must be worn by users of diagnostic x-ray equipment.
2. DISTANCE – radiation intensity decreases rapidly with distance. The farther that you are from a radiation source the less radiation exposure you will receive. For radiation therapy patients, the radiation will typically accumulate in an organ(s)/tissue(s) or will be placed in a specific area of the body (e.g., an intracavitary implant). Position yourself as far away from this source of radiation as you can without sacrificing appropriate and necessary patient care.
3. TIME – minimize the time that you spend in the vicinity of the radiation source. Less time means less exposure.
4. CONTAMINATION CONTROL – for radioactive materials in liquid or gaseous form, take steps to minimize your contact with the radioactivity. Wear appropriate Personal Protective Equipment (PPE) to minimize the possibility of internal contamination from the radioactive patient and their environment.

REMEMBER

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

Please contact the Radiation Safety Office staff if you work in or frequent an area where sources of radiation are used. You may be required to wear a personnel dosimeter to assess your exposure to these radiation sources. Safety, including radiation safety, is everyone's responsibility. Notify your supervisor immediately if you know of or suspect an unsafe condition.

EMERGENCY PREPAREDNESS AND MANAGEMENT

During a disaster the facility will implement its Emergency Operations Plan (disaster plan) and activate the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Preparedness & Management Manual, which is available on the Harbor-UCLA intranet.

In the event of an emergency, Harbor-UCLA will activate a Command Post which is located in Building 1-East.

DISASTERS THAT POSE THE GREATEST RISK

- Earthquake
- Infectious disease epidemic/pandemic
- Terrorism
- Mass-casualty hazardous material release (non-terrorism)
- Loss of water to the campus

We have incident-specific plans and medical, pharmaceutical and other resources to respond to these and other potential disasters.

CODE TRIAGE NOTIFICATION

- Key staff members are alerted via the Everbridge notification system during a Code Triage Alert when there is potential for a disaster.
- If a full-scale activation is required for an internal or external event:
 - General staff members are notified by means of “Code Triage Internal” or “Code Triage External” overhead page.
 - Key staff members are notified by text page, cell phone, and e-mail.

What You Should Do When “Code Triage Internal” or “Code Triage External” Is Announced

All Staff

- Remain calm.
- Provide reassurance to patients, visitors, and fellow workforce members.
- Return to your regularly assigned workstation, check in with your supervisor/designee, and await further instructions.

Inpatient Nurses

- Check the status of your patients.
- Ensure all life-critical equipment is plugged into a red outlet.
- Identify which of your patients could be safely discharged in the next 2 and 12 hours.

Inpatient and Emergency Department Physicians

- Review the status of your assigned patients.
- Identify any of your inpatients who could be safely discharged within the next 2, 12 and 24 hours.

Outpatient Physicians

- Review the status of your assigned patients.
- Determine which of your patients must be seen; which patients can be given a prescription refill, safely discharged and subsequently given a new appointment; which of your patients can safely be discharged and subsequently given a new appointment.

DEPARTMENT CHAIR/SERVICE DIRECTOR/NURSE MANAGERS RESPONSIBILITIES

- Assess your area for injuries, damage, loss of critical systems (i.e., electricity, water, wall oxygen, HIS), critical equipment (ventilators and lab equipment), or critical supplies.
- Provide the Command Post with a status report about your department/area. Written status reports can be submitted in person, by e-mail or by fax. Additionally, each inpatient and Emergency Department nursing unit has a two-way radio that can be used to give verbal status reports to the Command Post.
- Assign staff to go to the Code Triage Labor Pool as directed by the Command Post.

DISASTER COMMUNICATIONS SYSTEMS

- Two-way radio
- CWIRS 800 megahertz radio
- ReddiNet
- Ham radio (hospital only)
- HEAR radio (hospital only)
- Satellite phone/radio (medical center only)
- E-mail
- Fax
- Runner

EVACUATION

A "Code Triage" incident may render all or a portion of Harbor-UCLA unsafe for occupancy or prevent delivery of necessary patient care, and necessitate partial or total evacuation.

Partial Evacuation

Patients are transferred within the facility. There are two levels of a partial response:

- Horizontal evacuation: Individuals move/are moved from one smoke compartment -- beyond a set of barrier doors -- to another smoke compartment on the same floor.
- Vertical evacuation: Individuals move/are moved up or down staircases and to an area of safe refuge.

Full Evacuation

Patients are transferred out to other hospitals or health care facilities, and/or are discharged home.

- Evacuate the building from the top down. Evacuation of the lower levels of the hospital can be accelerated easily, should the danger increase rapidly.
- Full evacuation must be coordinated with the Los Angeles County Medical Alert Center, which will:
 - Divert paramedic transport of "9-1-1" or transfer patients away from the medical center.
 - Provide patient placement and/or transportation assistance.

Evacuation Sequence

- Evacuate the most hazardous areas first -- those closest to danger or farthest from a safe exit
- Patients shall be evacuated in the following order:
 - Patients in immediate danger.
 - Ambulatory patients who need little or no assistance to walk and go down stairs.
 - Non-ambulatory/wheelchair patients.
 - Non-ambulatory/special needs patients. This group includes patients who are bed-bound, bariatric, ventilator- or oxygen-dependent, on a legal hold, or require a transport monitor.

Evacuation Means/Methods for Semi-ambulatory or Non-ambulatory Patients

- Medsleds: For vertical evacuation of non-ambulatory/wheelchair and non-ambulatory/special needs patients. Upon completion of descent, these patients will require a wheelchair or gurney.
- Wheelchairs
- Gurneys

ARE YOU PREPARED AT HOME FOR A NATURAL DISASTER?

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

Materials and information are available outlining what you should do at home to be prepared:

- <http://publichealth.lacounty.gov/eprp/plans.htm>
- <http://ems.dhs.lacounty.gov/Disaster/DisasterMaterials.htm>

FIRE/LIFE SAFETY

FIRE RESPONSE (CODE RED)



The acronym **RACE** refers to steps you should take in the event of a fire. The steps are:

R	Remove/Rescue patients, staff and visitors.
A	Activate alarm and call emergency operator.
C	Contain and fight the fire (optional).
E	Extinguish .



Use the proper extinguisher for the type of fire you are trying to extinguish:



Type of Fire Extinguisher	Effective for These Types of Fires
Class A or H₂O	Paper, wood, or linen fires
Class BC or CO₂	Chemical or electrical fires
Class ABC or Dry Chemical	All types of fires
Halon – ABC Rated	All types of fires
K-Type	Combustible cooking media (vegetable or animal oils and fats)

STEPS IN THE USE OF THE FIRE EXTINGUISHER

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

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

REMEMBER

NEVER re-hang an extinguisher once it has been discharged, even if it is only for a few seconds.

Note: 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.

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

In order to ensure the safe operation of medical equipment, Facilities Management's Biomedical Shop is responsible for testing selected medical equipment at least annually. You can find the inspection label with the next test due date on the upper right side of most equipment. If the medical equipment is not functioning properly, remove the malfunctioned equipment from the clinical area and tag it (such as "Out of Order"). Report all medical equipment and utilities malfunctions to your supervisor and the Facilities Management Department at (310) 222-3301.

When there is an equipment malfunction, **DO NOT** leave a patient unattended. In life-threatening emergencies involving medical equipment, send a co-worker to get a replacement from the nearest location. When a device failure or operator error results in serious negative consequence to a patient, you must inform Risk Management by means of a Safety Intelligence (SI) Report or by phone at (310) 222-2168 as soon as possible (within 24 hours) and immediately impound the device. (See Risk Management reporting procedures.)

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).

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.

Verify LIFE

Before connecting any electrical device to a patient:

L	L abel: Check Due Date on Safety Label.
I	I nspect: Inspect unit and accessories for wear and damage.
F	F unction: Is the unit functioning correctly?
E	E lectrically Safe: Is the power cord intact?

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.

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

In the event of a fire or emergency, it may be necessary to shut off oxygen or medical gases. Only doctors, nurses and respiratory care practitioners may shut off or authorize other workforce members to shut off oxygen ward/zone valves. Ensure that all oxygen-dependent patients for that zone have alternate means of support. Facilities Management should be called in the event of the failure of a gas outlet or to turn oxygen or medical gases back on.

REMEMBER

Call (310) 222-3301 to report a mechanical emergency, mechanical failure, or the need for mechanical repair.

REPORTING WORK-RELATED INJURIES/ILLNESS

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)

In compliance with State regulations (Title 8, California Code of Regulations, Section 3203) and to provide for a healthy work environment, Harbor-UCLA has established, implemented and maintained an effective Injury and Illness Prevention Program (IIPP). The IIPP includes the following actions:

- Ensure that workforce members comply with safe and healthy work practices. This is accomplished through recognition, training, and discipline.
- Communicate with workforce members on matters relating to occupational safety and health. Workforce members can inform their supervisors/Safety Office of hazards at the worksite without fear of reprisal.

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

Why You Should Practice Good Body Mechanics

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

Maintaining Good Body Mechanics

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

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

GUIDELINES FOR DECREASING MUSCULOSKELETAL INJURY

General Guidelines for Maintaining Proper Body Mechanics During Activity

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

Reaching

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

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

Twisting/Turning

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

Standing

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

Sitting

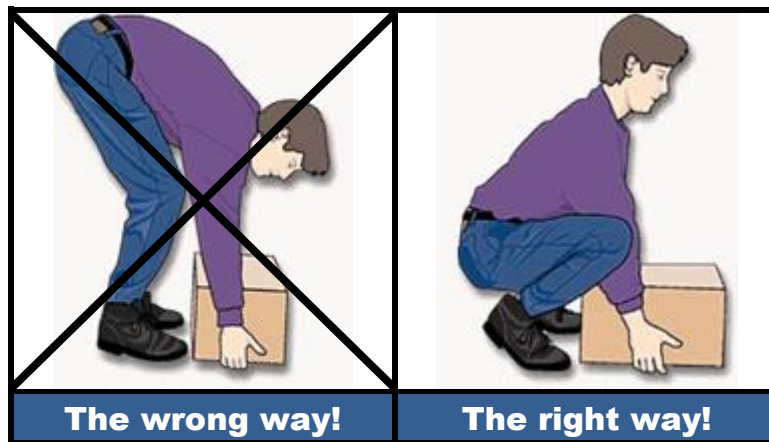
- Adjust the chair to position the hips, knees and elbows at about a ninety degree angle.
- Feet should be flat on the floor. If they are dangling, rest feet on a footrest to avoid strain on the lower back.
- Use the backrest of the chair to support the curves of the spine and to decrease fatigue. Avoid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

Patient Transfers

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

Equipment/Object Transfer

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



ERGONOMICS

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

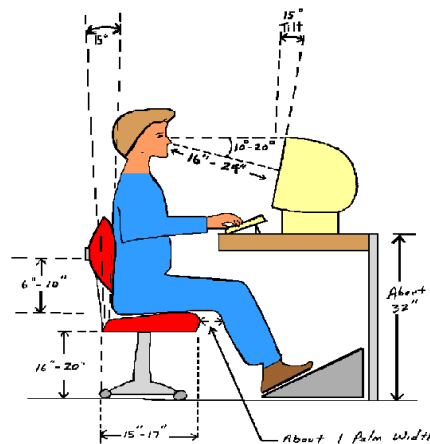
Common Causes and Types of Ergonomic Injuries

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

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:

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



RISKS FACTORS TO REMEMBER

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

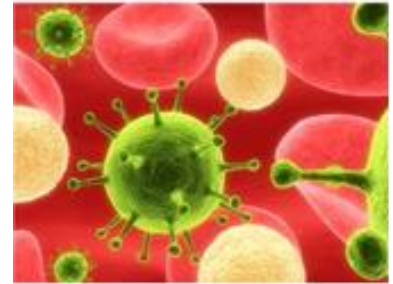
TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

1. **Recognize** the force or strain placed on your body caused when you grip, push, pull or lift heavy materials. Think about ways to minimize these strains or avoid some of these movements. Be aware of pain or numbness in the neck, shoulders, arm, wrist, fingers and back. Immediately, report any work related injuries to your supervisor.
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 worksite safety concerns to your supervisor. This will help your manager identify harmful patterns or environmental conditions so that necessary changes may be made.
6. **Ergonomic worksite evaluations** are available through the Safety Office. For an appointment, managers/supervisors may call Ext.2835 or e-mail the Safety Officer, Louise Flowers at lflowers@dhs.lacounty.gov.

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

INFECTION PREVENTION & CONTROL

This section addresses general patient care principles and workforce member guidelines related to infection prevention and control practices. It includes the Infection Prevention and Control Program, Hand Hygiene, Bloodborne Pathogen Exposure Prevention and Control Plan, Tuberculosis (TB) Control Plan, Airborne Transmissible Disease Plan, Pandemic Influenza Plan, and Waste Disposal.



INFECTION PREVENTION AND CONTROL

The goals of the infection prevention and control program are to:

- Prevent the transmission of infection to patients, visitors and workforce members.
- Provide a safe work environment.
- Improve patient care.

Infections can be spread through direct contact, indirect contact or by 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 be spread through frequently touched items, instruments, and articles that come in contact with the patient and/or the environment.

Components or processes that reduce risk for cross infection to the patient:

- **Cleaning:** Removal of visible soil and impurities.
- **Disinfection:** Elimination of many or all pathogenic microorganisms except spores.
- **High-Level Disinfection:** Complete elimination of all microorganisms except bacterial spores.
- **Sterilization:** A process that destroys or eliminates all forms of microbial life.

Categorization of instruments/items according to the degree of risk for infection in use of the item:

- **Critical:** Items used in sterile tissue or the vascular system that pose a high risk for infection if contaminated with any microorganism. Examples: surgical instruments, cardiac or urinary catheters, implant, and ultrasound probes used in sterile body cavities.
- **Semi-critical:** Items contact mucous membranes or non-intact skin. These items minimally require high-level disinfection using chemical disinfectants. Examples: Ultrasound Vaginal probes, cystoscopes, esophageal manometry probes, endoscopes, laryngoscopes, respiratory therapy and anesthesia equipment.
- **Non-critical:** Items that come in contact with intact skin but not mucous membranes. Examples: bedpans, blood pressure cuffs, crutches, computers, gurneys, and wheelchairs. Non-critical items are frequently touched by hands and can contribute to secondary transmission of infection. Meticulous cleaning of items is an important process to reduce or eliminate organisms in patient areas

Hand hygiene (hand washing with soap and water or use of an alcohol-based hand sanitizer), implementation of Standard Precautions, Transmission-based Precautions, proper cleaning, disinfection and sterilization can reduce the risk for transmission of health care related infection.

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. Hand washing consists of water, soap and friction and takes 15 – 20 seconds. Use of alcohol-based hand sanitizer consists of taking a small amount of the product and vigorously rubbing the surface of your hands, including in between your fingers, fingertips, cuticles and around your thumbs.

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 with *Clostridium difficile* (*C. difficile*) or *Bacillus anthracis* (anthrax)
- After removing gloves if gloves are visibly soiled with blood or body fluids
- After contact with body fluid or excretions, mucous membranes, non-intact skin, or wound dressings;
- After every 5 – 10 applications of the alcohol-based hand sanitizer



USE ALCOHOL-BASED HAND SANITIZER



- Before and after having direct contact with patients.
 - Before handling an invasive device for patient care, regardless of whether or not gloves are used (e.g., central lines, urinary catheters, intravenous catheters) and do not require a surgical procedure.
 - If moving from a contaminated body site to another body site during care of the same patient.
 - After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient.
 - After removing gloves (if gloves not visibly soiled with blood or body fluids).
- Before leaving work.
 - As a preferred means for routine hand antisepsis in all clinical situations describe above if hands are not visibly soiled. If alcohol-based hand sanitizer is not obtainable, wash hands with soap and water.

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

REMEMBER

Prevent the spread of infection by washing your hands OR using the alcohol-based hand sanitizer.

FINGERNAILS

Natural nails must be clean, with tips less than 1/4 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 patients, those who have contact with food, and select pharmacy personnel who prepare sterile admixtures under the laminar flow hood.

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

RESPIRATORY HYGIENE/COUGH ETIQUETTE

To prevent the transmission of all respiratory infections, including influenza, the following infection prevention and control measures should be implemented at the first point of contact with a potentially infected person. Health care personnel are advised to observe Droplet Precautions (i.e., wear a mask) and perform hand hygiene for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection. The elements of Respiratory Hygiene/Cough Etiquette include:

1. Education

- a. Education of health care facility staff, patients, and visitors emphasizing the importance of infection prevention measures to contain respiratory secretions and prevent the spread of respiratory pathogens when examining and caring for patients with signs and symptoms of a respiratory infection.

2. Visual Alerts/Posted Signs

- a. Post “Cover your Cough” posters: Emphasizes covering coughs and sneezes and hand cleaning.
- b. Personal Protective Equipment: Posters are available that demonstrate the donning and removing of personal protective equipment.

3. Source Control Measures

The following measures to contain respiratory secretions are recommended for all individuals with symptoms of a respiratory infection:

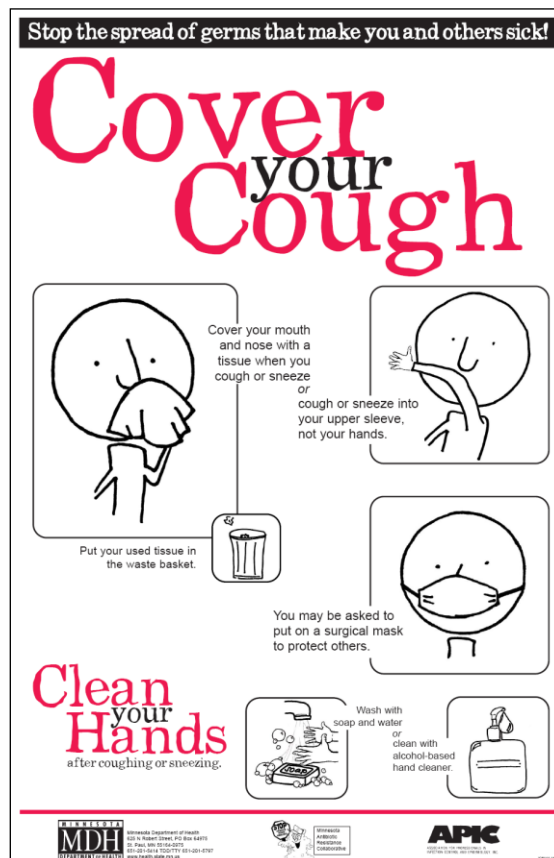
- a. Cover the mouth/nose when coughing or sneezing to prevent the dispersal of respiratory secretions into the air.
- b. Use tissues to contain respiratory secretions and promptly dispose of them in the nearest waste receptacle after use. Ensure the availability of tissues for patients, visitors, and staff.
- c. Use surgical masks on the coughing person when tolerated and appropriate. Masks are used to contain respiratory secretions and prevent dispersal into the air.

4. Hand Hygiene

- a. Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic hand wash) after having contact with respiratory secretions and contaminated objects/materials to prevent the transmission of viruses and reduce the incidence of respiratory infections.

5. Spatial Separation

- a. Encourage coughing patients to sit apart (at least three feet away, if possible) from others in common waiting areas.
- b. Distance infected persons from others who are not infected (at least three feet away) to decrease the risk for transmission of infections via the droplet route.



STANDARD PRECAUTIONS

Standard precautions are precautions designed to protect the health care worker from bloodborne pathogens and prevent the transmission of infectious agents between the health care worker and patients. Standard Precautions are based on the principle that all blood, body fluids, non-intact skin, secretions, excretions (except sweat), and mucous membranes may contain infectious agents. Standard Precautions include the use of proper hand hygiene before and after patient contact, safe injection practices, and the appropriate use of gloves, gowns, masks, and eye protection, depending on the anticipated exposure. These precautions are an important cornerstone of infection prevention and control and must be performed by all health care providers at all times and in all settings. Workforce members shall be trained and will use barrier devices provided for their safety to prevent contact with blood or other potentially infectious materials.

TRANSMISSION-BASED ISOLATION PRECAUTIONS

Transmission-based isolation precautions prevent the transmission of infection between infected patients, care givers, and visitors. Transmission of infection within a health care setting requires three elements: a source of infecting microorganisms, a susceptible host, and 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 of having an isolatable process he/she will be placed in the appropriated isolation precautions. Workforce members entering the patient area are to follow posted precautions.

The three types of precautions are:

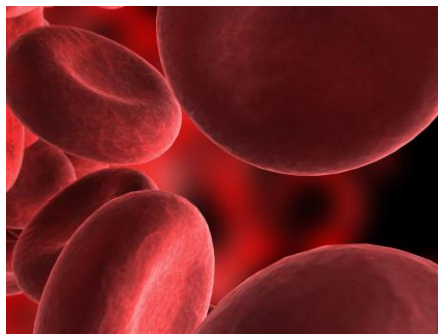
DROPLET	<p>Droplet Microorganisms (Green sign) are transmitted by patients during coughing, sneezing, and talking.</p> <ul style="list-style-type: none"> • Patient placement in a private room is recommended, not required. • Staff to observe: <ul style="list-style-type: none"> ▪ N95 or greater NIOSH-approved respirator when entering within 3 feet of the patient's face. ▪ Hand hygiene before entering and leaving the room or having contact with the patient. ▪ Droplet precaution signage must be posted on the wall at the head of the patient's bed and on the wall outside the entrance to the room.
	<p>PPE Needed: N95 mask (fit-tested) is required during contact with the patient.</p>
AIRBORNE	<p>Airborne) Microorganisms (Blue sign) transmitted by airborne droplet nuclei that remain suspended in the air for long periods of time and can be dispersed widely by air currents within the room or over long distances.</p> <ul style="list-style-type: none"> • Patient to be placed in a single-bed negative pressure room, with the door closed at all times. • Staff to observe: <ul style="list-style-type: none"> ▪ N95 or greater NIOSH-approved respirator. ▪ Hand hygiene before entering and leaving the room or having contact with the patient. ▪ Food Service Associates may not enter the room. ▪ Airborne precaution signage must be posted on the outside of the door to the isolation room and the door must be kept closed at all times.
	<p>PPE Needed: N95 or PAPR respirator (fit-tested) is required when entering the room; and removed after exiting the negative pressure room.</p>

CONTACT	<p>Contact) Microorganisms (Yellow sign transmitted by direct contact with the patient or indirect contact with the patient’s environmental surfaces.</p> <ul style="list-style-type: none"> • Patient placement in a private room is not required. • Staff to observe: <ul style="list-style-type: none"> ▪ Gown ▪ Gloves ▪ Hand hygiene before entering and donning gloves and after removing gloves. ▪ Contact precaution signage must be posted on the wall at the head of the patient’s bed and on the wall outside the entrance of the room.
	<p>PPE Needed: Gown and gloves.</p>

Multi-Drug Resistant Organisms (MDROs) such as VRE, MRSA, *C. difficile* and Multi-Drug Resistant Gram Negative Organisms are common causes of health care-acquired infections. Nearly all MDROs can be spread in the hospital or ambulatory health care setting via cross-transmission from colonized or infected patients or workforce members. The standard of care is to place all hospitalized patients with MDROs in Contact Precautions for the duration of the hospitalization.

Refer to the Infection Prevention and Control (IP&C) Plan and the IP&C webpage on the Harbor intranet for the list of isolatable organisms and the type of transmission-based precautions to be implemented and for the most current policies related to isolation precautions and MDROs. Contact Infection Prevention and Control Department at (310) 781-3646 if you have questions regarding transmission-based precautions.

BLOODBORNE PATHOGEN EXPOSURE PREVENTION & CONTROL PLAN



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

Bloodborne pathogens may be acquired through percutaneous (needle stick, puncture) and mucous membrane (splash to eyes, mouth, nose). 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 likelihood for blood or OPIM exposure.

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

Do not eat, drink, apply cosmetics or lip balm or handle contact lenses in work areas where exposure may occur, per Cal/OSHA regulations. Do not keep food or beverages in refrigerators, freezers or cabinets, on countertops or bench tops, or in any other area where they might be exposed to potentially infectious materials.

Workforce members with exudative lesions or weeping dermatitis should refrain from direct patient care and handling of patient-care equipment until the condition resolves. Workforce members with lesions or unexplained rash should go to Employee Health for evaluation.

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

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Use of PPE and proper hand hygiene dramatically reduces the likelihood of transmission of infections to other patients and hospital staff.

- ➔ Gloves
- ➔ Masks, eye protections, face shields, respirators
- ➔ Gowns, aprons, and other protective body clothing
- ➔ Powered air-purifying respirators (PAPR)



When to use Personal Protective Equipment (PPE) on the wards/ICUs:

- **Gloves:** Wear gown/gloves and face/eye protection if possibility of exposure to blood or body fluids, non-intact skin, contaminated skin (e.g., with excretions), and when caring for a patient in Contact Precautions.
- **Gowns:** Wear gown to prevent soiling of clothing by or exposure to blood or body fluids and when caring for/examining patient in Contact Precautions.
- **Eye protection (e.g., face shields):** Should be worn for patient care activities likely to generate splashes or sprays of blood or body fluids.
- **Mask:** As part of maximum sterile precautions when inserting a central venous catheter (CVC), and when caring for/examining patients in Droplet Precautions. A N95 mask (fit-tested mask) is required when entering rooms for patients in Airborne Precautions.
- **Cap (covering all hair):** As part of maximum sterile precautions when inserting a CVC.

All PPE: Remove **BEFORE** leaving the room/patient area. Exception: Remove the N95 mask **AFTER** leaving a room with a patient in Airborne Precautions (e.g., patient with TB).

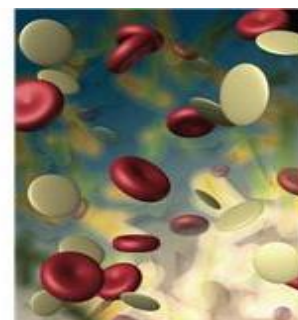
Precaution (Isolation) categories, initiation, and discontinuation: Standard Precautions are used for all patients, at all times. Standard Precautions includes use of PPE, as described above, and the practice of proper hand hygiene.



BLOODBORNE PATHOGENS

Some of the bloodborne diseases to which you can be exposed include:

- **Hepatitis C (HCV)** – Can cause serious liver disease and have no symptoms or flu-like symptoms (nausea, vomiting and fever). Many people with HCV become chronically infected. There is no vaccine for HCV.
- **Hepatitis B (HBV)** – Can cause serious liver disease and have no symptoms or flu-like symptoms (nausea, vomiting and fever). People infected with HBV may recover and clear the infection but some may become chronic carriers or have other serious effects from the illness. HBV is a greater transmission risk to health care workers than HCV and HIV since it is more easily transmitted. HBV is preventable by the Hepatitis B vaccine series of three vaccinations.
- **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.



Exposure to Blood and Body Fluids

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

If you are exposed, **IMMEDIATELY**:

- Wash the cut or exposed skin area with soap and water.
- Rinse out your eyes for a minimum of 2 minutes.
- Report the exposure to your supervisor.
- Go to Employee Health or the Emergency Department for follow-up.

REMEMBER

The most effective treatment is treatment that is started **within 2-4 hours of exposure**.

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.

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS

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

Prevention strategies for reducing the incidence and risk of CLABSIs

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

SURGICAL SITE INFECTIONS

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

Prevention Strategies for Reducing the Incidence and Risk of SSIs

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

VENTILATOR ASSOCIATED PNEUMONIA (VAP)

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

Prevention Strategies for Reducing the Incidence and Risk of VAP

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

CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)

The urinary tract is the most common site of health care-associated infection, accounting for more than 30% of infections reported by acute care hospitals. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality. Each year, more than 13,000 deaths are associated with urinary tract infections.

Prevention Strategies for Reducing the Incidence and Risk of CAUTI

- Use of aseptic technique in inserting urinary catheter
- Perform hand hygiene before and after insertion and catheter tubing and drainage manipulation
- Clean perineal area with soap and water every 8 hours
- Use condom or intermittent catheter if possible
- Ensure proper catheter position and unobstructed flow
- Daily assessment and documentation of catheter need

MULTI DRUG RESISTANT ORGANISMS (MDROS)

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

Prevention Strategies for Reducing the Incidence and Risk of MDROs

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

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

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

Prevention Strategies for Reducing the Incidence and Risk of MRSA Infections

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

MRSA Screening Protocol

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

VANCOMYCIN-RESISTANT ENTEROCOCCI (VRE)

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

Prevention Strategies for Reducing the Incidence and Risk of VRE Infections

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

CLOSTRIDIUM DIFFICILE (C. DIFFICILE)

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

Prevention Strategies for Reducing the Incidence and Risk of CDI

- Follow the hand hygiene policy.
- Use contact precautions for *C. difficile* patients.
- Educate patients and their families about *C. difficile* and how to prevent its spread.
- Ensure proper cleaning and disinfection of equipment and the environment (bleach products are recommended).

PREVENTING SHARP 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, needles for 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 (e.g., safety needles, angel wings).
- Get help with uncooperative patients.
- Let falling objects fall.
- Dispose of sharps into covered, labeled, and ridged puncture resistant sharps container.
- Use tongs or brush & dustpan to pick up broken glass.
- Practice safe handling techniques.



DO NOT

- Bend, break or recap needles.
- Leave needles and sharps.
- Rush or take shortcuts.
- Reach into disposal containers.
- Touch broken glass.
- Overfill sharps container.
- Carry loose sharps in your pockets.

SAFE INJECTIONS PRACTICES

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

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

- Use aseptic technique to avoid contamination of sterile injection equipment.
- Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.
- Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient.
- Use fluid infusion and administration sets (e.g., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use.
- Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
- Use single-dose vials for parenteral medications whenever possible.
- Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.



2016 Orientation/Reorientation

- 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

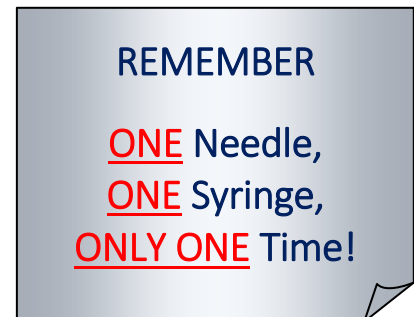
(Source: Centers for Disease Control and Prevention (CDC), March 2008)

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



- Medications packaged as single-use vials never be used for more than one patient;
- Medications packaged as multi-use vials be assigned to a single patient whenever possible;
- Bags or bottles of intravenous solution not be used as a common source of supply for more than one patient; and
- Absolute adherence to proper infection control practices must 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, health care providers also protect themselves. For example, the unsafe practice of syringe reuse also puts health care 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.



For more information about sharps safety, please see:

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

VACCINATIONS

Hepatitis B vaccine is provided free for DHS workforce members at risk of exposure to blood and body fluids per their job duties. Varicella (Chickenpox), MMR (measles, mumps and rubella), and Tdap (tetanus, diphtheria, and acellular pertussis) vaccines are recommended and/or may be required for workforce members per their exposure risk in their job duties.

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 health care professional; services provide through DHS will be billed to their contractor/agency as appropriate

SEASONAL INFLUENZA



To comply with DHS Policy No. 334.200, as a condition of employment/assignment, an annual influenza vaccination is mandatory for every workforce member who works in a DHS facility unless the workforce member completes and signs an informed declination form. A sticker will be affixed to the DHS photo identification badge of workforce members who have received the influenza vaccination. Compliance with annual mandatory influenza vaccination shall be required by November 1 of each year.

Influenza vaccination is available to all workforce members at no charge. All workforce members who have not been vaccinated by November 1 must wear a mask during the duration of the influenza season, regardless of submitting a signed declination, if they work in a health care area that provides patient care. If the workforce member later decides to accept the vaccination, it will be provided to them.

TUBERCULOSIS (TB) CONTROL PLAN

The TB Control Plan provides information and guidelines to be followed to ensure that all workforce members are protected against exposure to tuberculosis. It is the intent of Harbor-UCLA to standardize procedures so that health care workers may receive the same standard of care, regardless of their place of employment at the time of injury; recognizing that workforce members may work at different times in various locations.

Tuberculosis is spread through the air in droplets generated when a person with active TB coughs, sneezes, speaks or sings. These droplets are so small that regular air currents within a building can keep them airborne for hours. If these droplets are inhaled, the bacteria may become established in your lungs causing pulmonary TB or spread to other areas in your body. TB is most commonly spread by close, prolonged, intense and unprotected contact indoors to an active TB patient. The TB Control Plan provides information and identifies procedures to follow to ensure that all workforce members are protected against exposure to tuberculosis.

TB precautions include the following:

- Pre-placement baseline screening with a two-step tuberculosis skin test (TST).
- Pre-placement baseline documented positive TST will have a documented negative chest x-ray within the last 12 months.
- Annual TB screening for all workforce members who work or must perform duties inside a health care facility.
- Comprehensive training for all workforce members at New Employee/Non-County Staff Orientation.
- Early triage and screening for TB active disease in patients – testing Acid Fast bacilli in respiratory or other fluids.
- Screening all workforce members with a TB questionnaire annually, baseline TST, negative workforce members will receive annual TST placement. Chest x-ray will be done for workforce members with TST conversions and positive findings.
- Airborne precautions and placement in a negative pressure room for suspect and confirmed TB cases.
- Workforce members working with suspect or confirmed TB patients shall wear N95 or greater NIOSH approved respirator after pre-placement fit test and testing on an annual basis or a Powered Air Purified Respirator (PAPR) which does not require fit testing.
 - TB patient wears barrier (surgical) mask when outside of isolation room.
- Use and limitations of methods to prevent TB exposure, including engineering controls, work practice controls, fit testing and use of personal protective equipment.
- Workforce members who, in the judgment of the Employee Health Services, are suspect for TB will not be permitted to work until the diagnosis is excluded and/or appropriate treatment has rendered workforce member non-communicable.

REMEMBER

Don't share the air.
Wear an approved (fit-tested) respirator.

Any patient who has a positive acid-fast bacillus smear or is on TB medications must have TB Control approval (310) 222-3443 prior to discharge. After hours TB approval can be obtained from Public Health physician on-call at (213) 974-1234.

AEROSOL TRANSMISSIBLE DISEASE (ATD) PLAN

On August 5, 2009 the State of California adopted section 5199 to the California Code of Regulations, Title 8, Chapter 4 to safeguard workers from the spread of airborne diseases such as tuberculosis, measles, influenza, and other pathogens spread through airborne transmission. It was designed to protect workers in health care and related industries who have duties that increase their risk of exposure to infectious disease. The ATD standard requires facilities with health care workers and others at increased risk to develop exposure control procedures and train the workforce to follow those procedures.

The Aerosol Transmissible Disease Plan was developed to prevent the transmission of respiratory infections in health care settings, which includes airborne infection isolation for avian influenza, severe acute respiratory syndrome (SARS), tuberculosis, measles, and varicella; and Droplet Precautions for seasonal influenza, meningitis, pertussis, and rubella. If there is evidence of Pandemic Flu present in the community, refer to "Emergency Preparedness Harbor-UCLA Pandemic Influenza Response Plan".

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

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 strain. Once a novel virus is identified and a case definition is developed, it will be communicated by public health officials.

CLINICAL INFORMATION

- Affects people of all ages. Typically, those at greatest risk of severe complications of influenza are infants, young children, elderly adults, pregnant women, and individuals with chronic disease although these risk groups may differ according to the circulating influenza strain.
- Incubation period and duration of viral shedding may vary depending on the novel strain.
- Symptoms may include fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Gastrointestinal symptoms may also be present, such as nausea, vomiting, and diarrhea.



TRANSMISSION

- Direct and indirect contact.
- Transmission through coughing or sneezing (droplet ≥ 5 micron in diameter).

INFECTION PREVENTION AND CONTROL

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

- Respiratory hygiene and cough etiquette.

2016 Orientation/Reorientation

- Standard precautions and personal protective equipment (for workforce members and patients).
- Droplet Precautions.

Guidelines may be amended as more is learned about the infectivity of the pandemic virus. Refer to Emergency Preparedness policies and procedures: Pandemic Flu Plan. Infection Prevention & Control policies and procedures are located on the Harbor-UCLA intranet.

Further information regarding ATD, policies related to ATD, and Infection Control and Prevention can be found on the Harbor intranet under Policies and Procedures and under the Department of Infection Control and Prevention. Harbor Policies and Related State Regulations:

353 – Tuberculosis Exposure Plan

406B – Aerosol Transmissible Disease Exposure Control Plan and <https://www.dir.ca.gov/title8/5199.html>

435 – Bloodborne Pathogens Exposure Control Plan and <https://www.dir.ca.gov/title8/5193.html>

479A – Respiratory Protection Program and <https://www.dir.ca.gov/title8/5144.html>

479B – Respiratory Fit Testing

WASTE DISPOSAL

Harbor-UCLA maintains appropriate handling and storage areas for hazardous materials and waste that are separated and maintained to minimize the possibility of contamination of food, clean and sterile goods, or contact with staff, patients or visitors. Be aware of the various types of hazardous materials and waste and its appropriate measure of disposal.

Biohazardous Waste *	Container with red bag	Waste containing secretions, exudates and excretions containing blood is placed in containers labeled with a biohazardous label. *Pathology Waste is placed in container labeled “Pathology Waste/Incinerate Only” on the lid and on the sides of the container.
Sharps and Pharmaceutical Waste	Blue and white (semi-transparent)	All needles, syringes and other devices which have edges or capable of cutting or piercing corners, and pharmaceutical waste (all expired, reconstituted not used, or unused portion drugs that cannot be returned for credit). Containers are labeled “Biohazardous, Sharps, and Pharmaceutical Waste, For Incineration Only.”
Chemotherapy Waste	Yellow puncture-resistant container	All cytotoxic drug-related waste/deposit sharps. Containers are labeled with a biohazardous symbol and indicate “Caution chemotherapy waste, chemo safety”.
Radioactive Waste	Radioactive waste must be properly labeled. The Radiation Safety Office must be called to remove this waste to the designated area, where it must be monitored by qualified staff, until its safe and appropriate terminal disposal.	
Regular Waste (Non-Biohazardous)	White or neutral container	All waste (not glass) not listed in the other waste categories.

For additional information contact:

- Your Manager or Supervisor.
- Infection Prevention & Control Hospital Office/Message Line: (310) 781-3646.
- Employee Health Services: (310) 222-2360.
- STD Liaison Nurse: (310) 222-2254.
- Harbor-UCLA TB Control Liaison Nurse: (310) 222-3443
OR TB Control: (213) 744-6160 or (213) 974-1234 during after-hours.
- Environmental Safety Officer: (310) 222-2835.

REMEMBER

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



Remember:
Infection Control – It's in Your HANDS!

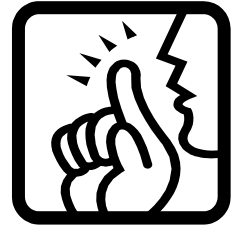


MANAGEMENT OF INFORMATION

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, 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 health care provider feels might be harmful to them.
3. Ask us to send their health information to someone.
4. Restrict who can see it or to whom we can send it.
5. Ask us to send their mail or call them at another address or telephone number.
6. Get a list of people or places where we sent their health information.
7. File a complaint.

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

D. Use and Disclosure of Patient Information

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



E. Protecting Patient Information

1. Safeguards
 - a. Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients' PHI.
 - b. We must take reasonable **safeguards** or **steps** to make sure patient health information is kept private.
2. Incidental Disclosures
 - a. We know that we cannot guarantee the privacy of patient information all of the time.
 - b. Some activities we do for business reasons, such as calling out a patient's name in the waiting area or talking to a patient on the phone or in an area where others might hear are called **incidental disclosures**.
 - c. Incidental disclosures do not violate laws as long as we take steps to protect the patient's privacy, such as moving close to the patient, closing doors or privacy curtains, eliminating 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 Harbor's Public Information Officer at Ext. 2101 during regular business hours, if the press or news media request information about one of our patients. After 5:00 p.m. and on weekends, contact the Shift Nurse Manager at Ext. 3434.
5. Social Networks
 - a. Do not post information about patients or work-related issues on social networking sites such as *Facebook, Twitter, Google+, YouTube, etc.*
 - b. It does not matter if you are not using County equipment or if you are at home or on your break.
 - c. Due to the nature and type of work you do, just small bits of information put together, can reveal identifying information about patients and cause you to violate privacy laws.



F. Access to PHI

1. In order to access PHI, you must have a legal or business "need-to-know." Your job duties determine how much patient information you can view or access.
2. Your supervisor will arrange for you to obtain access to systems and networks necessary for you to do your job.

G. Inappropriate Access to PHI

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

H. Minimum Necessary

1. Minimum necessary means you must only access the **information** you need to do your job.
2. Just because you have access to a system or network or to patient records, does not mean you have the right to access or view confidential or patient information that you do not need to do your job.
3. Only give out just enough information for someone else to do their job.
4. Never look at confidential or patient information "just because you want to know," even if you are not going to do anything with it.
5. It does not matter if the information is about a movie star, someone in the news, someone you work with, a close friend, or a family member.
6. All patient information is confidential and must be protected at all times.
7. You are not allowed to look at your own patient information.

I. Reporting Violations and Breaches of Patient Information

1. You must report anything a workforce member does that might be against DHS Policy or federal or state laws.

2. If a workforce member peeks at a patient's medical record we have to report it even if the workforce member did not tell anyone or the patient was not harmed.
3. You will not be retaliated against for reporting a suspected or actual violation in good faith.
4. If you falsely accuse someone on purpose you will be subject to discipline.
5. If you report a violation and you were involved, you will still be subject to discipline.
6. You **MUST** report suspected or actual breaches to your supervisor or the Harbor-UCLA facility Privacy Coordinator at (310) 222-8049, and submit a Safety Intelligence report within 4 hours of discovery.
7. If you feel you need to report it somewhere else, you can report it to any of the hotlines listed below.
 - o DHS Compliance Hotline at 1-800-711-5366
 - o County Fraud Hotline at 1-800-544-6861
8. Report suspected or actual security breaches to your supervisor or your facility Information Technology (IT) Service Desk at Ext. 5059

J. Fines and Penalties

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



SECURITY OF PATIENT INFORMATION

- A. The HIPAA Security Rule covers all electronic Protected Health Information (ePHI) when stored on computers and while being sent from computer to computer.
- B. ePHI is patient health information that is kept on computers and electronic media. Examples of electronic media include:
 1. Computer networks, desktop, laptop and handheld computers, personal digital assistants (PDAs) and handheld digital equipment such as cameras, tablets (*iPads, Androids, eReaders, etc.*), and cellular telephones;
 2. Computer software and databases; and
 3. Compact discs (CDs), digital versatile discs (DVDs), diskettes, USB storage devices such as flash/thumb drives and micro storage media, magnetic tapes, and any other means of storing electronic data.
- C. Each DHS facility must take steps to make sure ePHI is complete, it is protected, and it is available when someone needs it. Some of the steps include:
 1. Developing policies and procedures,
 2. Making sure computers do not get stolen, and
 3. Ensuring workforce members do not share their passwords.
- D. You must review and comply with the County and departmental IT security policies.
- E. The Acceptable Use Policy for County Information Technology Resources (DHS Policy No. 935.20) mandates the following:
 1. The County's computers and electronic devices belong to the County, and are to be used only for County business.
 2. You must protect all information created using County computers. Access to use a County computer is not a right. Your access may be modified or taken away at any time for abuse or misuse.



REMEMBER

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

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.

PATIENT CONFIDENTIALITY QUICK REFERENCE/KEY POINTS

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

Four primary ways patient confidentiality is most often violated:

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

See Privacy and Security Do's and Don'ts on Next Page

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 facility HIPAA Privacy Liaison or HIPAA Security Liaison.
- Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside the DHS e-mail domain.
- Obtain permission to store e-PHI on a laptop or other portable device, or USB thumb/flash drive and make sure the device is encrypted.
- Store paper records and medical charts in locked rooms and locked cabinets.
- Access to computers or computer systems containing e-PHI must be restricted to authorized users.
- Position computer workstations and monitors away from public view.
- Log off the computer when you are away from the work area or when the computer is not in use.
- Access to computers or computer systems containing e-PHI must be restricted to authorized users.
- 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 team 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.

Privacy and Security Don'ts

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

KEY POINTS TO REMEMBER – ALL STAFF

(What a Joint Commission Surveyor Is Likely to Ask You About)

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 inappropriate behavior by a licensed professional that may compromise patient or environmental safety, you must report it to the appropriate office (see telephone numbers listed under “Professional Credentials (License/Registration/Certification/Permit)”).
- It is important that you understand, whether you are a health care practitioner, technician, clerical or housekeeping member of our staff, that your job supports our organization’s mission to provide fully-integrated, accessible, affordable and culturally competent care, one person at a time.

THE JOINT COMMISSION ACCREDITATION

- Under The Joint Commission’s Accreditation Participation Requirements, any workforce member who has concerns about the safety or quality of care provided in the organization may report those concerns to The Joint Commission.
- All surveys are unannounced, so it is important to maintain continuous preparedness.

PATIENT SAFETY

We have a proactive, multifaceted, and integrated Patient Safety Program overseen by the Patient Safety Officer and the Patient Safety Council. 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. You must report events to your supervisor/manager and submit an event report in the Safety Intelligence, a web-based reporting system.
- The Joint Commission establishes National Patient Safety Goals (NPSGs) annually which Harbor-UCLA workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.
- Universal Protocol applies to all surgical and non-surgical invasive procedures and establishes a process for preventing wrong site, wrong procedure and wrong person surgery.
- If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility’s response mechanism and stay with the patient/visitor until help arrives.
- Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.

STAFF RIGHTS AND RESPONSIBILITIES

All Harbor-UCLA workforce members must complete all mandatory training and competency certification requirements for their respective positions [e.g., Network Orientation, Area or Unit Orientation, infection control, fire/life safety, emergency management, patient safety, CPR (if required) and other core competencies].

- Workforce members are responsible for reporting any activity that appears to violate the Code of Conduct. DHS will not retaliate against anyone who reports a suspected violation in good faith.

- Compliance Awareness training is provided to workforce members at the start of service. Compliance update training is provided every two years.
- The County of Los Angeles has established a “zero tolerance policy” for any conduct that could possibly be interpreted as harassing, offensive or inappropriate in the workplace, including actions of a sexual nature.
- It is the responsibility of the licensed professional to renew required professional credentials. Failure to comply with licensure requirements may subject the person to corrective action, up to and including discharge/release from County service or release from a contracted assignment. Professional staff that must maintain a current professional credential to perform the duties will not be allowed to work with an expired professional credential.
- It is the workforce member’s responsibility to obtain a health screening annually.

PATIENT RIGHTS AND SERVICES

- Harbor-UCLA posts Patients’ Rights and Responsibilities for patient, visitor and staff reference.
- Each inpatient receives a Harbor-UCLA Medical Center Admission Pamphlet.
- Administrative Patient Advocates are available at Harbor-UCLA and can provide assistance to ensure that patient rights are protected.
- It is prohibited to use minors as interpreters in any situation.
- An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their health care decisions.
 - The AHCD allows a person to give directives regarding health care decisions, such as whether or not they want life-sustaining treatment if they become terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their health care, when they are unable to do so.
 - Clinical Social Work staff informs patients of their options concerning AHCDs.
 - Patients can fill out an AHCD document or give oral direction to a physician who will document the directive in the patient’s medical record.
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the accountable supervisory staff to resolve the complaint at the first level whenever possible.

PERFORMANCE IMPROVEMENT (PI)

- Using our PI model, we measure our performance, assess how well we are doing, seek opportunities to improve, and look for evidence that we are making a difference.
- We use the Plan-Do-Study-Act (PDSA) performance improvement model.
- Ask yourself “How have I been involved in the improvements made in my department in the past 12 months? How have I worked with other departments to improve patient care/services?” If you don’t know, speak to your supervisor.
- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.

RISK MANAGEMENT

- 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. The phrase “risk thereof” includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.
- If you become aware of sentinel event or near miss you MUST report it within 4 hours of discovery.

You must report events in one of the following ways:

- Direct Supervisor AND
 - Safety Intelligence system accessible from the Harbor-UCLA Intranet Webpage; OR
 - Risk Manager's Office at (310) 222-2168.

ENVIRONMENT OF CARE

- Environmental safety concerns must be reported to your supervisor and the Environmental Safety Officer. You can report safety concerns anonymously via the Safety Intelligence.
- Know what all emergency codes mean and how you should respond to each, for example at Harbor-UCLA Medical Center:
 - 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 Behavioral 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/ Radiation Incident.
 - Code Yellow means bomb threat.
 - Code Rapid Response means urgent medical assistance is needed for inpatients.
 - Code Assist means urgent medical assistance is needed for outpatients, visitors, or staff.
 - Code Triage Alert means potential disaster situation.
 - Code Triage Internal means internal disaster situation.
 - Code Triage External means external disaster situation.
- The Safety Data Sheet (SDS) tells what hazards a chemical presents and how to handle spills/exposures. You must know the names of the hazardous materials that you work with and that you may come into contact with in your area. You have the "right to know" this information.
- You should know the location of the SDS sheets in your work area. If you don't know where they are kept, ask your supervisor. The SDS manual is also located in the Environmental Safety Office.
- In the event of a fire, follow the RACE and the PASS procedures, as appropriate.
- You must know where the fire alarm, fire extinguisher, fire box and fire evacuation route for your work area are located. If you are unable to find them, check with your supervisor.

INFECTION PREVENTION & CONTROL

- Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection.
- You must clean your hands before and after direct patient contact, after removing gloves, before/after eating, drinking, smoking, after using the toilet, whenever there is any doubt about contamination, and when hands are visibly soiled.

- 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, we will activate our Emergency Operations Plan and implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Preparedness & Management Manual, which is posted on the Harbor-UCLA intranet.

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 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's information as if it were your own.
- Report suspected HIPAA violations by means of the Safety Intelligence AND by phone to the facility Privacy Coordinator at (310) 222-8049 or facility Information Security Officer at (310) 222-2181.
- It is the responsibility of every member of our service delivery team to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and confidentiality of our patients' PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form.
- Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment, and health care operations (TPO).
- Personally Identifiable Information (PII), information similar to PHI, must be protected.
- We use the following safeguards to protect patient-specific information:
 - Use shredders and locked bins to dispose of PHI documents.
 - Cover carts used to transport Medical Records.
 - Lock doors and use sign-in logs to limit access to the Health Information Management Department.
 - Required Compliance Awareness and Compliance Update training for all workforce members.
 - Implement a "need to know" level of security to access PHI.
 - Use automatic log-off of PC's after non-use of systems.
 - Use user-ID and password to access PHI.
 - Encrypt laptops, external storage devices and portable medical equipment that store ePHI.
 - Regularly review reports to HIM showing outgoing, incoming and transferring staff, to ensure valid users.
 - Limited remote access is provided to user by Virtual Private Network (VPN).
- In the event of a disaster, we ensure against loss of data by activating the IT Disaster Recovery Plan. Additionally, HIM performs daily data backup on all servers and stores the backed-up information in an off-site location.
- Harbor-UCLA 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.

- Harbor-UCLA provides "knowledge-based data and information" through the Parlow Medical Library at Harbor-UCLA Medical Center. Leaders and care providers can access journals, text books, audio visual materials etc. The library is accessible online.

CLINICAL ORIENTATION

This section of the Orientation should be completed 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
Radiologic Technologists	Phlebotomy Technicians
Physical Therapists	Recreation Therapists
Speech Pathologists	Clinical Social Workers
Rehabilitation Therapy Technicians	Surgical Technicians
Licensed Physical Therapy Assistants	Dental Assistants
Nurse-Midwives	Dental Hygienists
Certified Nurse Anesthetists	Registered Dietitians
Physician Assistants	Occupational Therapy Assistants
Nurse Practitioners	Cardiac Monitor Technicians

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

PATIENT CARE PRACTICES

This section addresses general patient care principles related to population-specific guidelines, pain assessment/reassessment, and nutrition services.

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

Staff with direct patient care responsibilities is trained in working with the appropriate age groups (neonate, infant, child, adolescent, adult and geriatric patients) during the initial area/unit and job-specific orientation. Staff who interact with patients as part of their job must develop skills and competencies for delivering appropriate population-specific communications, care, and interventions to assure each patient's unique needs are met. People grow and develop in stages that are related to their age and share certain qualities at each stage. By adhering to the following guidelines, a sense of trust and rapport with patients can be established and psychological, social and physical needs of patients can be met. The population-specific guidelines are:

NEONATES (BIRTH TO 28 DAYS)

- Neonates are newborns.
- Keep in flexed position, with knees to chest and arms midline, when possible.
- Use warm hands, equipment, and room.
- Allow rest periods between procedures and treatments.
- Provide security and ensure a safe environment.
- Involve the parent(s) in care.
- Limit the number of strangers around the neonate.
- Ensure crib/gurney rails are up and incubator doors are closed.
- Use equipment and supplies specific to the age and size of the neonate.

INFANTS (1 MONTH TO 12 MONTHS)

- Rock, swaddle, and sing softly to infant.
- Use a distraction, (e.g., brightly colored toys, hand puppets).
- Keep the parent(s) in the infant's line of vision.
- Ensure crib/gurney rails are up at all times.
- Use equipment and supplies specific to the age and size of infant.

CHILDREN (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 6-12).
- Use simple, concrete terms when talking to younger children.
- Allow younger children to keep security object, (e.g., blanket, toy), if possible.
- Give praise, rewards, and clear rules. Encourage older children 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 in language used/choice of words. Involve older children in care and offer choices whenever possible.
- Provide for the safety of the child. Do not leave the 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 using simple terms and correct terminology to adolescents and parents.
- Consider the importance of the adolescents' peer group.
- Provide for privacy.

ADULTS (18 YEARS THROUGH 64 YEARS)

- Be supportive and honest.
- Respect the patient's personal values.
- Support the person in making health care decisions.
- Recognize commitments to family, career, and community.
- Address age-related changes.

GERIATRICS (65 YEARS & OLDER)

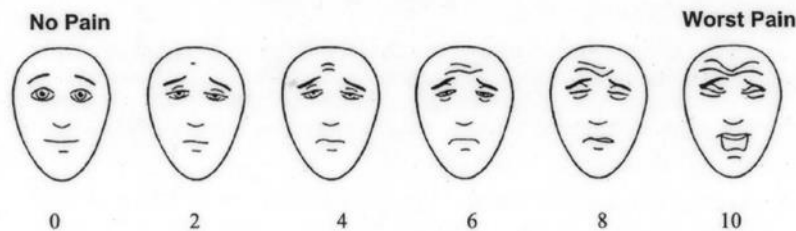
- Avoid making assumptions about loss of abilities, but anticipate the following:
 - Short term memory loss.
 - Decline in the speed of learning and retention.
 - Loss of ability to discriminate sounds.
 - Decreased visual acuity.
 - Slowed cognitive function (understanding).
 - Decreased heat regulation of the body.
 - Inability to chew food properly.
- Provide support for coping with any impairment.
- Prevent isolation; promote physical, mental, and social activity. Provide information to promote safety.

PAIN ASSESSMENT AND REASSESSMENT

Bieri Faces Pain Scale – Revised (FPS-R)

Bieri Faces Pain Scale-Revised (FPS-R)

Description: A self-report measure used to assess the intensity of pain. There are 6 faces arranged along a horizontal line in increasing pain intensity. Each face has a corresponding numeric score. Numeric scores are 0-2-4-6-8-10.



2016 Orientation/Reorientation

Pain is a common experience for a majority of our patients. Support every patient's right to have his/her pain assessed and treated promptly, effectively, and for as long as the pain persists. Care providers assess all patients receiving care at our facility for pain upon initial presentation and in subsequent reassessments. Pain is a "fifth vital sign". Document these reassessments at the same time as the patient's vital signs. On initial complaint of pain, a comprehensive assessment is performed to identify the intensity (pain score), character, location, onset, frequency, duration, aggravating or mitigating factors and other characteristics as determined by the nature of the pain. Reassessment of pain includes the effectiveness of interventions, pain score, location, frequency, duration, character, tolerable pain level and treatment plan that is documented. Appropriate pain assessment tools to assess, reassess, and document pain ratings can be used to compare these ratings over time.

Pain is a very subjective experience. Because the patient is the best judge of the intensity of his/her pain and the effectiveness of its treatment, most of the assessment tools we use depend on information from the patient's self-report. However, when a patient cannot self-report, we use tools that allow pain assessment based on physiologic changes and/or behavioral indicators to rate the severity of the patient's pain experience. On a scale of zero (0) to 10, with zero (0) being the absence of pain, the following severity levels apply:

Mild Pain	0 - 3
Moderate Pain	4 - 6
Severe Pain	7 - 10

The FLACC Scale is a tool that is used for infants and children aged 0-7 years that allows the nurse or physician to rate the patient's pain on a scale of zero (0) to 2, based on each of 5 categories, based on behavior signs.

FLACC SCALE



CATEGORIES	SCORING		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	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

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 10.

Harbor-UCLA identifies pain assessment tools to be used in their facility. Pain assessment tools that are age- and condition-appropriate are used. Additional pain tools used at Harbor-UCLA include the following:

Neonatal Pain, Agitation, and Sedation Scale (N-PASS):

Neonatal Pain, Agitation, and Sedation Scale (N-PASS) is a pain assessment tool used for neonates/infants in the Neonatal Intensive Care Unit (NICU) and nursery. Pain should be presumed in neonates/infants in all situations that are usually painful for adults and children, and treatment should be used if there is any possibility of pain. This pain scale is documented as 0 to 10 or 11. If the patient is ≥ 30 weeks gestation, pain intensity is rated on a scale of 0-10, with zero (0) being no pain and ten (10) being the worst possible pain. If the patient is <30 weeks gestation/corrected age, pain intensity is rated on a scale of 0-11, with zero (0) being no pain and eleven (11) being the worst possible pain.

Numerical Rating Scale (NRS):

A numeric pain assessment tool, in which patients are asked to verbally rate their current pain intensity on a scale of 0 to 10, with zero (0) being no pain and ten (10) being the worst possible pain. The NRS is used for population greater than 5 years of age.

Assumed Pain Present (APP):

APP is the culmination of a pain assessment of a nonverbal patient, “usually when there is no appropriate behavioral assessment instrument to quantify behaviors systematically.” (Quinn, 2006). This includes patients who are unresponsive due to traumatic brain injury, pharmacologically induced coma or neuromuscular blockade. Pain is assumed to be present in these patients. Analgesics will be administered when clinically indicated.

INTERVENTION/TREATMENT PLAN FOR PAIN

If the patient receives medication for pain, the pain score or physiological and/or behavior signs of pain are documented in the reason column of the Medication Administration Record (MAR) for inpatients or Clinic Record/Progress Note for outpatients.

The patient is reassessed for the effectiveness of the intervention/treatment and the pain score or physiological and/or behavior signs of pain are documented within one hour in the reason column of the Medication Administration Record (MAR) for inpatients or Clinic Record/Progress Note for outpatients. Effectiveness (or ineffectiveness) of the treatment is documented by the nurse or physician. If the pain is not relieved, then the next intervention or treatment plan is initiated and documented until the pain can be controlled.

Our approach to pain management includes the use of pharmacologic as well as non-pharmacologic interventions. Educate patients and families about their right to have their pain assessed and treated and give patients “Management of Your Pain” brochure. Tell them the purpose for the frequent reassessments and the use of the pain rating scales.

PATIENT FOOD SERVICES/NUTRITION SERVICES

Nutrition Services provides a highly specialized level of Medical Nutrition Therapy by Registered Dietitians that includes nutrition assessment, patient education and consultation for enteral and parenteral nutrition.

NUTRITION CONSULTS

Registered Dietitians are available for consultation between the hours of 7:00 a.m. to 5:30 p.m. on weekdays and 7:30 a.m. to 4:00 p.m. on weekends. An ORCHID consult order, which should include the reason for the consult, should be entered by the provider in the electronic medical record by choosing “consult to dietician”. A dietitian will complete an assessment within 24 to 48



hours of the order. Please refer to each patient care area for specific contact information for the dietitian assigned to that area, if needed.

DIET ORDERS

A diet order, which may include NPO or a specialized nutrition regimen, is required for each patient. When changes are made to the diet order, the newest/most restricted diet order will be carried out. Patient meals are served according to the table below. There are cut-off times for entering meal changes into ORCHID to receive a hot meal for a patient. After these times, sack meals will be provided until the next meal service. Enteral products are provided by Nutrition Services during meal delivery times. Nourishments (between meals snacks) must also be ordered by the physician and are delivered at approximately 10:00 a.m., 3:00 p.m., and 8:00 p.m. daily.

In accordance with state laws, meals, supplements and/or nourishments cannot be provided to the patient until it has been ordered by a physician or licensed practitioner and is entered into ORCHID.

	Meal time	Routine diet requests/orders must be entered by:
Breakfast	6:45 a.m. – 8:45 a.m.	6:30 a.m.
Lunch	11:15 a.m. – 1:15 p.m.	10:30 a.m.
Dinner	4:45 p.m. – 6:45 p.m.	4:30 p.m.

NUTRITION SERVICES PHONE LIST:

Dietitian Office(310) 222-5398
Outpatient Nutrition Clinic(310) 222-3376
Nutrition Services Department.....(310) 222-3374 or (310) 222-3375
Director, Food and Nutrition Services.....(310) 222-4127

PATIENT SAFETY

This section addresses general patient care principles related to patient safety including “read back” requirements, Universal Protocol, medication management, unapproved abbreviations, behavioral restraints, medical record requirements for physicians/licensed independent practitioners (LIP), and medical review checklist.

“READ-BACK” REQUIREMENTS

To improve communication among care providers, we have several processes in place to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

- **Telephone Orders** – While the physician issues the order, the registered nurse (RN) writes the order down on the physician’s order sheet. Before ending the telephone call, the RN “reads back” the order to the physician to confirm that he/she understood and transcribed it correctly. The RN will document the phrase “Telephone Order (or T.O.) issued by” with the physician’s printed full name and provider identification number on the physician’s order sheet. The RN will flag the order sheet to be countersigned by the physician.
- **Verbal Orders** – It is not always feasible to do a formal “read back” for a verbal order (e.g., during a code blue or in surgery). In such circumstances, a “repeat back” is an acceptable means of confirming the accuracy of the order. When able, the RN will record the order on the physician’s order sheet followed by “Verbal Order per _____” with the physician’s printed full name. The RN will flag the order sheet to be countersigned by the physician.
- **Critical Test Results** – Harbor-UCLA communicates the Critical Laboratory Values/Results in a timely manner to the physician providing care for the patient. When a Critical Laboratory Value/Result is called, the licensed staff member who accepts the critical test result is asked to do a verification “read back”. If the licensed staff member is not able to act on the result (such as a nurse, or a physician who is no longer taking care of the patient), that person should pass the information on to the person who can take appropriate action, and document these steps as soon as possible.

UNIVERSAL PROTOCOL

We have adopted all components of The Joint Commission’s Universal Protocol intended to prevent wrong site, wrong procedure and wrong person surgery or procedure. The Protocol establishes a process for a defined series of pre-procedure verifications designed to maximize patient safety and well-being. It applies to invasive procedures performed in the operating room as well as those performed in non-operating room settings (e.g., bronchoscopy, endoscopy, interventional radiology, cardiac catheterization, and the bedside). You share in the responsibility of conducting this verification process in cooperation with the patient.



The main components are:

- **Pre-Operative/Pre-Procedure Verification:** We use a checklist to ensure all relevant documents are available and correct before sending a patient for an invasive procedure. Ensure that the patient’s history and physical is present and current, that we obtained the patient’s informed consent, and that the patient agrees to the planned surgery/procedure. If you find any information missing or any discrepancy, postpone the procedure until the information is clarified and/or corrected.
- **Marking the Operative Site:** We require site marking for all surgical sites/invasive procedures involving right/left distinction, multiple structures, or levels, where the procedure does not involve an obvious wound or lesion. The site should be marked by one of the practitioners who will be participating in the procedure. In

most cases, the patient's skin should be marked with the word "YES" to indicate the intended site. Site marking must be visible after the patient is draped and positioned for the procedure. Alternative methods of marking the site may apply to certain patients, such as neonates. Whenever possible, involve the patient in the marking process.

- **"TIME OUT"** – Harbor-UCLA Medical Center employs two "time outs": One just before administration of anesthesia, and one just before the start of the procedure. All those who will be participating in the start of the procedure conduct a final verbal verification to confirm the correct identity of the patient, planned procedure, operative site, side, and level. In the Operating Room (OR) and other dedicated procedure areas, the nurse documents the "TIME OUT" on the back of the Pre-Op/Pre-Procedure Record. In non-specialty areas (e.g., bedside procedures), the provider documents the occurrence of the "TIME OUT" in his/her procedure note.
- Procedures for non-OR settings including bedside procedures: Site marking must be done for any procedure that involves laterality, multiple structures or level, when there is not an obvious wound or lesion. Procedures for verification, site marking, and "Time Out" procedures should be consistent as in the OR setting.



DETERIORATING PATIENT CONDITION

RESPONDING TO THE DECLINE IN PATIENT CONDITION

As patient caregivers, you need to know the signs and symptoms of the decline in a patient's condition, within your scope of practice. The assessment and recognition of the deteriorating patient is an ongoing challenge throughout the patient's stay or visit to your facility. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going health assessments, handoff communication reports, chart documentation and other communication modalities are good methods to use in recognizing declination in the patient's condition. Every member of the health care team is responsible to ensure that they give the highest level of care, and to immediately react upon 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 of 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.
- You are worried that the patient is deteriorating for some other reason.



If you are concerned that a patient is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. The patient's nurse will assess the situation and call for additional assistance if needed. For patients admitted in wards and PCU areas as well as the infusion and dialysis centers on 5 East, Harbor has rapid response teams set up to evaluate and stabilize patients who are deteriorating. RNs in those areas are trained on when and how to activate a rapid response team, if necessary. In other areas of the main hospital, nurses should contact a physician or nurse manager for assistance if they are concerned about a patient. Anyone can call a Code Blue or Code White for respiratory or cardiac arrest by dialing Ext. 112 from a

hospital phone. In areas outside the main hospital building, call 9-1-1 for a medical emergency (Note: The 1 South CRU is considered part of the hospital and is covered by the Medical Rapid Response Team and Code Blue Team).

FALL REDUCTION AND PREVENTION

Prevention of patient falls is the responsibility of **EVERY** workforce member. Creating a safe environment, enforcing fall prevention through education and training, and teaching patients reduces fall rates.

Outpatient Clinics (Hospital-Based and Ambulatory Care Network) will screen patients and mitigate risks for falls and harm, based on the patient population, setting, and environment. Documentation, as applicable, will include:

- Fall screening.
- Fall risk.
- Fall prevention measures implemented and patient education provided.

Hospitalized inpatients (1 year of age and older) will be assessed 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 health care professional will implement and document interventions to reduce the risk of falls; to include patient/family education.

Organization/Facility Assessment of Fall Risk:

There is, at minimum, an annual assessment of each facility's patient fall risk to determine prevention and intervention measures. The assessment may include, but not limited to, periodic environmental rounds, patient safety rounds, medical staff committee determination of risk based on clinical conditions, and review of adverse events (related to falls).

Performance Improvement, Quality Control, Monitoring, Reporting, and Benchmarking will be performed on a quarterly basis utilizing the identified DHS Fall Database.

DHS Employee Fall Prevention Program education will include training to all current DHS providers, nursing and clinical ancillary staff on the DHS System-Wide Fall Prevention Program. Additionally, the DHS System-Wide Fall Prevention Program will be incorporated into the New Employee Orientation Program.

Definition

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, such as a trash can or other piece of equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

Rehabilitation Fall: A fall is a loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair, excluding falls resulting from "purposeful actions".

Purposeful Action: A rehabilitation therapy session performed with the intent of challenging a patient's balance or to attempt a functional activity the patient is unable to perform without assistance.

HOSPITAL-BASED OUTPATIENTS

Outpatient Setting (Hospital-Based and Ambulatory Care Clinics):

- A. Screening for fall risk may be applied across a clinic or patient-specific:
1. Certain patient populations, settings, and environments pose an equivocal increased risk for falls. Risk may be based on factors, including but not limited to, patient demographics, diagnoses, medical condition, clinical situation, mobility, and ambulatory/mobility equipment needs.

Clinic-wide screening may include:

- Periodic Environmental Rounds
- Validation of clinic-wide safeguards (e.g. hand rails, level flooring/surfaces, wheelchair/walker access, grab bars)
- Patient Education
- Staff Education
- Evaluation of previous year's fall data

Screen each adult and/or pediatric patient (over 1 year of age) for fall risk using the age appropriate screening tool.

- Adult Ambulatory Care Fall Screening Criteria
- Pediatric Ambulatory Care Fall Screening Criteria (patient >1 year of age)

B. Patients identified as high risk during either screening methods will have a licensed professional further determine, implement, and document appropriate prevention measures including patient/family education.

C. Outpatient Fall Prevention Measures.

1. Maintain a safe, hazard free environment (remove any obstacles from patient pathway).
2. Place 'as-risk' patients who are identified as needing assistance on exam table only at the time of examination, with staff present.
3. Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so).
4. Ensure adequate lighting.
5. Use wheelchair locks when indicated.
6. Keep beds, stretchers, and/or gurneys in lowest, locked position with side rails up, as appropriate.
7. Keep call light, as applicable, within reach.
8. Identify and manage areas of concern during Environmental/Safety Rounds.
9. Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
10. Notify appropriate professional for focused fall reduction interventions and patient/family education, including, but not limited to:
 - Diagnosis and treatment underlying etiology of fall risk
 - Ensure 'fall risk' alert armband is in place based on patient condition and determination of fall risk.
11. Provide patient/family education regarding:
 - Fall risk determination.
 - Safety measures for prevention of falls during their outpatient visit.
 - Rising slowly from a sitting or lying position.

- If possible, consider having patient relocate to an area that allows closer nursing observation.

12. Offer wheelchair, if appropriate.
13. Ensure assistive devices (e.g., cane, crutches, walker, wheelchair) are within reach of the patient.
14. Assist patients walking with medical equipment, as appropriate (e.g., wound vacuum devices, IV poles, oxygen tubing, tanks, etc.)
15. Alert subsequent providers that patient is a fall risk (e.g., during transfers or hand-off to another clinical area/service).

D. Post-Fall Procedure

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm and complete all post fall documentation in the medical record.

Outpatient Fall Prevention Measures	
For ALL Patients	For at RISK Patients
<ul style="list-style-type: none"> • Maintain a safe, hazard free environment (remove any obstacles from patient pathway). • Ensure adequate lighting. • Use wheel locks when indicated. • Keep beds, stretchers, gurneys in lowest, locked position. • Keep call light (as applicable) within reach. • Identify and manage areas of concern during Environmental Safety Rounds. • Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings. 	<ul style="list-style-type: none"> • Ensure “Fall Risk” alert arm band is in place. • Provide education to patient/family regarding fall risk determination. • Place “at-risk” patients identified as needing assistance on exam table only at time of examination, with staff present. • Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so). • Offer wheelchair if appropriate. • Be sure assistive devices (cane, crutches, walkers, wheelchairs, etc.) are within reach of the patient. • Assist patients walking with medical equipment (wound vac, IV, etc.). • Alert subsequent provider that patient is a fall risk. • Notify appropriate professional for focused fall reduction interventions and patient/family education.

Falls screening in the outpatient area does not replace the requirement to complete a population and age-appropriate falls risk assessment on admission.

INPATIENTS

Assessment/Reassessment


1. Upon admission, the RN will assess all adult inpatients and children > 1 year of age for their risk for falls utilizing the appropriate Fall Risk Assessment Tool.
 - Adults: Morse Fall Assessment Scale
 - Pediatrics: Humpty Dumpty Scale

2016 Orientation/Reorientation

Morse Fall Risk Assessment		
Risk Factor	Scale	Score
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / Walker	15
	None / Bed Rest / Wheel Chair / Nurse	0
IV / Heparin Lock	Yes	20
	No	0
Gait / Transferring	Impaired	20
	Weak	10
	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

Morse Fall Score	
High Risk	51 and higher
Moderate Risk	25 – 50
Low Risk	0 – 24

Morse, J.M. (1997). *Preventing Patient Falls*. Thousand Oaks, Sage Publication
 Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. *Canadian Journal Aging*, 8,366-377.



Humpty Dumpty Falls Prevention Program™
Preventing falls, enhancing safety.
Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Humpty Dumpty Scale and Prevention – Inpatient Program

Parameter	Criteria	Score (Circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alteration in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitation	3
	Forgets Limitations	2
	Oriented to Own Ability	1
Environmental Factors	History of Falls or Infant – Toddler Placed in Bed	4
	Patient Uses Assistive Devices or Infant – Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/Anesthesia	Within 24 Hours	3
	Within 48 Hours	2
	More Than 48 Hours/None	1
Medication Usage	Multiple usage of: Sedatives (excluding I.C.U. patients sedated and paralyzed), Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotic	3
	One of the Meds Listed Above	2
	Other Medications/None	1
	Total	

Hill-Rodriguez D, Messmer PR, Williams PD, Zeller RA, Williams AR, et al. The humpty dumpty falls scale: A case-controlled study. *JSPN*. 2009;14(1):22-32

- Patients will be reassessed daily, upon inter-unit transfer, upon change of status, or post fall to determine the need for Fall Prevention Measures (FPM) implementation.

Risk Determination

Adults	
Low Risk	Any adult patient who receives a score of 0-24 on the Morse Fall Scale is considered as low risk. Level 1 interventions will be implemented for these patients
Moderate Risk	Any adult patient who receives a score of 25-50 on the Morse Fall Scale is considered as moderate risk. Level 2 interventions will be implemented for these patients <u>in addition</u> to Level 1 interventions
High Risk	Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients <u>in addition</u> to Level 1 and 2 interventions
<ul style="list-style-type: none"> When a patient is identified as moderate or high risk for falls, the nursing staff will initiate a plan of care related to the patient's identified risk factors and place a colored "fall risk" alert arm band on the patient Place a sign at the entrance to the patient's room and/or head of the patient's bed Place a fall precaution sticker on front of patient's chart. 	
Pediatrics	
Low Risk	Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and "General Fall Prevention Interventions for All Children" will be implemented for these patients
High Risk	Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for High Risk for the duration of his/her hospitalization
<ul style="list-style-type: none"> If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a falls risk reassessment may be performed and documented to justify the discontinuation of the high risk for falls identification and implementation of Falls Prevention Measures. If, in the nurse's judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures. 	

Initiation of Plan of Care

When a patient is identified as moderate or high risk for falls, the RN will initiate a plan of care related to the patient's identified risk factors. Injury and/or fall prevention strategies, including patient/family education will be incorporated into the plan of care for at risk patients.

Fall Prevention Measures

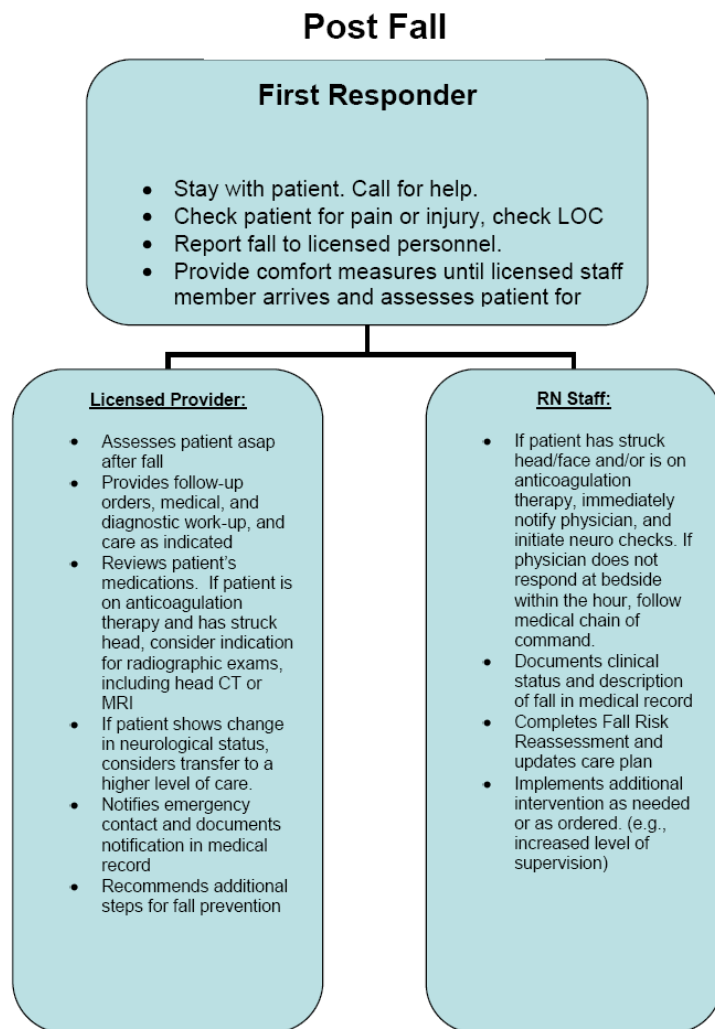
When a patient is identified as moderate or high risk for falls either on admission or during his/her hospitalization, the RN will implement the following fall prevention measures:

Adults	
<p>Level 1 Low Risk Score: 0 – 24</p>	<ul style="list-style-type: none"> • The patient’s risk for falls will be discussed with interdisciplinary team members. • Provide patient/family education related to fall prevention. <ul style="list-style-type: none"> • Purpose and importance of fall/injury prevention measures. • Use of call light • Maintain bedrails in appropriate position. • Safe ambulation/transfer techniques. • Importance of wearing non-skid footwear. • Reporting environmental hazards to nursing staff (e.g., spills, cluttered passages). • Family/ significant others may assist with fall reduction strategies once fall management training is completed. (Note: staff remains responsible for overall safety of patients even with family in attendance.) • Perform intentional rounds. • Orient patient to surroundings and hospital routines. • During exchange of patients between staff, hand off communication should include fall risk level, supervision provided, and observation of unsafe behaviors. • Set the bed in the lowest position with brakes locked. • Place personal belongings within reach on the bedside stand/table. • Reduce room clutter. Remove unnecessary equipment and furniture. • Provide non-skid (non-slip) footwear.
<p>Level 2 Moderate Risk Score: 25 – 50</p>	<ul style="list-style-type: none"> • Attach fall prevention stickers to the front of the medical record. • Place a sign at the entrance to the patient’s room and/or head of the patient’s bed. • Offer toileting, minimally, every 2 hours. • Activate the bed alarm and wheelchair seat belt alarm, if appropriate.
<p>Level 3 High Risk Score: 51 and higher</p>	<ul style="list-style-type: none"> • Increase frequency of nursing rounds based on patient need. • Collaborate with interdisciplinary team for therapy schedule/ activities. • Cohort patients, when possible. • Restraints are discouraged, however, if needed, apply per Hospital Specific Restraint Policy. • Provide continuous in-person observation with a trained staff member as needed for safety reasons. • Place the patient in a room or area where they can be easily observed. • Offer toileting, minimally, every 2 hours. • Stay with patient at all times while toileting out of bed. <ul style="list-style-type: none"> ○ Refusal by patient for direct observation during toileting must be documented in the patient’s medical record, as applicable. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.) ○ Notify the appropriate licensed professional of patient’s refusal.

Pediatrics	
<p>General Fall Prevention Measures</p>	<p>Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all children:</p> <ul style="list-style-type: none"> • Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings. • Leave crib side rails up at all times unless an adult is at the bedside. • Bed type and size shall be determined based on child’s developmental and clinical needs. • Instruct patient/parent on how to prevent falls in the hospital setting: <ul style="list-style-type: none"> ○ Maintain side rails in appropriate position. ○ Maintain crib rails up. ○ Do not allow the child to jump on the bed. ○ Do not allow the child to run in the room or hallway. ○ Do not allow the child to climb on hospital furniture or equipment. ○ Explain the importance of wearing non-skid footwear. ○ Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual. ○ Notify nursing staff of environmental hazards (e.g., spills, cluttered passages). ○ Supervise the child’s activities (e.g. walk next to the child and provide support as strength and balance are regained).
<p>Fall Prevention Measures for High Risk</p>	<ul style="list-style-type: none"> • Consider locating the child closer to nursing station for closer observation. • Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion and pain. • Offer Assistance with toileting, minimally, every 2 hours while awake. <ul style="list-style-type: none"> ○ Stay with child at all times while toileting out of bed. ○ Refusal by the child’s parent/guardian for direct observation during toileting must be documented in the patient’s medical record. ○ Notify the appropriate licensed professional of child’s parent/guardian’s refusal. • Provide calming interventions and pain relief. • Accompany patient with ambulation. • Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications). • Set bed alarms, as appropriate, to alert when child is exiting the bed. • Evaluate need for and encourage family to remain at the child’s bedside. • Assess need for continuous in-person observation with a trained staff member, as needed, for safety reasons. • Provide patient/family education related to fall prevention (in addition to education related to general injury prevention above): <ul style="list-style-type: none"> ○ Purpose and importance of fall/injury prevention measures. ○ Use of call light/maintaining bedrails in appropriate position. ○ Safe ambulation/transfer techniques. ○ Instruct family of pediatric patients to inform the nurse and/or physician if the child seems to be less coordinated than usual, or complains of dizziness or feeling weak. ○ Instruct family of pediatric patients that until the child regains his/her strength, someone should walk alongside him/her to provide support and protection in case he/she loses his/her balance.

POST-FALL PROCEDURE

After a patient fall initiate the Post-Fall Evaluation and Management Algorithm and complete all post fall documentation in the medical record.



Documentation

Outpatient	Inpatient
<p>For patients at risk for falls, staff will document the following on appropriate outpatient record:</p> <ul style="list-style-type: none"> Falls screening. Fall risk. Fall prevention measures and patient education provided. 	<p>The RN will document the following on the appropriate forms:</p> <ul style="list-style-type: none"> Using the appropriate Fall Risk Assessment Tool, document the initial assessment and ongoing reassessments. Patient/family education related to falls. Ongoing safety precautions. Any fall incident, related assessments, and notification of physician/family.

Emergency Department (ED)

- A. Screening (adult, pediatric, psychiatric, and all other ED areas) will take place at the time of triage assessment using age appropriate fall risk screening criteria:

Adult

1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure or syncope
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit-sight/hearing/speech impairment
7. Unsteady gait/weakness

Pediatrics

1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure in the last 6 months
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit – sight/hearing/speech impairment
7. Developmental problems causing difficulty walking
8. Neurologic diagnosis/condition causing difficulty walking (e.g., Muscular Dystrophy)

- B. Identify all patients who meet any one of the criteria as a possible fall risk.
C. All patients who are identified as a fall risk will have a fall risk armband placed.
D. Additional interventions will be implemented as applicable for the individual patient.

Adult Interventions

1. Provide assistance with ambulation
2. Move patient to allow closer nursing observation
3. Place the patient directly on bed (or on gurney)
 - I. Bed or gurney in lowest, locked position
 - II. Side rails up
4. Provide patient/family education on fall prevention measures
 - I. Environmental orientation
 - II. Call light
 - III. Call for assistance, as needed
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
7. Assess for elimination needs every 2 hours
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons.
 - I. Provide privacy when patient is toileting, if requested
 - II. Refusal by patient for direct observation during toileting must be documented in the patient's medical record.
 - III. Notify the appropriate licensed professional of patient's refusal.

Pediatrics Interventions

1. Assist with ambulation
2. Move patient to allow closer nursing observation.
3. Place the patient directly on bed (or on gurney)
 - I. Bed or gurney in lowest, locked position
 - II. Side rails up
4. Provide patient/family education on fall prevention measures
 - I. Environmental orientation
 - II. Call light
 - III. Call for assistance, as needed

5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons
7. Assess for elimination needs every 2 hours
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons
 - I. Provide privacy when patient is toileting, if requested
 - II. Refusal by child's parent/guardian for direct observation during toileting must be documented in the patient's medical record
 - III. Notify the appropriate licensed professional of child's parent/guardian's refusal
9. Encourage family to stay at patient's bedside

E. Post Fall Procedure

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm and complete all post-fall documentation in the medical record.

MEDICATION MANAGEMENT



Managing the use of medications to enhance patient safety is very important and involves multiple services and disciplines working closely together. When ordering/prescribing medications, it is important to remember the following:

- There is a documented diagnosis, condition, or indication for use for each medication ordered.
- As applicable, weight-based dosing for pediatric patients is required.
- Medication orders are written clearly.
- Dangerous abbreviations, acronyms or symbols are not used when writing orders. Enforcement/feedback policy and procedures are in effect.

MEDICATION USE

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

MEDICATION PRESCRIBING

As a practitioner, you have the responsibility of ensuring the appropriate prescribing of medications to your patients in an effort to decrease the potential risk for medication errors. You must clearly understand the correct indication, dose, route, and the pharmacological effects of each medication that you prescribe to avoid adverse drug events. We encourage you to review the formulary on an ongoing basis, and utilize formulary-approved medications.



SAFETY TIPS FOR SAFE MEDICATION PRESCRIBING

Write **CLEARLY, BOLDLY, AND LEGIBLY** in the patient's orders, specifying the name of the medication, drug dosage, route, and frequency. Make your medication orders clear and complete by:

- Identifying your patient with TWO identifiers (*Patient Name and MRUN for inpatients; Patient Name and Date of Birth for outpatients*)
- Placing the date and time on all orders

- A complete medication order requires the name of the medication, dose route, and frequency
- Not using range orders (Pharmacy will not accept ranges such as 1-2 tabs; q 4-6h in orders)
- Writing a specific indication for all as needed (PRN) orders (e.g., PRN pain)
- Signing all orders and printing your name and physician and pager number so that you may be located for any questions
- Entering the patient's diagnosis, allergies, and height/weight on all admitting orders to avoid delay in dispensing
- Using weight-based dosing on all pediatric patients less than 40 kg of weight
- Avoiding the use of unapproved abbreviations. When in doubt, do not abbreviate! To prevent any confusion, spell out the entire name of the drug.

DANGEROUS ABBREVIATIONS: DO NOT USE



Harbor-UCLA will NOT accept the following abbreviations/symbols



Illegible prescriptions and medication abbreviations/symbols may lead to medication errors. To avoid confusion and facilitate safe medication use practice, the Pharmacy & Therapeutics Committee and Medication Safety Committee have designated that the following abbreviations/symbols are unacceptable at Harbor-UCLA Medical Center. Dangerous abbreviations/symbols apply to all patient-specific documentation.

Dangerous Abbreviations	Intention Alternative	Misinterpretation
U or u	Unit (write "unit")	Read as zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44")
µg	Microgram (Use the abbreviation of "mcg" or write "microgram")	Mistaken for "mg" when written resulting in an overdose
Zero after decimal point (1.0)	1 mg (do not use terminal zeros for doses expressed in whole numbers)	Misread as 10 mg if the decimal point is not seen
No zero before decimal dose (.5 mg)	0.5 mg (always use zero before a decimal when the dose is less than a whole unit)	Misread as 5 mg.
IU	International unit (Avoid use)	Misread as IV (intravenous)
X3d	For three days (Write "days")	Mistaken for "three doses"
t.i.w or T.I.W	3 times weekly or three times weekly	Mistaken for three times a day or twice weekly
q.d. or QD	Every day (write "every day" or "daily")	Mistaken as q.i.d. especially if the period after the "q" or the tail of the "q" is misunderstood as an "l"
q.o.d. or QOD	Every other day (write "every other day")	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written
MS MSO ₄ MgSO ₄	Morphine sulfate Or Magnesium sulfate	Confuse for one another. Can mean morphine sulfate or magnesium sulfate

“LOOK-ALIKE/SOUND-ALIKE” MEDICATIONS

To further enhance medication safety, the Medication Safety and Pharmacy and Therapeutics Committee has developed the following Look-Alike/Sound-Alike (LASA) Medication List. These medications are stored apart in the Pharmacy and in patient care areas. Special attention should be given when administering one of these drugs to ensure that it is the correct drug.

Be aware that “Tall-Man” lettering is used to differentiate look alike/sound alike drugs.

The following strategies are implemented at Harbor-UCLA Medical Center to minimize medication errors associated with look-alike, sound-alike (LASA) medications:

9. Tall man lettering is used to describe LASA drugs on medication labels, Medication Administration Record (MAR).
10. LASA drugs are separated where drugs are stored and labeled with a cautionary sticker.
11. Prescribers are encouraged to include the indication for use when prescribing LASA medications.

LOOK-ALIKE/SOUND-ALIKE MEDICATION LIST		
1.	CARBO platin (antineoplastic)	CIS platin (antineoplastic)
2.	clon AZEPAM (anticonvulsant)	Clon IDINE (alpha-adrenergic agent)
3.	DAUN Orubicin (antineoplastic)	DOX Orubicin (antineoplastic)
4.	DOP Amine (adrenergic agonist)	DOBUT Amine (adrenergic agonist)
5.	ePHED rine (bronchodilator)	EPINEPH rine (alpha-beta agonist)
6.	fo LIC acid (vitamin)	fo LINIC acid (antidote)
7.	hydromor PHONE (narcotic analgesic)	MORPH ine (narcotic analgesic)
8.	hydro OXYzine (anti-histamine)	hydr ALAZINE (anti-hypertensive)
9.	LAMIV udine (anti-retroviral)	LAMO trigine (antiepileptic)
10.	LOR azepam (benzodiazepine)	ALPR Azolam (benzodiazepine)
11.	Suf SALAzine (anti-inflammatory agent)	Sulfa DIAZINE (antibiotic)
12.	Vin BLAS ^t ine (antineoplastic)	Vin CRIS ^t ine (antineoplastic)



MEDICATION DISPENSING

Before dispensing medications, the pharmacists must review all medication orders for appropriate indication, dose, route, frequency, and drug/allergy interactions. The pharmacist utilizes the patient age, height, weight, diagnosis provided to determine appropriateness, and reviews the patient medication profile to avoid therapeutic duplication and drug interactions. If orders are incorrect or require clarification, the pharmacist will contact the prescriber to clarify before dispensing the medication.

MEDICATION ADMINISTRATION

If you administer medication to patients, you are responsible for properly performing patient identification, using two identifiers, (*Patient Name and MRUN for inpatients; Patient Name and Date of Birth for outpatients*) per hospital policy. Bring the Medication Administration Record (MAR) into the patient's room to identify patient, verify and document the medication and dose administered. The Pharmacy routinely provides a daily copy of a printed MAR, generated from the pharmacy computer system. The nurse reviews all physician orders, reconciles and initials each medication on the pharmacy-generated MAR on a daily basis before use, sending the reconciled MAR copy to the pharmacy daily.



ADVERSE DRUG REACTION (ADR) REPORTING

Report all adverse drug reactions by submitting a Safety Intelligence report. Provide the patient's name, MRUN number, location, date of occurrence, name of the suspected medication, type of reaction, and your name.

MEDICATION ERRORS

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. 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, (including an identified potential medication error), through the Safety Intelligence reporting system.

REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

1. Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or the Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
2. Prevent multi-drug resistant organism (MDRO) infections. Learn about transmission-based precautions (for example, standard precautions, contact precautions, airborne precautions, droplet precautions) described in the Infection Prevention and Control section in this handbook. Encourage patients to take only antibiotics that are prescribed, and to complete all antibiotics in a prescription, even if they feel better. Taking just a few doses of an antibiotic promotes resistance.
3. Prevent central line-associated blood stream infections. A standardized cart/kit containing all necessary equipment should be used for central line infections:
 - Practice hand hygiene before placing or handling central lines.
 - Use maximal sterile barrier for central line insertion, including mask, cap, sterile gloves, sterile gown, and large sterile drape.
 - Prepare the insertion site with Chlorhexidine scrub, not Betadine.
 - Avoid line placement in the femoral vein unless other sites are not available.
 - Remove unnecessary central lines as soon as possible.
 - Document review of line necessity daily.
4. Prevent surgical site infections. The following strategies are critical to prevent infections in patients undergoing surgery and other invasive procedures:
 - Appropriate administration of prophylactic antibiotics just before the start of the procedure.
 - These antibiotics can be stopped within a day or two after the procedure in most cases.
 - Appropriate sterile techniques should be observed.

- When hair must be removed from a surgical site, it should be done using clippers. Razors significantly increase the risk of infection when used before surgery.
5. Prevent catheter associated urinary tract infections. The following strategies are critical in preventing urinary tract infections in patients:
- Appropriate aseptic technique in inserting urinary catheter.
 - Perform hand hygiene before and after insertion and catheter tubing and drainage manipulation.
 - Clean perineal area with soap and water every eight (8) hours and as needed.
 - Use condom or intermittent catheter if possible.
 - Ensure proper catheter position and unobstructed flow.
 - Daily assessment and documentation of catheter need.

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

Harbor-UCLA Medical Center is dedicated to preventing, reducing, and ultimately eliminating, the use of restraints throughout our facility. We are committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints and/or seclusion. These less restrictive measures include verbal de-escalation, decreased stimulation, medication administration and provision of diversion activities.

When used for behavior management, limit restraints to those emergency situations in which the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or visitors, and when maintaining safety requires an immediate physical response. In such instances, a "Code Gold" is activated to dispatch the Code Gold Team to diffuse crises and maintain safety.

The Code Gold Team works collaboratively with other staff present in an attempt to de-escalate the emergency. If efforts to de-escalate fail, and physical intervention is necessary, the Code Gold Team may initiate restraints. The Code Gold Team provides 24 hours, 7 days/week coverage throughout the hospital to assist in these emergencies. All members of the Code Gold Team receive specialized training in non-violent crisis intervention, less restrictive alternatives and restraint application.

TEAM COMPOSITION

The team will operate on a twenty-four hour basis, seven days a week. The team is composed of licensed and non-licensed staff and shall be under the direction of a Registered Nurse.

All team members shall receive training and demonstrate competency in:

- Non-Violent Crisis Intervention Techniques.
- Management of Aggressive Behavior.
- Restraint Application.
- Restraint and/or Seclusion Policy/Protocol.
- Care of Patients in Restraints and/or Seclusion.
- Restraint Documentation.

CODE GOLD ACTIVATION

1. Call Ext. 111.
2. Request "Code Gold" activation.
3. Provide your name, location and extension.
4. Operator will overhead page and activate the Code Gold Team's group pager.

5. Operator will notify the facility security of “Code Gold.”
6. Operator calls requesting ward to verify Code Gold Team’s response.

USE OF RESTRAINTS AND SECLUSION

As defined by the Centers for Medicare and Medicaid Services (CMS), a **restraint** is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely or a drug or medication when it is used as a restriction to manage the patient’s behavior or restricts the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition. **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is used only for management of violent or self-destructive behavior.

All Harbor-UCLA Medical Center workforce members including both direct and indirect care providers need to be aware of the hospital’s philosophy regarding the use of restraints and seclusion as well as general factors to consider when restraints are utilized.

There are two distinct types of classifications and guidelines related to the use of restraints:

- ◇ **Behavioral justifications:** Used in emergency situations when the patients exhibit violent, aggressive and/or destructive behaviors, which represents imminent risk of an individual’s self-harm or harm to others.
- ◇ **Non-behavioral justifications (medical/surgical):** Used as an adjunct to medical/surgical care. Includes patients that are restrained for reasons other than violent, aggressive or destructive behaviors (i.e., attempting to pull out lines, tubes, or other necessary medical devices).

Restraints are to be used only when alternative measures are ineffective in protecting the patient or others from injury. Attempts of alternative measures to control the patient’s physical activity in order to protect the patient or others from injury are critical and must be documented prior to placing the patient in restraints. Restraints cannot be used as a punishment, aversive treatment, or for the convenience of staff. The patient and family (with the consent of the patient in the psychiatric areas) will be notified of the reason for placing the patient in restraints. **Restraints should be applied only when a need is supported by patient behavior that will result in harm to self or others and alternative methods have proven to be ineffective.**

Behavioral indications for restraints include the patient being physically threatening to self/staff/other patients by attempting to hit, kick, bite, etc., verbally threatening staff or other patients with bodily harm and indicates intent to carry out threat, physically destroying property, throwing objects, breaking windows, etc., forcefully grabbing people, or expressing a suicidal plan such as jumping out of a window with intent to carry out the plan.

Non-behavioral indications for restraints include the patient attempting to remove lines, tubes, or disrupt other essential medical devices, or requiring bed rest to limit mobility along with the inability to follow the plan of care.

Alternative methods and specific examples that can be considered include moving the patient closer to the central nursing station, providing the patient closer access to nursing staff, and separating the patient from other patients to allow the patient to experience a less stimulating and quieter atmosphere or different environment (e.g., move the patient from a 4 bed to a 2 bed or a single bed room). It is also a good idea to move a patient away from the window if the patient is at risk of suicide. In the psychiatric areas, the patient may be placed in open seclusion.

When alternatives have failed to de-escalate violent, aggressive behavior in patients that represent an immediate and serious danger to safety, a Code Gold will be called to activate the Behavioral Response Team (BRT). Restraints shall be implemented in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques, and used only when less restrictive measures have been found to be ineffective. The patient’s plan of care will be modified as appropriate. The patient shall be evaluated and treated for any injuries.

2016 Orientation/Reorientation

The Use of Restraints and Seclusion			
CRITERIA	BEHAVIORAL JUSTIFICATION		NON-BEHAVIORAL JUSTIFICATION (MEDICAL/SURGICAL)
	Psychiatric Areas	All Other Areas	All Areas
Prior to Initiation (Assessment)	<ul style="list-style-type: none"> Considers any pre-existing conditions/disabilities/limitations that would place the patient at greater risk for harm from the application of restraint/seclusion. Determines the patient's condition or symptom that warrant use of restraint or seclusion Determine benefits to patient and whether a less restrictive intervention would offer the same benefit at less risk. 		
	<ul style="list-style-type: none"> Determines whether patient has an advance directive with respect to behavioral health care and ensures that direct care staff is aware of the behavioral health advance directive. 		
Initiation	Restraints/seclusion can be initiated by an MD or Crisis Response (CRT) RN Team Leader or behavioral health RN	Restraints initiated by Crisis Response (CRT) RN Team Leader.	Restraints may be initiated upon order of physician (telephone order accepted).
<i>Application</i>	CRT will place patient in seclusion or apply restraints.		Clinical staff apply restraints.
In-Person Evaluation by Licensed Independent Practitioner	Within 1 hour.	Within 1 hour.	Within 1 hour.
PHYSICIAN'S ORDERS	May never be written as a standing order or PRN		
<ul style="list-style-type: none"> Obtaining 	Within one hour.	Within one hour.	Prior to application.
<ul style="list-style-type: none"> Time limitation 	<p style="text-align: center;">Maximum</p> <ul style="list-style-type: none"> 4 hours for ages 18 and older 2 hours for ages 9 – 17 1 hour for ages under 9 		<p style="text-align: center;">Maximum</p> <ul style="list-style-type: none"> 24 hours all ages
<ul style="list-style-type: none"> Include the following 	<ul style="list-style-type: none"> Specific violent, aggressive, or destructive behavior. 	<ul style="list-style-type: none"> Medical/Surgical justification e.g., trying to pull out lines, tubes. 	
<ul style="list-style-type: none"> Renewal 	Requires face to face physician re-evaluation before expiration of original order to determine the patient's response to the intervention including the rationale for continued use of the intervention.		
<ul style="list-style-type: none"> Trial release 	Trial release is unacceptable for non-behavioral and behavioral orders. Removing the restraints before the order expires would require a physician's order for reapplication.		

KEY POINTS TO REMEMBER (CLINICAL STAFF)

PATIENT CARE PRACTICES

PROVISION OF CARE

- Know the characteristics of each population group that you serve.
- Harbor-UCLA supports every patient's right to have his/her pain assessed and treated promptly, effectively, and for as long as the pain persists.
- Know that “Code Blue” means adult cardiac (or cardiopulmonary) arrest and “Code White” means pediatric cardiac (or cardiopulmonary) arrest.

PATIENT SAFETY

- Harbor-UCLA has instituted “READ BACK” procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider. Use “READ BACK” procedures to ensure important information is accurately communicated and recorded.
- When it is not feasible to do a formal quote READ BACK for a verbal order (i.e. during a code blue), a REPEAT BACK is an acceptable means of confirming the accuracy of the order.
- Universal Protocol applies to all surgical and non-surgical invasive procedures and establishes a process for preventing wrong site, wrong procedure and wrong person surgery or procedure.
- The Universal Protocol's three main components are: conduct the pre-procedure verification process, mark the operative site, and perform a “Time Out” before the procedure.
- Harbor-UCLA Medical Center is committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints.
- Use of restraints should be limited to those emergency situations in which the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or visitors, and when maintaining safety requires an immediate physical response.
- Harbor-UCLA Medical Center will dispatch a Code Gold Team for a “Code Gold” emergency.
- Before you administer medication to patients, identify the patient using two identifiers, *Patient Name and MRUN number for inpatients; Patient Name and Date of Birth for outpatients* per hospital policy.
- 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.
- Adverse drug reactions must be reported by submitting a Safety Intelligence report.
- Report all medication events, whether an actual medication error or an identified potential to lead to a medication error, through the Harbor-UCLA Safety Intelligence reporting system.
- Avoid the use of unapproved abbreviations. When in doubt, do not abbreviate! To prevent any confusion, spell out the entire name of the drug.
- Data collection for any of The Joint Commission processes will be based on your chart documentation or other appropriate documentation.
- Harbor-UCLA's direct patient care workforce member obtains clinical information from other treatment sites by requesting the patient's medical record from the Health Information Management (HIM) Department. Patient information may also be accessed through ORCHID, the electronic medical record. Access to ORCHID is controlled through a security clearance process.
- Staff authorized to make entries in ORCHID is limited to medical, nursing and ancillary staff.

HUMAN RESOURCES

PERFORMANCE EVALUATION

As a DHS workforce member, it is important that your work is evaluated. During the course of your employment/assignment, you may receive both informal and formal performance evaluations. Evaluations let you know how you're doing and give you guidance on how to do your job even better. All DHS workforce members shall be evaluated at least once each year and probationary employees by the end of the specified probationary period. A revised rating may be submitted by the appointing power at any time. Each workforce member's performance evaluation shall include a signed copy of the related job description or acceptance of work plan in Performance Net. **Exception:** Physicians and mid-level providers must comply with privileging requirements.

Although non-County workforce members are not governed by Civil Service Rules, appropriate evaluation of performance, similar to that of County workforce members must be conducted. Non-County workforce members must receive performance assessments at 6-months and 12-months from the beginning of their assignment, and annually, thereafter, including competency assessment, as applicable. Certain contract agencies (i.e., Insight) have been approved to independently be responsible for conducting performance assessments of their own staff and to certify that their employees are performing competently. Contract agencies must make the performance evaluations of contract staff available upon request.

The immediate supervisors shall communicate to the workforce members the Department's expectations, the performance standards and expectations for the workforce member's position, and shall provide the necessary leadership and direction needed by their subordinates to meet and maintain the required performance standards.

In accordance with Memoranda of Understanding, annual step advancement for employees is contingent upon a current performance evaluation with a rating of "competent" or better. Physicians subject to the Physician Pay Plan and Management Appraisal and Performance Plan (MAPP) participants must achieve a "met expectations" or better to receive their step/merit increase. If no performance evaluation is on file by the appropriate date, or if an employee receives a "needs improvement" or "failed to meet expectations" rating, the employee will not receive a step advance on their step anniversary date or merit increase, as applicable.

NOTE

See DHS – Human Resources Operational Policy No. 780.000 for detailed guidelines.

All managers and supervisors are expected to ensure performance evaluations are completed and fully executed on time. Managers and supervisors who fail to adhere to the performance evaluation policy and procedures will be subject to disciplinary action in accordance with DHS Policy 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 ASSESSMENT

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. one (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.

2016 Orientation/Reorientation

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.

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES)

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

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

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 preceding the first day of leave.

FMLA and CFRA entitle eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- The employee's own serious health condition;
- The care of a child, spouse, or parent with a serious health condition;
- The birth of a child and to care for the child within one year of birth (baby bonding);
- Newly adopted child or a foster care placement; or

FMLA (only) entitles eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- Prenatal care.
- Any qualifying exigency arising from a spouse, child, or parent's call to active duty.

FMLA (only) also entitles eligible employees up to 26 workweeks of unpaid job protected leave in a 12-month period to care for a spouse, child, parent, or next of kin, who is an Armed Forces member recovering from an injury or illness sustained within the last five (5) years

NOTE

See DHS Policy No. 756.6 for detailed guidelines.

CFRA (only) entitles eligible employees up to 12 workweeks of unpaid job protected leave in a 12-month period for any of the following reasons:

- The care of a domestic partner with a serious health condition.
- The care of a domestic partner's child with a serious health condition.

PDL (only) entitles a female employee up to 16 workweeks of unpaid job protected leave in a 12-month period if she is disabled due to pregnancy or any prenatal or childbirth related medical condition. Employees do not have to meet the 12 months of County Service or the 1,250 work hours to receive this leave.

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 time sheet and submit it as directed within the time period specified by payroll and management.

Time recorded as worked must only reflect time that is actually spent performing work for the County. Employees may not spend time working on non-County/non-DHS related activities during County working hours, such activities may not be reflected as County time on the employee's time collection document/timesheets.

Timesheets are to be submitted as directed by management and Payroll. Each year, payroll publishes a calendar for submission and approval of timesheets. Employees are reminded to be diligent in submitting their timesheets 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 part-time employees will accumulate holiday time based on their Title Sub (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 time sheet. 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 used 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 time sheet 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 used as time off at a later date.

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:

2016 Orientation/Reorientation

- 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/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 SubTitles: 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

2016 Orientation/Reorientation

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

Employees do not earn Sick Leave for:

- Unpaid absence (absent without pay (AWOP), or sick without pay (SWOP));
- Overtime worked;
- Regular weekend RDO hours (i.e., two day (16 hours) based on a 5/40 schedule);
- Long-Term Disability (LTD) hours, or Workers' Compensation hours after salary continuation benefits have ended.

The total amount of Full-Pay Sick Leave earned by each eligible full-time employee each year is defined in the County Code or his/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/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 practical.
- 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/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/her request in writing.

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/her supervisor of the absence.

The employee must personally notify his/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/her supervisor when he/she is aware that a previously-specified expected return date will not be met, and provide a new date. See "Time Off Request" section above for absences exceeding three (3) workdays.

Unwarranted sick leaves shall be deemed an abuse of the provisions of the salary ordinance allowing leaves of absence on full pay for illness. Any employee found to have abused or is abusing such sick-leave privileges may be subject to suspension for a period of 30 days without pay for a first offense and subject to discharge for a subsequent offense.

Employees may use existing vacation, personal leave, or compensatory time off, for planned absences so that the employee can participate in the school or child day care program activities of their children, grandchildren under their custody, and/or children under their legal guardianship, who are enrolled in kindergarten through twelfth grade or licensed child day care facility. Pursuant to Labor Code Section 230.8, such absences are not to exceed eight (8) hours per month and cannot exceed a total of forty (40) hours per year. Also, the employees must give reasonable notice to their supervisor of the planned absence.

The department may require reasonable written documentation that the employee actually participated in school activities. Such documentation could be a simple statement on school letterhead, flyer and/or email with a description of the school activity.

MegaFlex

MegaFlex employees do not accrue Vacation or Full-Pay (or Part-Pay) Sick Leave. In lieu of Vacation and Sick Leave, a MegaFlex employee earns or purchases two kinds of annual leave: Non-Elective and Elective Leave. A MegaFlex employee can earn up to 12.5 days of Non-Elective Leave per year, periods of absence without pay will affect the accrual of this leave. MegaFlex employees will earn from four up to five hours of Non-Elective Leave each pay period, depending upon the years of service, to a maximum of 100 hours. This leave may be carried over to the following year and can be accumulated up to a maximum of 60 days (480 hours).

MegaFlex employees can use unused Full-Pay Sick Leave 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 before 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 a supervisor's approval it 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 paystubs 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 the "Help/Information" tab on the left of the screen to view the tutorial.

WORK HOURS/WORK WEEK

Management is responsible for establishing work hours/shift for each employee that includes a regular start time and end time, and appropriate lunch and rest breaks in accordance with the Los Angeles County Code and applicable Memorandum of Understanding (MOU).

An official work week is defined as five days of work per week for a total of 40 hours. Management shall comply with County regulations, applicable MOUs and the Fair Labor Standards Act when establishing an employee's work week.

A normal workday consists of eight (8) consecutive hours exclusive of at least a 30 minute lunch period and inclusive of two (2) fifteen (15) minute rest periods to be taken as determined by management in accordance with Los Angeles County Code provisions and applicable MOU. A rest period should be taken approximately midmorning and midafternoon, they shall not be accumulated or combined to lengthen the lunch period, shorten the workday or to make up tardiness or absences.

Management shall ensure that the scheduling and taking of rest periods shall not interfere with essential workload coverage nor adversely affect the ability of the facility/organization to accomplish its mission.

The number of work hours per day and week may vary based on employee agreement of an alternate work schedule.

Management shall provide advance written notice to employees of work schedule changes, as required in applicable MOUs. All permanent employees will have their timesheets pre-populated with the work schedule on record. Changes to these work schedules must be reported to Payroll Services using an official Work Pattern ID form which is available online or can be obtained from the employee's timekeeper or payroll clerk.

OVERTIME

Overtime is time requested and authorized by management, in excess of the number of hours regularly worked in the workweek. Departmental managers and/or supervisors may require employees to work overtime in accordance with County Code, Federal Fair Labor Standards Act (FLSA) and MOU provisions. However, overtime shall be kept to a minimum and used when it is the only alternative to meet workload demands.

Employees shall not enter into informal agreements with managers or supervisors allowing unrecorded compensatory time. Employees shall not arrive to work early nor leave late as this may constitute a violation of FLSA. Under FLSA, all overtime "suffered" to be worked by a FLSA-covered employee must be paid whether or not it is authorized. Some examples include work taken home, work done at a desk while eating during the lunch period, or work performed at the end of a workday or shift. Overtime must be approved in advance in accordance with departmental and facility policy and procedures.

Compensation for overtime is dependent upon the employee's job classification and whether or not they are represented by a labor union and is or is not covered under FLSA. County and Departmental policy will determine the method and rate of compensation for overtime.

SALARY INCREASES

Salary increases are dependent on your pay plan. The types of pay plans are:

- General Step Pay Plan
- Physician Pay Plan
- Management Appraisal and Performance Plan

General Step Pay Plan

The step pay plan is intended to increase an employee's pay in steps as he or she acquires experience. Most County employees are paid on the County Standardized Salary Schedule. A number-and-letter combination is used to define the pay level. The number is referred to as the schedule, and the letter is referred to as the level. For each schedule and level there are five steps, which are approximately 5.5 percent apart.

A few classes are paid on an alternate salary grid. The pay level and the number of steps are identified for each item by the Board of Supervisors. Steps may be in increments of more or less than the standard 5.5 percent.

Step Anniversary Date

Employees normally are initially placed on the first step in the salary schedule for their classification, although some classifications begin at higher steps. Future steps are granted on the employee's step anniversary date, which is usually one year from the appointment date.

Step Advances and Salary Adjustments

Step advances are granted, usually at one-year intervals, until the top step approved for the class is reached. The top step is usually the fifth step, but some classes are paid on a range with more or fewer than five steps. Step advances are granted only if the employee's current annual performance evaluation is rated "Competent" or better.

In addition to step advances, salaries are adjusted periodically by the Board of Supervisors or through negotiations with labor unions to ensure County salaries are sufficient to attract and retain quality employees. All adjustments must be approved by the Board of Supervisors.

Effective April 2012, the step advancement anniversary date will be the actual date of appointment. Employee appointments made prior to April 2012 retain the current 1st of the month as the step advancement anniversary date. Also, employees paid under the Tier II Management Appraisal and Performance Plan (MAPP) will continue to have a step advancement date of October 1st.

Management Appraisal and Performance Plan

The Management Appraisal and Performance Plan (MAPP) is the pay plan for top management and high-level staff positions. Under this pay plan, salary increases are linked to performance.

There are two levels of MAPP participants, Tier I which includes the department head and his/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 SubTitles: Full-time, Permanent (“A” or “N” SubTitle), 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 in writing far enough in advance to provide supervisors time to consider coverage, per Departmental requirements. Supervisors will provide instruction on when and how to submit vacation requests.

An employee may carry over unused and accrued Vacation to the following year. Such carried-over Vacation is called “Deferred” Vacation, while Vacation that is earned during the current year is called “Accrued” Vacation. At the end of the year, an employee may have some Deferred Vacation and some Accrued Vacation still remaining; these two are combined at the beginning of the following year and become the new year’s Deferred Vacation balance. There is a limit (320 hours for most employees) to the amount of vacation that can be deferred. At the

end of December of that year, any Vacation in excess of 480 hours (320 hours deferred and 160 hours current) will be paid the following January.

When an employee leaves County service, he or she receives payment for unused Vacation hours. The only requirement for receiving such payment is that the employee must have at least one year of service, unless otherwise provided by a collective bargaining agreement.

MEGAFLEX EMPLOYEES

MegaFlex employees do not earn Vacation Leave. They earn Non-Elective Leave and during benefit enrollment are able to purchase up to an additional 20 days of Elective Leave.

If an employee is new to the County and is an eligible MegaFlex participant, or is newly eligible as a result of an appointment from a full-time permanent position covered under Choices or Options benefit plan to an eligible MegaFlex position, the following applies:

- Any vacation the employee earned under Choices or Options will remain available for use after the employee has become a MegaFlex participant, subject to the same policy and procedure for using Vacation leave. However, before they can use any Elective Leave they may have purchased, MegaFlex employees must use all previously accrued leave such as Vacation, Holiday, and Compensatory Time Off. In addition, MegaFlex participants must use their Non-Elective Leave prior to using any Elective Leave.

Elective Leave that is not used during the calendar year when it is purchased may be paid off at the end of that year, and is paid off if not used upon termination, if applicable.

Unused Non-Elective leave may be carried over from year to year until it exceeds 480 hours. The system automatically calculates and pays off the excess at the employee's workday hourly rate in effect on January 1st in the New Year. All Non-Elective Leave is paid upon termination.

BEREAVEMENT LEAVE

Any person employed in a full-time, permanent position who needs to be absent from duty because of death of his/her father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, husband, wife, child, stepchild, grandfather, grandmother, grandchild, domestic partner, domestic partner's father, mother, stepfather, stepmother, child, stepchild or, grandchild, shall be allowed the time necessary to be absent from work at his regular pay.

The intent of this Bereavement Leave provision is to allow an eligible employee to be absent from work for a prescribed number of 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 needs additional time off.

Bereavement Leave for Temporary Monthly Employees

A full time monthly recurrent or monthly temporary employee who qualifies for Bereavement Leave receives 8 hours Bereavement Leave per year if he or she has completed at least 200 days of active service in the preceding calendar year, and four hours if such employee has completed less than 200 days of active service in the preceding calendar year.

Monthly Permanent 9/10 Time Employees (RN's or 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

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/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!

POST-TEST

1. All of the following are fall prevention measures for patients EXCEPT:
 - a. Provide patient/family education related to fall prevention.
 - b. Immediately report environmental hazards, such as wet floors, spills, blocked passageways, etc.
 - c. Setting the bed in highest position to facilitate getting in and out of bed.
 - d. Place a sign at the entrance to the patient's room and/or head of the patient's bed.

2. Any workforce member who provides care, treatment, and services to/for patients can report concerns about the safety or quality of care, without retaliatory action by the Department of Health Services (DHS), to:
 - a. DHS Quality Improvement Program hotline.
 - b. Your supervisor.
 - c. The Joint Commission.
 - d. All of the above.

3. The best infection control measure for preventing health care associated infection:
 - a. Follow contact precautions whenever possible.
 - b. Wear gloves and gown during each patient contact.
 - c. Use proper hand hygiene before and after patient care.
 - d. Use alcohol-based hand sanitizer always before and after patient care.

4. The goals of the patient safety program include:
 - a. Gathering safety issues data and creating a comprehensive catalog.
 - b. Improving patient safety, patient safety awareness, and reducing the risk of harm to patients.
 - c. Promoting a "Just Culture" that focuses on learning and improving systems than finding someone to blame.
 - d. Both b and c.

5. The National Patient Safety Goals for hospitals are:
 - a. Identify Patients Correctly, Improve Staff Communication, Use Medicines Safely, Use Alarms Safely, Prevent Infection, Identify Patient Safety Risks, and Prevent Mistake in Surgery.
 - b. Identify the Correct Patients, Improve Communication, Infection Control, and Universal Protocol.
 - c. Use Medicines Safely, Infection Control, Patient Safety, and Prevent Mistakes in Surgery.
 - d. Prevent Infection, Improve Communication, Patient Safety, and Universal Protocol.

6. You are in a patient care area and you notice that a patient's condition has deteriorated. Your first step should be to:
 - a. Notify the patient's doctor.
 - b. Notify the patient's nurse.
 - c. Call Ext. 112 to issue a "Code Blue" page.
 - d. Call 9-1-1.

7. You see a patient that has fallen next to a car in the parking lot. The patient is not moving and you think the patient may be unconscious. What is the best way to call for help in this situation?
 - a. Dial Ext. 112 and ask for a code white.
 - b. Dial Ext. 112 and ask for a code blue.

- c. Dial 9-1-1.
 - d. Return to your work area and notify your supervisor.
8. All staff members are required by the DHS Code of Conduct to:
- a. Report fraudulent activity.
 - b. Investigate fraudulent activity.
 - c. Ignore fraudulent activity.
 - d. Retaliate against staff who reports fraudulent activity.
9. Competency assessment is required:
- a. Upon hire/assignment and completed within the first 90 days of hire/assignment.
 - b. Annually.
 - c. When new procedures/policies or equipment are introduced.
 - d. All of the above.
10. A workforce member must notify his/her supervisor within ____ hours of being notified by the issuing agency that disciplinary action is being brought against the member's professional credential:
- a. 24
 - b. 48
 - c. 72
 - d. 96
11. If you are arrested or charged with a crime (including traffic violations, if your 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.
- a. True.
 - b. False.
12. All workforce members are responsible for obtaining a health screening:
- a. One time only.
 - b. Every six months.
 - c. Every year.
 - d. Every two years.
13. The County Policy of Equity addresses:
- a. Sexual harassment.
 - b. Discrimination.
 - c. Inappropriate behavior.
 - d. All of the above.
14. Harassment or inappropriate behavior complaints should be reported to:
- a. County Equity Oversight Panel.
 - b. DHS Audit & Compliance.
 - c. Your Supervisor.
 - d. Any of the above.

15. Which of the following is a true statement about “Cultural Competency”? Cultural competency is:
 - a. One of the main ingredients in closing the disparities gap in health care.
 - b. A way patients and clinicians can talk about health concerns without cultural differences hindering the discussion.
 - c. Health care services that is respectful of and responsible to health beliefs, practices, cultural and linguistic needs of diverse patients.
 - d. All of the above.

16. 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:
 - a. To his/her supervisor.
 - b. To the facility Los Angeles County Sheriff’s Department.
 - c. To the Safety Intelligence reporting system.
 - d. All of the above.

17. Mandated reporters must report child abuse/neglect, elder abuse/neglect, and intimate partner violence to the appropriate agency:
 - a. Immediately or as practicably as possible with written follow up within the specified time frames.
 - b. Within 24 hours.
 - c. Within 48 hours.
 - d. Within two weeks.

18. Patients have the right to:
 - a. Know the names of physicians and non-physicians who will see them.
 - b. Privacy concerning their medical care.
 - c. Receive care in a reasonably safe setting.
 - d. All of the above.

19. The Patient Advocate can provide assistance to patients/family members with resolving:
 - a. Billing conflicts.
 - b. Difficulty in making appointments.
 - c. Complaints/grievances about our staff.
 - d. All of the above.

20. A patient and his wife show up for a clinic appointment. The patient speaks only Korean. Although the patient’s wife speaks Korean and English, clinic staff should:
 - a. Ask the patient’s wife to interpret, so patient care is not delayed.
 - b. Escort the patient to the Language Center.
 - c. Use local area bilingual staff or use the Video Medical Interpreter (VMI) equipment to interpret.
 - d. Ask the patient to provide an interpreter.

21. Harbor UCLA’s Five Organizational Pillars are:
 - a. Quality & Safety, Patient Centered, Education & Research, and Infrastructure & Financial.
 - b. Quality & Safety, Service, People & Community, Education & Research, and Equitable.
 - c. Quality & Safety, Service, People & Community, Efficient, and Infrastructure & Financial.
 - d. Quality & Safety, Service, People & Community, Education & Research, and Infrastructure & Financial.

22. Adverse events which require submission to the Safety Intelligence within 4 hours of discovery and must be reported to California Dept. of Public Health (CDPH) include:
 - a. Surgery performed on the wrong body part.
 - b. An infant discharged to the wrong person.
 - c. Death or serious disability associated with a fall while being cared for in a health facility.
 - d. All the above.

23. To ensure that the right medication is administered to the right patient, identification for inpatients should include:
 - a. Patient name and date of birth.
 - b. Patient name and social security number.
 - c. Patient name and MRUN number.
 - d. Patient name and medication prescribed.

24. To report an environmental safety concern or an unsafe condition, you should:
 - a. Notify your supervisor.
 - b. Notify the Environmental Safety Officer.
 - c. Submit a Safety Intelligence report.
 - d. All the above.

25. When a "Code White" page is issued, it is because of:
 - a. Pediatric cardiac arrest.
 - b. Adult cardiac arrest.
 - c. Both A & B.
 - d. Behavior Response Team.

26. A "Code Purple" page is used to alert staff of a:
 - a. Hazardous material exposure/spill.
 - b. Child abduction.
 - c. Bomb threat.
 - d. Infant abduction.

27. Which of the following strategies minimize security risks:
 - a. Staff identification badges.
 - b. Metal detectors at hospital entrances.
 - c. On-site Sheriff's Department/security guards.
 - d. All of the above.

28. As a workforce member of Harbor-UCLA Medical Center, it is critical to our mission that you treat customers and each other with courtesy, dignity, and respect at all times. You should always:
 - a. Introduce yourself by name and when appropriate, SMILE.
 - b. Be responsive to their cultural and linguistic needs.
 - c. Listen carefully and patiently to our customers.
 - d. All of the above.

29. When “Code Pink” is announced overhead, all available staff must immediately:
 - a. Prepare to evacuate visitors from the building.
 - b. Report to the Emergency Department to help.
 - c. Call the Sheriff’s Department.
 - d. Cover exits in their areas and report suspicious persons to the Sheriff’s Department.

30. The Safety Data Sheets (SDS) provide information on how to handle a(n):
 - a. Hazardous electrical malfunction.
 - b. Hazardous chemical spills and exposures.
 - c. Hazardous radiation emergency.
 - d. Hazardous power outage.

31. Use precautionary measures when caring for patients having radioactive procedures and treatments. Your best defense from radiation exposure is:
 - a. Distance – maintain an appropriate distance.
 - b. Shielding – wear radiation protective devices.
 - c. Time – keep the length of exposure time to a minimum.
 - d. All the above.

32. An earthquake has occurred near Harbor-UCLA Medical Center. The overhead paging system announces a “Code Triage,” thus activating the hospital’s Emergency Management Plan. Staff should immediately:
 - a. Evacuate patients from the building.
 - b. Report to the nearest emergency management station.
 - c. Ensure that the crash cart and emergency box are readily available.
 - d. Return to one’s own assigned work area, check in with your supervisor and await further instructions.

33. During a partial evacuation, a horizontal evacuation is moving the patients, visitors, and staff to:
 - a. Another room in the same smoke compartment on the same floor.
 - b. Another smoke compartment on the same floor.
 - c. Another smoke compartment on another floor.
 - d. Do nothing.

34. The correct sequence of steps of the PASS method of using a fire extinguisher are:
 - a. Push the lever, Aim the extinguisher nozzle at the fire, Squeeze the handle, and Sweep from top to bottom of the fire.
 - b. Push the lever, Assemble the extinguisher nozzle together, Squeeze the handle, and Shoot from bottom to top at the fire.
 - c. Pull the pin, Aim the extinguisher nozzle at the base of the fire, Squeeze the handle, and Sweep from side to side at the base of the fire.
 - d. Pull the pin, Assemble the extinguisher nozzle together, Squeeze the handle, and Shoot from top to bottom at the fire.

35. The “E” in RACE response to fire or smoke stands for:
 - a. Evacuate.
 - b. Exit.

- c. Egress.
 - d. Extinguish.
36. A “Class ABC or Dry Chemical” fire extinguisher can be used on which type of fire(s):
- a. Paper.
 - b. Chemical or electrical.
 - c. Wood.
 - d. All types of fires.
37. Before connecting any medical electrical device to a patient, verify L I F E which is an acronym for:
- a. Listen: for any humming noise from the power supply. Inform: the patient of indication for the device being used. Find: the emergency shut-off switch. Explain: the rationale for using the device.
 - b. Look: does the unit show signs of wear and tear. Initiate: start treatment with device. Find: the label to check for voltage. Examine: the unit for damage.
 - c. Label: check the inspection label due date. Intact: power cord. Function: does the unit function correctly. Examine: the unit for damage
 - d. Label: check inspection label due date. Inspect: the unit for damage. Function: does the unit function correctly. Electrically safe: power cord is intact.
38. Which behavior of the staff indicates a risk factor that may lead to injury:
- a. Using good body mechanics.
 - b. Overreaching for documents.
 - c. Limiting repetitive motions.
 - d. Sitting in a natural position.
39. Teamwork is essential in a health care setting. Essential elements of teamwork include:
- a. Effective communication and collaboration.
 - b. Coordination of care.
 - c. Conflict resolution.
 - d. All of the above.
40. Alcohol-based hand sanitizer may be used in which of the following situations?
- a. When hands are visibly soiled.
 - b. After using the restroom.
 - c. Before eating or preparing food.
 - d. After touching equipment near the patient’s bed.
41. Proper hand washing with water, soap and friction takes:
- a. 5-10 seconds.
 - b. 15-20 seconds.
 - c. 20-25 seconds.
 - d. 25-30 second.
42. The three bloodborne pathogens of primary concern to health care workers are:
- a. Hepatitis B, Hepatitis C, HIV.
 - b. Hepatitis B, Hepatitis C, Clostridium difficile.
 - c. Hepatitis B, tuberculosis, HIV.

- d. Hepatitis B, salmonella, tuberculosis.
43. Coordination of Care requires adequate and efficient _____ and collaboration of services:
- a. Communication.
 - b. Teamwork.
 - c. Response.
 - d. All of the above.
44. Staff can prevent sharps injuries by all of the following EXCEPT:
- a. Activating needle/sharps safety devices.
 - b. Letting falling objects fall.
 - c. Leaving needles and sharps on the patient's bed.
 - d. Using tongs or a brush and dustpan to pick up broken glass.
45. During the influenza season, workforce members must:
- a. Obtain a mandatory seasonal influenza vaccination.
 - b. Complete a mandatory declination form if the workforce member declines to receive the seasonal influenza vaccination.
 - c. Wear a surgical mask if the workforce member declines and works in a health care area that provides patient care.
 - d. All of the above.
46. Minimum necessary rule means:
- a. It is never acceptable to look at patient information “out of curiosity”.
 - b. Only acquire, access, view, or disclose the amount of information needed to do your job.
 - c. All patient information is confidential and must be kept protected at all times.
 - d. All of the above.
47. Patient confidentiality is violated when staff:
- a. Closes patient exam room doors or draws curtains before talking to the patient.
 - b. Covers cart when transporting medical records so that patients' names are not visible.
 - c. Discusses patient information on *Facebook*, *Twitter* or other social network websites.
 - d. Talks about patients in a private place or speaks quietly.
48. The tool used to assess pain in infants and children through the age of 7 is called the:
- a. Bieri Faces Pain Scale.
 - b. N-PASS.
 - c. FLACC Scale.
 - d. Wong-Baker Faces Pain Rating Scale.
49. When dealing with patient confidentiality, privacy and security “do’s” include:
- a. Storing PHI on a computer’s hard drive.
 - b. Discarding documents or medical supplies that contain PHI in the trash.
 - c. Using only dhs.lacounty.gov e-mail or obtaining permission to encrypt e-mails.
 - d. All of the above.

50. Which of the following is a true statement about Patient Safety?
- a. Promoting a “Just Culture” focuses on finding someone to blame after an incident occurs.
 - b. Staff is held accountable for reckless, dangerous behaviors only when a patient has been harmed.
 - c. In order to maintain a safe and just culture it is important to recognize the difference between system failures and human behaviors that lead to an event.
 - d. The only way to report patient safety issues, concerns, and/or suggestions is via the Safety Intelligence system.

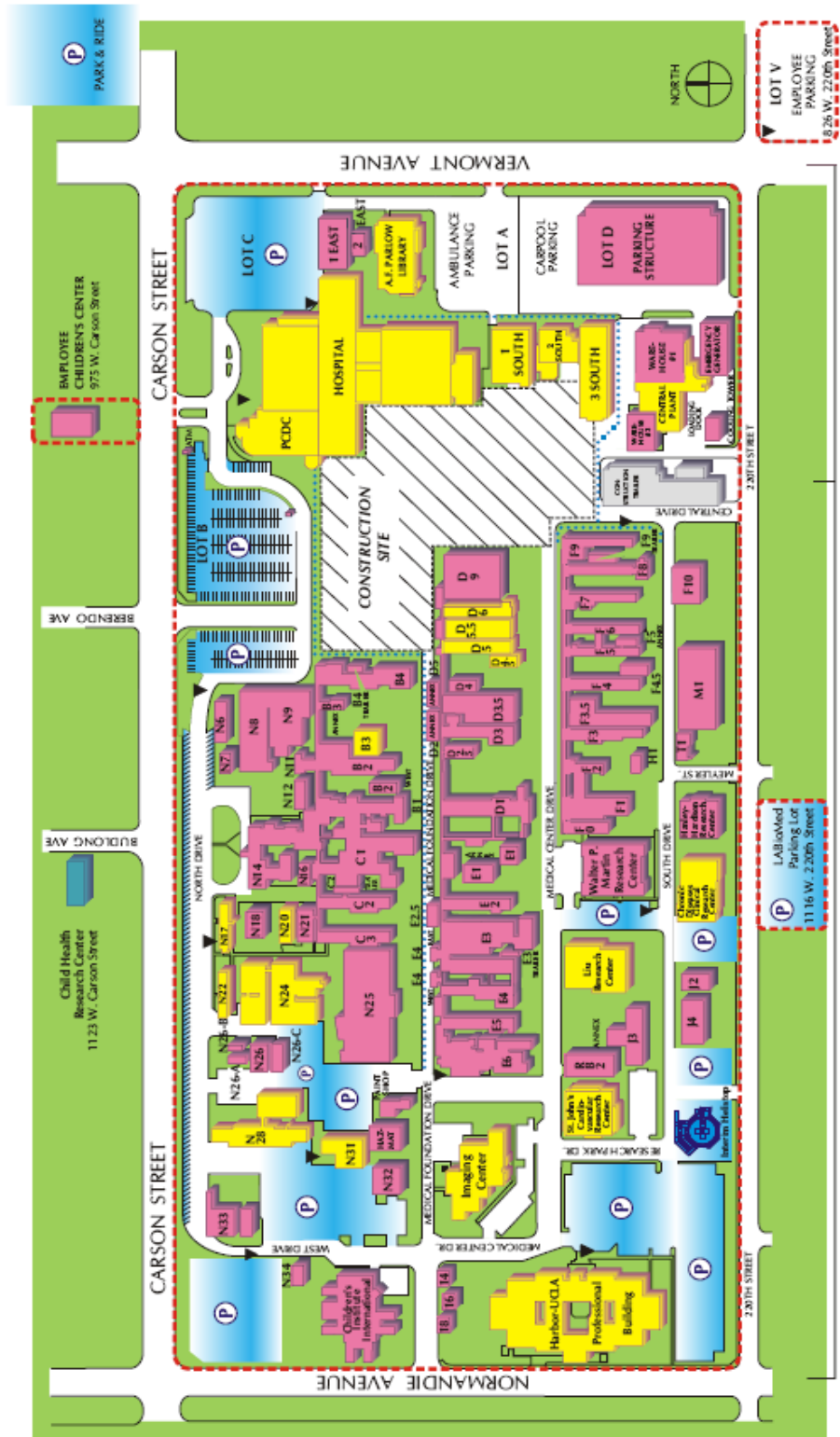
FACILITY MAP



Campus Plan Plano del Hospital



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(310) 222-2345



HF764-AA 10/12
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Hospital Planning & Architecture 10/12

Patient Service Building
Edificio para servicio público y atención al paciente

Campus Building
Edificios en los terrenos del hospital

Patient/Visitor Parking
Estacionamiento para visitantes y pacientes

Shuttle Bus Stops
Paradas del autobús

Smoke and Tobacco Free Campus
Campus limpio de humo y tabaco

Pedestrian Walkway

LOT V
EMPLOYEE PARKING
8.26 W. 220th Street

Provided By:

County of Los Angeles
Department of Health Services
Human Resources
Office of Regulatory Compliance
5555 Ferguson Drive, Suite 120-25
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Mitchell H. Katz, MD
Director
Department of Health Services

DHS Mission

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



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To Enrich Lives Through Effective and Caring Service