

# 2016



**LAC+USC**  
MEDICAL CENTER

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## Orientation/Reorientation Handbook

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Chief Executive Officer



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

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## QUICK REFERENCE

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Customer Service Center	Shawn McGowan, RN	(800) 341-9211
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Return to Work	Leticia Gordo	(323) 869-7111
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<b>Public Information</b>	Rosa Saca, RN	(323) 409-6899
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<b>MRI</b>	Wendy O'Connor	(323) 409-1290
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<b>Referral Office</b>	Behnaz Hekmatnia	(800) 341-9211
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<b>Rehabilitation Services</b>	Pat Hokama, PT	(323) 409-5096
<b>Revenue Management</b>		(323) 226-7773
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<b>Safety Officer</b>	Gregory Van Dam	(323) 409-7485
<b>Supply Chain Operations</b>	Dolores Gonzalez	(323) 226-5305
<b>Support Services</b>	Cecil Clark	(323) 409-4242
<b>TB Control</b>	Yesenia Eras	(323) 226-7962
<b>STD Control</b>	Terry Miller, RN	(323) 226-5252
<b>Volunteer Services</b>	Coco Ceja	(323) 409-6945
<b>Surgical Services</b>	Marie Pecson	(323) 409-3501

## Hotlines

<b>Adverse Drug Reaction (ADR)</b>	(323) 226-2246
<b>Child Abuse</b>	(800) 540-4000
<b>DHS Compliance/HIPAA</b>	(800) 711-5366
<b>DHS Patient Safety</b>	(213) 989-7233
<b>DHS Quality Improvement Program</b>	(800) 611-4365
<b>Domestic Violence/Intimate Partner</b>	(800) 978-3600
<b>Elder Abuse/Adult Abuse</b>	(877) 477-3646
<b>Fraud (LA County)</b>	(800) 544-6861

## Hotlines

<b>The Joint Commission</b>	(800) 994-6610
<b>L.A. County Sheriff Department</b>	(323) 226-3333
<b>Patient Safety</b>	(323) 226-SAFE (7233)
<b>Poison Center</b>	(800) 411-8080
<b>Safely Surrendered Baby</b>	(877) 222-9723
<b>Suicide Prevention</b>	(877) 727-4747

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Welcome to the LAC+USC Medical Center Team!

You are joining an historical facility that has provided compassionate health care services to the community since 1878. Through our affiliation with the Keck School of Medicine at USC and the completion of the new facility in 2008, we have become one of the leading teaching hospitals in the nation and train over 1,500 medical professionals per day while providing world class care to all patients, regardless of ability to pay.

The patient experience is our priority. This encompasses exemplary customer service, continuously striving to improve quality of care in a safe environment, and providing timely access to medically necessary services.

You will find a wealth of knowledge and dedication among the over 8,000 LAC+USC employees and physicians that work hard every day to make a difference in patients' lives. I encourage you to ask questions, get to know your fellow colleagues, and most of all enjoy your time here as an elite team member of this wonderful facility.

Sincerely,

Dan Castillo, MHA, FACHE, FACMPE  
Chief Executive Officer

# LAC+USC MEDICAL CENTER

This section provides a broad organizational overview of LAC+USC Medical Center service delivery. Included is the LAC+USC Medical Center's history, its Mission, Vision, and Values.

## INTRODUCTION

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The LAC+USC Medical Center consists of General Hospital, Clinic Tower, Inpatient Tower, Diagnostic & Treatment Tower, Interns & Residents, Rand Schrader Clinic, Outpatient Department, and Psychiatric Services at Augustus Hawkins Mental Health Center at Martin Luther King, Jr. – Multi-Service Ambulatory Care Center (MLK-MACC).

We 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 LAC+USC Medical Center. We are also committed to meeting our Mission, Vision, and Values. In addition, we must meet quality standards established by accrediting agencies as they evaluate our programs and services by way of surveys, reviews, and other indicating tools.

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

We have designed this handbook so that important information about our facility is readily available. It provides you with general information about the LAC+USC Medical Center and can be used as a quick reference guide to our 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 HIGHLIGHTS

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The County of Los Angeles was chartered in 1850. The Board of Supervisors began providing hospital care in a 100-bed facility founded in 1878 with 47 patients and 6 staff members. An affiliation was developed with the University of Southern California for medical training in 1885. In 1929 the General Hospital cornerstone was laid and in 1932 the General Hospital Building was completed.



Today the LAC+USC Medical Center provides world-class emergency, trauma and medical services to the County's 10 million residents. It is the County's largest medical center and the backbone of the County's safety net for emergency care and the County's "Flagship" trauma center, providing more than 28% of all trauma care in Los Angeles County.

LAC+USC Medical Center is the primary teaching hospital for the USC Keck School of Medicine training more than 870 medical residents a year in multiple specialties. It is one of the largest teaching hospitals in the nation.

**New Facility:** Structural damage occurred in several hospital buildings in 1994 as a result of the Northridge Earthquake. Plans for a 600-bed hospital were submitted in 1998. The Office of Statewide Health Planning and Development (OSHPD) approved the plans in September 2002 and a contract was awarded in December 2002 for construction of the new facility. Construction began in April 2003 and was completed in November 2008. The patient move to the new hospital took place on November 7, 2008.

# 2016 Orientation/Reorientation

## LAC+USC MEDICAL CENTER SERVICES

- ◇ Has a formal affiliation with the U.S. Navy for Trauma Center staff to train their nursing, medical and paramedical personnel.
- ◇ Provides obstetrical, gynecological, pediatric and specialized (Level III) Neonatal Intensive Care Services.
- ◇ Provides psychiatric inpatient and outpatient services for adults, adolescents and children on-site and at off-site locations at Augustus Hawkins Building at Martin Luther King, Jr. Multi-Service Ambulatory Care Center (MLK-MACC).
- ◇ Operates one of only three burn centers in Los Angeles County.
- ◇ Provides one-half of all sickle cell care in Los Angeles County.
- ◇ Provides care for about 35% of all HIV/AIDS patients in Los Angeles County.
- ◇ Operates the hyperbaric chamber on Catalina Island.
- ◇ Graduates 160 nursing students yearly from the College of Nursing.
- ◇ Provides training for other health care professionals such as pharmacists and physician assistants, physical and occupational therapists.
- ◇ Provides spiritual care to patients and staff.



LAC+USC Medical Center annually provides services to approximately 150,000 emergency patients, over 500,000 outpatients, approximately 39,000 inpatients and over 4,500 trauma patients.

**The LAC+USC Medical Center consists of Clinic Tower, Inpatient Tower, Diagnostic & Treatment Tower, Outpatient Building, and Psychiatric Services at the Augustus Hawkins Building at MLK-MACC.**

## MISSION, VISION AND VALUES

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### MISSION

To provide fully-integrated, accessible, affordable and culturally sensitive care one person at a time.

### VISION

To be nationally recognized for our superior patient care, medical education, clinical research and contributions to community health.

### VALUES

#### Responsibility to Community

We have an obligation to improve the healthcare status of the communities we serve by providing accessible, affordable, and culturally sensitive healthcare. We actively contribute our clinical expertise to provide a valuable service, while gaining community trust.

#### Service Excellence

We work collaboratively with each other, our care and educational partners, other organizations and the community to provide safe, quality, service, care, treatment, and needed education.

# 2016 Orientation/Reorientation

## Trustworthiness

We are responsible and prudent stewards of the resources entrusted to us. We are transparent in the work we do and honest, fair and equitable in our decision making.

## Improving the Work Environment

We focus on recruiting and retaining talented, compassionate and caring people. LAC+USC Medical Center is a place where people are valued and respected for their diversity, talents, background and unique perspectives.

## Continuous Learning

We are a teaching hospital promoting continuous learning at all levels, expecting continuous improvement from our USC partners and ourselves. We continually strive to improve patient care through active research and exchange of ideas. The Mission, Vision and Values are aligned with operations using the Balanced Scorecard Program.

## LOS ANGELES COUNTY STRATEGIC PLAN

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### MISSION

- To enrich lives through effective and caring service.



### VALUES

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

- **Accountability** – We accept responsibility for the decisions we make and the actions we take.
- **Can-Do Attitude** – We approach each challenge believing that, together, a solution can be achieved.
- **Compassion** – We treat those we serve and each other in a kind and caring manner.
- **Customer Orientation** – We place the highest priority on meeting our customers' needs with accessible, responsive quality services, and treating them with respect and dignity.
- **Integrity** – We act consistent with our values and the highest ethical standards.
- **Leadership** – We engage, motivate and inspire others to collaboratively achieve common goals through example, vision and commitment.
- **Professionalism** – We perform to a high standard of excellence. We take pride in our employees and invest in their job satisfaction and development.
- **Respect for Diversity** – We value the uniqueness of every individual and their perspective.
- **Responsiveness** – We take the action needed in a timely manner.

### STRATEGIC PLAN GOALS

#### Countywide Goal

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

#### Programmatic Goals

2. **Fiscal Sustainability:** Strengthen and enhance the County's capacity to sustain essential County services through proactive and prudent fiscal policies and stewardship.
3. **Integrated Services Delivery:** Maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety service.

# CUSTOMER SERVICE

## CUSTOMER SERVICE PHILOSOPHY

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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 with service plan development.
- Following-up to ensure appropriate delivery of services.
- Responding to customer concerns immediately and following up within 24 hours.

### SERVICE ENVIRONMENT

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

- Report any unsafe conditions to your supervisor or the LAC+USC Medical Center Safety Officer at (323) 409-7485.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers.



## AIDET

All staff members can help improve patient satisfaction through courtesy and clear communication. In order to assist staff in doing this, we have implemented a new customer service tactic, called **AIDET** (Acknowledge, Introduce, Duration, Explanation, Thank you). **AIDET** is a simple acronym that represents a very powerful way to communicate with people who are often nervous, anxious, and feeling vulnerable. The five fundamental principles of **AIDET** are:

<b>A</b>	<b>Acknowledge</b>	<ul style="list-style-type: none"> <li>○ Make eye contact.</li> <li>○ Smile.</li> <li>○ Stop what you are doing, so that your patient or visitor knows that they are important.</li> </ul> <p><i>Sample: "Good morning, Ms. Jones."</i></p>
<b>I</b>	<b>Introduce</b>	<ul style="list-style-type: none"> <li>○ Welcome.</li> <li>○ State your name.</li> <li>○ State your role in the patient's care.</li> </ul> <p><i>Sample: "Welcome to LAC+USC. My name is Jane. I am Dr. Smith's Nurse and will be assisting her with your exam today."</i></p>
<b>D</b>	<b>Duration</b>	<ul style="list-style-type: none"> <li>○ Explain how long a procedure will take.</li> <li>○ Explain how long an interaction will take.</li> <li>○ Explain how long it will take to get test results back.</li> </ul> <p><i>Sample: "Dr. Smith ordered an x-ray procedure for you today, just to make sure your finger is not broken. The procedure takes about 15 minutes to complete. Go to the Medical Imaging Department to check-in and when you are done, come back to this office to get your result."</i></p>
<b>E</b>	<b>Explanation</b>	<ul style="list-style-type: none"> <li>○ Explain the test or procedure.</li> <li>○ Explain any post-procedure instructions.</li> </ul> <p><i>Sample: "Ms. Jones, I will be taking an x-ray image of your finger with this machine. The machine will produce an image of your bone and will allow us to see if your finger is broken. Do you have any questions for me?"</i></p>
<b>T</b>	<b>Thank you</b>	<ul style="list-style-type: none"> <li>○ Let patients know you have enjoyed working with them.</li> <li>○ Thank them for entrusting us with their healthcare needs.</li> </ul> <p><i>Sample: "Thank you, Ms. Jones, for allowing us to take care of you. Your follow-up appointment with Dr. Smith has been scheduled. Please let me know if you have any questions."</i></p>

The five basic principles of **AIDET** can be applied by all staff members, and by using them regularly, we can stay true to our commitment of providing quality care and courteous service.

## TEAMWORK

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



## EFFECTIVE WORKPLACE COMMUNICATION

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

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

<b>Written:</b>	Charting notes, reports, e-mail, documents, logs
<b>Verbal:</b>	Talking, teleconferences, telephone
<b>Visual:</b>	Demonstrations, videos
<b>Electronic:</b>	Computer, e-mail, text messages
<b>Nonverbal:</b>	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.

### 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.

- Be objective.
- Document accurately.
- Remember nonverbal communications such as facial expressions, tone of voice, body language and movements, and hand gestures express messages (both negative and positive), intended and unintended.
- Remember to follow patient privacy and confidentiality laws and regulations when dealing with patient information in any information format.

## PRINCIPLES OF INTERDISCIPLINARY COLLABORATION

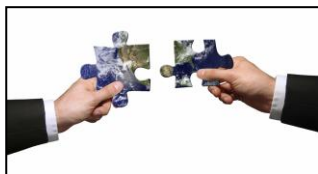
Collaboration involves working together to satisfy the needs of our patients. High quality patient care is achieved when all workforce members contribute their best efforts in a coordinated manner. Hierarchy, or perceptions of strict levels of power, should not be a barrier to the collaborative effort. 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 discusses 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 not 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 the key to providing effective coordination of care. Up-to-date information about a patient's care, treatment or services, condition, expected outcomes and anticipated changes must be maintained to ensure appropriate care of the patient. Effective coordination of care makes it possible for patients to feel secure in the knowledge that they are receiving appropriate and timely care. This is a necessary part of the process of developing patient trust.

## 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 that promotes success in team building.



# THE JOINT COMMISSION

## THE JOINT COMMISSION'S FOCUS ON PATIENT SAFETY AND QUALITY CARE

For more than 60 years, The Joint Commission has been a champion of patient safety by helping health care organizations improve the quality and safety of the care they provide. The Joint Commission's many patient safety-focused initiatives encourage and support organizations in their efforts to make patient safety a continuous priority. Our focus in preparation for re-accreditation is to use Joint Commission's standards for achieving and maintaining efficient and effective systems to support safe and high-quality patient care. The components of maintaining accreditation include:



- **Focused Standards Assessment (FSA)**, previously known as Periodic Performance Review (PPR) – A required 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, a subset of indirect and direct impact standards, and standards listed as requirement for improvement (RFI) from our previous triennial survey.
- **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.
- **14 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.
- **System Tracer** – Sessions devoted to evaluating three high priority safety and quality-of-care issues on a system-wide basis: Dietetic/Food Service, Infection Control, Medication Management, Pharmaceutical Services, Medical Staff and Data Management.
- **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 that the surveyors will select specific inpatients and review their medical records to determine the services each patient received during their hospitalization. By tracing the course of care and services experienced by the patient (a real time review), the surveyors will interact with direct care providers and/or other applicable workforce members to determine the relationship among departments involved in the care, the integration and coordination of important processes, opportunities for improvement and education (as appropriate) and validation of findings through review of additional records. The surveyors will observe:

- Direct patient care
- Medication administration
- Care planning processes



# 2016 Orientation/Reorientation

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

## OTHER SURVEY ACTIVITIES

- System Tracers
  - Medication Management
  - Data Management
  - Infection Control
  - Medical Staff Functions/California Department of Public Health (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

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

## THE JOINT COMMISSION ACCREDITATION PARTICIPATION REQUIREMENTS (APR 09.02.01)

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

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

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

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

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

# PATIENT SAFETY PROGRAM

## LAC+USC MEDICAL CENTER PATIENT SAFETY PLAN

The LAC+USC Medical Center is 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 current National Patient Safety Goals (NPSGs).
- ✦ Promoting a "Just Culture" that encourages the reporting of errors and near misses. After an incident occurs, there is an emphasis on education and learning, not on finding someone to blame.

### PROGRAM STRUCTURE

The Chief Executive Officer has appointed the chair of the Patient Safety Committee as the Patient Safety Officer.

#### Patient Safety Committee (PSC)

The PSC is a multidisciplinary committee established to manage the organization-wide Patient Safety Plan and ensure compliance with current The Joint Commission's NPSGs. The PSC also provides leadership and direction for all patient safety initiatives and activities.

### KEY POINT

Know that we have a proactive, multifaceted, and integrated Patient Safety Program. The purpose of the Plan is to ensure that LAC+USC Medical Center is in compliance with current patient safety standards as required by The Joint Commission's National Patient Safety Goals and standards.

## 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.

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

#### Create and Maintain a Just Culture by:

- Encouraging staff to recognize and report patient safety issues, and suggest ideas of how we can improve.
- Acknowledging that errors in 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.

# 2016 Orientation/Reorientation

- 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.

## DETERIORATING PATIENT CONDITION

Your job duties may or may not involve direct patient care, and you may not have special training in assessing patients. Nonetheless, any of us working in a hospital/patient care area may at times notice a patient/visitor who does not seem to be doing well. What do you do if a patient/visitor appears to you to have fallen, is having trouble breathing, appears unconscious, or is behaving strangely? If you notice a patient/visitor who 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 LAC+USC Rapid Response Teams (Code Blue Team and Airway Team). Registered nurses in the areas covered by a 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 call 9-1-1, in response to a change in patient condition. This is why notification of the patient's nurse is the first step in getting assistance for a person who is in possible distress.

If you are in a non-patient care area on campus, activate a "Man Down" by calling Ext. 111 from any hospital phone and stating that there is a person in distress or "Man Down". The telephone operator will direct the call to the Base Station in the Emergency Department where a nurse (Mobile Intensive Care Nurse or MICN) will respond to the call.

The MICN will obtain basic information regarding the status of the patient. It is at the discretion of the MICN to dispatch the Airway or Code Blue team if the patient appears to be in extremis. If the patient is outside of this area covered by those teams a paramedic ambulance may be dispatched via 9-1-1 (See Code Blue Policy #912.).

If the patient primarily needs transportation for medical assistance, the MICN will contact the appropriate Man Down Team to respond and transport the patient to the Emergency Department.

If you are outside the main hospital buildings/areas (such as Rand Schrader Building, Parking Lot 9, School of Nursing, etc.), call 9-1-1 for a medical emergency.

At **LAC+USC Medical Center**, it is important that you know that anyone can call for emergency medical assistance by **dialing Ext. 111** from a hospital phone. **If you encounter a situation that you feel requires emergency assistance, then you should always act on it by calling for help!**

### AT LAC+USC MEDICAL CENTER:

➤ <b>Man Down</b> ➤ <b>Code Blue (Cardiac or Respiratory Arrest)</b>	<b>Main hospital buildings/areas</b> Call Ext. 111
	<b>Outside the main hospital buildings/areas</b> Call 9-1-1

### AMBULATORY CARE HEALTH CENTERS

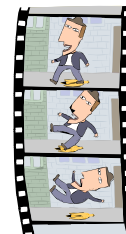
- ◆ Call 9-1-1 for **ALL** medical emergencies



## 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, the parking lot, waiting rooms, clinic areas, and patient's rooms.
  - Maintain adequate levels of lighting.
  - Report wet floors, spills, blocked passageways immediately.
  - Remove obstacles and trash on the ground or in passageways/hallways.

#### Inpatients

- ◆ Check for "Fall Risk Alerts" and Fall signage for inpatients.
- ◆ Ensure bed and wheelchair brakes are locked.

# 2016 Orientation/Reorientation

- ◆ Ensure patients have non-skid footwear.
- ◆ Keep bedside rails raised during patient transport.
- ◆ Keep children's bed rails raised when child is not attended by an 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.

Fall Risk



## 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:

1. Notify your supervisor/manager.
2. Dial Ext. 111 to activate the Man Down code.
3. Document the incident via Safety Intelligence and follow other reporting procedures.



A Man Down will be activated by calling Ext. 111 from any hospital phone and stating there is a person in distress or Man Down. The telephone operator will direct the call to the Base Station in the Emergency Department where a nurse (MICN) will respond to the call.

The MICN will obtain basic information regarding the status of the patient/visitor. It is at the discretion of the MICN to dispatch the Airway or Code Blue team if the victim appears to be in extremis. If the victim is outside the area covered by those teams a paramedic ambulance may be dispatched via 9-1-1 (See Policy No. 912, Code Blue). If the victim primarily needs transportation for medical assistance, the MICN will contact the appropriate Man Down team to respond and transport the patient to the Emergency Department.



Report environmental hazards to Facility Management or the Facility Safety Officer. Safety concerns/complaints may be made through your supervisor, the facility risk manager, and/or the DHS Quality Improvement Program hotline at (800) 611-4365.

In order to monitor, measure, and analyze conditions associated with falls, it is critical that you report **ALL** falls. If you encounter, witness a fall, help or assist someone whom has fallen; follow the facility's reporting process (or immediately notify your supervisor), so conditions associated with falls can be corrected and documented. **Falls are to be reported in the 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 stairs 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. a 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”**

## NATIONAL PATIENT SAFETY GOALS

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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 healthcare organizations. The Joint Commission accredited healthcare organizations are surveyed for the implementation of the NPSGs and requirements, or acceptable alternatives. The LAC+USC Medical Center Patient Safety Program initiatives are based on meeting the NPSGs, and focusing on system-wide solutions. The Network 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 current National Patient Safety Goals that are applicable to your duties. For detailed explanations, see The Joint Commission's 2015 NPSGs chart.

## DHS Patient Safety Brochure: Tips for Patients

LAC+USC Medical Center provides each patient with a **DHS Patient Safety Brochure: Tips for Patients** pamphlet and a LAC+USC Network Information Handbook. We encourage each patient to review the brochure 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 patient and staff; and ultimately a safer environment.

## Ways You Can Report Patient Safety Issues/Concerns/Suggestions

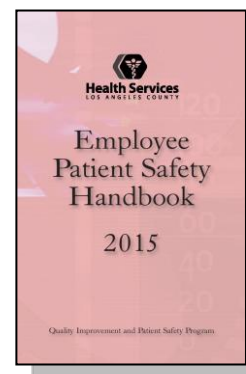
- Patient Safety Hotline at **(323) 226-SAFE**.
- Executive Leadership WalkRounds.
- DHS Patient Safety Hotline at (213) 989-SAFE or e-mail at [patientsafety@dhs.lacounty.gov](mailto:patientsafety@dhs.lacounty.gov).
- The Joint Commission at (800) 994-6610 or e-mail at [complaint@jointcommission.org](mailto:complaint@jointcommission.org).
- Executive Leadership Cyber WalkRounds website on the LAC+USC Medical Center intranet.
- Safety Intelligence (a web-based DHS-wide system).
- Event Notification Report.
- Medication Event Report.
- Adverse Drug Events at (323) 226-7741 (Drug Information Center).
- Patient Care Statement of Concern.
- Discuss your concerns or issues/suggestions with your supervisor.
- See Risk Management Section for additional reporting.

## Ways You Can Stay Updated on Patient Safety Initiatives

One of the ways you can keep updated is by reviewing the current **National Patient Safety Goals** on the mini badges which are annually distributed to each workforce member. The mini badge should be worn with your identification badge. The current NPSG workforce member mini card serves as a constant reminder that we must keep patient safety as our first priority. Each workforce member is responsible for knowing the current NPSGs and which NPSGs apply to their work environment.

Additional ways to keep current with patient safety initiatives include:

- ◇ Reviewing the poster presentations of important safety information posted in each unit;
- ◇ Participating in patient safety discussions in your unit staff meetings;
- ◇ “Speaking Up” during Executive Leadership WalkRounds in your department;
- ◇ Reviewing the Patient Safety Committee webpage on the intranet;
- ◇ Attending Network-sponsored educational presentations;
- ◇ Attending the annual DHS Patient Safety seminar; and
- ◇ Reviewing the Employee Patient Safety Handbook.



See 2016 NPSG Chart on Next Page

## 2016 Hospital National Patient Safety Goals

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

### Identify patients correctly

NPSG.01.01.01

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

NPSG.01.03.01

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

### Improve staff communication

NPSG.02.03.01

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

### Use medicines safely

NPSG.03.04.01

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

NPSG.03.05.01

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

NPSG.03.06.01

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

### Use alarms safely

NPSG.06.01.01

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

### Prevent infection

NPSG.07.01.01

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

NPSG.07.03.01

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

NPSG.07.04.01

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

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

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

### Identify patient safety risks

NPSG.15.01.01

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

### Prevent mistakes in surgery

UP.01.01.01

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

UP.01.02.01

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

UP.01.03.01

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



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](http://www.jointcommission.org).

## UNIVERSAL PROTOCOL

The Joint Commission's Universal Protocol (UP) was developed to assist in preventing wrong site, wrong procedure, and wrong person surgery/procedure. The UP, as a National Patient Safety Goal, establishes a process for a defined series of pre-procedure verifications to take place prior to surgery or a procedure. LAC+USC Medical Center has adopted each component of the UP as it applies to invasive procedures performed in the operating room as well as those performed in non-operating room settings (e.g., endoscopy, interventional radiology, cardiac catheterization, and the bedside). Workforce members share in the responsibility of conducting the pre-procedure verification process with the patient.

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



## 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](http://www.jointcommission.org).

## STAFF RIGHTS AND RESPONSIBILITIES

This section discusses your rights and responsibilities as a workforce member in the LAC+USC Medical Center. 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 background checks, personal appearance, attendance/tardiness, health screening, smoke-free environment, the Employee Assistance Program, sexual harassment prevention, cultural and linguistic competency; preventing and reporting of abuse/neglect; workforce behavioral expectations; zero tolerance; Safe Haven/Safely Surrendered Baby Law; and Americans with Disabilities Act (ADA).

### DHS WORKFORCE MEMBER EMERGENCY PROTOCOL

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

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

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

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

#### What to Do When a Disaster Occurs

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

If you are at work and have a pre-designated emergency response assignment, you must respond in accordance with that assignment. If you do not have a pre-designated assignment, report to your supervisor or the Building Emergency Coordinator (BEC) to receive instructions.

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



#### DISASTER SERVICE WORKER

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

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



## STAFF RIGHTS

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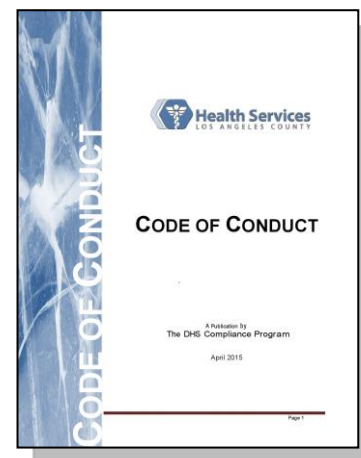
LAC+USC Medical Center seeks to provide high quality patient care in an environment that protects all members of our service delivery team and respects their cultural values, ethics, and religious beliefs. Network leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious belief conflicts 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/agreement.

## DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

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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 LAC+USC Medical Center can be reached at (323) 409-4242.



A significant element of the DHS Compliance Program is the DHS Code of Conduct which is our guide to appropriate conduct and behaviors. Together with applicable laws, County and Department policies, and program-specific guidelines, we have set standards to ensure that we all do the right thing. These legal and ethical standards apply to our relationships with patients, workforce members, affiliated providers, third-party payers, contractors, subcontractors, vendors, and consultants. Each workforce member has a personal responsibility to comply with the Code of Conduct and must sign an acknowledgement stating they will abide by the Code of Conduct and understand that non-compliance with the Code of Conduct can subject them to corrective action up to and including discharge from service or termination of assignment.

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

- 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  
DHS Compliance Hotline: (800) 711-5366.

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

Please note that the Los Angeles County Fraud Hotline (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 “whistle-blower” protections. DHS will not discharge, demote, suspend, threaten, harass, or in any manner discriminate against workforce members who exercise their rights under any federal or state whistleblower laws.

Compliance awareness training is provided to workforce members at the start of service 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 liabilities with respect to false claims and statements; protections for workforce members who report wrongdoing (whistleblower protections) under those laws and regulations, policies and procedures to detect and prevent fraud, waste and abuse and workforce training (*Federal False Claims Act, 31 U.S.C §§3729-3733*).

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

The laws described in the federal False Claims Act are intended to control fraud in federal and state healthcare programs by giving certain governmental agencies the authority to seek out and investigate violations and prosecute violators. DHS Policy 1003, False Claims Act, discusses both federal and state law provisions which protect health care programs against false claims and protect individuals who detect and report fraud.

The policy discusses the federal FCA, 31 U.S.C. §§3729 et seq., which precludes, among other things, the submission to the federal government of false claims and false documentation to support such claims, as discussed in more detail below. The policy also describes a federal law, 31 U.S.C. §§3801-3812, which allows certain federal agencies, including the U.S. Department of Health and Human Services, to impose penalties for the submission of false or fraudulent claims or false supporting documents. That law, as well as the California False Claims Act, is 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 it a crime to conduct certain types of improper claiming practices.
- Welfare & 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.
- Welfare & Institutions Code § 14107.4 – Makes it a crime to submit false information in a cost report to falsely certify a cost report.
- Welfare & Institutions Code § 14123.2 – Imposes administrative fines for presenting or causing to be presented various kinds of improper claims to Medi-Cal.
- Welfare & Institutions Code § 14123.25 – Allows civil monetary penalties 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.

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

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

Actions that violate the federal FCA include:

1. Presenting or causing to be presented a false or fraudulent claim for payment to the federal government or to someone else who will pay all or part of the claim using federal funds;
2. Making or using, or causing to be made or used, a false record or statement which is material to a false claim. A statement is “material” if it has a natural tendency to influence the payment;
3. Conspiring to violate the federal False 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 that is found in violation of 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 employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee to support or assist an action under the Act or because the workforce member took actions to prevent one or more false claims, is entitled to all relief necessary to make the employee 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 California False Claims Act, 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 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 prosecutes the case, and between 25 and 50% (plus reasonable costs and attorney's fees) if the qui tam plaintiff litigates the case of 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 FCA, the CFCA bars employers from interfering with an individual's ability to bring or cooperate with the government's action under CFCA. Employees who report fraud and are discriminated against may be awarded: (1) Reinstatement at the seniority level they would have had except for the discrimination; (2) Double back pay plus interest; (3) Compensation for any costs or damages they have incurred; and (4) Punitive damages, if appropriate. Employees who participated in the violation, but were coerced into doing so and cooperated with the government, are also protected from discrimination and may receive the same types of awards.

## PROCUREMENT PROCESS

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**No Department of Health Services (DHS) workforce member has independent authority to purchase supplies, equipment or services, or commit County funds.**

### COUNTY AUTHORITY

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

### 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 the 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 corrective 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 LAC+USC Network's orientation within 30 days of hire/assignment or transfer to the hospital. The LAC+USC Medical Center will document completion in your official personnel folder and/or area file. Your supervisor will also document your unit-based, job-specific orientation and initial competency assessment in your area file. Documentation of initial competency assessment must be initiated immediately upon hire/assignment and completed **within the first 90 days** of your assignment to the actual unit/division. Your supervisor should ensure that you know how to use equipment in the performance of your job and should apprise you of the policies and procedures you must follow. Assignments shall include only those duties and responsibilities for which competency has been validated. Ongoing competency assessment is required annually or as needed (i.e. new equipment, new procedure/policy, remedial education process, etc.) and should be documented in the 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). Education cards must be kept up to date and document Continuing Education Units (CEUs), safety modules, mandatory training and any education or training pertinent to your position.



## 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. If you are a licensed professional, **it is your responsibility to renew all required professional credentials or other requirements and to ensure the professional credential is kept in good standing with the appropriate issuing board or agency.** Failure to comply with professional credential requirements may subject you to corrective action, which may include discharge/release from County service or assignment.

Primary source verification must be conducted during in-processing, 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.

### REMEMBER

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

# 2016 Orientation/Reorientation

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

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

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

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

All licensed medical professionals are expected to adhere to the highest ethical and professional standards of behavior and performance. However, if you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report as follows:

**Medical Staff.....Medical Administration – (323) 409-6734**

**Nursing Staff .....Nursing Administration – (323) 409-6747**

**OR contact:**

**Human Resources .....Performance Management – (323) 226-8207**

## CRIMINAL BACKGROUND CHECKS

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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.

# 2016 Orientation/Reorientation

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

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

If you are **arrested or charged** with a crime (including traffic violations, if position requires driving on County business), you must report being arrested or charged with such crime to DHS Human Resources **within 72 hours** of the arrest/charge. If you are **convicted** of a crime (including a traffic violation, if position requires driving on County business), you are required to report the conviction to DHS Human Resources (HR) Performance Management (PM) within 24 hours of the conviction. Failure to report may result in corrective 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

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Your personal appearance on the job is important. It is part of how you represent DHS and LAC+USC Medical Center. All workforce members are expected to comply with DHS and LAC+USC Medical Center 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 our business atmosphere, health care standards, and workplace safety must not interfere or detract from our mission. It must be appropriate to the type of work being performed and take in consideration the expectations of our patients, and customers served. DHS photo identification badge must be worn at all times while on duty and in County-facilities. Do not obscure your name, title, or 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.

## ATTENDANCE/TARDINESS

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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

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All workforce members within the LAC+USC Medical Center's service delivery team as well as all students, volunteers, and non-DHS/non-County workforce members must have an initial and annual health assessment, including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), communicable disease status, vital signs, and/or laboratory tests, as needed. **You and your supervisor are responsible** to comply with DHS policy and ensure you obtain a health screening annually as a condition of continued employment/assignment. If you do not comply with the annual health screening requirements, you will be given a "Direct Order" memorandum indicating you have until the end of the month to comply or face corrective action up to and including discharge/release from County service. Documentation of annual health clearance is to be kept up-to-date in the area file. You may contact Employee Health to find out when your health screen is due.

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.

### IMPORTANT!

You must complete your health screening clearance annually.



## SMOKE-FREE ENVIRONMENT

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Smoking is not permitted inside any LAC+USC Medical Center building, structure, or vehicle. **Additionally, smoking is not permitted anywhere outside on hospital grounds. LAC+USC Medical Center campus is now a smoke-free facility.**

## EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES ONLY)

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

## COUNTY POLICY OF EQUITY

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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, 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 LAC+USC Medical Center, the DHS or County including off-site conferences, lunch meetings, or clients’ homes or businesses.
3. Sexual harassment can occur between people of the opposite sex and people of the same sex. The aggressor can be male or female.
4. The aggressor can be the staff member’s supervisor, manager, customer, co-worker, supplier, peer, or vendor.
5. A workforce member can be a victim of sexual harassment because sexual harassment exists in the work environment, even if it does not specifically involve or is directed toward that individual.
6. Sexual harassment can be verbal, physical, written or visual in nature.

## UNLAWFUL HARASSMENT (OTHER THAN SEXUAL)

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

## THIRD-PERSON HARASSMENT

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

## INAPPROPRIATE CONDUCT TOWARD OTHERS

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

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

## RETALIATION

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

## EXAMPLES OF PROHIBITED ACTIVITIES (NOT A COMPLETE LIST):

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

## PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

As a member of LAC+USC Medical Center workforce, you are responsible to ensure sexual harassment does not occur in the workplace. If you believe you have been the object of, have witnessed, or have been affected by sexual harassment in the workplace, you should immediately report the action or incident to your manager/supervisor, hospital or Comprehensive Health Care Center Chief Executive Officer, facility on-site 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

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

### WHAT IS CULTURAL AND LINGUISTIC COMPETENCE?

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

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



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

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

### WHY IS CULTURAL COMPETENCY IMPORTANT?

Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to

function effectively to understand the needs of groups accessing health information and health care—or participating in research—in an inclusive partnership where the provider and the user of the information meet on common ground. (Source: <http://www.nih.gov/clearcommunication/culturalcompetency.htm>)

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

(Source: [http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf))

## CULTURAL COMPETENCE

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

### Culture and language may influence:

- Accurate communication with providers and the healthcare system;
- Health, healing, and wellness belief systems;
- How illness, disease, and their causes are perceived; both by the patient/consumer;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; and as well as
- The delivery of services by the provider who looks at the world through his/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 healthcare** – a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.



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

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

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

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

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

- ✓ Improved quality in the delivery of care.
- ✓ 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 healthcare 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 healthcare 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).

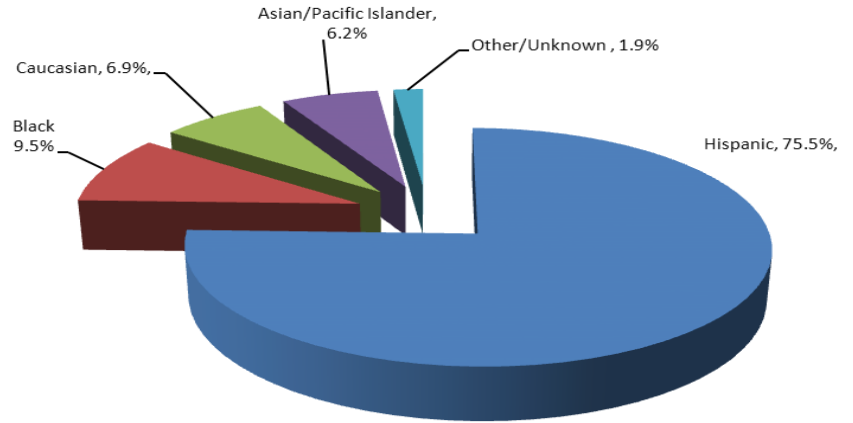


## LAC+USC PATIENT POPULATION

Culturally competent patient care is not just a right; it's also a key factor in the safety and quality of patient care. Our hospital inpatient population consists of the following groups:

### Patient Population

Hispanic .....	75.5%
Black .....	9.5%
Caucasian .....	6.9%
Asian/Pacific Islander .....	6.2%
Other/Unknown .....	1.9%



## *DHS Cultural Bill of Rights*

### **We Believe in**

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

DHS/Office of Diversity  
Approved on October 30, 2001

## THREAT MANAGEMENT “ZERO TOLERANCE”

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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 to local law enforcement.

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

- Arrest and prosecution for violation of pertinent laws. (Threats of harm are illegal.)
- 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.

## WORKFORCE BEHAVIORAL EXPECTATIONS

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

DHS and LAC+USC Medical Center will not tolerate any disruptive, inappropriate, or unprofessional behavior/conduct by any workforce member towards another workforce member, the public, or patients.

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

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

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

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

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

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

## ABUSE PREVENTION, SEXUAL ABUSE, SEXUAL COERCION (INAPPROPRIATE BEHAVIOR TOWARDS A PATIENT)

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

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

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

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

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

A workforce member determined to have violated this policy shall be subject to appropriate corrective action which may lead up to termination. The workforce member may also be subject to criminal and/or civil prosecution and reporting to the appropriate professional credential issuing 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

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

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

- **Child Abuse** includes emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years. Healthcare providers are mandated to report incidents of suspected abuse to Department of Children and Family Services **Child Abuse Hotline at 1-800-540-4000** immediately or as practically as possible. A written report must be submitted (within 36 hours of the telephone report) through their website at <http://dcfs.lacounty.gov>.
- **Elder Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Healthcare providers are mandated to report incidents of suspected elder abuse immediately or as practically as possible by calling the **Elder Abuse Hotline at 1-800-992-1660 or 1-877-477-3646 during after-hours**. A written report must be submitted within two (2) working days of the telephone report by fax at (213) 738-6485.
- **Dependent Adult Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals between the ages of 18-64. This includes individuals who are mentally or physically challenged. Healthcare providers are mandated to report incidents of dependent adult abuse by calling the **Adult Abuse Hotline at 1-800-992-1660 or 1-877-477-3646 during after-hours** and submit a follow-up report immediately or as practically as possible by fax at (213) 738-6485.
- **Domestic/Intimate Partner Abuse** involves any individual who has been abused by their domestic/intimate partner. Domestic/intimate partners are those individuals who are currently dating, married, cohabitating, or separated. The abuse includes physical violence, sexual assault, severe emotional distress and economic coercion. Domestic/intimate partner abuse must be reported if there is a current injury. Healthcare providers are **mandated to report the violence as soon as practically possible to local law enforcement or the Los Angeles County Sheriff's Department (LASD) at Ext. 3333 or to the Domestic Violence Hotline at 1-800-978-3600** and follow up report within 48 hours.



# 2016 Orientation/Reorientation

In addition, contact the Clinical Social Work Department at (323) 409-5253 for assistance with evaluations, reporting forms and referrals.

## REPORTING SUSPICIOUS INJURIES

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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/she knows or reasonably suspects has a suspicious injury to report such injury by telephone to local law enforcement immediately or as soon as practical. Section 11160 requires the reporter to make a written follow-up report within two (2) business days to the same local law enforcement agency.

If the suspicious injury is to a patient/inmate, per BOS mandate, it must be reported to the Internal Affairs Unit or the Captain of the jail facility where the patient/inmate is housed. The Los Angeles County Sheriff's Department Internal Affairs Bureau can be reached at (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.

## AMERICANS WITH DISABILITIES ACT (ADA)

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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. 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 Risk Management, Return to Work Units at (323) 869-7122 for assistance. Non-County workforce members should contact their agency/school to seek assistance for an accommodation. The facility will work with the contract agency/school to the extent possible.

## SAFE HAVEN/SAFELY SURRENDERED BABY (SSB) LAW

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In compliance with Senate Bill 1368 (Brulte) Chapter 824, Statutes of 2000, Safe Haven/Safe Surrendered Baby Law and Network Policy No. 115, it is the policy of the Network 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). Emergency Medical Treatment and Active Labor Act (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 Neonatal Intensive Care Unit (NICU) Team (323-409-3322 or 323-409-3290) is called to assume care of the newborn.
- The Department of Children and Family Services is notified by Clinical Social Work or by the Emergency Department during after-hours, weekends, and holidays at (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, Clinical Social Work and the Nurse Manager/Supervisor are called. The NICU attending physician must sign for the release of the infant.

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](http://www.babysafela.org) or call 1-877-BABY SAFE.

In the event an infant is surrendered at other network facilities/areas not designated as a Safe Haven site, the infant must be transported as quickly as possible to health care staff in the emergency room, urgent care, or a clinic. Staff will call 9-1-1 to request transport. Staff will provide all necessary medical evaluation and care until the paramedics arrive. Other hospital areas, the Comprehensive Health Centers, and Health Centers will maintain and use Newborn Safe Surrender Packets.



## PATIENTS' RIGHTS AND SERVICES



This section explains LAC+USC Medical Center's patient rights and services such as patient advocacy, interpreter services, the Chaplaincy Program, advanced 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, LAC+USC Medical Center has a Patient Rights and Organizational Ethics 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 consults to LAC+USC Medical Center 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 committee through your Physician, Nurse, Social Worker, or Chaplain or call:

**(213) 919-6497 Adults**

**(323) 409-3886 Fetus/infant/child**

Or you can call (323) 409-4906 and ask the pager operator for assistance in locating the physician assigned to review ethical issues and direct them to the appropriate ethics committee member.

Patients of LAC+USC Medical Center have both rights and responsibilities. Each patient is given a **Welcome to LAC+USC Medical Center (Patient Rights) Handbook** upon admission. Patients who are not formally admitted (i.e. via the emergency room) are provided a *Welcome (Patient Rights) Handbook* by Clinical Social Work Department. LAC+USC Medical Center has posted these rights and responsibilities throughout the hospital for reference.



If a patient comes to you with a complaint about any part of his/her medical care or treatment, refer them 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 Administration at (323) 409-2800. Patients may contact Patient Relations Department directly with a complaint at (323) 409-6959.

## PATIENTS' RIGHTS

### Patients have the right to:

1. Considerate and respectful care, and to be made comfortable. They have the right to respect for their personal values and beliefs.
2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of other physicians and non-physicians who will see them.
4. Receive information about their health status, course of treatment and prospects for recovery in terms that they can understand. Patients have the right to be informed, when appropriate, of outcomes of care, including unanticipated outcomes. They have the right to participate in the development and implementation of their plan of care. They have the right to participate in ethical questions that arise in

the course of their care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding their medical care, and receive as much information about any proposed treatment or procedure as needed in order to give informed consent or refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, a patient does not have the right to demand inappropriate or medically unnecessary treatment or services. They have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Assessment and management of pain.
10. Formulate advance directives. This includes designating a decision maker if they become incapable of understanding a proposed treatment or become unable to communicate their wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on the patient's behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Patients have the right to be told the reason for the presence of any individual. Patients have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to their care and stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by the patient. Written permission shall be obtained before medical records are made available to anyone not directly concerned with the patient's care, except as otherwise required or permitted by law.
13. Access information contained in their records within a reasonable time frame, except in certain circumstances specified by law.
14. Receive care in a safe setting, free from verbal or physical abuse or harassment. They have the right to access protective services including notifying government agencies of neglect or abuse.
15. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
16. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing care.
17. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital.
18. Know which hospital rules and policies apply to their conduct while a patient.
19. Designate visitors of their choosing, if they have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
  - No visitors are allowed.
  - The facility reasonably determines that the presence of a particular visitor endangers the health or safety of the patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
  - The patient has told the health facility staff that they no longer want a particular person to visit.
  - However, a health facility may establish reasonable restriction upon visitation, including restrictions upon the hours of visitation or the number of visitors.
20. Have their wishes considered, if they lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include persons living in the patient's household.

21. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
22. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
23. File a grievance and/or file a complaint with the state Department of Public Health, Joint Commission and/or the health facility and be informed of the action taken.

These Patient Rights incorporate the requirement of The Joint Commission, Title 22, California Code of Regulations, Section 70707, and Medicare Conditions of Participation.

## **AUGUSTUS F. HAWKINS FAMILY MENTAL HEALTH CENTER – PATIENTS' RIGHTS**

*(Source: Rights for Individuals in Mental Health Facilities Handbook; Admitted Under the Lanterman-Petris-Short Act; California Department of Mental Health, 2004)*

1. Patients have the right to see a patient rights advocate who has no clinical or administrative responsibility for the patient's mental health treatment and to receive services.
2. Patients have the right to complain about living conditions, any physical or verbal abuse, any threats or acts of cruelty, or treatment in the facility without being punished for voicing such complaints.
3. Rights while being involuntarily detained include:
  - 72-Hour Hold or "5150" – Patients considered to be a danger to themselves, a danger to others, or gravely disabled because of a mental disorder may be involuntarily detained for up to 72 hours for treatment and evaluation unless the person in charge can establish that the patient needs an additional 14 days of mental health treatment.
  - 14-Day Certification for Intensive Treatment or "5250" – If a patient was held beyond 72 hours, the patient has the right to remain in the hospital for voluntary treatment. If they do not wish to stay voluntarily, then a certification review hearing will be scheduled (within four days of the end of the 72-hour hold).
  - Re-certification for Intensive Treatment or "5250" – If the patient attempted or threatened to take their own life and remain an imminent threat of taking their own life during the 14-day certification, the patient's physician may place the patient on an additional 14-day hold (re-certification). No hearing will take place for re-certification.
  - Additional 30-Day Hold or "5270.1" – If a patient completed a 14-day period of treatment, the patient may be held for an additional 30 days if the patient's physician determines that the patient remains gravely disabled and is unwilling to accept voluntary treatment.
  - Post Certification for Dangerousness or "5300 et. al." – If sufficient reason exists at the end of the 14-day certification to believe the patient is a danger to others because of mental disorder, the person in charge of the facility may petition the court to require the patient to remain in the facility for further treatment. The treatment is not to exceed 180 days. The patient has the right to representation by an attorney and to a jury trial.
  - Temporary Conservatorship – If the person in charge of the facility believes the patient may benefit from the services of a conservator because the patient remain gravely disabled, may be placed on temporary conservatorship for up to 30 days. At the end of 30 days, a hearing will be held to determine whether the patient remains gravely disabled and whether a one-year conservatorship will be necessary.
4. Patients have the right to privacy concerning their care and confidentiality of records and communications of their care.
5. Patients have the right to prompt medical care and treatment.
6. Patients have the right to refuse any type of medical or mental health treatment including medications, unless the situation is an emergency. All patients have the right to refuse to take part in any research project or medical experiment. Patients have the right to refuse electroconvulsive treatment (ECT) or any form of convulsive therapy. However, if a court determined that the patient lack the capacity to make the decision, then ECT may be given without the patient's consent.



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- Involuntary patients have the right to refuse medical treatment or treatment with medications (except in an emergency) unless a capacity hearing is held and a hearing officer or a judge finds that the patient do not have the capacity to consent to or refuse treatment.
  - Patient on conservatorship – If a judge has granted the patient’s conservator power to make mental health treatment decisions, the patient no longer have the right to refuse treatment. In some cases, a judge may allow the patient on conservatory to retain the right to consent to or refuse medical treatment.
7. Patients have the right to consent to or refuse taking antipsychotic medications (except in an emergency). Patients may be treated with antipsychotic medications only after the hospital has completed the informed consent process.
    - Involuntary patients detained against their will have the right to refuse treatment with antipsychotic medications unless the situation is an emergency or a hearing officer or a judge has determined that the patient is incapable of making their decision.
  8. A capacity hearing (also called a Riese hearing) may be held to determine whether the patient may or may not refuse treatment with medications. The capacity hearing is conducted by a hearing officer at the facility or by a judge in court. Patients have the right to be represented at the capacity hearing by an advocate or by an attorney. If the patient disagrees with the decision, he/she have the right to appeal the decision to a superior court or to a court of appeal.
  9. Patients with mental illness have the same legal rights and responsibilities that are guaranteed to all other persons by the federal and state constitution and laws unless specially limited by federal or state laws and regulations.
  10. Patients have the right to dignity, privacy, and humane care. Patients have the right to treatment services that promote their potential to function independently. Treatment must be provided in ways that are least restrictive to the patient.
  11. Patients have the right to be free from abuse, neglect, or harm, including unnecessary or excessive physical restraint, isolation, or medication. Medication shall not be used as punishment, for the convenience of staff, as a substitute for treatment, or in quantities that interfere with the treatment program. Patients have the right to be free from hazardous procedures.
  12. Patients have the right to social interaction and participation in activities within the community or within the facility if the patient is hospitalized. Patients have the right to physical exercise and recreational opportunities.
  13. Patients have the right to participate in appropriate programs of publicly supported education.
  14. Patients have the right to religious freedom and practice.
  15. Patients have the right to receive mental health services without discrimination on the basis of race, color, religion, sex, national origin, ancestry, age, marital status, physical or mental disability, medical condition, or sexual orientation.
  16. Facility’s staff and doctor may deny patient’s rights with good cause, but cannot deny any of the following rights:
    - Clothing – Patients have the right to wear their own clothing (except as prohibited by law in some state hospitals).
    - Money – Patients have the right to keep and be allowed to spend a reasonable sum of their own money or personal funds for canteen expenses and small purchases.
    - Visitors – Patients have the right to see visitors each day.
  17. Patients have the right to have access to storage space for their personal belongings.
  18. Patients have the right to keep and use their own personal possessions, including their own toilet articles.
  19. Patients have the right to have reasonable access to a telephone both to make and to receive confidential calls or to have such calls made to them.
  20. Patients have the right to receive mail and unopened correspondence.
  21. Patients have the right to have letter-writing materials, including stamps, made available to them.



## PATIENTS' RESPONSIBILITIES

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1. Provide as accurate and complete information as possible about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
2. Report unexpected changes in his or her condition to the doctor or health care team member.
3. Inform the doctor or health care team member when a proposed treatment plan or what is expected of him or her is not understood.
4. Cooperate with the agreed-upon treatment plan recommended by the doctor or health care team member and follow the instructions.
5. Keep appointments and, when unable to do so for any reason, notify the responsible practitioner or the facility (hospital/clinic).
6. Accept the consequences of any refusal of treatment after he or she has thoroughly discussed the treatment plan with the doctor and has understood the possible consequences of refusal.
7. Provide financial information as necessary to qualify for health care benefits and fulfill financial obligations not covered by insurance.
8. Request health information and/or education as needed.
9. Be considerate and respectful of the rights of other patients, families, and staff, and assist in the control of noise, smoking, and the number of visitors.
10. Be respectful of the property of other persons and of the facility.

## PATIENT RELATIONS REPRESENTATIVES

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Patient Representatives are available at the LAC+USC Medical Center, 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, clinic appointment or emergency room visit, it is important that you make every attempt to resolve the complaint at the point it is first expressed. If you cannot resolve the complaint, please contact your supervisor for assistance.

If the problem cannot be resolved at the point it is first expressed by the staff present, the complaint becomes a grievance. Patient Representatives are available to assist in coordinating resolution of the grievance. It is important to note that every attempt should be made to immediately resolve verbal and/or written complaints made by patients, and their family or friends. Patient complaints and grievances 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.

For inpatients, the Patient Relations and Guest Services Department is located in, Inpatient Tower Room 2N115, on the second floor. A Patient Relations Representative may be reached by phone at (323) 409-6959.

For outpatient concerns, a Patient Representative is available in the Clinic Tower, Room A6A. They can be reached at (323) 409-5101.

For Emergency Room concerns, a Patient Representative may be reached at (323) 409-1612

## INTERPRETER SERVICES

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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-LAC+USC Medical Center personnel may not be used as interpreters unless expressly requested by the patient or in an emergency. **The**





## ADVANCE HEALTH CARE DIRECTIVES

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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. LAC+USC Medical Center 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 the LAC+USC Medical Center 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 (323) 409-5253 or the patient's physician. Remember patients can change their mind at any time regarding AHCDs.

## AMERICANS WITH DISABILITIES ACT (ADA)

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

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

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

A patient has the right to not participate in any program or service designed specifically for persons with disabilities. The Department has adopted an informal complaint procedure to investigate and resolve general complaints that allege DHS has not complied with the ADA. Patients may address concerns regarding access to services or reasonable accommodations to their care provider, the facility Patient Relations 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

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*(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

# 2016 Orientation/Reorientation

and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks. **Service animals are working animals, not pets.**

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

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

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

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

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

Violators of the ADA can be required to pay monetary damages and penalties. If you have any questions, please contact your ADA Coordinator or Human Resources at (323) 890-8422. Additional information may be obtained by calling the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

## ORGAN/TISSUE DONATION

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LAC+USC 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).

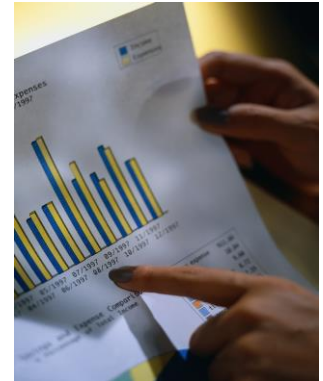
### EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

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

# PERFORMANCE IMPROVEMENT

The mission of the LAC+USC Medical Center Performance Improvement Program is to facilitate, support and train teams of medical and all other LAC+USC staff in adopting the management system, culture, tools and methodologies based on learned principles, adapted to the LAC+USC environment, to focus on relentless continuous improvement that delivers best in class patient experience, employee satisfaction, operational excellence, clinical quality and outcomes, and financial performance.



## BASIC PRINCIPLES

- Focus on strategic and supporting initiatives that deliver significant impact
- Continue to prioritize enhancing the patient experience as the focus of operational and quality improvements
- Empower the front line to own continuous improvement by facilitating staff-led projects that cross organizational silos
- Involve the medical staff through participation in teams and Lean training
- Foster a culture where key performance indicators are used daily to manage

## PURPOSE

The purpose of the LAC+USC Medical Center Performance Improvement (PI) Program is to define, implement and maintain the collaborative, systematic, and organization-wide approach for improving organizational performance. The Performance Improvement program focuses on creating highly reliable systems and processes that produce optimal health outcomes and eliminate errors. Understanding and improving clinical and operational processes provides the basis of our institution's performance improvement approach. The basic performance improvement model, Plan-Do-Study-Act (PDSA) is an accelerated improvement process and is utilized to systematically address opportunities for improvement. For prioritized projects, robust process improvement tools and techniques are used. Trained facilitators support the improvement process and provide formal training as well as just-in-time training in concepts and the process of performance improvement. The improvement of processes and outcomes relative to the following patient and organization functions are elements of the PI Program.

## TESTING A CHANGE – THE PLAN-DO-STUDY-ACT CYCLE

The Plan-Do-Study-Act cycle describes how we test an improvement idea by making changes and then reflecting on the consequences of those changes.

### Action:

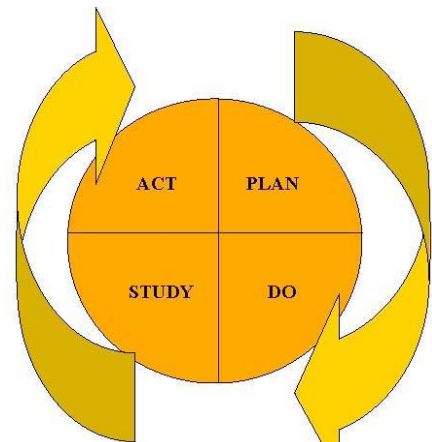
**PLAN** a test of change, preferably on a small scale

**DO** carry out the test as planned

**STUDY** the results of the test

**ACT** on what was learned from studying the results

(i.e.: What worked and what didn't work? What should be kept or changed)





## PERFORMANCE IMPROVEMENT ACTIVITIES

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### Current Performance Improvement Activities/PI Projects at LAC+USC Medical Center:

- Clinical Alarms Compliance
- Improve Pain Assessment/Reassessment
- Improve Patient Flow
- Simplify and Improve Materials Management Practices and Processes
- Ventilator Associated Pneumonia (VAP) Prevention
- Institute for Healthcare Improvement (IHI) – “100,000 Lives Campaign”

### 100,000 Lives Campaign

LAC+USC Medical Center has been an active participant of the 100,000 Lives Campaign. This is a nationwide initiative launched by the Institute for Healthcare Improvement (IHI) to significantly reduce morbidity and mortality in American health care. Building on the successful work of health care providers all over the world, our hospital has introduced proven best practices to help extend or save as many as 100,000 lives. LAC+USC Medical Center has fully adopted changes in care that save lives and reduce patient injuries, including:

- ✚ Prevention of Adverse Drug Events (Medication Reconciliation)
- ✚ Improved Care for Acute Myocardial Infarction
- ✚ Prevention of Central Line Infections
- ✚ Prevention of Ventilator Associated Pneumonia
- ✚ Prevention of Surgical Site Infection

In addition to the FOCUS-PDCA, another PI model that is used is the Failure Mode and Effects Analysis (FMEA). The performance of at least one new or high-risk process is measured and analyzed annually using this proactive, prospective technique. The following are two current FMEA Projects:

- Critical Lab Values
- Anticoagulation

If you have questions, contact Quality Improvement at (323) 409-6738.

## ORYX INITIATIVE/CORE MEASURES

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### What is ORYX?

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

### REMEMBER

Be prepared to know what has been done in your department or area to make improvements. Find out how you can participate in the performance improvement projects in your department. How have you been involved in the improvements made in your department in the past 12 months? How can you work with other departments to improve care/services? If you do not know, speak to your supervisor.

The Joint Commission developed the ORYX performance measures or indicators based on standardized, evidence-based measures, or factors that medical literature show a positive difference in patient health outcomes. Currently, LAC+USC Medical Center is collecting data on the following ORYX measurement sets:

- **Acute Myocardial Infarction (AMI)**
- **Heart Failure (HF)**
- **Pneumonia (PN)**
- **Pregnancy and Related Conditions**
- **Surgical Infection Prevention (SIP)**

Multiple data elements are collected for each Core Measure. The data elements are based on *your* chart documentation. It is very important that you document all medications administered as well as patient education. Reports of our hospital's performance will be available to The Joint Commission surveyors at the time of our survey as well as the general public through the Centers for Medicare and Medicaid Services (CMS).

## How are we doing compared to other hospitals?

Overall, LAC + USC Medical Center is doing well. We do well in initiating timely interventions at arrival, providing education at discharge and low inpatient mortality for acute myocardial infarction (AMI). However, we need to improve in documenting smoking cessation education and counseling on AMI and heart failure, and pneumonia cases.

## What could a surveyor ask you about ORYX / or a Core Measure?

When performing tracers, if the patient has a diagnosis of congestive heart failure, pneumonia, acute myocardial infarction, or is pregnant, the surveyor may ask you about the related ORYX indicators. Be prepared to speak to how you assure that LAC+USC Medical Center provides evidence-based care to your patients. Know what data is being collected in your area and how you are involved. You should be able to discuss what information is monitored by your department, when data results are discussed in your department (e.g. staff meetings, QI Clinical Council Meetings), what your department is working on improving, and how you help to make a difference in your job. Analysis of data is the basis of all quality performance and patient safety improvement activities.

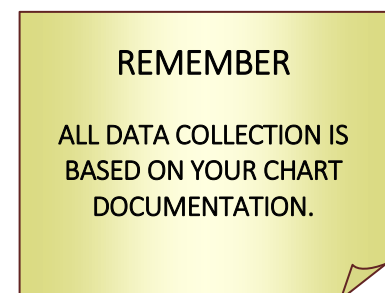


Some samples of data collection include:

- Falls.
- Pressure Sores.
- Restraints.
- Infection Rates in the Intensive Care Units.

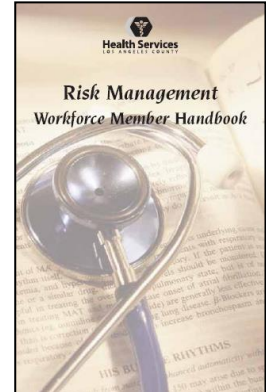
Some hospital-wide examples of data collection include:

- Care of patients with pneumonia, heart failure, and pregnancy-related conditions.
- Healthcare Effectiveness Data and Information Set (HEDIS) is a tool developed by the National Committee for Quality Assurance (NCQA) which is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.



# RISK MANAGEMENT

Risk Management involves the identification, evaluation, and reduction of the risk of injury and/or loss. 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, 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.
- Acts performed outside the course and scope of licensure, registration, certification, and/or permit.
- Acts performed outside the scope of privileging/prerogatives.
- Any acts performed outside the course and scope of employment with Los Angeles County.
- When you rotate to facilities that are not owned or operated by Los Angeles County.
- When **you** are performing outside employment (non-County facilities).

## REPORTING NEAR MISS, ADVERSE AND SENTINEL EVENTS

### Definitions of Events

A “**near miss**” or “**close call**” is an event, situation or unsafe condition that could have resulted in an adverse event but did not, either by chance or through timely intervention, but could reasonably be anticipated to result in harm if the event or unsafe condition recurs.

An “**adverse event**” is an untoward incident, therapeutic misadventure, medical injury, or other adverse occurrence directly associated with care or services provided; these events may result from acts of commission or omission. The California Health and Safety Code has identified specific adverse events that must be reported to the California Department of Public Health (CDPH). Reportable adverse events include those listed as sentinel events as well as:

- Unexpected death during or up to 24 hours after induction of anesthesia in a healthy patient.
- Death or serious disability from contaminated drug/device/or biologic.
- Death or serious disability associated with use/function of device in a way other than as indicated.
- Death or serious disability associated with intravascular air embolism.
- Death/serious disability associated with patient disappearance for more than 4 hours (excludes adults with capacity).
- Attempted suicide resulting in serious disability that occurs within the facility.

- Death/serious disability associated with medication error.
- Maternal death/serious disability associated with labor or delivery in a low-risk pregnancy.
- Death/serious disability related to hypoglycemia onset in a hospital.
- Death/serious disability with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life.
- Stage 3 and 4 ulcers acquired after admission.
- Death/serious disability from spinal manipulation therapy at hospital.
- Death/serious disability associated with electrical shock.
- Oxygen lines or other gas lines with wrong gas or contaminated by toxic substances.
- Death/serious disability associated with burn in the facility.
- Death associated with fall in the facility.
- Death/serious disability associated with use of restraints or bedrails.
- Care ordered/provided by someone impersonating licensed health care provider.
- Death/significant injury of patient or staff from physical assault that occurs within or on the grounds of the facility.
- Major permanent loss of function (disability) associated with: Neurological deficit not present at time of admission including coma, paralysis, nerve damage, blindness, related or unrelated to medical or surgical procedures; Medication Error/Adverse Drug Reaction; Healthcare Acquired Infection; Birth trauma; Unanticipated medical/surgical complication; Birth/brain injury unrelated to congenital condition; or Attempted suicide resulting in serious disability.

**CDPH Reportable Adverse Events must be immediately reported to your direct supervisor, reported to Risk Management via the telephone operator, and entered into the Safety Intelligence (SI), a web-based, DHS-wide system accessible from the LAC+USC Medical Center Intranet Webpage.**



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

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

- 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.
- Rape (by another patient, visitor, or staff).
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
- Surgical or non-surgical invasive procedure performed on the incorrect patient or incorrect body part, or wrong procedure.
- Unintended retention of a foreign object in an individual after surgery or other procedure.
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

LAC+USC Medical Center requires you to immediately report all sentinel events at the time of the event to your direct supervisor, report to Risk Management via the telephone operator, and enter an event report into the Safety Intelligence (SI), a web based, DHS-wide system accessible from the LAC+USC Medical Center Intranet Webpage.

If you become aware of an event that relates to any of the above or an incident, event, or injury involving a patient, visitor, vendor, contract staff, or workforce member, you must report it to:

- Direct Supervisor and
- Safety Intelligence (SI) – a web-based, DHS-wide system accessible from the LAC+USC Intranet Webpage, or
- Patient Care Statement of Concern.

The Patient Care Statement of Concern form is available in all departments or from the Risk Management Office.

## REPORTABLE UNUSUAL OCCURRENCES

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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 complete the Reportable Unusual Occurrence form. The workforce member must submit a Safety Intelligence report within 24 hours of the occurrence (see LAC+USC Medical Center Policy No. 303.1).

## TIMELY REPORTING

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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 (LAC+USC Medical Center Policy No. 300):

- **Safety Intelligence (SI) – a web-based DHS-wide system accessible from the LAC+USC Intranet Webpage.**
- **Adverse and Sentinel events** (as defined above) must be reported **immediately** to your Department Supervisor.
- Your Department Supervisor is responsible for **immediate** notification of Administration and the Director of Risk Management (see LAC+USC Medical Center Policy No. 300).
- The Risk Management Office can be reached by calling **(323) 226-6657 during business hours or through the Telephone Operator after hours.**
- When in doubt, call the Risk Manager at **(323) 226-6657**. Follow-up with all calls by submitting a Safety Intelligence report.

**Note:** You cannot be disciplined or retaliated against for reporting an event in good faith. However, if you have knowledge of an event and fail to report it or deliberately make a false accusation, this is against LAC+USC Medical Center Policy; and, there is a possibility that you may be disciplined for failure to report.

### REMEMBER

Risk Management must be immediately notified when an Adverse Event or a Sentinel Event occurs. See Network Policy No. 300, Event Notification Guidelines for information regarding adverse and sentinel event notification, reporting and documentation. For information on a “Near Miss” event, situation or unsafe condition, see Network Policy No. 303.

### REMEMBER

**Do not** make copies of the SI reports or refer to the SI report in the patient’s medical records.

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**Remember: Notify your department supervisor whenever possible before reporting a case to the Risk Management Office. Do not make copies of the SI reports and do not refer to the SI reports in the patient's medical record.** 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 Hospital Administration or recorded in the Safety Intelligence or Statement of Concern form, as appropriate.

### Your documentation must include:

- Date.
- Time.
- Care and treatment provided.
- Signature of the provider with title and assigned staff identification (SID) number.

### Make your documentation:

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

### Correct handwritten errors in the medical record by:

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

**Corrections/edits to the electronic medical record will be captured via audit trail, which includes original entry, date/time of correction/edit and person making the correction/edit.**



## SUBPOENAS AND SUMMONS

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

If you receive a summons, lawsuit, subpoena, notice of deposition relating to incidents, telephone call or other contact by outside investigators, attorneys, etc. immediately contact the Risk Management Office at (323) 226-6657. Participating in a formal deposition or discussion of incidents with any representative of a plaintiff (patient) should only occur after consultation with Risk Management and may require the presence of Risk Management and County Counsel. This advice does not apply to discussion with a patient, their relatives/family and/or other attending professional staff within the context of the usual physician/patient relationship.

Additionally:

- Document the date and time you received the subpoena or summons.
- Keep the original envelope that the notice came in.
- Bring the documents to the Risk Management Office (IRD Room 912) or fax to (323) 226-5923.

### Contacting Risk Management

Hospital Risk Manager's Office can be reached at (323) 226-6657 or contact the Hospital Telephone Operator during after-hours.

## ENVIRONMENT OF CARE

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

### WORKFORCE SAFETY PROGRAM

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It is our ongoing priority here at LAC+USC Medical Center to provide a safe environment for our customers and workforce members. Our Safety Program looks for and identifies hazards through surveillance rounds and data collection. All identified hazards are investigated and acted upon by the Safety Council, Safety Committees, Safety Officers and the department/service managers. Address any concerns you have regarding safety to your supervisor or your facility Safety Officer.

#### FACILITY SAFETY OFFICER

LAC+USC Medical Center: General Hospital Building, Clinic Tower, Inpatient Tower, Diagnostic & Treatment Building, Interns & Residents Building, Rand Schrader Clinic, Outpatient Department, Psychiatric Services at the Augustus Hawkins Mental Health Center at MLK, Jr. Multi-Service Ambulatory Care Center (MACC).

**LAC+USC Medical Center ..... (323) 409-7485**  
**DHS Health, Safety & Environmental Manager ..... (323) 869-8957**

#### While at work, know:

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

Examples include:

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

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

- Notify your Supervisor/Manager.
- Complete an “Employee’s Report of Unsafe Condition”.
- Notify the Safety Office. (*Can be Anonymous.*)
- Safety Intelligence on LAC+USC Medical Center Intranet.

### EMERGENCY CODES

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Emergency overhead paging is used at LAC+USC Medical Center to alert staff of potential emergency situations, announce codes and to summon staff responsible for responding to specific emergency situations.

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## LAC+USC MEDICAL CENTER HOSPITAL CODES

LAC+USC MEDICAL CENTER		
INCIDENT	EXT. / TELEPHONE NO. TO CALL	PAGING CODE
Cardiopulmonary Arrest - Adult	Ext. 111	Code Blue
Cardiopulmonary Arrest-Pediatric	Ext. 111	Code White
Fire	Ext. 111	Code Red
Mental Health/Behavioral Response	Ext. 111	Code Gold
Combative Person	Ext. 111 and Ext. 3333	Code Gray
Person with a Weapon or Hostage Situation	Ext. 111 and Ext. 3333	Code Silver
Patient Elopement	Ext. 111	Code Green
Child Abduction	Ext. 111 and Ext. 3333	Code Purple
Infant Abduction	Ext. 111 and Ext. 3333	Code Pink
Hazardous Material Spill/Radiation Incident	Ext. 111	Code Orange
Bomb Threat	Ext. 111 and Ext. 3333	Code Yellow
Urgent Medical Attention to Inpatients	Ext. 111	Code Rapid Response
Urgent Medical Assistance to Outpatients, Visitors, and Staff	Ext. 111	Code Assist
Potential Disaster	Ext. 111	Code Triage Alert
Internal Disaster	Ext. 111	Code Triage Internal
External Disaster	Ext. 111	Code Triage External
Man Down	Ext. 111	
Sheriff Deputies/Security	Ext. 3333	
Poison Control	(800) 411-8080	
Risk Management	(323) 226-6657	
Infection Control	(323) 409-6645	Nurse Epidemiologists
Safety Officer	(323) 409-7485	Greg Van Dam

**Note:** To report an incident from a non-in-house phone (such as from your cell phone), call (323) 227-0410

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## AUGUSTUS F. HAWKINS FAMILY MENTAL HEALTH CENTER CODES

<b>AUGUSTUS F. HAWKINS – CALL EXT. 4512</b>	
<b>CODE</b>	<b>DESCRIPTION</b>
<b>Code Blue</b>	<b>Adult Medical Emergency</b>
<b>Code White</b>	<b>Pediatric Medical Emergency</b>
<b>Code Red</b>	<b>Fire</b>
<b>Code Gold</b>	<b>Mental Health/Behavioral Response</b>
<b>Code Gray</b>	<b>Combative Person</b>
<b>Code Silver</b>	<b>Person with Weapon or Hostage Situation</b>
<b>Code Green</b>	<b>Patient Elopement</b>
<b>Code Purple</b>	<b>Child Abduction/Missing</b>
<b>Code Pink</b>	<b>Infant Abduction/Missing</b>
<b>Code Orange</b>	<b>Hazardous Material Spill/Release</b>
<b>Code Yellow</b>	<b>Bomb Threat</b>
<b>Code Rapid Response</b>	<b>Urgent Medical Attention to Inpatients</b>
<b>Code Assist</b>	<b>Urgent Medical Assistance to Outpatients, Visitors and Staff</b>
<b>Code Triage – Emergency Alert</b>	<b>Limited Activation of Key Personnel for Incident</b>
<b>Code Triage – Internal</b>	<b>Activate Emergency Operations Plan – Internal Incident</b>
<b>Code Triage – External</b>	<b>Activate Emergency Operations Plan – External Incident</b>

## SECURITY

The Los Angeles County Sheriff's Department provides LAC+USC Medical Center with professional police and security services. The Sheriff's personnel include Deputies and Sheriff's Security Officers who provide law enforcement services. Sheriff's personnel strive to provide a crime free and secure environment for patients, visitors, patrons, and workforce members at LAC+USC Medical Center. There are also contract security officers who are responsible for basic perimeter and security needs.

### The Role of Deputies and Sheriff's Security Officers

The Deputies are full-time, State-certified peace officers. They enforce California Penal codes, Federal and State laws, and County ordinances. They also assist in attaining compliance with hospital policies. Sheriff's personnel conduct foot and vehicle patrols of LAC+USC Medical Center. They are on-site and available to respond and assist workforce members and the public.

### The Role of Contract Security Officers

- Contract Security Officers observe and report suspicious activities to Sheriff's personnel.
- Contract Security Officers monitor the entrances to LAC+USC Medical Center and provide weapons screening and workforce member badge checks.



## SAFETY AWARENESS

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

- Walking in groups when leaving the workplace after dark.
- Reporting any suspicious activities to the Sheriff's personnel by contacting (323) 226-3333.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.

## INFANT/CHILD ABDUCTION (CODE PINK/PURPLE)

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

## BOMB THREATS (CODE YELLOW)

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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:

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



Also, pay attention to details, such as:

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

**Immediately notify your Supervisor, Emergency Operator (Ext. 111), and the Sheriff's personnel (Ext. 3333).**

## WEAPONS

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It is a felony to bring a weapon onto County property. Sheriff's personnel will strictly enforce all weapons related laws at LAC+USC Medical Center.

## WORKPLACE VIOLENCE

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The County and LAC+USC Medical Center will not tolerate any form of violence (for example: threatening gestures, intimidating behaviors or verbal threats). The County of Los Angeles promotes a safe work environment for all its workforce members.

The County of Los Angeles has a "zero tolerance" policy that addresses workplace violence and violent behavior. Violation of this policy may result in corrective 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 Sheriff's personnel, and complete an SI report and Security Incident Report on LAC+USC Medical Center Intranet. Please refer to DHS policy on workplace violence or see Threat Management "Zero Tolerance" section in this handbook for further information.

## HAZARDOUS MATERIALS/HAZARD COMMUNICATION

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Whenever there is an actual release or spill of a hazardous material or waste, the following emergency procedures shall be placed into effect in accordance with Emergency Hazardous Material Response Procedure.

1. Remove all individuals from immediate danger if condition permits safe removal. Block off contaminated area and deny entry.
2. Report the incident by contacting your facility's Hazardous Material Spill/Radiation Incident code ("**Code Orange**"). Give the operator your location, name, hazardous material and quantity, if known.
3. The operator will notify the Building Engineer, Sheriff's Department and Safety Office. The Fire Department will be notified, if necessary. The telephone operator shall page "**Code Orange**" three times at 15-second intervals giving location and room number.
4. Obtain the Material Safety Data Sheet/Safety Data Sheet (MSDS/SDS) for the spilled hazardous material.

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

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

The Material Safety Data Sheet (MSDS) or Safety Data Sheet (SDS) tells what hazards a chemical presents and how to handle spills and exposures. You should know the location of the MSDS/SDS in your work area. If you do not know where it is kept, ask your supervisor. The master MSDS/SDS manual is located in the hospital's Safety Office and on the LAC+USC Medical Center Intranet.

### KEY POINT

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



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Material Safety Data Sheet (MSDS)	Safety Data Sheet (SDS)
<p>Information Provided:</p> <ol style="list-style-type: none"> <li>1. Product Identification</li> <li>2. Manufacturer Identification</li> <li>3. Hazardous Ingredients, Permissible Exposure Limit, and Threshold Limit Value</li> <li>4. Physical and Chemical Properties</li> <li>5. Physical Hazards</li> <li>6. Health Hazards and Potential Route(s) of Entry</li> <li>7. Carcinogenicity</li> <li>8. Instruction for Safe Use and Handling</li> <li>9. General Control Measures, including Personal Protective Equipment</li> <li>10. Spill Clean-Up Procedures</li> <li>11. Emergency and First-Aid Procedures</li> <li>12. Date of Preparation of MSDS/SDS</li> </ol>	<p>Required Format:</p> <ol style="list-style-type: none"> <li>1. Identification</li> <li>2. Hazards Identification</li> <li>3. Composition/Ingredients</li> <li>4. First-Aid Measures</li> <li>5. Fire-Fighting Measures</li> <li>6. Accidental Release Measures</li> <li>7. Handling and Storage</li> <li>8. Exposure Controls/Personal Protection</li> <li>9. Physical/Chemical Properties</li> <li>10. Stability and Reactivity</li> <li>11. Toxicological Information</li> <li>12. Ecological</li> <li>13. Disposal</li> <li>14. Transport</li> <li>15. Regulatory</li> <li>16. Other Information</li> </ol>

## Shipped Container Labels

Old Label (Cannot be shipped after 12/1/2015)	New Label
<ol style="list-style-type: none"> <li>1. Hazardous substance identifier</li> <li>2. Hazard warnings</li> <li>3. Supplier identifier</li> </ol>	<ol style="list-style-type: none"> <li>1. Product identifier</li> <li>2. Signal word: <b>Danger</b> (more severe hazard) <b>Warning</b> (less severe hazard)</li> <li>3. Hazard statement</li> <li>4. Pictogram</li> <li>5. Precautionary statement*</li> <li>6. Supplier identifier</li> </ol>

\*Precautionary statement describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure or improper storage or handling.

## Hazard Pictograms on Labels



## RADIATION EXPOSURE

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1. Personnel radiation monitoring devices (film badges) must be worn **BETWEEN THE WAIST AND THE COLLAR** for those persons working with radioactive materials or radiology equipment.
2. Film badges are submitted to the Radiation Safety Office (D&T 4D334, Telephone No.: (323) 409-7855) for accurate analysis and readings. Badges are exchanged on a monthly basis.
3. Safety, including radiation safety, is everyone's responsibility. Notify your supervisor immediately for all safety related issues.

### REMEMBER

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

### External Radiation Exposure:

- Department of Emergency Medicine and attending physician will notify Radiation Safety Officer at (323) 409-7855 and Decontamination Team at (323) 409-4096.
- Set up decontamination area on the DEM ambulance ramp. Mark off and close the area.
- If victim/patient is seriously injured, medical staff must give life-saving assistance regardless of radiation contamination.
- Radiation staff will check for contamination. If contaminated, tag the victim/patient "Radioactive" and follow specific decontamination procedures. If the victim/patient is not contaminated, treat the victim/patient with "regular" emergency procedures.

### Internal Radiation Exposure:

- Isolate victim/patient and notify Radiation Safety Officer at (323) 409-7855.

## EMERGENCY PREPAREDNESS AND MANAGEMENT

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### Emergency Management Plan

During an emergency, (for example, a sudden influx of a large number of infectious patients), LAC+USC Medical Center will implement the Hospital Incident Command System (HICS).

When LAC+USC Medical Center announces a "**Code Triage**" to activate the Emergency Management Plan (Disaster Plan), you should follow your unit/area Emergency Response Plan.

## EMERGENCY TRANSPORT (CARRIES)

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


### EMERGENCY TRANSPORT-SAFELY

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

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


#### ONE-PERSON CARRIES

##### HIP CARRY




- Put patient's arm over your back and slide your arm under patient's back.
- Lean backward, into patient's abdomen, and grip patient behind his knees.
- Hold patient snugly against your back, then lean forward to carry.
- Lean patient against wall, and slide to floor as you drop to one knee.

##### PACK STRAP CARRY



- Cross patient's arms and grab both wrists.
- Pull up as you turn to step under patient's arms, cross his arms in front.
- Lean forward, and step to the head of the bed, patient will roll out, onto your back.
- Lean patient against wall and slide to floor as you drop to one knee.


##### CRADLE DROP



- Place blanket on floor next to bed, then grip patient under shoulders and knees.
- Slide patient to edge of bed.
- On one knee, lower his legs then his body, to blanket, or on both knees, slide patient down your chest to blanket.
- Pull patient out, head first, on blanket.


#### TWO-PERSON CARRIES

##### SWING




- Each nurse grasps the other's shoulder with one hand, as patient places his arms around both of their shoulders.
- Reaching under patient, each nurse grasps the other's wrists.

##### EXTREMITY



- Patient must be sitting on the edge of the bed.
- One nurse hugs patient from behind, grasping her own wrist.
- The other nurse stands between patient's legs, and lifts him from behind his knees.

##### SEMI-AMBULATORY



- Stand next to patient, and place one of his arms around your waist.
- Reach behind and around patient's waist and grasp his other arm.
- "Hug from behind" and walk in step, grasping your wrist.

## FIRE/LIFE SAFETY



### FIRE RESPONSE (CODE RED)

The acronym **S A F E** refers to steps you should take at the LAC+USC Medical Center in the event of a fire.

<b>S</b>	Safety of Life/ Close Doors (remove patients and others from danger).
<b>A</b>	Activate alarm and call emergency operator at Ext. 111.
<b>F</b>	Fight the fire (optional).
<b>E</b>	Evacuate.



### 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:

<b>P</b>	Pull the pin out. Some extinguishers require release of a lock hatch, pressing a puncture lever or other motion.
<b>A</b>	Aim the extinguisher nozzle (horn or hose) at the base of the fire.
<b>S</b>	Squeeze or press the handle.
<b>S</b>	Sweep from side to side at the base of the fire until it goes out.



## CLASSIFICATION OF FIRES

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

## TYPES OF EXTINGUISHERS

### Type A: Silver canister. Symbol A

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

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

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

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

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

**Class D** fires require special extinguishing agents and procedures.



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

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

In order to ensure the safe operation of medical equipment, the Clinical Engineering Department is responsible for testing selected medical equipment at least annually (defibrillators are tested semi-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 Clinical Engineering Department at (323) 409-5053. 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 at (323) 226-6657 as soon as possible (within 24 hours) and immediately impound the device. You must also submit an event report via the Safety Intelligence online incident reporting system which can be found on the intranet. (Also 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).

## VERIFY LIFE

Before connecting any electrical device to a patient, follow **L-I-F-E**:

<b>L</b>	<b>Label</b>	Check Due Date on Safety Label.
<b>I</b>	<b>Inspect</b>	Inspect unit and accessories for wear and damage.
<b>F</b>	<b>Function</b>	Is the unit functioning correctly?
<b>E</b>	<b>Electrically Safe</b>	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.
- Never touch the patient and electrical equipment at the same time.
- Do not try to make electrical repairs yourself.

### Avoid using any electrical equipment if:

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

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

**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. **Call Plant Management in the event of the failure of a gas outlet or to turn on oxygen or medical gases.**

Call Ext. 6444 to report a mechanical emergency, mechanical failure, or the need for mechanical repair.

## REPORTING WORK-RELATED INJURIES/ILLNESSES

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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)

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In compliance with State regulations (Title 8, California Code of Regulations, Section 3203) and to provide for a healthy work environment, the LAC+USC Medical Center 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

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

### Why You Should Practice Good Body Mechanics

- To prevent injury to you, 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.

# 2016 Orientation/Reorientation

- 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.



# 2016 Orientation/Reorientation

- Sit at least an arm's length away from the computer screen.
- **Check** the lighting to reduce monitor screen glare.
  - Aim the light at the task, not the screen.
  - Adjust the contrast and brightness of your monitor to improve viewing comfort at your computer workstation.
- **Change** your position, stretch and change your pace of work regularly throughout the day.

## RISKS FACTORS TO REMEMBER

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

## TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

1. **Recognize** the force or strain placed on your body caused when you grip, push, pull or lift heavy materials. Think about ways to minimize these strains or avoid some of these movements. Be aware of pain or numbness in the neck, shoulders, arm, wrist, fingers and back. Report any work related injuries to your supervisor immediately.
2. **Alternate** tasks to use different muscles and to give you time to recover. Pace yourself.
3. **Use** eyeglasses, if needed. Remember uncorrected vision problems can cause eyestrain. Remember to blink and look away from the monitor frequently to decrease strain on your eyes.
4. **Use** tools in a safe and appropriate manner. Keep your worksite safe and clean. Do not use unsafe tools. Remove them and report them.
5. **Report** any concerns to your supervisor about making your worksite safe. This will help your manager to identify harmful patterns or environmental conditions so that necessary changes may be made.
6. **Keep** yourself fit with regular exercise and proper diet, and manage your daily stress.

## INFECTION PREVENTION & CONTROL

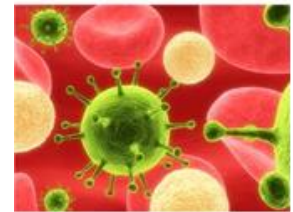
This section addresses general patient care principles and workforce member guidelines related to infection prevention and control practices. It includes Infection Control and Infectious Disease Prevention practices, information on Tuberculosis (TB), Bloodborne Pathogen Control Plan, Meningococcal Meningitis Exposure Plan, Prion Disease, Guidelines for Hand Hygiene, Communicable Disease Reporting, Respiratory Protection Program, Influx/Surge and Hospitalization of Large Number of People with Infectious Diseases, Pandemic Influenza Plan, Airborne Transmissible Disease Plan, Multiple Drug Resistant Organism Policy, Management and Infection Control Plan for Prevention, Management and Control of Bed Bugs, Ambulatory Care Infection Control Plan, Hospital Acquired Central Line Associated Blood Stream Infection Prevention, Hospital Acquired Catheter Associated Urinary Tract Infection Prevention, Hospital Acquired Surgical Site Infection Prevention, Hospital Acquired Ventilator Associated Events Infection Prevention, Waste Management, Decontamination, and Sterilization.

### INFECTION PREVENTION & CONTROL PROGRAM GOALS

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

At LAC+USC, healthcare workers may have to use different **SPICE**: Strategies to Prevent Infection through Care, Cleaning, Communication, Education and Evaluation of care.

- The first step in infection prevention and control is standard precautions, which includes hand hygiene and cough etiquette.



### STANDARD PRECAUTIONS

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Standard precautions are precautions designed to protect the health care worker from blood-borne pathogens and prevent the transmission of infectious agents between the health care worker and patients. These precautions are an important cornerstone of infection 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.

### 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 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, under your fingernails, and around your thumbs.

## Proper Steps on Performing Hand Hygiene

Washing Hands with Soap and Water	Using Alcohol-based Hand Sanitizer
<ol style="list-style-type: none"> <li>1. Wet both hands.</li> <li>2. Obtain 2-3 “pumps” of soap in the palm of one hand.</li> <li>3. Vigorously rub all surfaces of both hands.</li> <li>4. Scrub for at least a <b>full 15 seconds</b>.</li> <li>5. Rinse well.</li> <li>6. Dry thoroughly with paper towels.</li> <li>7. Do not touch faucet/sink/counter.</li> <li>8. Do not touch door knob with your clean, bare hands.</li> <li>9. Keep paper towel in hand while opening door.</li> <li>10. Discard towel in trash.</li> </ol>	<ol style="list-style-type: none"> <li>1. Apply enough sanitizer to open palm.</li> <li>2. Rub hands together palm to palm.</li> <li>3. Rub in between and around fingers.</li> <li>4. Rub back of each hand with palm of other hand.</li> <li>5. Rub fingertips of each hand in opposite palm.</li> <li>6. Rub each thumb clasped in opposite hand.</li> <li>7. Rub each wrist clasped in opposite hand.</li> <li>8. Keep rubbing hand surfaces until hands are dry.</li> </ol>

### 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 with patients with *Clostridium difficile*.
- After removing gloves if gloves are visibly soiled with blood or body fluids.
- After every 5 – 10 applications of the alcohol-based hand sanitizer (see manufacturer’s guidelines).



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



- Before direct contact with patients.
- After contact with patient’s intact skin.
- After contact with inanimate objects (medical equipment, bed, etc.) in patient’s immediate area.
- After removing gloves (if gloves not visibly soiled with blood or body fluids).
- Before leaving work.

### 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.

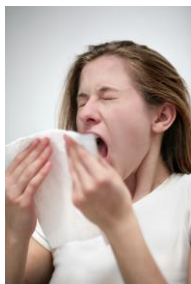
Artificial fingernails are not permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or equipment that will be used by a patient or used directly on a patient, or for those who have contact with food.



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

## RESPIRATORY HYGIENE/COUGH ETIQUETTE

Respiratory Hygiene and cough etiquette has been promoted by the *Centers for Disease Control and Prevention* (CDC) as a strategy to contain respiratory viruses at the source and to limit their spread in areas where infectious patients might be awaiting medical care (such as in Emergency Department, Urgent Care, Clinics, Admitting areas, etc.).



- **Patients** exhibiting signs of symptoms of respiratory illness should be given a plain surgical mask and instructed to wear it if medically feasible, until communicable infection is ruled out or patient is placed on isolation precautions.
- **Family members and other visitors** exhibiting signs and symptoms of respiratory illness should be given and instructed to wear a plain surgical mask while in the facility.

Individuals with signs and symptoms of a respiratory infection should:

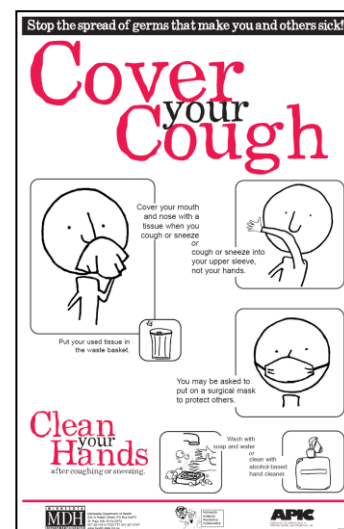
- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
- Wash hands or use alcohol-based hand sanitizer/hand gel after having contact with respiratory secretions and contaminated objects/materials.

Masking and separation of persons with respiratory symptoms

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

Healthcare Workers: Precautions to minimize exposure to respiratory droplets

- Healthcare workers should wear a mask for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection, particularly if fever is present.
- Effective September 1, 2010, personnel performing procedures on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an Aerosol Transmitted Pathogen in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens are to wear a **Powered Air Purifying Respirator (PAPR)**. Such procedures include, but not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.



Refer to Airborne Transmissible Disease Plan. See written procedure on PAPR use, Appendix F. For video on how to use PAPR, go to <http://lacusc-nursing.lacusc.org/pap/web%20files/pap.html>

## ISOLATION PRECAUTIONS

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### CARE OF PATIENT IN ISOLATION PRECAUTIONS

1. By preventing transmission of infections such as:
  - Multi Drug Resistant Organism (MDRO)
    - Methicillin-Resistant Staphylococcus Aureus/Oxacillin-Resistant Staphylococcus Aureus (MRSA/ORSA)
    - Vancomycin-Resistant Enterococci (VRE)
    - Clostridium Difficile (C. difficile)
2. By wearing personal protective equipment:
  - Gloves
  - Gown
  - Protective Eyewear
  - Mask (N95 or Powered Air Purifying Respirator)
3. By avoiding crowds/sick people.













### Infections can be spread by three ways:

- Direct Contact
- Indirect Contact
- Airborne Route

Some infections can be transmitted in more than one way and their isolation reflects this.

Isolation precautions or transmission based precautions prevent the transmission of infection between infected patients, care givers, and other patients 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 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 of having an isolatable process he/she will be placed in isolation. Workforce members (WFM) entering the patient's room must wear personal protective equipment (PPE) as posted on the isolation precautions signage **before** entering the patient's room.

# 2016 Orientation/Reorientation

<p><b>Airborne Precautions</b> Precaucion Aerotransportado</p> <p><b>VISITORS</b> Report to Nurses' Station Before Entering Room. <b>VISITANTES</b> Repórtense a la estación de enfermería antes de entrar al cuarto</p>   <p>WASH LÁVESE</p> <p>MASK MÁSCARA</p>	<p><b>Pink Sign</b></p> <p>PPE needed: N95 NIOSH or PAPR Respirator (fit-tested).</p> <p>WFM must practice proper hand hygiene prior to and upon leaving the room or having contact with the patient.</p>
<p><b>Droplet Precautions</b> Precaucion de Gotitas</p> <p><b>VISITORS</b> Report to Nurses' Station Before Entering Room. <b>VISITANTES</b> Repórtense a la estación de enfermería antes de entrar al cuarto</p>      <p>WASH LÁVESE</p> <p>GOWN BATA</p> <p>MASK MÁSCARA</p> <p>GOGGLES GAFAS</p> <p>GLOVES GUANTES</p> <p>PROTECTORAS</p>	<p><b>Orange Sign</b></p> <p>PPE needed: Gown, Mask, Gloves (and protective eyewear*).</p> <p>*If there is a chance of aerosol or fluid splash to the eyes, protective eyewear is to be worn.</p> <p>WFM must practice proper hand hygiene prior to and upon leaving the room or having contact with the patient.</p>
<p><b>Contact Precautions</b> Precaucion de Contacto</p> <p><b>VISITORS</b> Report to Nurses' Station Before Entering Room. <b>VISITANTES</b> Repórtense a la estación de enfermería antes de entrar al cuarto</p>    <p>WASH LÁVESE</p> <p>GOWN BATA</p> <p>GLOVES GUANTE</p>	<p><b>Green Sign</b></p> <p>PPE needed: Gown and Gloves.</p> <p>WFM must practice proper hand hygiene prior to and upon leaving the room or having contact with the patient.</p>

## MULTIPLE SIGNAGE MAY ALSO BE POSTED

AIRBORNE/CONTACT	Pink <u>and</u> Green Signs
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## METICULOUS CLEANING

- ❖ Infections can also be spread through frequently touched items, instruments, and articles that come in contact with the patient, other individuals, or the environment.
- ❖ Meticulous cleaning is an important process in reducing the transmission of organisms in both Critical Care and Ambulatory Care Units.
  - Use appropriate environmental cleaning agents and equipment as instructed.
  - Read product label and follow instructions.
  - Use disinfectant solution.
    - Read the product label.
    - Wipe the entire surface of the item.
    - Comply with CONTACT TIME.
      - Time the item must remain wet (i.e., *CaviWipes* – two minutes, *Dispatch* – one minute).

Categorization of instruments/items according to the degree of risk for infection in use of the item dictates how the item should be processed.

# 2016 Orientation/Reorientation

- ❖ **Critical Items** – Items used in an invasive procedure that pose a high risk for infection if contaminated with any microorganism. Examples: Surgical instruments, etc.
- ❖ **Semi-critical Items** – Items having contact with mucous membranes or non-intact skin. These items minimally require high-level disinfection. Examples: Gastro-intestinal endoscopes, reusable items on ventilation circuits, flexible endoscopes used for intubations or vaginal ultrasound probes.
- ❖ **Non-critical Items** – Items that come in contact with intact skin or items that are frequently touched by hands and can contribute to secondary transmission of infection. These items are to be cleaned and disinfected between patients. Meticulous cleaning of these items is an important process to reduce or eliminate organisms in patient areas. Examples: Gurneys, wheelchairs, etc.

## WASTE DISPOSAL GUIDELINES

TYPE OF WASTE	STORAGE	DESCRIPTION OF WASTE
Sharps Waste	Red puncture resistant or container	Needles, syringes, disposal scalpels, guide wires, broken glass or other devices with sharp edges.
Biohazard Waste	Red	Waste containing secretions, exudates and excretions containing blood.
Chemotherapy Waste	Yellow puncture resistant container	All chemotherapy or cytotoxic drug-related waste/deposit sharps (Biohazardous and hazardous).
Radioactive Waste	-----	Must remain in identified area until the waste is monitored by Radiation Safety staff and deemed free of any radioactivity.
Pharmaceutical Waste	White and blue container	All expired, reconstituted not used, or unused portions of drugs that cannot be returned for credit.
Regular Waste	White or neutral container	All waste not glass and not listed in any other waste category.

## COMMUNICATION

- ❖ Report when a communicable disease is suspected or diagnosed that requires isolation precautions or follow-up.
- ❖ Report percutaneous or mucous membrane exposure to Bloodborne Pathogens.

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

- Wash the puncture site and cuts with soap and water.
- Rinse nose or mouth with clean water.
- Flush eyes with clean water/saline for a minimum of two (2) minutes.
- Report the exposure to your supervisor.
- Complete an Industrial Accident (IA) forms/packet.
- Go to Employee Health Services (EHS) or the Emergency Department (if EHS is closed) for follow-up.

### REMEMBER

The most effective treatment involving treatment with medications is treatment that is started **within 2-4 hours of exposure**. Refer to *Bloodborne Pathogens Exposure Control Plan*.

# 2016 Orientation/Reorientation

## EDUCATION

Workforce Member Education	<ul style="list-style-type: none"> <li>➤ Orientation.</li> <li>➤ Reorientation.</li> <li>➤ As needed:             <ul style="list-style-type: none"> <li>• New policies/procedures.</li> <li>• New products.</li> <li>• Identified issues by the department/unit.</li> </ul> </li> </ul>
Patient/Visitors Education	<ul style="list-style-type: none"> <li>➤ Cough etiquette.</li> <li>➤ Hand hygiene before entering and leaving room.             <ul style="list-style-type: none"> <li>• Alcohol-based hand sanitizer/hand rub.</li> <li>• Hand washing with soap and water.</li> <li>• Isolation precautions: VRE, MRSA, C. diff, SSI and CLABSI and CAUTI prevention (documentation required in ORCHID).</li> <li>• Education materials available on the intranet.</li> <li>• Informational brochures.</li> </ul> </li> </ul>

## EVALUATION

Surveillance	<ul style="list-style-type: none"> <li>➤ Hand Hygiene Compliance.</li> <li>➤ Personal Protective Equipment Compliance.</li> <li>➤ Hospital Acquired Infection.             <ul style="list-style-type: none"> <li>• Central Line Associated Blood Stream Infection.</li> <li>• Ventilator Associated Pneumonia.</li> <li>• Catheter Associated Urinary Tract Infection.</li> <li>• Surgical Site Infection.</li> <li>• Clostridium Difficile.</li> <li>• MRSA/ORSA.</li> </ul> </li> </ul>
Other Observations	<ul style="list-style-type: none"> <li>➤ Visitor compliance with instructions.</li> <li>➤ Employee/visitor cough etiquette compliance.</li> </ul>

## HOSPITAL ACQUIRED INFECTION SURVEILLANCE

Effective April 1, 2010 - State requires acute care facilities to report Hospital Acquired Infections (HAI) through the National Healthcare Safety Network (NHSN). Facilities implemented bundles to reduce HAI:

- Ventilator Associated Pneumonia (VAP) (optional at this time)
- Central Line Associated Blood Stream Infections (CLABSI) (all inpatient)
- Surgical Site Infections (SSI) related to deep and organ space

# 2016 Orientation/Reorientation

- AFL procedures and NHSN procedures
- MDRO infections:
  - VRE in the blood
  - MRSA in the blood
  - *C. difficile*
- Central Line Insertion Practices (CLIP)
  - All Intensive Care Unit (ICU) including Pediatrics Intensive Care Unit (PICU) and Neonatal Intensive Care Unit (NICU)

A Bundle is a group of evidence-based interventions that when implemented together, result in better outcomes than when implemented individually.

- ❖ Best Practices Procedures to reduce Hospital Acquired Infections (HAI):
  - Central Line Bundle to prevent Central Line Associated Blood Stream Infections (CLABSI).
  - Ventilator Bundle to prevent Ventilator Associated Pneumonia (VAP).
  - Surgical Care Improvement Project Measures to prevent Surgical Site Infections (SSI).
  - Catheter Associated Urinary Tract Infection (CAUTI) Prevention Bundle to prevent CAUTI.

CARE TO PREVENT CENTRAL LINE BLOOD STREAM INFECTIONS	
AT INSERTION	AFTER INSERTION
<ul style="list-style-type: none"> <li>■ Catheter checklist at the time of CVC insertion.</li> <li>■ Hand hygiene before catheter insertion or manipulation.</li> <li>■ Antimicrobial impregnated catheters.</li> <li>■ Catheter cart or central line kit.</li> <li>■ Maximal sterile barrier precautions during insertion.               <ul style="list-style-type: none"> <li>○ Including cap, mask, &amp; sterile- gown, gloves, large drape.</li> </ul> </li> <li>■ Antiseptic for skin preparation.               <ul style="list-style-type: none"> <li>○ Chlorhexidine based for older than 2 months.</li> <li>○ Povidone-iodine solution for infants less than 2 months.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Daily documentation of line necessity-remove nonessential catheters.</li> <li>■ Do not routinely replace central line catheter unless there are clear indications for replacement.</li> <li>■ Replace administration sets as per protocol.</li> <li>■ Bathe daily with a chlorhexidine-based bath (&gt; 2 MONTHS).</li> <li>■ Disinfect catheter hubs, connectors and injection ports before accessing the catheter.</li> <li>■ Dressing changed and site care as per policy.</li> </ul>



## CARE TO PREVENT VENTILATOR ASSOCIATED PNEUMONIA

- Maintenance of respiratory equipment.
- Perform regular antiseptic oral care.
  - Daily Oral Care with Chlorhexidine.
- Institute protocols to promote the use of noninvasive ventilation.
  - Daily "Sedation Vacations" and Assessment of Readiness to Extubate.
- Use subepiglottic ETT to suction.
- HOB elevated minimum 30 degrees.
- Peptic Ulcer Disease Prophylaxis.
- Deep Venous Thrombosis Prophylaxis.

## CARE TO PREVENT SURGICAL SITE INFECTIONS

- Administer prophylactic antibiotics within 1 hour of the surgical incision time.
- Do not remove hair at the operative site unless the presence of hair will interfere with the operation.
  - Do not use razor.
- Control blood glucose levels during immediate post-op period.
  - Tight glycemic control < 200 mg/dL.
- Ensure normothermia during surgery.
- Use chlorhexidine-based prep agent.

## 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,
- Previously discharged from a hospital within the last 30 days,
- Being admitted to the intensive care unit,
- Receiving dialysis, and
- Transferred from a Skilled Nursing Facility.

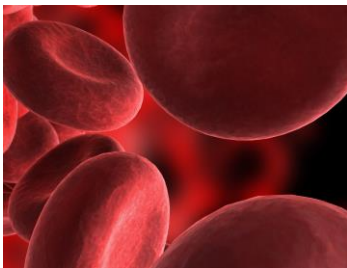
The patient must be provided with MRSA education. In addition, the physician responsible for patient's medical care must inform the patient or the patient's representative or positive MRSA screen. It's the Law!

## VANCOMYCIN-RESISTANT ENTEROCOCCI (VRE)

Vancomycin Resistant Enterococcus (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.

## BLOOD-BORNE PATHOGEN CONTROL PLAN

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The purpose of this plan is to minimize, if not prevent the transmission of infectious organisms from patient's blood or body fluids and prevent the acquisition of disease should an exposure to a patient's blood/body fluids occur. All healthcare workers, whose reasonably anticipated duties may result in exposure to blood borne pathogens, must practice Standard Precautions.

Blood-borne pathogens may be acquired through open skin (cut, puncture, rash, wound, burn) or through mucous membrane exposure (splash to eyes, nose, mouth). It is impossible for you to know who is or is not infected. Therefore, consider ALL blood, body fluids or substances from ALL persons as potentially infectious.

Personal protective equipment (PPE) must be used when there is likelihood for blood or body fluid exposure (splashing).

## PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Gloves
- Gown
- Protective eyewear or face shield
- Mask



## BLOODBORNE PATHOGENS

Some of the blood-borne diseases to which you can be exposed include:

- Hepatitis C.
- Hepatitis B.
- Hepatitis D.
- Human Immunodeficiency Virus (HIV).
- Syphilis.



## PREVENTING SHARPS INJURIES



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

## SIMPLE MEASURES TO REDUCE THE RISK OF SHARPS INJURIES

### DO

- Use and activate needle/sharps safety devices.
- Get help with uncooperative patients.
- Let falling objects fall.
- Dispose of sharps into covered, labeled, and 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 at the bedside.
- Rush or take shortcuts.
- Reach into disposal container.
- Touch broken glass.
- Overfill sharps container.
- Carry loose sharps in your pockets.

## SAFE INJECTION PRACTICES

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

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

- Use aseptic technique to avoid contamination of sterile injection equipment.
- Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.
- Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient.



# 2016 Orientation/Reorientation

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

## INJECTION SAFETY TIPS FOR PROVIDERS

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

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

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

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

For more information about sharps safety, please see:

- [www.cdc.gov/sharpssafety](http://www.cdc.gov/sharpssafety)
- [www.oneandonlycampaign.org](http://www.oneandonlycampaign.org)



**REMEMBER**  
**ONE Needle,**  
**ONE Syringe,**  
**ONLY ONE TIME**

## 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 healthcare professional; services provided 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 and continued 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 workforce member's DHS identification badge after he/she has received the influenza vaccination.

Influenza vaccination is available to all workforce members at no charge. Workforce members who decline the influenza vaccination will be required to wear a surgical mask whenever they work in a health care area that provides patient care beginning November 1<sup>st</sup> and extending for the duration of the influenza season. If the workforce member later decides to accept the vaccination, it will be provided to them.

## TUBERCULOSIS (TB) CONTROL PLAN

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The TB Control Plan provides information and guidelines to be followed to ensure all workforce members are protected against exposure to tuberculosis. It is the intent of LAC+USC Medical Center 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:

- Annual TB screening for all workforce members who work or must perform duties inside a healthcare facility.
- Comprehensive training for all workforce members at New Employee/Non-County/Non-DHS Staff Orientation and on an annual basis to include, but not be limited to:
  - ☒ What is TB – organism inhaled that usually attacks the lungs.
  - ☒ How it is spread – Airborne transmissible disease spread through coughing, sneezing.
  - ☒ Prevalence in the United States (2013) – 9,582 cases.
  - ☒ Prevalence in California (2013) – 2,169 cases.
  - ☒ Prevalence in LA County (2013) – 662 cases – 30.5% of total California cases.
  - ☒ Breakdown by age:

<b>Years:</b> 65 > .....	30.4%
55 > 64 .....	17.7%
45 > 54 .....	14.7%
35 > 44 .....	14.7%
15 > 34 .....	18.9%
5 > 14 .....	1.1%
0 > 4 .....	2.7%

# 2016 Orientation/Reorientation

- Prevalence of cases at LAC+USC Medical Center – Approximately 18% of cases reported in Los Angeles County.
- Screening for TB active disease in patients – Acid Fast bacilli in respiratory or other fluids.
- Screening of workforce members for TB – PPD skin test every year. Chest x-ray every four years if PPD skin test is positive unless otherwise indicated.
- Airborne isolation in negative pressure room for suspect and confirmed TB cases.
- Workforce members working with suspect or confirmed TB patients shall wear N95 NIOSH approved respirator.
  - TB patient wears barrier (surgical) mask when outside of isolation room or if a ventilator is required then a portable ventilator with heated moisture exchange (HME) filter that traps TB micro-organisms. If a patient requires manual ventilation the HME filter can be attached to the Ambu bag.
- 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 (WFM) who, in the judgment of the HCSS, are suspect for TB will not be permitted to work until the diagnosis is excluded and/or appropriate treatment has rendered WFM non-communicable.

Workforce members who work with patients who may have Tuberculosis are “fit tested” for the N95 NIOSH approved respirators on an annual basis.

Any patient who has a positive acid-fast bacillus on Aurimine Rhodamine stain or is on TB medications must have TB Control approval **prior to discharge**. To obtain TB Control approval during normal business hours, contact (323) 226-7962. During after-hours, contact Public Health on-call physician at (213) 974-1234.

## AIRBORNE TRANSMISSIBLE DISEASE PLAN

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

The Airborne Transmissible Disease Plan was developed in November 2009 to prevent the transmission of respiratory infections in healthcare settings, including seasonal influenza, pandemic influenza, severe acute respiratory syndrome (SARS) and other respiratory viral pathogens that can be potentially transmitted via aerosol, small particles (airborne transmission). If there is evidence of Pandemic Flu present in the community, refer to “LAC+USC Medical Center Pandemic Influenza Response Plan”. The facility Safety Officer, Biological Safety Officer, and Nurse Epidemiologist / Infection Control Practitioner will administer the Aerosol Transmissible Disease Program.

Infection control measures should be implemented at the first point of contact with a person who is potentially infected with an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent e.g., TB, Influenza. The recommendations are based on the Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings and Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Control and Prevention (CDC) and Cal/OSHA Aerosol Transmissible Disease Protections (2009).

Effective September 1, 2010, health care providers are required to wear a powered air purified respirator (PAPR) when performing high hazard procedures. **Refer to Airborne Transmissible Disease Plan. See written procedure on PAPR use, Appendix F. For video on how to use PAPR, go to <http://lacusc-nursing.lacusc.org/pap/web%20files/pap.html>**



## HIGH HAZARD PROCEDURES

Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

For additional information on this high hazard procedure or other infection control procedures, access the Infection Control Plan on the facility intranet home page under Reference Materials > Medical Center Plans.

CAL/OSHA standard for disease transmitted by aerosols (i.e., TB, influenza) refer to:

- TB Control Plan
- Fit Testing Program
- Pandemic Influenza Plan including algorithms
- Airborne Transmissible Disease Plan

## EXPECTATION – CONTROL MEASURES

- Early identification/screening and placement in isolation precautions.
- Respiratory Hygiene / Cough Etiquette.
- PPE and use of respiratory protective devices.
- N95 masks – minimum requirement.
  - PAPR (Powered Air Purifying Respirator) – to be worn when performing high risk procedures, such as bronchoscopy, sputum induction, etc.
- Cleaning and decontamination.
- Fit-testing to workforce members, as needed.
- Vaccinations of workforce members (MMR, TDAP, Influenza).
- Annual training.

## PANDEMIC INFLUENZA PLAN

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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. Infants, young children, elderly adults, pregnant women, and individuals with chronic disease are at greatest risk.
- 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. Additional gastrointestinal symptoms may also be present, such as nausea, vomiting, and diarrhea.
  - Up to 30% of people with influenza have no symptoms, allowing transmission to others.

## Transmission

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

## Infection Control

Using of the following containment measures will be critical to reduce the spread of pandemic influenza:

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

Guidelines may be amended as more is learned about the infectivity of the pandemic virus. Refer to Infection Control: Pandemic Flu Plan which is on the intranet under Reference Materials >Medical Center Plans. Also on the intranet is the **Infection Control Plan** which contains the following guidelines:

- Tuberculosis Exposure Control Plan.
- Blood borne Pathogen Exposure Control Plan.
- Meningococcal Exposure Control Plan.
- Prion Disease Plan.
- Hand Hygiene Policy.
- Reporting Diseases and Conditions.
- Respiratory Fit Testing Plan.
- Pandemic Influenza Control Plan.
- CDC Influenza Season Triage Algorithm for Adults and Children with Influenza-like illness.
- Influx – Surge of Large Number of Infected Patients.
- Airborne Transmissible Disease Plan.
- Design/Construction and Maintenance Risk Assessment Policies and Procedures.
- Infection Control Procedures Requiring Implementation During Construction.

### REMEMBER

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

## For additional information contact:

- ◆ Your Manager or Supervisor.
- ◆ Infection Control Practitioner / Nurse Epidemiologists: (323) 409-6645.
- ◆ Employee Health Services: (323) 226-5235.
- ◆ LAC+USC TB Control Liaison Nurse: (323) 226-7962 **OR** TB Control: (213) 744-6160.



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

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

## D. Use and Disclosure of Patient Information

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



## E. Protecting Patient Information

1. Safeguards
  - a. Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients' PHI.
  - b. We must take reasonable **safeguards** or **steps** to make sure patient health information is kept private.
2. Incidental Disclosures
  - a. We know that we cannot guarantee the privacy of patient information all of the time.
  - b. Some activities we do for business reasons, such as calling out a patient's name in the waiting area or talking to a patient on the phone or in an area where others might hear are called **incidental disclosures**.



- c. Incidental disclosures do not violate laws as long as we take steps to protect the patient's privacy, such as moving close to the patient, closing doors or privacy curtains, eliminating use of patient name while talking on phone, or using lowered voices.
3. Disclosing Information to Spouses, Family Members, and Friends
  - a. Workforce members should use good professional judgment when disclosing health information to a patient in front of a spouse, family members or friends. If in doubt or to be sure, ASK.
  - b. You can disclose this information if the patient says it is okay or when asked, does not object, or if the person is the patient's legal representative.
  - c. You should only talk about current relevant information.
4. Disclosing Information to the Media
  - a. It is against the law to sell patient information to the media.
  - b. Call the facility Public Information Officer or the facility Privacy Coordinator if the press or news media request information about one of our patients.
5. Social Networks
  - a. Do not post information about patients or work-related issues on social networking sites such as *Facebook, Twitter, Google+, YouTube, etc.*
  - b. It does not matter if you are not using County equipment or if you are at home or on your break.
  - c. Due to the nature and type of work you do, just small bits of information put together, can reveal identifying information about patients and cause you to violate privacy laws.



## F. Access to PHI

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

## G. Inappropriate Access to PHI

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

## H. Minimum Necessary

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

## I. Reporting Violations and Breaches of Patient Information

1. You must report anything a workforce member does that might be against DHS Policy or federal or state laws.
2. If a workforce member peeks at a patient's medical record we have to report it even if the workforce member did not tell anyone or the patient was not harmed.
3. You will not be retaliated against for reporting a suspected or actual violation in good faith.
4. If you falsely accuse someone on purpose you will be subject to discipline.
5. If you report a violation and you were involved, you will still be subject to discipline.
6. You **MUST** report suspected or actual breaches to your supervisor or the facility Privacy Coordinator at (323) 226-6100 and submit a Safety Intelligence (SI) 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

## J. Fines and Penalties

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

## SECURITY OF PATIENT INFORMATION

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





2. You must protect all information created using County computers. Access to use a County computer is not a right. Your access may be modified or taken away at any time for abuse or misuse.
  3. DHS may log, review, or monitor any data you have created, stored, accessed, sent, or received, and these activities may be subject to audit.
- F. Privacy and security policies are posted on the DHS intranet (361.1 – 361.30 and 935.00 – 935.20). You should review and familiarize yourself with these policies and those of your facility/unit so you fully understand your role in the protection of patient health information as it pertains to your job responsibilities.

## REMEMBER

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

### PATIENT CONFIDENTIALITY QUICK REFERENCE/KEY POINTS

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

#### Four primary ways patient confidentiality is most often violated:

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

## Privacy and Security Don'ts

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

## KEY POINTS TO REMEMBER

### ALL STAFF (What The Joint Commission Surveyor Is Likely to Ask You)

#### LEADERSHIP

- Our mission, vision and values statements are included in various training programs. In addition to the definition of LAC+USC Medical Center's mission, vision and values contained in this handbook, the hospital makes available in a wallet-size format so that you can attach it to your Identification (ID) badge holder.
- All licensed medical professionals are expected to adhere to the highest ethical and professional standards of behavior and performance.
- If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should report it to the appropriate office (see telephone numbers listed under "Professional Credentials (License/Certification/Registration/Permit)").
- It is important that you understand, whether you are a healthcare practitioner, technician, clerical or housekeeping member of our staff, that your job supports our organization's mission to 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 PROGRAM

We have a proactive, multifaceted, and integrated Patient Safety Program. The goal of the Plan is to prevent adverse occurrences rather than just react to them.

- The Patient Safety Plan and Patient Safety Committee identify and investigate all recognized hazards to patient safety.
- You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental condition, or "near miss" that causes you to have concern for the safety of patients, visitors, or staff as soon as possible.
- The Joint Commission annually establishes National Patient Safety Goals (NPSGs) which LAC+USC Medical Center workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.
- LAC+USC Medical Center 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 laboratory values/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.
- Before you administer medication to patients, identify the patient using two identifiers, ***Patient Name and MRUN number***, per hospital policy.
- 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 nonsurgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery.

## STAFF RIGHTS AND RESPONSIBILITIES

All LAC+USC Medical Center workforce members must complete all mandatory training and competency certification requirements for their respective positions [e.g., New Employee Orientation, Area/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/Update 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 of a sexual nature that could possibly be interpreted as harassing, offensive or inappropriate in the workplace.
- It is the responsibility of the licensed professional to renew required professional credentials. Failure to comply with professional credential 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 your responsibility to obtain a health screening annually.

## PATIENT RIGHTS AND SERVICES

- LAC+USC Medical Center Patients’ Rights and Responsibilities are posted throughout the medical center for reference.
- Each patient is given a Welcome to the LAC+USC Medical Center (Patient Rights) handbook upon admission. Patients who are not formally admitted (i.e. via the emergency room) are provided a Welcome (Patient Rights) handbook by the Clinical Social Services Department.
- Patient Advocates are available for the LAC+USC Medical Center 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 their health care decisions, such as whether or not they want life-sustaining treatment should they become terminally ill or permanently unconscious. It also allows patients to name representatives and/or to state their desires about their health care, when they are unable to do so.
- LAC+USC Medical Center Admissions and Clinical Social Services staff informs patients of their options concerning AHCD’s.
- Patients can fill out an AHCD document or give oral direction to a physician, who will document the directive in the patient’s medical record including completing appropriate documentation(s).
- 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.

## 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 a sentinel event or a near miss, you must report it promptly.

## Report events in one of the following ways:

- Direct Supervisor **AND**
- Safety Intelligence – a web-based event reporting system, DHS-wide system accessible from the LAC+USC Intranet Webpage, **OR**
- Patient Care Statement of Concern.

### **OR contact:**

- Hospital Risk Manager's Office at (323) 226-6657.
- Pharmacy to report Adverse Drug Events at (323) 226-7741.
- Medical Administration at (323) 409-6734.
- Patient Safety Officer at (323) 409-6738.

## ENVIRONMENT OF CARE

- Safety concerns must be reported to your supervisor and the Safety Officer. Completion of the Unsafe Conditions Report is also required.
- You can report safety concerns anonymously.
- Know what all emergency codes mean and how you should respond to each, for example at LAC+USC Medical Center:
  - **Code Blue means Adult Cardiac (or cardiopulmonary) Arrest**
  - **Code White means Pediatric Cardiac (or cardiopulmonary) Arrest**
  - **Code Red means Fire Emergency**
  - **Code Gold means Behavior Response Team**
  - **Code Gray mean 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 Attention is needed for Inpatients**
  - **Code Assist means Urgent Medical Assistance is needed for Outpatients, Visitors, and 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 hospital's 24/7 Nursing Office and the Safety Office.
- In the event of a fire, follow the **SAFE** and the **PASS** procedures, as appropriate.
- You must know where the fire alarm, fire extinguisher, 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 AND CONTROL

- Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection.
- You must wash your hands before and after direct patient contact, after removing gloves, before/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, LAC+USC Medical Center will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the disaster manual; all departments have copies of the disaster manual.

## 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 that contain 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 confidential information as if it were your own.
- Report suspected HIPAA violations by means of an entry in the Safety Intelligence system AND by phone to the facility Privacy Coordinator at (323) 226-6100.
- It is the responsibility of every member of our service delivery team to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and confidentiality of our patients' PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form.
- Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment, and healthcare operations (TPO).
- Personally Identifiable Information (PII), information similar to PHI, must be protected.
- LAC+USC Medical Center uses the following safeguards to protect patient-specific information:
  - Required Compliance Awareness and Compliance Update training for all staff within 30 days of hire/assignment.
  - Use shredders and locked bins to dispose of PHI documents.
  - Cover carts used to transport medical records.
  - Implement a need to know level of security to access PHI.
    - ◆ If you access or disclose patient information that is not related to your job or that does not have the patient's authorization, you are in violation of DHS policy, HIPAA and State law and may be subject to monetary fines, civil or criminal penalties, or corrective action including



discharge from County service or assignment. Licensed professionals may be reported to their professional credential board/agency for disciplinary action.

- Use automatic log-off of PC's after non-use of systems.
  - Use user-ID and Password to access PHI.
  - Regularly review reports to HIM showing outgoing, incoming and transferring staff, to ensure that system's access is restricted to valid users.
  - Limited remote access is provided to user by Virtual Private Network (VPN).
  - Lock doors and use sign-in logs to limit access to the Health Information Management Department and other areas where confidential documents and equipment that store confidential information are located.
  - Encrypt laptops, external storage devices and portable medical equipment that stores ePHI.
- In the event of a disaster, LAC+USC Medical Center ensures 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 at an off-site location.
  - LAC+USC Medical Center 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.

LAC+USC Medical Center provides "knowledge-based data and information" through the medical libraries in the Inpatient Tower, General Hospital, and the Nursing Library located in the Educational Resources building at the College of Nursing and Allied Health. Leaders and care providers can access journals, textbooks, audio visual materials etc. The medical library is accessible online.

## Clinical Orientation (Clinical Staff Only)

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	Clinical Laboratory Scientists
Dentists	Pharmacists
Respiratory Care Practitioners	Pharmacy Technicians
Occupational Therapists	Nuclear Medicine Technologists
Radiology Technologists	Phlebotomy Technicians
Physical Therapists	Recreation Therapists
Speech Pathologists	Social Work Employees
Rehabilitation Therapy Technicians	Surgical Technicians
Licensed Physical Therapy Assistants	Dental Assistants
Nurse-Midwives	Dental Hygienists
CRNA'S	Registered Dietitians
Physician Assistants	Occupational Therapy Assistants
Nurse Practitioners	Cardiac Monitor Technicians

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

## PATIENT CARE PRACTICES

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

### POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

Staff members with direct patient care responsibilities are trained in working with the appropriate population groups (neonate, infant, child, adolescent, adult and geriatric patients) during the initial area/unit and job-specific orientation. If you interact with patients as part of your job, you must develop skills and competencies for delivering population appropriate communications, care and interventions in order to assure that each patient's care meets his/her unique needs. People grow and develop in stages that are related to their age and share certain qualities at each stage. By adhering to these guidelines, you can build a sense of trust and rapport with your patients and meet their psychological needs, as well. Our population-specific guidelines are:

#### NEONATES (BIRTH TO 28 DAYS)

- Neonates may include newborns.
- Provide security and ensure a safe environment.
- Involve the parent(s) in care.
- Limit the number of strangers around the neonate.
- Use equipment and supplies specific to the age and size of the neonate.

#### INFANTS (1 MONTH TO 12 MONTHS)

- Use a firm direct approach and give one direction at a time.
- Use a distraction, e.g., pacifier or bottle.
- Keep the parent(s) in the infant's line of vision.
- Use equipment and supplies specific to the age and size of infant.

#### CHILDREN (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 6-12).
- Give praise, rewards, and clear rules. Encourage the older child to ask questions.
- Use toys and games to teach the child and reduce fears.
- Always explain what you will do before you start; be age appropriate. Involve the older child in care.
- Provide for the safety of the child. Do not leave the younger child unattended.
- Use equipment and supplies specific to the age and size of the child.

#### ADOLESCENTS (13 YEARS THROUGH 17 YEARS)

- Treat the adolescent more as an adult than a child. Avoid authoritarian approach and show respect.
- Explain procedures to adolescents and parents using correct terminology.
- Provide for privacy.

## ADULTS (18 YEARS THROUGH 64 YEARS)

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

## GERIATRICS (65 YEARS & OLDER)

- Avoid making assumptions about loss of abilities, but anticipate the following:
  - 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.
- Provide support for coping with any impairment.
- Prevent isolation; promote physical, mental, and social activity. Provide information to promote safety.

## PAIN ASSESSMENT AND REASSESSMENT

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### Wong-Baker FACES Pain Rating Scale



*From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: Wong's Essentials of Pediatric Nursing, 6/e, St. Louis, 2001, P. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.*

Pain is a common experience for a majority of our patients. LAC+USC Medical Center supports every patient's right to have his/her pain assessed and treated promptly, effectively, and for as long as the pain persists. Health care providers assess all patients receiving care at our facility for pain upon initial presentation and in subsequent reassessments. We routinely include pain as a "fifth vital sign" and document these reassessments at the same time we take a 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. LAC+USC Medical Center uses an appropriate pain assessment tool to assess, reassess, and document pain ratings so that we can compare these ratings over time.

# 2016 Orientation/Reorientation

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 at LAC+USC Medical Center 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:

<b>Mild Pain</b>	<b>1 – 3</b>
<b>Moderate Pain</b>	<b>4 – 6</b>
<b>Severe Pain</b>	<b>7 – 10</b>

The FLACC Pain Scale can be used with infant and pediatric patients ages 0-5 years, cognitively impaired patients, and those patients unable to use other scales. Based upon physiologic and/or behavioral signs, assess the patients (from 0 to 2) in each area– total the score – evaluate the total using the 0-10 pain scale.

## FLACC SCALE



CATEGORIES	SCORING		
	0	1	2
<b>Face</b>	No particular expression or smile	Occasional grimace or frown, withdrawn	Frequent to constant quivering chin, clenched jaw
<b>Legs</b>	Normal position or relaxed	Uneasy, restless tense	Kicking, or legs drawn up
<b>Activity</b>	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
<b>Cry</b>	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
<b>Consolability</b>	Content, relaxed	Reassured by occasional touching, hugging or being talked to; distractible	Difficult to console or comfort
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.			
<b>USED TO EVALUATE PAIN FOR CHILDREN 0 TO 5 YEARS</b>			

*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*

## THE N-PASS SCALE

### N-PASS: Neonatal Pain, Agitation, & Sedation Scale

Assessment Criteria	Sedation		Sedation/Pain	Pain / Agitation	
	-2	-1	0/0	1	2
<b>Crying Irritability</b>	No cry with painful stimuli	Moans or cries minimally with painful stimuli	No sedation/ No pain signs	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
<b>Behavior State</b>	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	No sedation/ No pain signs	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	No sedation/ No pain signs	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	No sedation/ No pain signs	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	No sedation/ No pain signs	↑ 10-20% from baseline SaO <sub>2</sub> 76-85% with stimulation - quick ↑	↑ > 20% from baseline SaO <sub>2</sub> ≤ 75% with stimulation - slow ↑ Out of sync/fighting vent

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Premature Pain Assessment

+ 1 if <30 weeks gestation / corrected age

#### Assessment of Sedation

- Sedation is scored in addition to pain for each behavioral and physiological criteria to assess the infant's response to stimuli
- Sedation does not need to be assessed/scored with every pain assessment/score
- Sedation is scored from 0 → -2 for each behavioral and physiological criteria, then summed and noted as a negative score (0 → -10)
  - A score of 0 is given if the infant has no signs of sedation, does not under-react
- Desired levels of sedation vary according to the situation
  - "Deep sedation" → goal score of -10 to -5
  - "Light sedation" → goal score of -5 to -2
- Deep sedation is not recommended unless an infant is receiving ventilatory support, related to the high potential for hypoventilation and apnea
- A negative score without the administration of opioids/ sedatives may indicate:
  - The premature infant's response to prolonged or persistent pain/stress
  - Neurologic depression, sepsis, or other pathology

#### Pavulon/Paralysis

- It is impossible to behaviorally evaluate a paralyzed infant for pain
- Increases in heart rate and blood pressure at rest or with stimulation may be the only indicator of a need for more analgesia
- Analgesics should be administered continuously by drip or around-the-clock dosing
  - Higher, more frequent doses may be required if the infant is post-op, has a chest tube, or other pathology (such as NEC) that would normally cause pain
  - Opioid doses should be increased by 10% every 3-5 days as tolerance will occur without symptoms of inadequate pain relief

#### Assessment of Pain/Agitation

- Pain assessment is the fifth vital sign - assessment for pain should be included in every vital sign assessment
- Pain is scored from 0 → +2 for each behavioral and physiological criteria, then summed
  - Points are added to the premature infant's pain score based on the gestational age to compensate for the limited ability to behaviorally communicate pain
  - Total pain score is documented as a positive number (0 → +11)
- Treatment/interventions are suggested for scores > 3
  - Interventions for known pain/painful stimuli are indicated before the score reaches 3
- The goal of pain treatment/intervention is a score ≤ 3
- More frequent pain assessment indications
  - Indwelling tubes or lines which may cause pain, especially with movement (e.g. chest tubes) → at least every 2-4 hours
  - Receiving analgesics and/or sedatives → at least every 2-4 hours
  - 30-60 minutes after an analgesic is given for pain behaviors to assess response to medication
  - Post-operative → at least every 2 hours for 24-48 hours, then every 4 hours until off medications



## Scoring Criteria

### Crying / Irritability

- 2 → No response to painful stimuli
  - No cry with needle sticks
  - No reaction to ETT or nares suctioning
  - No response to care giving
- 1 → Moans, sighs, or cries (audible or silent) minimally to painful stimuli, e.g. needle sticks, ETT or nares suctioning, care giving
- 0 → No sedation signs or No pain/agitation signs
- +1 → Infant is irritable/crying at intervals - but can be consoled
  - If intubated - intermittent silent cry
- +2 → Any of the following
  - Cry is high-pitched
  - Infant cries inconsolably
  - If intubated - silent continuous cry

### Behavior / State

- 2 → Does not arouse or react to any stimuli:
  - Eyes continually shut or open
  - No spontaneous movement
- 1 → Little spontaneous movement, arouses briefly and/or minimally to any stimuli
  - Opens eyes briefly
  - Reacts to suctioning
  - Withdraws to pain
- 0 → No sedation signs or No pain/agitation signs
- +1 → Any of the following
  - Restless, squirming
  - Awakens frequently/easily with minimal or no stimuli
- +2 → Any of the following
  - Kicking
  - Arching
  - Constantly awake
  - No movement or minimal arousal with stimulation (not sedated, inappropriate for gestational age or clinical situation)

### Facial Expression

- 2 → Any of the following
  - Mouth is lax
  - Drooling
  - No facial expression at rest or with stimuli
- 1 → Minimal facial expression with stimuli
- 0 → No sedation signs or No pain/agitation signs
- +1 → Any pain face expression observed intermittently
- +2 → Any pain face expression is continual

### Extremities / Tone

- 2 → Any of the following
  - No palmar or planter grasp can be elicited
  - Flaccid tone
- 1 → Any of the following
  - Weak palmar or planter grasp can be elicited
  - Decreased tone
- 0 → No sedation signs or No pain/agitation signs
- +1 → Intermittent (<30 seconds duration) observation of toes and/or hands as clenched or fingers splayed
  - Body is *not* tense
- +2 → Any of the following
  - Frequent (≥30 seconds duration) observation of toes and/or hands as clenched, or fingers splayed
  - Body is tense/stiff

### Vital Signs: HR, BP, RR, & O<sub>2</sub> Saturations

- 2 → Any of the following
  - No variability in vital signs with stimuli
  - Hypoventilation
  - Apnea
  - Ventilated infant - no spontaneous respiratory effort
- 1 → Vital signs show little variability with stimuli - less than 10% from baseline
- 0 → No sedation signs or No pain/agitation signs
- +1 → Any of the following
  - HR, RR, and/or BP are 10-20% above baseline
  - With care/stimuli infant desaturates minimally to moderately (SaO<sub>2</sub> 76-85%) and recovers quickly (within 2 minutes)
- +2 → Any of the following
  - HR, RR, and/or BP are > 20% above baseline
  - With care/stimuli infant desaturates severely (SaO<sub>2</sub> < 75%) and recovers slowly (> 2 minutes)
  - Out of sync/fighting ventilator



Facial expression of physical distress and pain in the infant

Reproduced with permission from Wong DL, Hess CB: Wong and Whaley's Clinical Manual of Pediatric Nursing, Ed. 5, 2000, Mosby, St. Louis

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## 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 document 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. We educate our patients and families about their right to have their pain assessed and treated and give patients "Management of Your Pain" brochure. We also tell them the purpose for the frequent reassessments and the use of the pain rating scales.

**Palliative Care** focuses on the comfort and well-being of patients, in particular those with incurable, progressive illnesses. It is a team approach to comprehensive management of physical, social, spiritual, and psychological needs of patients and their families. The goal is to achieve the best possible quality of life through relief of suffering and control of symptoms.

Reasons when to ask for a consult:

- Team/ patient/ family needs help with complex decision making.
- Code status discussions.
- Goals of care clarification.
- Unacceptable symptom distress (i.e. pain, dyspnea, nausea, etc.).
- Provide information and resources to patients/ family.

Please call (323) 409-8532 to place a consult.

## PATIENT FOOD SERVICES/NUTRITION SERVICES

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The Department of Food and 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 7:30 a.m. - 6:30 p.m. on weekdays and 7:30 a.m. to 4:00 p.m. on weekends and holidays. A written consult order or referral, which may include reason for consult or referral, is required for each patient. The Parenteral and Enteral Nutrition Service (PENS) nursing staff is available for consultation on Home Total Parenteral Nutrition (TPN) and procurement of Dobhoff tubes. PENS nursing staff can be reached at (323) 226-7764.



## DIET ORDERS

A written diet order, which may include NPO or a specialized nutrition regimen, is required for each patient. A change in the diet order written on physician's order form will automatically cancel all previous diet orders written. Patient meal service includes meal delivery and hospitality services, operated by Morrison Healthcare Food Service, Inc. Each meal is delivered accordingly to the time schedule (see table below). Changes to patient's diet order must be entered into ORCHID. In order to have the patient's meal delivered automatically, the patient's diet order must be entered into ORCHID prior to specific electronic ordering cut-off times (see table below). Diet orders that are entered into ORCHID after a given electronic ordering cut-off time, must be communicated to a diet clerk via telephone (Ext. 96906). These late requests will be delivered by Food & Nutrition personnel up until the delivery cut-off times (see table below). Telephone meal tray requests that are made after a given delivery cut-off time must be retrieved from the Food & Nutrition department (IPT Main Kitchen) by the requestor. Nourishments (between meals snacks) may be ordered for any patient within the diet prescribed and are delivered at 10:00 a.m., 2:00 p.m., and 8:00 p.m. daily.

MEAL	MEAL TIME	ELECTRONIC ORDERING CUT-OFF TIME	DELIVERY CUT-OFF TIME
<b>BREAKFAST</b>	7:00 a.m. – 8:30 a.m.	6:10 a.m.	9:15 a.m.
<b>LUNCH</b>	11:00 a.m. – 12:30 p.m.	9:30 a.m.	1:15 p.m.
<b>DINNER</b>	5:00 p.m. – 6:30 p.m.	12:15 p.m.	7:15 p.m.

## FOOD AND NUTRITION SERVICES PHONE LIST

Dietitian Office: ..... (323) 409-6979  
 To Order Meals: ..... (323) 409-6906  
 Hospitality Supervisor: ..... (323) 409-1742

## PATIENT SAFETY

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

### “READ-BACK” REQUIREMENTS

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In an effort to improve communication among care providers, LAC+USC Medical Center has several processes in place to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

- **Telephone Orders** – While the physician issues the order, the Registered Nurse (RN) writes the order down on the order sheet. Before ending the telephone call, the RN verifies for accuracy by “reading it back” to the physician to confirm that he/she understood and transcribed it correctly. The RN will flag the order to be co-signed 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.
- **Critical Laboratory Values/Results** – LAC+USC Medical Center communicates the Critical Laboratory Values/Results in a timely manner to the physician providing care for the patient. The medical center laboratory will relay all Critical Laboratory Values/Results for adult patients to the Customer Service Center from 7:01 a.m. to 11:00 p.m. (0701-2300 hour) except lab results originating from the Department of Emergency Medicine Intensive Care Units, Pediatrics, Employee Health, and Operating Rooms. For all other areas and the critical laboratory values from 11:01 p.m. to 6:59 a.m. (2301-0659 hour), the performing laboratory staff will handle notification per LAC+USC Medical Center Policy No. 911. When a Critical Laboratory Value/Result is called, the physician/designee or the customer service workforce member who accepts the critical test result is asked to do a verification “read back”.



### DETERIORATING PATIENT CONDITION

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As patient caregivers, you need to know the signs and symptoms of the decline in a patient’s condition, within your scope of practice. The assessment and recognition of the deteriorating patient is an ongoing challenge throughout the patient’s stay or visit to your facility. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going health assessments, handoff communication reports, chart documentation and other communication modalities are good methods to use in recognizing declination in the patient’s condition. **Every** member of the healthcare team is responsible to ensure that he/she gives 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 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. That patient's nurse will assess the situation and call for additional assistance if needed. RNs are trained on when and how to activate Emergency Response Teams (Man Down Team, Code Blue Team or Airway 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 for respiratory or cardiac arrest by dialing **Ext. 111** from a hospital phone. In areas outside the main hospital buildings/areas, call 9-1-1 for a medical emergency.

## FALL REDUCTION AND PREVENTION

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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)
- A. 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.
  - B. 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.



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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).

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

## INPATIENTS

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

### Assessment/Reassessment

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

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

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

Morse, J.M. (1997). *Preventing Patient Falls*. Thousand Oaks, Sage Publication

Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. *Canadian Journal Aging*, 8,366-377.

# 2016 Orientation/Reorientation



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
<b>Total</b>		

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"> <li>• 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.</li> <li>• Place a sign at the entrance to the patient's room and/or head of the patient's bed.</li> <li>• Place a fall precaution sticker on front of patient's chart.</li> </ul>	

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"> <li>• 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.</li> <li>• 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.</li> </ul>	

## 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.

# 2016 Orientation/Reorientation

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

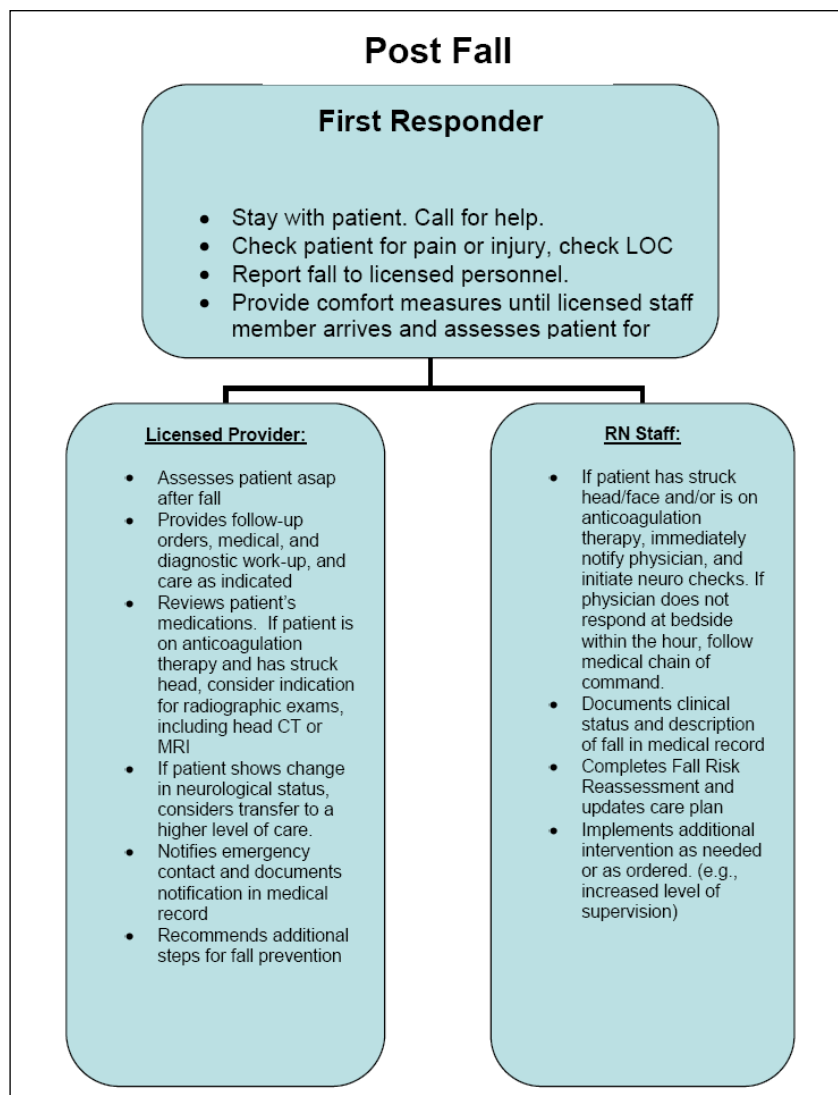
Pediatrics	
<p><b>General Fall Prevention Measures</b></p>	<p>Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all children:</p> <ul style="list-style-type: none"> <li>• Do not leave children unattended when using equipment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



Pediatrics	
	<ul style="list-style-type: none"> <li>o Instruct family of pediatric patients that until the child regains his/her strength, someone should walk alongside him/her to provide support and protection in case he/she loses his/her balance.</li> </ul>

## 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.



**NOTE**

Refer to DHS Policy No. 311.101, DHS system-wide Fall Prevention Program.

Each facility has policies and procedures in place that should be reviewed regularly. Use your facility's report mechanism for falls and medical response.

Documentation and assessment tools for patient fall risks and high fall risk patient alerts vary for each facility. Follow your facility's protocols and guidelines as set forth.

## DOCUMENTATION

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

### Emergency Department (ED)

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

#### Adult

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

#### Pediatrics

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

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

#### Adult Interventions

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

6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
7. Assess for elimination needs every 2 hours
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons.
  - a. Provide privacy when patient is toileting, if requested
  - b. Refusal by patient for direct observation during toileting must be documented in the patient's medical record.
  - c. Notify the appropriate licensed professional of patient's refusal.

## **Pediatrics Interventions**

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

## **E. Post Fall Procedure**

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

## **UNIVERSAL PROTOCOL**

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LAC+USC Medical Center has adopted all components of 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 three main components are:

1. **Pre-Operative/Pre-Procedure Verification** – LAC+USC Medical Center uses 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.
2. **Marking the Operative Site** – LAC+USC Medical Center requires site marking for all surgical sites/invasive procedures involving right/left distinction, multiple structures, or levels. For exceptions to site marking at LAC+USC, the physician marks the patient's skin with the word "YES" to indicate the intended site. Whenever possible, involve the patient in the marking process.

3. **"TIME OUT"** – Immediately before starting the procedure, all members of the service delivery team conduct a final verbal verification to confirm the 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 physician 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 verification, site marking, and "Time Out" procedures should be consistent as in the OR setting.

## 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. An enforcement/feedback policy and procedures are in effect at LAC+USC.

## 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. LAC+USC Medical Center encourages you to review the formulary on an ongoing basis, and utilize formulary-approved medications.



## SAFETY TIPS FOR SAFE MEDICATION PRESCRIBING

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

- Identifying the patient with **TWO** identifiers (**Patient Name and MRUN**).
- Placing the date and time on all orders.
- Using generic drug names on all medication orders.
- Including specific dose, route, and frequency.
- Not using range orders (Pharmacy will not accept ranges such as 1-2 tabs; q 4-6h in orders).

- Qualifying all as needed (PRN) orders (e.g., PRN pain).
- Signing all orders and printing your name and physician number so that you may be located for any questions.
- Entering the patient's diagnosis, allergies, and height/weight on all admitting orders to avoid delay in dispensing.
- Using weight-based dosing on all pediatric patients less than 40 kg of weight.
- Using addressograph machines for patient identification on ALL patient orders. You **must** list unit location on ALL patient medication orders.
- Avoiding the use of unapproved abbreviations. When in doubt, do not abbreviate. To prevent any confusion, spell out the entire name of the drug.

**See Unapproved Abbreviations & Look-Alike/Sound-Alike Medications Lists  
on Next Page**



## PROHIBITED/UNSAFE ABBREVIATION LIST: DO NOT USE

Make Patient Safety a Part of Your Patient Care Routine!  
**Unapproved Abbreviations**

The following abbreviations/symbols are **unacceptable** at LAC+USC and shall **NOT** be used for patient medication orders:

PROHIBITED & UNSAFE	SAFE AND ACCEPTABLE	RATIONALE
	<b>DO USE</b>	
<b><u>Drug Name Abbreviations</u></b>	<b>Use the complete spelling for drug names</b>	Helps reduce misinterpretation
MgSO4 MSO4 MS	Magnesium Sulfate Morphine Sulfate Morphine Sulfate	Clarifies which medication is being ordered.
Q.D.	Write: daily	Clarifies frequency of dose
Q.O.D.	Write: every other day	Clarifies frequency of dose
U or u	Write: unit	The abbreviation can look like an "0" and result in dosage errors.
IU	Write: international units	The abbreviation can look like a "10" and result in dosage errors.
Do not use apothecary symbols for dram and minim	Write out the metric system equivalent	Reduces the chances of order/directions being misread.
qn (nightly)	Write: bedtime	Clarifies time that medication is to be taken.
BT	Write: bedtime	Clarifies time that medication is to be taken.
<i>Prohibited only for medication related notations</i>		
Do not use trailing zeros (example: 5.0 mg)	Write: 5 mg	Unnecessary 0's after the decimal point can be misread and result in dosage errors.
Do not omit preceding zeros when writing decimals that are less than a whole number (example: .2mg)	Write: 0.2 mg	<b>Always</b> put a ZERO before a decimal point to avoid the dosage being misread as a whole number.

## “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 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 sound alike/look alike drugs.

<b>Look-Alike/Sound-Alike Medication List</b>		
1.	<b>DAUNOrubicin</b>	<b>DOXOrubicin</b>
2.	<b>Ephedrine</b>	<b>EPINEPHrine</b>
3.	<b>HumULIN</b>	<b>humALOG</b>
4.	<b>vinBLASStine</b>	<b>vinCRISStine</b>
5.	<b>CARBOplatin</b>	<b>CISplatin</b>
6.	<b>LANTus</b>	<b>LENte</b>
7.	<b>CeLEBRex</b>	<b>CEREbyx, CeLEXA</b>
8.	<b>KLONopin</b>	<b>cloniDINE</b>
9.	<b>laMISIL</b>	<b>lamicTAL</b>
10.	<b>ZYRtec</b>	<b>zyPREXA</b>
11.	<b>ChlorproPAMIDE</b>	<b>chlorproMAZINE</b>
12.	<b>foLIC acid</b>	<b>foliNIC acid</b>
13.	<b>LamiVUDINE</b>	<b>LamoTRIGINE</b>
14.	<b>ReTROvir</b>	<b>RITONAvir</b>
15.	<b>ZANTac</b>	<b>XaNAX</b>
16.	<b>NeLFINavir</b>	<b>NeVIRapine</b>
17.	<b>HydrALAZINE</b>	<b>hyrOXYzine</b>
18.	<b>TRAZOdone</b>	<b>TRAMadol</b>
19.	<b>GlipiZIDE</b>	<b>glyBURIDE</b>
20.	<b>aIPRAZolam</b>	<b>LORazepam</b>
21.	<b>MethoCARBamol</b>	<b>metFORmin</b>



## 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's age, height, weight, and 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**, 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.

## PATIENT'S OWN MEDICATIONS



Patients are discouraged from bringing their own medications into the hospital. Medications shall be given back to the patient's family/representative, when admitted to the hospital. Under limited and unusual circumstances, the patient's own medication may be used according to guidelines established by the Pharmacy and Therapeutics Committee.

If the medication is to be stored in the Pharmacy Department until discharge, medications (controlled drugs, drugs requiring refrigeration will be placed in separate security bags) are to be listed, packaged in the security bag, and sealed, along with a completed "Patient's Own Medications Deposit" form. The

required information includes: the patient's name, MRUN number, ward location, Valuables PAK number, and total containers.

If it is determined that there is a compelling reason to use the patient's own medication, the medication shall not be administered unless:

1. The drugs have been positively identified by the pharmacist.
2. There is a written order for the medication in the patient's medical record signed by the person lawfully authorized to give such an order.
3. The medication containers are clearly and properly labeled.

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## ADVERSE DRUG REACTION (ADR) REPORTING

Report all adverse drug reactions to the Drug Information Center by telephone at (323) 226-2246. Provide the patient's name, MRUN number, location, date of occurrence, name of the suspected medication, type of reaction, and your name. An Event Notification Report should be entered into the Safety Intelligence reporting system by the end of the shift of occurrence or becoming aware of the event. All events shall be reported even if only partial statements of fact are available at the time the report is entered.

## 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.

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

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LAC+USC 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, a "**Code Gold**" is activated to dispatch the Behavioral Response Team (BRT) to diffuse crises and maintain safety.

The BRT 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 BRT may initiate restraints. The BRT provides 24 hours, 7 days/week coverage throughout the hospital to assist in these emergencies. All members of the BRT 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.

### Training

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 to activate "Code Gold".
3. Provide your name, location and extension.
4. Operator will overhead page and activate the BRT's group pager.
5. Operator will notify the Sheriff personnel of "Code Gold".
6. Operator calls requesting ward to verify BRT's response.

When documenting on each restraint and/ seclusion episode: **REMEMBER J A A C**

<b>J</b>	<b>JUSTIFICATION</b>	Circumstances that led to the use of restraint.
<b>A</b>	<b>ALTERNATIVE METHODS</b>	Use of Alternative methods.
<b>A</b>	<b>ADVISEMENT</b>	Patient advisement of the behavior/condition necessary to be released from restraints.
<b>C</b>	<b>CONTINUOUS OBSERVATION</b>	Patient monitoring/assessments.

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

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- Begin medical record entry with an identifier (e.g., Attending note, Cardiology Fellow note).
- Legibly sign and indicate identification number and degree on all paper documents. Electronic signatures do not require a separate time or date if that information is automatically recorded by the system.
- All verbal orders must be validated/authenticated as soon as the emergency permits and before leaving the patient. LAC+USC Medical Center pharmacies accept verbal orders from a prescribing physician only in extreme emergencies, in the course of treatment, or during a surgical procedure.
- Specify reason(s) when prescribing the medication on all as needed (PRN) orders (i.e., conditions/symptoms, etc.).

If a handwritten error is made while charting in the medical record, make the correction by drawing a single line through the error. Write the correction along with the date, time and your initials. Do not document the word "ERROR." Erasing or using "white out" is not allowed in a patient's medical record. If an error is made in the electronic medical record, follow procedures in accordance with established protocols.

## MEDICAL RECORD REVIEW CHECKLIST

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Use the checklist below to review the medical records of the patients for whom you are responsible. Use this checklist as a reminder of medical record documentation that is needed:



- All orders and progress notes must have legible physician signature and identification number. Electronic signatures do not require a separate signature if the information is automatically recorded by the system.
- Did the patient sign the consent to treatment?
- Any language or cultural accommodations required?
- Was the H&P (History and Physical) dictated, written or typed within 24 hours of admission?
- For telephone orders in the record, is "Read Back" verification documented? Did the physician sign off on the orders within 24 hours?
- Were restraints used? If so, did the physician fill out the order form completely? Is there evidence that members of the service delivery team tried other least restrictive measures before applying restraints? Were restraints re-ordered if used longer than 24 hours?
- Are H&P and progress notes legible/organized and informative?
- Are all orders dated, timed, and signed?
- Are allergies identified in the orders?
- Are any DO Not Use abbreviations used? If so, was the order clarified?
- Are the resident's orders and notes cosigned by the attending physician?
- Did the attending physician write notes documenting his/her supervision of the resident?
- Is there evidence of multidisciplinary care planning?
- Is pain management well documented?
- Does the patient have an advance directive? If so, is there a copy in the record? If not, is there evidence of multidisciplinary care planning?
- Is there a diagnosis or indication recorded for each medication ordered?
- Do all as needed (PRN) orders include indications?
- If this is a surgical case, was the pre-op checklist completed to confirm that all required documentation was present before surgery?
- If a procedure was performed was the operative report dictated immediately after surgery or within 24 hours after surgery?
- Was the handwritten post-operative report noted in the medical record immediately after surgical procedure providing information until the dictated operative report reached the medical record?
- Was the dictated summary done within 14 days of discharge for patients hospitalized over 48 hours? (A dictated summary is required for all patients in the hospital over 48 hours.)

## KEY POINTS TO REMEMBER (CLINICAL STAFF)

### PROVISION OF CARE

- Know the characteristics of each population group that you serve.
- LAC+USC Medical Center 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 cardiac (or cardiopulmonary) arrest.

### PATIENT SAFETY

- Use "READ-BACK" procedures to ensure important information is accurately communicated and recorded.
- LAC+USC Medical Center 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.
- You must know how to seek medical assistance when there is a decline in patient condition.
- Prevention of patient falls is the responsibility of EVERY workforce member. Become familiar with the LAC+USC Fall/Injury Prevention Program.
- Universal Protocol **applies to all surgical and nonsurgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery or procedure.
- The Universal Protocol's three main components are: **conduct the pre-procedure verification process, mark the operative site, and perform a "Time Out" before the procedure.**
- The medication process must ensure that the right medication is administered to the right patient, at the right dose, at the right time, using the right route.
- Adverse drug reactions must be reported to the Adverse Drug Reaction phone number (323) 226-2246.
- Report all medication events, whether an actual medication error or an identified potential medication error, through the LAC+USC Medical Center 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.
- LAC+USC Medical Center will dispatch a Behavioral Response Team (BRT) for a "Code Gold" emergency.
- LAC+USC 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.
- All medical records must contain an identifier, legible signature and identification number, counter signature for verbal orders, and a rationale for medicine prescribed.
- LAC+USC Medical Center'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", an electronic patient information system. Access to the system is controlled through a security clearance process.
- Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.

## PERFORMANCE EVALUATION

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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:** Physician's 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.

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.

### NOTE

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

## COMPETENCY ASSESSMENT

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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.



## 2016 Orientation/Reorientation

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.

## **FAMILY AND MEDICAL LEAVE ACT (COUNTY EMPLOYEES)**

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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

**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.

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

### NOTE

See DHS Policy No. 756.6 for detailed guidelines.

above, that may adversely impact or interfere with existing medical limitations and/or restrictions. Outside activities subject to approval include, but are not limited to: outside employment; expert witness testimony; volunteer activity; and performance of charity medical relief.

## BEREAVEMENT LEAVE (COUNTY EMPLOYEES)

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

The intent of this Bereavement Leave provision is to allow an eligible employee to be absent from work for a prescribed number of working days, not hours, except in the case of employees on a job with SubTitle D (Monthly Permanent 9/10 time employee).

### Definitions of Working Days for Bereavement Leave Purposes

- For employees on a 5/40 schedule, the working day equals 8 hours.
- For employees on a 9/80 schedule, the working day equals 8 or 9 hours (i.e., whatever number of hours are scheduled for the day that is taken as Bereavement Leave).
- For employees on a 4/40 schedule, the working day equals 10 hours.
- For employees on 12 hour flex schedules, the working day equals 12 hours.

### Bereavement Leave for Full time, Permanent Employees

A full time, permanent employee is allowed up to three working days of Bereavement Leave, except that an employee who is required to travel a minimum of 500 miles one-way in connection with a Bereavement Leave may take an additional two working days as Bereavement Leave.

In addition, represented employees are allowed to use other paid or unpaid leave if the employee 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/she has completed at least 200 days of active service in the preceding calendar year, and four hours if such employee has completed less than 200 days of active service in the preceding calendar year.

### Monthly Permanent 9/10 Time Employees (RN's or SubTitle D)

Such employees are allowed 24 hours for each qualifying occasion.

## USE OF BEREAVEMENT LEAVE

Bereavement Leave need not be taken on three consecutive working days. For example, if an employee takes two working days of Bereavement Leave at the time of death, he/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.**

# 2016 Orientation/Reorientation

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.

### NOTE

Refer to DHS Policy 756.8, Bereavement Leave or contact DHS Payroll for questions concerning bereavement leave.

## 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

## JURY DUTY (COUNTY EMPLOYEES)

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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.

## PAYROLL (COUNTY EMPLOYEES)

### TIME REPORTING

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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/timesheet.

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 fall on a Sunday, the following Monday is a holiday.

If a holiday falls on an employee's regular day off, permanent full-time and permanent part-time employees will accumulate 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.

# 2016 Orientation/Reorientation

There is no limit to how long an employee can carry over the time, but management has the option of paying the employee for unused holiday time after two years have elapsed from the date the time was earned.

Employees on the 9/80 or 4/40 work schedule must check with their supervisor regarding the use of accumulated holiday time on a regular workday in their department.

The eHR application keeps up with holidays and codes them on the online timesheet. Coding of the time worked on a County holiday requires 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 timesheet 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 Sub. 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 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 to work date, the supervisor may ask the employee for an estimated return date or ask the employee to call in on a regular basis until a return date is identified. An employee must make every reasonable effort to inform his/her supervisor.
- If the emergency is sudden and the employee is on duty, he/she must speak to the manager/supervisor immediately to obtain permission to leave work and the amount and type of time to be used. The employee may not leave the work area without first reporting to his/her manager/supervisor or designee.

An employee who is off three (3) or more consecutive work days may be required to present an original verifiable medical certification of illness or injury upon return to work:

- For absences of three (3) consecutive work days, the medical certification, if requested, must be provided to the employee's immediate supervisor on the first day the employee returns to work.
- If the absence is extended to four (4) or more days, the employee, if requested, must provide medical certification to his/her immediate supervisor by the fifth (5th) work day of the absence. If the absence is extended further, the employee must provide updated medical certification to his/her immediate supervisor prior to the expiration of each extension. The employee must have a current medical certification on file with his/her supervisor at all times, or the timesheet will be coded as Absent Without Pay (AWOP).

Acceptable medical certification is an original, signed and dated document from a licensed physician provided on letterhead stationery of the physician or health care facility providing the care. The certification must include the following:

- The date the employee was seen by the physician.
- Date(s) the illness or injury prevented the employee from performing his/her duties.
- Earliest date the employee can return to work with or without restrictions.
- If there are work restrictions, the certification must include the nature of the restrictions and their duration.

An employee who fails to report an absence within the specified time period, call within the specified time period, or provide medical certification, as required, the absence is considered unapproved. Therefore, the timesheet will be coded unapproved Absent Without Pay (AWOP) for the period of the unreported absence. Unauthorized absences may subject the employee to disciplinary action.

An employee who demonstrates a clear pattern of absenteeism (such as absenteeism in conjunction with regular days off (RDOs), weekends, holidays, or vacation time off) may be placed on medical certification.

An employee who, without prior authorization or notification, is absent or fails to work his/her regularly assigned duties for three (3) consecutive regular working days or two (2) consecutive regularly scheduled on-duty shifts, is considered to have resigned from County service, unless the employee resumes his/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 one-half (1/2) time or more ("C", "D", "E", "U", "V", "W", "X", "Y", or "Z" SubTitles).



# 2016 Orientation/Reorientation

During each pay period, eligible employees earn some fraction of an hour of Full-Pay Sick Leave for performing the following (active service) hours that are counted for leave accrual purposes:

- Regular hours worked or scheduled;
- Full and part-pay leave taken, such as Vacation, Compensatory Time Off (accumulated overtime taken), Part-Pay Sick Leave, etc.; and
- Industrial Accident Leave covered by County Code or California Labor Code 4850 benefits.

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; and
- Under the California Kin Care Law, an employee is entitled to use that amount of Sick Leave the employee earns in any calendar year during a six-month period to attend to the illness or injury of a child, parent, spouse, or domestic partner.

Non-MegaFlex employees may elect to use Vacation, Compensatory Time Off (accumulated overtime taken), or Holiday time to cover their absences rather than using Full-Pay Sick Leave. When Vacation or other leave is being used for non-emergency care, such as doctor appointments, prior supervisory approval is required when practical and should not be reasonably denied. The request should be submitted in writing.

However, a non-MegaFlex employee may not use Sick Leave for a vacation or any other absence, unless the Sick Leave qualifies as "Personal Leave," as discussed below.

## Personal Leave

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.

# 2016 Orientation/Reorientation

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 or she is aware that a previously-specified expected return date will not be met, and provide a new date. See "Time Off Request" section above for absences exceeding three (3) workdays.

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

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

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

## MEGAFLEX

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

MegaFlex employees can use unused Full-Pay Sick Leave 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

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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 normally available to view/print within two business days prior to payday. Current and historical paystubs and W-2's can be viewed and downloaded. A tutorial on how to read your paystub can also be found under the "Paystub Viewer" tab. Select "Help/Information" tab on the left of the screen to view the tutorial.

## WORK HOURS/WORK WEEK

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

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

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

Where a person's yearly anniversary date is between the first and the 15th of the month, inclusive, his first step advancement shall be made on the first of that month, and where the anniversary date is on or after the 16th of the month, the step advancement shall be made on the first of the following month. Such persons shall then retain these new dates as their respective anniversary dates.

Effective beginning on and after January 1, 2012, or such later date as may be determined by the Chief Administrative Officer when the human resources management system reflecting this provision is implemented, the first step advancement for all persons newly appointed to a position shall be made one year from the date of the appointment unless otherwise specified by this Code. Those persons with adjusted anniversary dates according to rules in effect prior to system implementation in 2012 shall retain their adjusted anniversary date for that position.

## 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 participants' merit increases are based on recommendations by the Department Head and approved by the CEO. Tier II MAPP participants' 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

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To be eligible to earn Vacation 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).

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.

<b>Vacation Years of Service</b>	<b>40-Hour Employees Vacation Annual Maximum Hours</b>
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



# 2016 Orientation/Reorientation

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 in using Vacation leave. However, before they can use any Elective Leave they may have purchased, MegaFlex employees must use all previously accrued leave such as Vacation, Holiday, and Compensatory Time Off. In addition, MegaFlex participants must use their Non-Elective Leave prior to using any Elective Leave.

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

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

## 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!



**Provided By:**

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**Mitchell H. Katz, MD  
Director  
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### **DHS Mission**

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



**Board of Supervisors  
County of Los Angeles**

**Hilda L. Solis  
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### **County Mission**

*To Enrich Lives Through Effective and Caring Service*