Los Angeles General

Medical Center

2024-2025

ORIENTATION / REORIENTATION

HANDBOOK

Los Angeles County - Department of Health Services

Welcome to
LOS ANGELES GENERAL
Medical Center!

Jorge Orozco
Chief Executive Officer

Welcome to the Los Angeles General 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 Los Angeles General Medical Center 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.

Equity, Diversity, Inclusion, and Anti-Racism

As a part of LA County's goal to create an Anti-Racist Los Angeles, Health Services is engaged in a multi-phase Equity, Diversity, Inclusion, and Anti-Racism Initiative. The Initiative, launched in December of 2020, seeks to transform the policies and practices that in the past have contributed to inequitable employment and patient care at DHS. We are committed to creating a work environment that is safe and inclusive for everyone, and to doing whatever we can to end racial and identity-based disparities in healthcare. This multi-year initiative engages stakeholders across all sectors of DHS to bring their perspectives, experiences, and ideas for change to the table. Together we can build a more equitable organization. Your voice is essential to this process and we want to hear from you. Have questions or want to get involved? E-mail the EDIA Initiative at helloedia@dhs.lacounty.gov.

Los Angeles County's Racial Equity 10-Year Strategic Goals

Through a process of research, analysis, and deliberation, the County will pursue five identified strategic goals over the next decade. "Strategic Goals" are defined as changes in population-level outcomes that will be achieved through multiple strategic initiatives.

STRATEGIC GOAL NO. 1:
Increase the Attainment of Postsecondary Credentials with Significant Labor Market Value

STRATEGIC GOAL NO. 2:
Reduce Adult First-Time Felony Convictions

STRATEGIC GOAL NO. 3:
Increase Stable Full-Time Employment Among Individual Adults with Incomes at or Above 250% Federal Poverty Level (FPL)
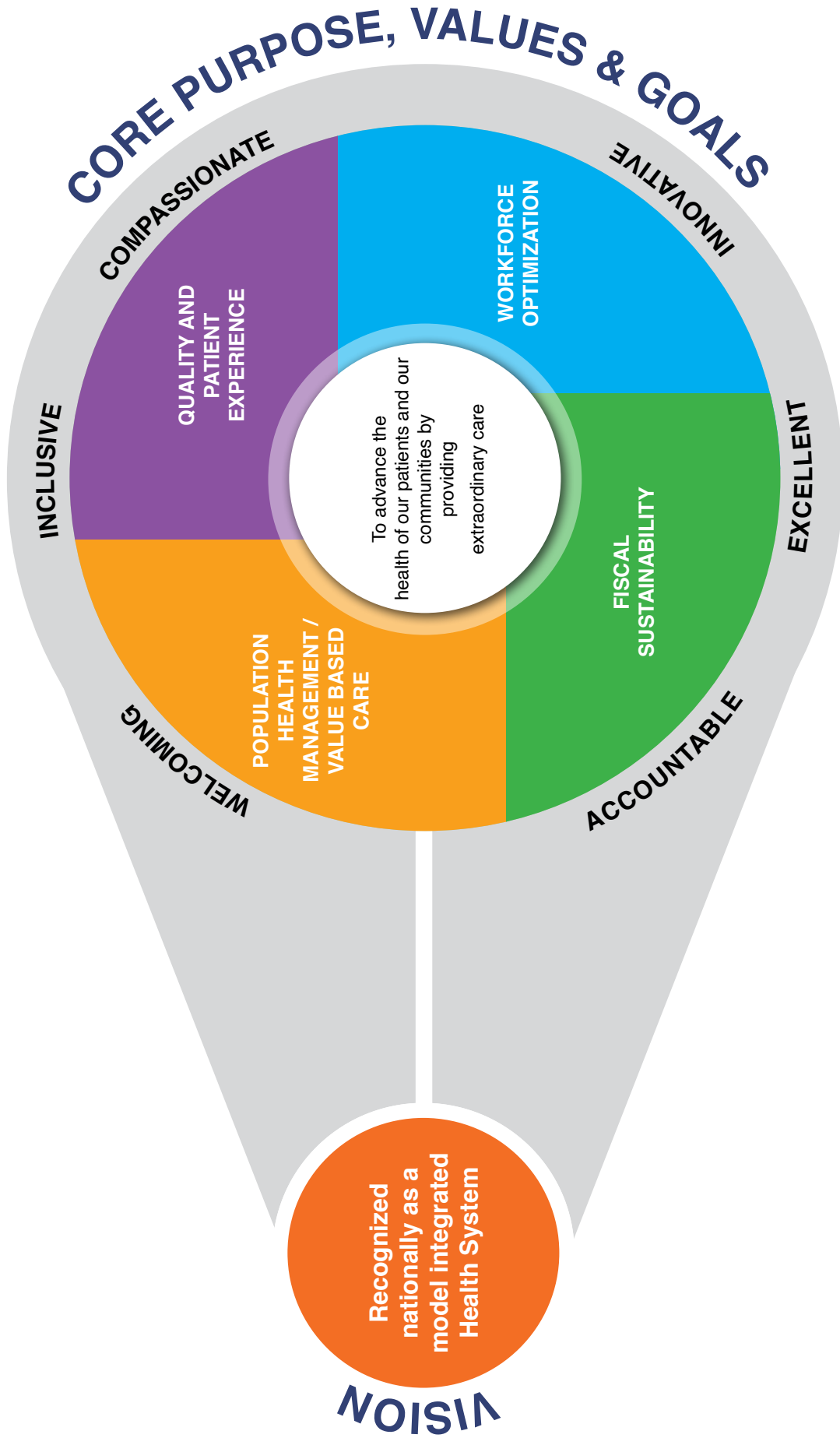
STRATEGIC GOAL NO. 4:
Increase the Percentage of Families with Incomes Above 250% Federal Poverty Level (FPL) for a Family of Four

STRATEGIC GOAL NO. 5:
Reduce Infant Mortality

DHS CORE PURPOSE, VISION, VALUES, AND GOALS

CORE PURPOSE, VALUES & GOALS

COMPASSIONATE

INNOVATIVE

INCLUSIVE

EXCELLENT

WELCOMING

ACCOUNTABLE

QUALITY AND PATIENT EXPERIENCE

WORKFORCE OPTIMIZATION

POPULATION HEALTH MANAGEMENT / VALUE BASED CARE

FISCAL SUSTAINABILITY

To advance the health of our patients and our communities by providing extraordinary care

Recognized nationally as a model integrated Health System

VISION

DHS CORE PURPOSE: To advance the health of our patients and our communities by providing extraordinary care.

DHS VISION: To be recognized nationally as a model integrated Health System.

VALUES: Welcoming, Inclusive, Compassionate, Innovative, Excellent, Accountable

GOALS: Population Health Management/Value Based Care, Quality and Patient Experience, Workforce Optimization, Fiscal Sustainability
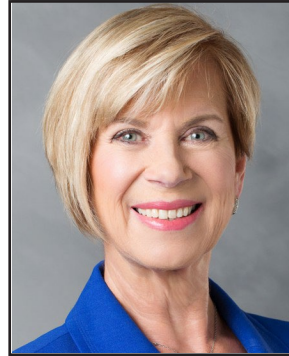
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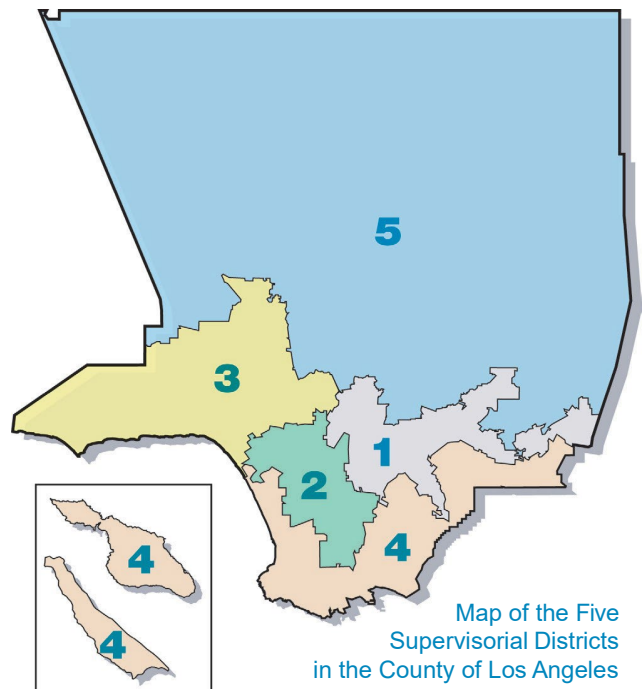
Map of the Five Supervisorial Districts in the County of Los Angeles

As of December 12, 2022

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LOS ANGELES GENERAL MEDICAL CENTER

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

INTRODUCTION

The Los Angeles General Medical Center consists of General Hospital, Clinic Tower, Inpatient Tower, Diagnostic & Treatment Tower, Interns & Residents Department, Rand Schrader Clinic, Outpatient Department, and Psychiatric Services at Augustus Hawkins Mental Health Center at Martin Luther King, Jr. Outpatient Center.

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 Los Angeles General 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 important information about our facility is readily available. It provides you with general information about the Los Angeles General 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 AND HIGHLIGHTS

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.

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.

Today the Los Angeles General Medical Center, formerly known as LAC+USC Medical Center, provides world-class emergency, trauma and medical services to the County's 10.4 million residents. It is the County's largest medical center, 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.

Los Angeles General 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.

Imgur

LOS ANGELES GENERAL MEDICAL CENTER

- 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 the off-site location at Augustus Hawkins Building at Martin Luther King, Jr. Outpatient Center.
- 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 and Allied Health.
- Provides training for other health care professionals such as pharmacists and physician assistants, physical and occupational therapists.
- Provides spiritual care to patients and staff.

Los Angeles General Medical Center annually provides services to approximately 116,641 emergency patients, over 500,000 outpatients, approximately 30,566 inpatients and over 4,500 trauma patients.

LOS ANGELES GENERAL MEDICAL CENTER MISSION, VISION AND VALUES

Core Purpose: To provide world-class care and education for all in our community

Vision: To lead the nation in building healthy communities

Values: Teamwork, Accountable, Trust, Compassion

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LOS ANGELES COUNTY STRATEGIC PLAN

MISSION

Establish superior services through inter-departmental and cross-sector collaboration that measurably improves the quality of life for the people and communities of Los Angeles County.

VISION

A value driven culture, characterized by extraordinary employee commitment to enrich lives through effective and caring service, and empower people through knowledge and information.

VALUES

Integrity – We do the right thing: being honest, transparent, and accountable.

Inclusivity – We embrace the need for multiple perspectives where individual and community differences are seen as strengths.

Compassion – We treat those we serve, and each other, the way we want to be treated.

Customer Orientation - We place our highest priority on meeting the needs of our customers.

STRATEGIC PLAN GOALS

GOAL 1: MAKE INVESTMENTS THAT TRANSFORM LIVES

We will aggressively address society's most complicated social, health, and public safety challenges. We want to be a highly responsive organization capable of responding to complex societal challenges – one person at a time.

GOAL 2: FOSTER VIBRANT AND RESILIENT COMMUNITIES

Our investments in the lives of County residents are sustainable only when grounded in strong communities. We want to be the hub of a network of public-private partnering entities supporting vibrant communities.

GOAL 3: REALIZE TOMORROW'S GOVERNMENT TODAY

Our increasingly dynamic and complex environment challenges our collective abilities to respond to public needs and expectations. We want to be an innovative, flexible, effective, and transparent partner focused on public service and advancing the common good.

The entire Strategic Plan is available at: https://ceo.lacounty.gov/strategic-plan-and-goals/

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BENEFITS AND LEAVES (COUNTY EMPLOYEES)

This section will provide performance guidelines and describe some of the benefits currently available to County Employees. This Orientation/Re-Orientation handbook is intended as a reference guide to help staff work in a cooperative and healthy environment that promotes efficient administration of the County's business.

PAYCHECKS

County employees are paid on a semi-monthly basis on the 15th and 30th. Taxes and most deductions are split and deducted twice a month. Some deductions such as medical, dental and life are deducted on the 15th of the month. Employees who elect to be paid through direct deposit will receive their pay statements 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 pay statements online.

EMPLOYEE PAY STATEMENTS

Pay statements are viewable online through the Los Angeles County Workplace site. To view pay statements the employee must log into Los Angeles County Workplace at https://ewp.lacounty.gov/workplace and choose "W2 & Pay Statements." Pay statements are usually available to view/print within two business days before payday. Current and historical paystubs and W-2's can be viewed and downloaded. A tutorial on how to read your pay statements can also be found under "W2 & Pay Statements". Select the "Help/Information" link to view the tutorial.

COUNTY PAID HOLIDAYS

Only monthly employees (permanent & some temporary) are eligible for **paid holiday leave.**
Currently, the Board of Supervisors has approved **13 annual holidays.**

NEW YEAR'S DAY January 1st	**MARTIN LUTHER KING, JR DAY** Third Monday in January	**PRESIDENTS' DAY** Third Monday in February	**CESAR CHAVEZ DAY** Last Monday in March
MEMORIAL DAY Last Monday in May	**JUNETEENTH DAY** June 19	**INDEPENDENCE DAY** July 4th	**LABOR DAY** First Monday in September
INDIGENOUS PEOPLES' DAY Second Monday in October	**VETERANS DAY** November 11th	**THANKSGIVING DAY** Fourth Thursday in November	**FRIDAY AFTER THANKSGIVING** Fourth Friday in November
CHRISTMAS DAY December 25th			

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If January 1st, June 19th, July 4th, November 11th, or December 25th falls on a Saturday, the previous Friday is a holiday.
If any of the dates fall on a Sunday, the following Monday is the holiday.

VACATION AND SICK LEAVE ACCRUAL

A portion of sick leave and vacation leave is earned/accrued each pay period up to the allowable limit based on years of service. New employees can use sick leave but must wait 6 months to use sick personal leave and 12 months to utilize accrued vacation. Some employees (MegaFlex Plan) earn a portion of leave and must purchase additional leave hours on an annual basis during the benefit enrollment period. Your classification will determine which will apply to you.

Vacation Years of Service	40-Hour Employees Vacation Annual Maximum Hours	Vacation Years of Service	40-Hour Employees Vacation Annual Maximum Hours
Less than 4	80	13 to less than 20	160
4 to less than 9	120	20 to less than 21	168
9 to less than 10	128	21 to less than 22	176
10 to less than 11	136	22 to less than 23	184
11 to less than 12	144	23 to less than 24	192
12 to less than 13	152	24 or more	200

40-Hour-Week Megaflex participants earn Non-elective Annual Leave based on active service as follows:

Years of Service	Non-elective Annual Leave Hours Earned	Pay Period Rate
Less than 20 years	80	4:00
20 to less than 21 years	84	4:12
21 to less than 22 years	88	4:24
22 to less than 23 years	92	4:36
23 to less than 24	96	4:48
24 years or more	100	5:00

The Sick Leave Accrual maximum hours for employees on a 40-hr workweek is as follows:

Sick Leave Years of Service	Sick Leave Accrual Hours Per Pay Period	Sick Leave Maximum Hours
0 - 1	4:21	80
More than 1 to 4	4:21	88
More than 4	4:21	96

FAMILY SCHOOL PARTNERSHIP ACT

Employees may use existing vacation, elective leave, nonelective leave, personal leave, compensatory time off (CTO), or leave without pay, for planned absences to participate in the school or 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, in a licensed day care facility, or in a preschool program serving children under five years of age. Such absences are not to exceed eight (8) hours per month and cannot exceed forty (40) hours per year. Reasonable notice must be provided to the supervisor and documentation that the employee attended the activity must be submitted upon return to work. No adverse employment action shall be taken against any employee for taking advantage of time off for such purposes.

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BEREAVEMENT LEAVE

Represented employees and non-represented employees in a full-time, permanent position who need to be absent from duty because of the death of their father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, brother-in-law, sister-in-law, husband, wife, child, stepchild, grandfather, grandmother, great-grandfather, great-grandmother, grandchild, domestic partner, domestic partner's father, mother, stepfather, stepmother, child, stepchild or, grandchild, shall be allowed up to five (5) days of leave, three (3) of which will be bereavement leave and two (2) of which shall be deducted from the employee's accrued vacation, overtime, personal leave, holiday time, or taken as time without pay, as elected by the employee. If an employee is required to travel a minimum of 500 miles one way, they shall be eligible to receive 5 working days of bereavement leave. In addition, the employee shall be allowed use of other paid or unpaid leave if one-way travel over 500 miles is required.

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, as specified in applicable Memoranda of Understanding (MOUs). Documentation on the death of the family member and travel distance must be submitted to be eligible for use of this leave.

DHS Policy 756.8 provides additional information on this subject.

JURY DUTY

County employees summoned to serve as jurors will be granted jury duty leave. An employee must notify their supervisor as soon as they receive 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 their 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 their 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 civil grand jury, if the employee's department approves an unpaid leave of absence, but the employee does not receive their regular pay or 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.

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.

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 their 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.

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FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Department of Health Services (DHS) complies with the provisions of FMLA and designates FMLA leave whenever applicable to any eligible employee (including temporary and part-time employees).

Under FMLA and California Family Rights Act (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); or
- Newly adopted child or a foster care placement.

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 or domestic partner's child with a serious health condition.
- The care of a designated person with a serious health condition. A designated person is defined as "any individual related by blood or whose association with the employee is the equivalent of a familial relationship."

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

Management's determination will 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 DHS outside employment policies and procedures if they have non-conflicting outside employment or activities. Employees are responsible for appropriately disclosing outside activity 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.

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MILITARY EXIGENCY

Employees may apply for military exigency leave if they have a family member who serves in the military or the reserves. Both the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) allow eligible employees to take protected leave for any qualifying reason related to or resulting from the deployment of a spouse, child, or parent that serves in the Armed Forces (Army, Navy, Air Force, Marines, etc.). Employees will be required to submit supporting certification which may include a copy of the military member's active-duty orders.

TIME OFF FOR BONE MARROW AND ORGAN DONATION

As of October 27, 2022, County employees are eligible for time off needed for testing, harvesting, and recovery time to make an organ or bone marrow donation. Employees may take up to 40 hours of paid leave within a 12-month period to support a donation of bone marrow. If any additional time is needed, employees should contact their departmental leave coordinator to discuss options. Employees can take up to 60 days of leave within a 12-month period to support organ donation. The first 30 days of organ donation leave are paid by the County. Employees may request an additional 30 days of protected time off and use accrued time or may choose to take the additional days without pay. It is important to note that this leave covers all appointments and activities related to the official donation process.
For more information, see PPG 701 – Time Off for Bone Marrow and Organ Donation.

NOTE

See DHS Policy No. 756.6 for detailed guidelines on FMLA, or contact fmlaunit@dhs.lacounty.gov for assistance.

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TIME OFF TO VOTE

California law allows you to take up to two hours off to vote in a statewide election without losing any pay, if you do not have sufficient time outside of working hours to vote. On Election Day, polls are open between 7:00 AM and 8:00 PM. If you are scheduled to be at work during those hours and need to take time off to vote, you may take as much time as you need, but only two hours of that time will be paid. You should also consider taking advantage of the Early Voting or Voting by Mail resources that are available to all Los Angeles County registered voters.

Your time off to vote can only be at the beginning or end of your regular work shift, whichever allows the most free time to vote and the least time off from your regular working shift, unless you make another arrangement with your supervisor. You must notify your supervisor at least two working days prior to the election if you need to take time off to vote.

PERSONAL LEAVE FOR VICTIMS OF DOMESTIC VIOLENCE

Employees who are victims of domestic violence, sexual assault, or stalking may be allowed time off from work to attend to legal issues, obtain medical assistance (physical or mental), safety planning, arrange relocation for him/herself or a child, and/or obtain related services. Such employees shall inform management in a reasonable amount of time in advance, if feasible, of the need to take time off for such reasons and provide appropriate documentation (e.g., police report, court order, medical certification).

California law prohibits employers from discharging, threatening to discharge, demoting, suspending, discriminating, or retaliating against an employee who takes a leave of absence or leave of absence to attend legal proceedings resulting from a crime against the employee, asks for leave to obtain assistance, or asks for reasonable accommodations to ensure a safe work environment for the employee, their immediate family or registered domestic partner.

Any employee who feels that they have been discriminated or retaliated against as a result of a leave of absence for these purposes may file a complaint with the Division of Labor Standards Enforcement of the California Department of Industrial Relations.

RETIREMENT

The Los Angeles County Employee Retirement Association (LACERA) is the agency that administers retirement plan benefits for Los Angeles County employees. Most plans available are contributory retirement plans, meaning both you and the County contribute to it. Semimonthly contributions are through automatic payroll deduction. Placement in a plan is determined by LACERA membership date.

- General Information
  - Membership is a condition of employment for all permanent employees
  - "Defined benefit" retirement plans (pays you a specific monthly benefit for the rest of your life)
  - Safety members—Plan C
  - General Members—Plan G
  - Contributions rates are based on a flat rate % of base salary
  - Enrollment deadline—60 days after hire
- LACERA's new membership process
  - Go to website: www.lacera.com or call (800) 786-6464
  - Watch your mailbox for the latest issue of PostScript, the quarterly newsletter for active members
- Any questions? Contact your Human Resources office

Freepik.com

ADDITIONAL EMPLOYMENT BENEFITS

INSURANCE BENEFITS

Employees can choose from a variety of pre-tax and after-tax benefits

- Flexible Benefit Plans
- Options, Choices, Megaflex
  - Each plan offers medical, dental, group term life, AD&D, and health and dependent care spending accounts.
  - Part-time employees (except student positions) who work an average of 20 hours or more per week during a period of three (3) consecutive months may be eligible to enroll in a County medical plan.
- Must enroll within 60 days of hire at mylacountybenefits.com

DEFERRED INCOME PLANS

Employees may voluntarily participate in supplemental retirement plans

- Deferred Compensation & Thrift Plan (Horizons) 457 (b) (full-time permanent employees)
- Savings Plan 401(k) (full-time permanent, non-represented employees)
- Contact Empower Retirement
  - Go to website www.countyla.com or call (800) 947-0845

Employees may voluntarily participate in these additional benefits to help them save money and maintain or promote a healthy lifestyle.

- Spending Account (medical and child/elder/dependent care)
- Wellness Program
- Commuter Benefits Plan (pre-tax savings on public transportation, vanpools, parking)
- Health Plan Continuation Coverage Rights (COBRA)
- Group Banking - (Provides special products and services for County employees)
- Visit https://my.lacounty.gov/ on the County Intranet to view more benefit details

LACTATION ACCOMMODATION

DHS provides designated private lactation rooms near an employee's work station. The lactation time shall run concurrently with the break time, and, if possible, the already established break time. Employees requiring additional breaks or extended break times will be granted additional, unpaid time or an extended work shift equivalent to the extended or additional breaks. The location may include the employee's normal work area, such as a private office, if it meets the requirements of the policy.

Covered employees may use earned accrued time to cover the unpaid break time. Managers, supervisors and employees may also agree, based on the needs of service, to adjust the employee's work schedule to cover the unpaid break time.

To request accommodation under this policy, speak to your supervisor/manager or your facility's Return-to-Work coordinator.

Breastfeeding and lactation are promoted under County policy and shall not constitute a source of discrimination in employment or in access to employment. It is prohibited to harass a breastfeeding and/or lactating employee. Such conduct may unreasonably interfere with an employee's work performance and creates an intimidating, hostile or offensive working environment. Any incident of harassment of a breastfeeding and/or lactating employee will be addressed in accordance with the County's policies and procedures. Non-compliance could result in citation and a civil penalty for each violation. The procedures for citations and civil penalties are provided for in state and federal laws.

LACTATION ACCOMMODATION LOCATIONS

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
Hubert H. Humphrey Comprehensive Health Center	5850 S. Main St. Los Angeles	2nd Floor, Room 2032	Latasha Smith issmith@dhs.lacounty.gov Marla Villicana mvillicana@dhs.lacounty.gov	(323) 897-6363 (323) 897-6369
High Desert Health Center Group: High Desert Reginal Health Center	335 East Avenue I Lancaster, CA 93535	Employee Health Fit Testing Room 2D29	Mary Flint-Herrera, RN mflint-herrera@dhs.lacounty.gov	(661) 471-4342
High Desert Health Center Group: South Valley Health Center	38350 40th Street East, Suite 100 Palmdale, CA 93552	Pediatric Clinic Conference Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019
High Desert Health Center Group: Antelope Valley Health Center	335 East Avenue K-6, Suite B Lancaster, CA 93535	Lactation Room (Off main lobby, across from Business Office entrance)	Neelu Malhotra, RN NMalhotra@dhs.lacounty.gov	(661) 471-4822
High Desert Health Center Group: Littlerock Community Clinic	8201 Pearblossom Highway Littlerock, CA 93543	Employee Break Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019
High Desert Health Center Group: Lake Los Angeles Community Clinic	16921 East Avenue O, Space G Palmdale, CA 93591	Employee Break Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019
Mid-Valley Comprehensive HC	7515 Van Nuys Blvd. Van Nuys, CA 91405	5th floor, Room 560	Dolores Lopez dlopez@dhs.lacounty.gov	(818) 627-3060
Glendale HC	501 N. Glendale Ave. Glendale, CA 91206	Room 112	Sylva Aghmalian, RN saghmalian@dhs.lacounty.gov	(818) 627-3282
San Fernando HC	1212 Pico Street San Fernando, CA 91340	Exam Room #133	Irma Pineda, RN icpineda@dhs.lacounty.gov	(818) 627-4720 (818) 627-4721
West Valley HC	20151 Nordhoff Street Chatsworth, CA 91311	Exam Room #5	Mary Joan Centina, RN mcentina@dhs.lacounty.gov	(818) 627-3078
Long Beach CHC	1333 Chestnut Ave. Long Beach, CA 90813	2nd Floor Staff Lounge, Women's Restroom (212-5)	Jacqueline Valle jvalle@dhs.lacounty.gov	(562) 753-2310
Wilmington HC	1325 N. Broad Ave. Wilmington, CA 90744	Station C, Intake Room	John Ibay jibay@dhs.lacounty.gov	(310) 404-2041
Bellflower HC	10005 E. Flower St. Bellflower, CA 90706	Suite 20, Room A3	Patricia Jimenez Pjimenez2@dhs.lacounty.gov	(562) 526-3028
Edward Roybal CHC	245 S. Fetterly Ave. Los Angeles, CA 90022	2nd floor Room 2250	Crystal Diaz crystaldiaz@dhs.lacounty.gov	(323) 362-1493
MLK OPC	1670 E 120th St Los Angeles, CA 90059	1st Floor N. Support Building Room 1H04	Leonor Bango lbango@dhs.lacounty.gov	(424) 338-1001

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
El Monte CHC	10953 Ramona Blvd. El Monte, CA 91731	2nd Floor Room 2148	Rosalinda Villalobos rvillalobos@dhs.lacounty.gov	(626) 434-2800
Hudson CHC	2829 S. Grand Ave. Los Angeles, CA 90007	1st Floor, Room 1296	Tyrone Clark tyclark@dhs.lacounty.gov	(213) 699-7270
Juvenile Court Health Services Administration	1925 Daly St.1st Floor Los Angeles, CA 90031	First Floor Women's Lounge, Women's Restroom	Elena Laurich Elaurich@dhs.lacounty.gov	(323) 986-2240
Health Services & DPH Administration	313 N. Figueroa St. Los Angeles, CA 90012	7th Floor Women's Lounge	Melanie Pascua MPascua@dhs.lacounty.gov HSAFMD@dhs.lacounty.gov	(213) 288-8129
Health Services & DPH Administration	5555 Ferguson Drive Commerce, CA 90022	3rd Floor Room 3023	Marisela Alderete malderete@ph.lacounty.gov	(323) 659-6029
Health Services Office of Patient Access Central Contact Center	1000 S. Fremont Ave Alhambra, CA 91803	Building A9E 6th Floor, South/West Wall	Dezerae Jordan dezjordan@dhs.lacounty.gov	(323) 987-4706
Los Angeles General Medical Center	2051 Marengo St. Los Angeles, CA 90033	1st Floor – Inpatient Tower Room C1C102	LA-General-Lactationrooms@dhs.lacounty.gov with first, last name, and employee number for access requests Coordinator: Angela Baca-Cooper Assistant: Christina Iniguez	(323) 409-2800
Los Angeles General Medical Center Outpatient	2010 Zonal St. Los Angeles, CA 90033	Outpatient Tower 5P45	LA-General-Lactationrooms@dhs.lacounty.gov with first, last name, and employee number for access requests Coordinator: Angela Baca-Cooper Assistant: Christina Iniguez	(323) 409-2236
La Puente Health Center	15930 Central Ave., La Puente, CA 91744	1st Floor, Room 102-A	Israel Castellanos lcastellanos@dhs.lacounty.gov	(626) 434-2820
Rancho Los Amigos NRC	7601 Imperial Hwy. Downey, CA 90242	Harriman Bldg. Room 2016 Outpatient Bldg. Room 2079 Support Services Bldg., Room 2034	Verenice Lopez-Arevalo vzepeda@dhs.lacounty.gov	(562) 401-7651
Olive View-UCLA Medical Center	14445 Olive View Drive Sylmar, CA 91342	4B126	Administrative Nursing Office Monica Duran, RN mduran4@dhs.lacounty.gov Danielle De Vito, RN ddevito@dhs.lacounty.gov	(747) 210-3170
Harbor-UCLA Medical Center	1000 W. Carson St., Torrance, CA 90509	7th Floor West Room 20 Professional Building Lactation Room	Trecilla Samson TSamson2@dhs.lacounty.gov Minda Madrid LMadrid@dhs.lacounty.gov	(424) 306-4029 (424) 306-4336

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
Harbor-UCLA Medical Center Family Medicine Clinic	1403 Lomita Blvd., Harbor City, CA 90710	Module C, 2nd Floor	Rochaun Smith RSmith@dhs.lacounty.gov	(310) 897-6363 Pager: (310) 501-0259
CHS – Men's Central Jail	441 Bauchet St., Los Angeles, CA 90012	Female Locker Room	Elvia Trujillo Etrujillo2@dhs.lacounty.gov	(213) 972-2212
CHS – Twin Towers Correctional Facility	450 Bauchet St., Los Angeles, CA 90012	Room E234	Elvia Trujillo Etrujillo2@dhs.lacounty.gov	(213) 972-2212
CHS – Central Regional Detention Facility	11705 S. Alameda St., Lynwood, CA 90262	Room 3132	Elvia Trujillo Etrujillo2@dhs.lacounty.gov	(213) 972-2212
EMS Agency	10100 Pioneer Blvd., Suite 200 Santa Fe Springs, CA 90670	2nd Floor EMS Agency in the Paramedic Training Institute Library	Jacqui Rifenberg jrifenburg@dhs.lacounty.gov	(562) 378-1640
EMS Agency Warehouse	10430 Slusher Drive, Santa Fe Springs, CA 90670	Room #7	Terry Crammer tcrammer@dhs.lacounty.gov	(562) 378-2445

Image by: Freepik

HEALTH AND WELLNESS

The goal of the County's Wellness Program is to improve the health and productivity of County employees and lessen their health-related costs, mainly by helping employees change their lifestyle patterns through wellness initiatives.

As outlined in the Memorandum of Understanding (MOU), the County and SEIU Local 721 agreed to cooperate in developing an employee wellness program called "My Health is My Wealth." A joint labor-management subcommittee on Employee Wellness coordinates worksite wellness activities to promote the health and well-being of County employees. The County provides a variety of pro-grams and resources to encourage and support employee wellness through:

- Health Connection Seminars
- Wellness Webinars
- Wellness Fairs
- Civic Center Exercise Classes

For more information on any Los Angeles County Wellness Program.
send an e-mail to: workplaceprograms@hr.lacounty.gov
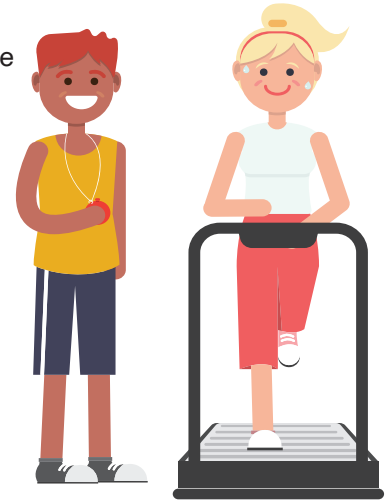
RESPECTFUL WORKPLACE

The Department of Health Services (DHS) is committed to fostering a professional and healthy workplace, where all workforce members are treated with dignity and respect. Disrespectful and disruptive behavior, including workplace bullying, is not accept-able. DHS supervisors and managers are responsible for treating complaints of bullying seriously, whether between co-workers or a supervisor and subordinate; addressing disruptive conduct; and promoting a professional and respectful work environment.

What can you do to build a healthy, professional, and safe work environment?

Employees throughout DHS can **help build a healthy workplace** by adopting the following values:

- Honor DHS' mission and give the public, our patients and your co-workers extraordinary care
- Be fair to each other, build trust, and support teamwork
- Strive to resolve conflict and disruptive behavior early on and at the lowest possible level
- Communicate effectively and respectfully
- Always display a professional demeanor
- Acknowledge and respect power dynamics between and among co-workers

HEALTH SCREENING

All workforce members who work in a DHS healthcare facility, including students, volunteers, and non-DHS/non-County workforce members, must have an initial and annual health screening. This includes, but is not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease screening, and/or any other medical tests, as indicated. 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. You may contact the facility Employee Health Services to find out when your health screening 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 Centers for Medicare & Medicaid Services (CMS) standards for a workforce member to work without appropriate health clearance and will subject the facility to possible accreditation citations.

Images by Freepik

NOTE

You must complete your health screening <u>annually</u>.

SMOKING POLICY

Smoking is not permitted inside any DHS building, structure, or vehicle. Additionally, smoking shall not be permitted within 50 feet of main entrances, exits, and operable windows of any occupied building, within 25 feet of an access ramp or disabled path, or a County parking lot, parking structure, or parking garage. Smoking is permitted only in the approved outdoor designated smoking areas, if any. Some DHS facilities have implemented a smoke-free environment. The smoking prohibition includes e-cigarettes (vaping/liquid tobacco) and cannabis/marijuana.

SUBSTANCE ABUSE

All workforce members must report to work free of the influence of alcohol, illegal drugs or improperly used prescription drugs. Reporting to work under the influence of alcohol, illegal drugs, misused prescription drugs, or possessing, manufacturing, or selling illegal drugs while on County time/business will result in appropriate discipline.

Workforce members who observe any usage of alcohol, illegal drugs or misuse of prescription drugs must report the incident to their supervisor, facility Human Resources or Performance Management representative, a member of management, and/or the facility police personnel.

DHS management teams should be trained in reasonable suspicion procedures. Managers and supervisors can access the mandatory Drug Free Workplace: Reasonable Suspicion Training module in TalentWorks. Contact DHS Performance Management Unit with any questions related to reasonable suspicion.

BODY MECHANICS

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

Why You Should Practice Good Body Mechanics
- To prevent injury to yourself, patients, and others
- To prevent cumulative trauma disorders, such as carpal tunnel syndrome
- To maintain good general health
- To increase capacity to work comfortably
- To reduce stress and fatigue while working

Maintaining Good Body Mechanics

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

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

GUIDELINES FOR DECREASING MUSCULOSKELETAL INJURY

General Guidelines for Maintaining Proper Body Mechanics During Activity

- Plan your actions!
  - Test the load, making sure that you can handle the weight.
  - Get help when necessary.
- Use proper footwear. Look for properly fitting shoes that are low heeled.

- If wearing a lab coat, minimize items carried in your pockets and distribute the load evenly between the pockets to minimize strain on the neck and shoulders.
- Wear clothing that allows your body to move.

Reaching

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

Twisting/Turning

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

Standing

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

Patient Transfers

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

Equipment/Object Transfer

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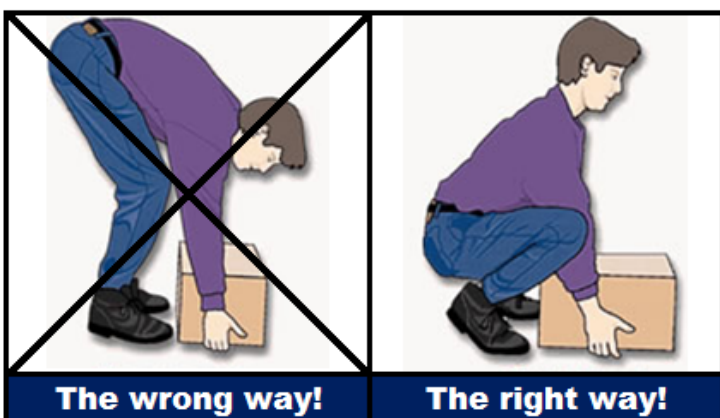
The wrong way!   The right way!

MarineInsight

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!

REPORTING WORK RELATED INJURIES/ILLNESSES

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

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

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

- Prevent the pain, suffering, and loss that workforce members and their families experience due to work-related injuries or illnesses.
- Enhance productivity by reducing lost time caused by work-related injuries or illnesses.
- Comply with California Code of Regulations, Title 8, Section 3203.
- Conduct periodic inspections to identify unsafe conditions and work practices.
- Investigate occupational injury or occupational illness.
- Correct unsafe or unhealthy conditions in a timely manner based on the severity of the hazard.
- Provide safety training and instruction to all workforce members.

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

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES)

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

To schedule an appointment, call during regular office hours (see Quick Reference for details). 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. 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.

VEHICLE TRIP REDUCTION - RIDESHARING

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.

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There are a number of benefit 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; 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 (unexpected overtime, personal illness/ family emergency) up to 4 times a year.
✓	**ALTERNATIVE WORK SCHEDULES (COMPRESSED WORK WEEK)**	Working a 4/40 or 9/80 work schedule can reduce traffic and air pollution. Discuss this management option with your immediate supervisor or manager.
✓	**FLEXIBLE WORK SCHEDULES**	Rideshare doesn't fit your schedule? Employee work schedules 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.
✓	**COMMUTER BENEFIT PLAN**	Save money by enrolling in the County's Commuter Benefit Program. Elect to purchase your bus, train, or vanpool fare using pre-tax dollars. This lowers your taxable income, resulting in annual tax savings.
✓	**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. The Electrifyze Program is available to answer all your electric vehicle questions and can help you purchase an electric vehicle. Refer to the County's 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!

Rideshare L.A. County

TAKE PRIDE, SHARE THE RIDE!

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 Rideshare Website at http://rideshare.lacounty.gov/

AVAILABLE RESOURCES

- Events & Resource Calendar

- Workplace Concerns

- Social Justice

- Career, Training, & Finances

- Workforce Collaboratives

- H3

CLICK HERE

Workforce Well-Being

Well-Being for Everyone!

As Los Angeles County Employees it is important that we prioritize our workplace and personal well-being. Take a moment to explore the **DHS Workforce Well-Being** site for resources, guidance and information about how to care for yourself and each other.

https://lacounty.sharepoint.com/sites/dhs-wellness

Open smart device camera and scan this code to connect and view content

LEARNING AND DEVELOPMENT

The Department of Health Services values continuous learning and development. Workforce members are given the tools to grow and are continually challenged to work at the peak of their skill set. Below you will find information on training and competency, competency assessment, performance evaluations, and the Management Appraisal and Performance Plan.

TRAINING AND COMPETENCY

You are mandated to complete orientation **within 30 days** of hire and/or transfer of assignment to a facility. 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. Ongoing competency assessment is required annually or as needed (i.e. new equipment, new procedure/policy, remedial education process, etc.), and must be documented in your area file. You must also complete all mandatory trainings and competency certification requirements for your position (e.g., orientation, infection control, fire/life safety, emergency management, CPR and other core competencies).

The County has established mandatory trainings for all DHS workforce members. Workforce members are expected to comply with completion of mandatory trainings by their deadlines.

Mandatory trainings include:

• Sexual Harassment and Discrimination Prevention Training (SHDPT)
• County Policy of Equity (CPOE)
• Disaster Service Worker (County employees only)
• Privacy & Security Survival Training (HIPAA)
• CSEC 101: The Commercial Sexual Exploitation of Children
• Implicit Bias and Cultural Competency: An Introduction
• Defensive Driver (Mileage Permittees)
• Compliance Awareness Training (CAT)
• Cyber Security Awareness Training 2023
• Workplace Violence Prevention
• Safe Youth Zone Initiative

Mandatory trainings have also been established for managers/supervisors that include the above plus the following:

• Fair Labor Standard Act Essentials
• Assembly Bill 1234 (Ethics)
• Drug Free Workplace: Reasonable Suspicion Training
• Domestic Violence Awareness.

Click here for a full list of Mandatory Training Requirements.

COMPETENCY ASSESSMENT

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 by participating in the Department's ongoing competency assessment and skills validation process.

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 maintain their professional credential(s) and enhance their job skills by attending mandatory training(s) 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 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.

Refer to DHS Policy 780.200 for additional information on the competency assessment process.

PERFORMANCE EVALUATION

All DHS workforce members will be given a job description/work plan upon assignment and shall receive a performance evaluation (P.E.) based on that job description/work plan at the end of the 6-month or 12-month probationary period, and annually thereafter. Exceptions: Physicians and mid-level providers comply with credentialing privileging requirements.

Non-County workforce members receive performance assessments at 6-months or 12-months from the beginning of their assignment, and annually, thereafter. The immediate supervisor will discuss the job description/work plan, and area/unit expectations with the workforce member.

A current performance evaluation with a rating of "competent/met expectations" or better is required to be eligible for salary/step increases. Physicians subject to the Physician Pay Plan must achieve a "met expectations" or better to receive their step/merit increase.

> For detailed guidelines, refer to DHS Policy 780.000.
>
> Work plans (job descriptions) can be viewed and acknowledged, and most performance evaluations can be completed in TalentWorks at https://lacounty.csod.com/ by clicking the Performance tile.
> For technical assistance and performance evaluation questions,
> contact regulatorycompliance@dhs.lacounty.gov.
> Performance evaluation training is available on TalentWorks.

MANAGEMENT APPRAISAL AND PERFORMANCE PLAN (MAPP)

The Management Appraisal and Performance Plan (MAPP) was developed to evaluate and compensate executive level and senior management staff. Staff at this level are expected to help achieve County and DHS priorities and goals like delivering quality services to County residents while reducing costs and realizing expected revenues. To be eligible for a salary/step increase, a MAPP participant must receive a rating of "met expectations" or better.

> **NOTE**
>
> MAPP orientation is available and can be scheduled by contacting DHS Human Resources, Regulatory Compliance.

EMPLOYEE STANDARDS OF CONDUCT

This section discusses your rights and responsibilities as a workforce member. This includes behavioral expectations, Security of Confidential Information, the County Policy of Equity and other essential information.

PROFESSIONAL APPEARANCE

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

All clothing must be professional and consistent with both our business atmosphere and health care standards and must not interfere or detract from our mission. It must be appropriate to the type of work being performed and take into consideration the expectations of our patients and customers. Your DHS photo identification badge must be worn above the waist at all times while on duty and in County facilities.

NOTE

See DHS Policy No. 706.1, Business Office Dress Policy, for detailed guidelines.

TIME REPORTING

Each employee is held accountable for complete and accurate time reporting daily.

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

DHS uses eHR web-based timesheets (TIMEI) for documenting and recording time worked and time off. DHS is transitioning to a new acuity, scheduling, and time system (ASTER). Some workforce members will be using the ASTER system to punch in/out or record their time, while others will be using the TIMEI until ASTER is implemented at their facility.

ATTENDANCE/TARDINESS

You are expected to report to work each day and arrive on time in accordance with your work schedule. You are required to notify your supervisor if you are going to be late or absent as established by DHS, facility and/or departmental policy.

WORK HOURS/WORK WEEK

Your manager/supervisor is responsible for establishing your work hours, which include 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. 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. Rest periods/breaks and the meal period cannot be used to cover a tardy or shorten the workday. Rest periods/breaks cannot be combined to lengthen the meal period unless as noted below and approved by management (DHS Policy 750):

1. Based on the needs of the department and current workloads, exceptions such as combining meal and breaks (noting that the breaks are paid breaks) may be an acceptable practice. A manager/supervisor who requests a waiver (to combine breaks), must demonstrate, that all reasonable efforts were taken to notify and encourage employees of their right to take breaks during an appropriate break schedule. The waiver would be for the needs of the entire department, unit, or area and not on an individual basis.

2. If a manager/supervisor determines that a request for a waiver is necessary, they must submit a memo through the appropriate chain-of-command to DHS Human Resources, Employee Relations, establishing justification for the request. Employee Relations will review the request for appropriateness, and if determined to be justified, make a recommendation for approval to the Chief, Audit and Compliance.

Alternate work schedules (9/80, 4/40) may be available and approved at the discretion of management.

WORKFORCE BEHAVIORAL EXPECTATIONS

All workforce members are expected to conduct themselves in a courteous, cooperative and professional manner at all times.

Disruptive, inappropriate, or unprofessional conduct by any workforce member toward another workforce member, the public, or patients is unacceptable.

Disruptive conduct 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, like angry verbal outbursts, throwing objects, or disrespectful language. 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. 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.

ACKNOWLEDGEMENT OF EMPLOYEE RESPONSIBILITIES

It is the responsibility of every County and Non-County workforce member to conduct themselves in a manner consistent with federal and state laws, and County policies. Federal and state laws, the Los Angeles County Code, and policies of the County and its departments prohibit conduct by County employees in the workplace that is considered unlawful discrimination, including creation of a hostile work environment based on race, color, gender, age, disability, sexual orientation, gender identity, gender expression, pregnancy, sexual harassment, socioeconomic status, and retaliation.

This is a reminder that conduct that violates these laws or County policies could subject an employee to personal liability for damages in court proceedings and/or disciplinary action by the County.

COUNTY POLICY OF EQUITY (CPOE)/SEXUAL HARASSMENT/GENDER NON-DISCRIMINATION

The purpose of the County Policy of Equity is to preserve the dignity and professionalism of the workplace as well as to protect the right of employees to be free from discrimination, sexual harassment, unlawful harassment (other than sexual), retaliation and inappropriate conduct toward others based on a protected status. Any such conduct is contrary to the values of the County and a violation of the Policy of Equity. Such conduct may also be illegal under local, county, state, and federal law.

The County will not tolerate unlawful discrimination on the basis of age (40 and over); ancestry; color; ethnicity; religious creed (including religious dress and grooming practices); denial of family and medical care leave; disability (including mental and physical disability); marital status; medical condition (cancer and genetic characteristics); genetic information; military and veteran status; national origin (including language use restrictions); race; sex (including pregnancy, childbirth, breastfeeding, and medical conditions related to pregnancy, childbirth, or breastfeeding); gender; gender identity; gender expression; sexual orientation; and any other characteristic protected by state or federal law. Further, the County will not tolerate retaliation for filing a complaint under the Policy or similar state or federal law, for participating in an administrative investigation or proceeding under the Policy, for performing duties under the Policy, or for otherwise opposing conduct prohibited by the Policy.

As a preventive measure, the County also will not tolerate inappropriate conduct toward others based on a protected status, even if the conduct does not meet the legal definition of discrimination or unlawful harassment. All County employees are responsible for conducting themselves in accordance with this Policy and its associated Procedures. Violation of the Policy and/or Procedures will lead to prompt and appropriate administrative action including, but not limited to, counseling, training, written warning, written reprimand, suspension, demotion, or discharge.

The law prohibits coworkers, supervisors and managers, and third parties from engaging in conduct prohibited by the Fair Employment and Housing Act (FEHA).

All County employees are required to conduct themselves in accordance with this Policy, and all applicable local, county, state, and federal laws.

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

It is the responsibility of all workforce members to ensure discrimination, sexual harassment, retaliation, harassment (other than sexual), third person harassment, and inappropriate conduct toward others does not occur in the workplace. Any workforce member who believes he or she has been the object of, has witnessed, or has been affected by inappropriate behavior shall report the action or incident to his or her manager/supervisor, hospital or Comprehensive Health Care Center Chief Executive Officer, facility Human Resources office, or the County Equity Oversight Panel.

PROHIBITED CONDUCT

Each County employee is responsible for understanding and abiding by the following definitions of prohibited conduct as they may impact any administrative process/proceeding for potential violations of this policy and/or associated procedures.

Discrimination
Discrimination is the disparate or adverse treatment of an individual based on or because of one or more of the protected classes listed above.

Sexual Harassment
Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other verbal, visual or physical conduct of a sexual nature which meets any one of the following criteria:
- Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment;
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
- Such conduct has the purpose or effect of unreasonably interfering with the individual's employment or creating an intimidating, hostile, offensive, or abusive working environment.

Unlawful Harassment (Other than Sexual)
Unlawful harassment of an individual because of one or more of the protected classes above 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, they assume the risk that someone may pass by or otherwise witness the behavior; the County considers this to be the same as directing the harassment towards that individual.

Inappropriate Conduct Towards Others
Inappropriate conduct toward others is any physical, verbal, or visual conduct based on or because of one or more of the protected classes listed above 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 the 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, up to and including discharge from County service. 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.

GENDER IDENTITY AND GENDER EXPRESSION NONDISCRIMINATION

Existing anti-discrimination laws such as the Fair Employment and Housing Act and the Unruh Civil Rights Act prohibit discrimination based on certain protected characteristics. Under AB 887 (Atkins), Chapter 719, Statutes of 2011, gender, gender identity and gender expression are added as protected characteristics. Gender expression can mean gender-related appearance and behavior. AB 887 grants workforce members the right to appear or dress consistently with their gender identity and gender expression in the workplace.

REPORTING VIOLATIONS OF THIS POLICY

Any County employee who believes to have been subjected to conduct that potentially violates this Policy is strongly encouraged to report the matter to a supervisor or manager, whether the employee is or not directly supervised by that person, or to the County Intake Specialist Unit (CISU). The CISU may be reached by phone: 1-855-999-CEOP (2367) or via its website: https://ceop.lacounty.gov/ and is located at: Kenneth Hahn Hall of Administration, 500 West Temple Street, Room # B-26, Los Angeles, CA 90012.

Any County employee who believes they have been subjected to conduct that potentially violates this Policy has the right to, without undue obstruction or interference, report the potential violation to a supervisor or manager other than their direct supervisor. Any non-supervisory County employee who has knowledge of conduct that potentially violates this Policy is also strongly encouraged to report the matter.

County employees may also contact the California Department of Fair Employment and Housing (DFEH) by calling (800) 884-1684 or via their website at www.dfeh.ca.gov and/or may contact the Federal Equal Employment Opportunity Commission (EEOC) by calling (213) 785-3090 or (800) 669-4000 or via their website at www.eeoc.gov.

NEPOTISM

Nepotism is the practice of individuals with power or influence providing unfair advantage (personal, economic, or employment) to a relative or someone with whom the individual in power has a personal relationship.

Employees shall not supervise or be placed in positions of interrelated trust with a relative and/or someone with whom they have a personal relationship as defined by this policy. Workforce members are responsible for disclosing, in writing, any instance where they will be assigned to work or will work with someone who they have a personal relationship or is a relative at the time of hiring, promotion, reassignment, or when circumstances change that would require disclosure. This extends to relationships with non-County staff members, such as contractors, temporary agency employees, commissioners, or volunteers, where reporting or working arrangements may present a conflict of interest. Departments shall assess all relationships disclosed by employees to evaluate whether potential nepotism or conflicts of interest may occur and act as necessary in accordance with this policy.

Personal relationship is defined as a current relationship between persons as a result of cohabitation, romantic partnership or dating, financial partnership unrelated to official job duties, or any such other relationship as defined by the "Relative" section below.

A Relative is defined as any known relationship formed by blood, marriage, or adoption, such as an individual's:
- spouse, ex-spouse, domestic partner, ex-domestic partner
- child (including stepchild, adopted child, child of domestic partner, foster child)
- parent, stepparent, adoptive parent, legal guardian, foster parent
- sibling (including stepsibling, adoptive sibling, half-sibling)
- grandparent, grandchild, step or adoptive grandparent, step or adoptive grandchild
- father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, and similar relationships from a previous marriage or domestic partnership
- aunt, uncle, spouse of aunt or uncle, cousin, niece, or nephew

STAFF RIGHTS IN PATIENT CARE

DHS 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. Leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious beliefs conflict with the rendering of patient care. Speak with your supervisor to submit a request for consideration, to be excused from that aspect of patient care. Non-County workforce members should contact the facility contract administrator for terms and conditions of their contract.

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

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.

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. Physicians and health care providers shall avoid any situation that may be construed as sexual misconduct.

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, their family member, or legal representative has the right to file a complaint or grievance, without fear of retaliation, with the patient advocate, patient relations, or other designated section of the hospital, and to have timely review and notification.

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 their supervisor and to the facility Los Angeles County Sheriff's Department.

The Department is prohibited from taking disciplinary action against a workforce member for making a good faith report.

IMPLICIT BIAS

What is Implicit Bias?

Implicit bias is defined as having an unconscious, hidden, or unknown preference. Implicit biases unconsciously affect our attitudes, decisions, and actions. Biases may be based on characteristics such as race, gender, or income.

How does Implicit Bias Impact Healthcare?

Implicit bias is not unique to healthcare. However, in healthcare, implicit biases may affect the way we interact with patients and provide care, even if we are not consciously aware of them. Every patient entering our facilities deserves the same level of care, no matter their appearance, race, age, gender, economic/social status, or other characteristics. Unconscious beliefs and assumptions can affect medical decisions and negatively affect an already vulnerable patient population.

Examples of implicit bias in healthcare include the following:
- Disparities in pain management; patients of color are less likely to be prescribed pain medication.
- Patients of color are less likely to receive cardiovascular interventions.
- Higher mortality rate for black women after being diagnosed with breast cancer.
- Lack of empathy toward minority patients.

Some actions you can take to help prevent implicit bias are:
- Exploring and confronting your own biases.
- Acknowledging the importance of implicit bias and its effect on healthcare.
- Recognizing which interactions with patients are based on stereotypes and reflecting on your response. Work to change similar future responses.
- Having a basic understanding of the cultures of the patients we serve.
- Practicing "evidence-based medicine".
- Embracing diversity and inclusion.

All workforce members are required to take the Implicit Bias and Cultural Competency training on TalentWorks.

Sources:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/
https://www.aafp.org/fpm/2019/0700/p29.html
https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-23-implicit-bias-in-health-care/implicit-bias-in-health-care/#.Yo1jh6jMKUk

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SAFE HAVEN/SAFELY SURRENDERED BABY LAW

California law, SB 1368 (Brulte) Chapter 824, Statutes of 2000 provides criminal immunity for any person with lawful custody of a newborn who is less than 72 hours old, if he or she voluntarily surrenders physical custody of the child to a workforce member at the facility. Newborn babies may also be safely surrendered at hospitals with emergency rooms and fire stations designated by the County Board of Supervisors. For a list of Los Angeles County's Safely Surrendered Baby Sites visit
https://lacounty.gov/residents/family-services/child-safety/safe-surrender/.
Child Protective Services must be notified as soon as possible, but no later than 48 hours.

Unsplash

PRIVACY OF PATIENT INFORMATION (HIPAA)

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

WHY DO WE NEED TO PROTECT PATIENT INFORMATION?

It is the right thing to do. Federal laws, the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and California laws require us to protect the privacy and security of all patient health information. These laws:
- Require 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 released.
- Give patients more rights and increase fines for violating the law.
- Protect all forms of patient health information, including paper, electronic, verbal, video, photos, etc.
- Require DHS to take additional steps to keep patient information safe, such as providing additional privacy & security training for workforce members to stay up to date with the vast amount of information and policies.

WHAT IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION?

Under HIPAA, a patient's health information is called **Protected Health Information (PHI)**. PHI is any health information created, used, stored, or transmitted by DHS that could be used to describe the health and identity of a patient.

Protected Health Information (PHI)
• Demographic information, e.g., name, address, phone number, e-mail address • Physical or health condition of a patient, e.g., diagnosis, condition, medications • Services or treatment provided, e.g., care plan, treatment records, progress notes • Payment information, e.g., medical record number, health insurance numbers, account number, credit card number, social security number, date of birth, date of death, dates of service • Other information about past, current and future medical/health care, e.g., photographs

Other laws also require the protection of **Personal Identity Information (PII)** which is electronic information that can be used to 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.

Personally Identifiable Information (PII)
PII includes an individual's first name or initial, and last name, in combination with any one or more of the following: • Social Security number (SSN). • Drivers license number or state-issued Identification Card number. • Financial account number, credit card number, or debit card number in combination with any required security code, access code, or password such as expiration date or mother's maiden name that could permit access to an individual's financial account. • Medical information (any information regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional). • Health insurance information (an individual's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records).

PII and PHI share some similarities under the law but are governed by distinctively different regulatory bodies. The best practice is to protect all information associated with a patient and follow the Department's policies related to patient privacy.

DHS defines "Restricted Information" as collectively including any PHI/ePHI, PII, confidential, sensitive or other data/information, in any form, which is protected by law, regulation, or DHS policy and must be protected.

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, DHS staff are required to provide patients with a Notice of Privacy Practices, usually during their first encounter or visit with us or anytime they request a copy. Under the Notice of Privacy Practices, patients have the right to:

- Access, inspect, and request copies of most of their PHI, except information the healthcare provider feels might be harmful to them.
- Ask us to send their health information to someone.
- Restrict who we can disclose their information, including verbally.
- Ask us to send their mail or call them at an alternative address or telephone number.
- Request corrections or changes to their medical record if they feel there is an error.
- Get a list of people or places where we sent their health information.
- 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 for processing.

USE AND DISCLOSURE OF PATIENT INFORMATION

- The patient's written permission is usually needed for us to disclose their health information to someone or an organization/agency.
- The patient's permission is not needed if the use or disclosure is for treatment (may include continuum of care), payment, healthcare operations; or as required by law, e.g., to certain agencies that protect the public.
- The ORCHID Amwell module is the only authorized platform for direct-to-patient/virtual healthcare visits.
- Microsoft (MS) Teams should only be used by DHS staff for educational rounds, clinician-to-clinician conversations, or staff meetings.
- A signed General Consent (Conditions of Admission) allows pictures or video of patients to be taken (only for clinical or medical reasons).
- The MS Teams application has replaced HIPAABridge and is the only DHS approved platform to be used for photos, videos, quick chats and file exchanges to ensure secure internal staff communications.
- Be sure to delete the quick chats and files from MS Teams as soon as the picture or video has been uploaded onto the electronic medical record or no longer needed. Pictures should not be stored indefinitely on a cellular device, OneDrive, Teams, or Home drive. The official storage for any document pertaining a patient is the electronic health record system.
- MS Teams may also be used for discussions regarding treatment between healthcare providers, including Instant messaging.
  - A separate written authorization signed by the patient is required if taking pictures or video of the patient for any reason not covered by the General Consent, such as research, education, publications, or news media.
  - The authorization must describe the purpose and use of the pictures or video and list any restrictions the patient or their legal representative has placed on its use.
  - The authorization is only good for that use. Another authorization will be needed to use the pictures or video for something else.

PROTECTING PATIENT INFORMATION

<u>SAFEGUARDS</u>

- Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients' PHI.
- You must have a legal or business "need-to-know" to access PHI. Your job duties determine how much patient information you can view or access, not your relationship to the patient.
- Your supervisor will arrange for you to obtain access to systems and networks necessary for you to do your job.
- It is a violation of HIPAA and state law to access or look at a patient's electronic medical record(s) without a business need; violations will be investigated.
- To protect our patients' privacy, patient access audits are conducted to detect unauthorized access to electronic medical records.
- To minimize the risk of a privacy breach or adverse patient safety event, take the time to verify the identity of the patient by using at least two patient identifiers, before providing them with documents and/or medications.
- Make sure all pages of documents such as discharge summaries, clinic summaries, and medications belong to the patient. Pages can get mixed up from shared printers.

- Patient information is often inputted/uploaded into the electronic medical record, and is used to make treatment decisions, therefore it's important to ensure the information and documents pertain to the correct patient.
- Immediately remove documents from fax machines and printers.
- PHI/Restricted Information, including photos should not be sent via SMS.
- Use a privacy screen or position monitors away from visibility by patients and/or the public.
- We must take reasonable safeguards or steps to make sure patient health information is kept private.

INCIDENTAL DISCLOSURES

- 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.
- Incidental disclosures do not violate laws if we take sufficient steps to protect the patient's privacy, such as closing exam room doors or privacy curtains, eliminating use of patient name while talking on phone, or using lowered voices to minimize the risk of others hearing the conversation.

DISCLOSING INFORMATION TO SPOUSES, FAMILY MEMBERS, AND FRIENDS

- Workforce members should use good professional judgment when disclosing health information to a patient in front of a spouse, family members or friends. It is best practice to ASK the patient before disclosing (e.g., a sensitive diagnosis that the patient may wish to keep private from the family member that came with them to their appointment).
- You should verify the identity of any caller (i.e. family member, spouse, etc.) requesting information about a patient. If possible, ask the patient if you can provide information about them to the caller.
- You can disclose the patient's information if the patient says it is okay or when asked, does not object, or if the person is the patient's legal representative.
- You should only talk about current relevant information.

DISCLOSING INFORMATION TO THE MEDIA

- It is against the law to sell patient information to the media.
- Call the facility Public Information Officer or the facility Privacy Manager immediately if the press or news media requests information about one of our patients.

DISCLOSING INFORMATION TO LAW ENFORCEMENT

Although HIPAA allows disclosures of PHI to law enforcement, state law is more restrictive and must be followed. Generally, a court order or subpoena is required. However, there are exceptions, and you should contact your supervisor, facility Privacy Manager and/or Risk Manager before sharing information about a patient with law enforcement.

DISCLOSING INFORMATION TO BUSINESS ASSOCIATES

DHS may disclose PHI to a contracted Business Associate (BA) only as necessary for the BA to perform the work for which they were contracted to perform. A contractor who is BA is required to sign a Business Associate Agreement.

Some examples of BAs include supportive housing services, collection agencies, food and nutrition services, information systems that interact with patient information. If you are unsure whether an entity has a contract and BAA, contact DHS Contracts and Grants or the DHS Privacy Office.

PHOTOGRAPHING AND RECORDING

Written authorization from the patient must be obtained prior to taking photographs, video, or audio recordings of patients.

- The General Consent/Conditions of Admission permits photographs for clinical purposes and certain healthcare operations. Other uses require a separate patient signed consent (e.g., publications, case presentations outside of DHS, media events, etc.) and must contain the specific reason and use which is only valid for that particular request.
- The MS Teams application is the only approved platform for photos and videos for secure internal staff communications. Facility-owned cameras, memory cards and other equipment may also be used for approved patient photography.
- Taking photographs or the recording of patients for your own personal use is strictly prohibited and violates privacy laws.

SOCIAL MEDIA

- Do not post photos or information about patients or work-related issues on social networking sites such as Facebook, Twitter, Snapchat, Instagram, TikTok, YouTube, Tumblr, Reddit, WhatsApp, etc.
- It does not matter if you are not using County equipment, if you are at home, or on your break.
- 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 (e.g., a public snapchat post of the hospital, the patient's condition and details about what happened to them can be seen by the patient's family member).
- Please keep the workplace professional. Do not take selfies or pictures where a patient or patient document(s) can be visible in the background.

INAPPROPRIATE ACCESS TO OR DISCLOSURE OF PHI

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 (e.g., friend, family member or person of the general public), you will violate DHS policies, HIPAA, and/or state law. If your family member, a personal friend, or workforce member is admitted to the hospital, you do not have the right to view or access their information in ORCHID even if you they provided you with their written or verbal consent/authorization. You must follow DHS policy and submit their written authorization to Health Information Management to obtain copies of the medical record.

DHS audits access to ORCHID and other applications/systems to ensure that workforce members only access the information needed to perform their job duties. Workforce members who inappropriately access a patient's health record will be investigated and subject to corrective or disciplinary action.

MINIMUM NECESSARY

- "Minimum necessary" means you must only access the information you need to do your job.
- Just because you have access to a system, network or 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.
- Only give out just enough information for someone else to do their job.
- If you are not assigned to the patient's care team or have a work-related justification to access a patient's medical record, you will be in violation of state and/or federal laws and regulations.
- It is a violation of the law to view confidential or patient information out of curiosity or "just because you want to know," even if you do not disclose the information to others. The mere fact that it was viewed may result in corrective or disciplinary actions. This includes famous people, close friends, neighbors, coworkers, and family members. You may also be held personally liable by the regulatory agencies or if a lawsuit is filed related to the impermissible access.
- All patient information is confidential and must always be protected.
- If you have been a DHS patient, you are not allowed to access your own patient information but may request access or copies of your medical record through the facility HIM.

SECURITY OF CONFIDENTIAL INFORMATION

The HIPAA Security Rule covers all electronic Protected Health Information (ePHI) when stored on computers and while being sent from computer to computer. ePHI is patient health information that is either accessed, stored or transmitted through computers, via an electronic media, or across remote servers. Each DHS facility must take reasonable steps to make sure ePHI is complete, protected, and available when someone needs it.

Examples of electronic media include:
- Computer networks, desktops, laptops and handheld computers, personal digital assistants (PDAs) and handheld digital equipment such as cameras, audio and video recorders, tablets (iPads, Androids, eReaders, etc.), and cellular telephones.
- Computer software and databases.
- Compact discs (CDs), digital versatile discs (DVDs), diskettes, USB storage devices such as flash/thumb drives, micro storage media, magnetic tapes, and any other means of storing electronic data. Data stored onto these media should be adequately secured so that any unauthorized access with be prevented. Never store files with sensitive content onto any non-DHS computer or cloud server.

Even a small incident is enough to wipe out important data from your laptop's hard drive or your flash drive. You should always store your important files in a location where your organization can regularly back them up. Always maintain at least one copy of the data stored on your portable devices on a network storage drive or DHS OneDrive cloud storage.

Privacy and security policies are posted on the DHS SharePoint 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.

E-MAIL

- All e-mail communications containing PHI/Restricted Information sent outside of the County's e-mail system must be encrypted to comply with state and federal privacy laws and DHS policies. Encryption is not required for e-mail sent to recipients whose e-mail account ends in "lacounty.gov." or "lasd.org," such as @dpss.lacounty.gov, @dmh.lacounty.gov, @ph.lacounty.gov, etc. However, you may choose to encrypt the e-mail.

- To encrypt an e-mail, type "Secure" in square brackets [Secure] in the subject line of the e-mail. Avoid including the patient's name in the subject line, However, do not send work-related e-mail containing PHI/Restricted Information to your personal e-mail account even if it is encrypted.

- Your e-mail account should not be used as storage device. If your e-mail account is phished or inappropriately accessed, the threat actor may have access to all of your e-mail. Save important e-mail in your share drive and delete those you no longer need. Remember to also empty your deleted item folder in your e-mail.

REMEMBER

County equipment is for County business purposes only.

SECURITY INCIDENTS AND POTENTIAL PRIVACY BREACHES CAUSED BY SOCIAL ENGINEERING

A more recent threat making headlines is Social Engineering. Unlike computer hacking, in which a cybercriminal uses their computer to break into other computers and steal their data, social engineering uses a person's willingness to help, vulnerabilities, sense of urgency, and fears against them to gain access to important personal information. The activities are designed to get you to willingly give up your personal information, mostly for their financial gain, or identity theft, etc. These social engineering attacks go by some interesting names: phishing, smishing, and vishing.

Freepik

PHISHING

Phishing is the most common method used by cybercriminals to gain access to information contained in e-mail, including internal e-mail contacts, computers and servers. Cybercriminals send familiar looking e-mail pretending to be a workforce member, charitable organization, healthcare program or agency, or e-mail provider, asking you to click on a link to a fake website or document, download a malicious attachment, or reply to a fake request with your username and password; sometimes making threats if you do not comply. If in doubt, report the e-mail via the " 🐟 " button or contact the DHS Enterprise Helpdesk at Helpdesk@dhs.lacounty.gov or at (323) 409-8000 so that one of their experts can validate its legitimacy for you.

Some telltale signs of a potential phishing or malicious e-mail:

• Does the tone of the e-mail typically represent the sender? Be extra cautious if the e-mail style is not the way the sender generally communicates with you. Beware of e-mail that is unexpected or where the content does not appear to directly apply to you.
• Are there any grammar, spelling errors or typos? E-mail from legitimate sources should be free of grammar and spelling errors.
• Are there any threats or a sense of urgency to the e-mail? E-mail that threatens negative consequences or demands immediate action should be treated with suspicion.
• Does the e-mail direct you to a link or direct you to input your credentials in order to open an attachment? Beware of unexpected e-mail, especially if it contains links and/or attachments. Most legitimate companies do not ask for personal information through e-mail.
• Verify sender(s) e-mail addresses, domains, or links are from a reliable source. Look for spelling discrepancies and verify links. Hover your cursor over the sender's e-mail address and the link to see the actual web address, but DO NOT click on it. Ensure the links match. For example, if the e-mail is allegedly from PayPal, but the domain of the link does not include "paypal.com", it's likely phishing. If the domain names don't match, don't click.
• Be especially suspicious of any Microsoft Office e-mail attachment that advises you to enable macros to view its content. Unless you are sure it is a genuine e-mail from a trusted source, do not enable macros and instead immediately delete the e-mail.

Scenario:

An employee from a County department falls victim to a phishing attack. The cybercriminal sends an e-mail that appears to be from the phished employee and includes a malicious attachment to everyone in the employee's contacts. If just one DHS employee falls victim to the scheme, the cybercriminal can continue sending e-mail to the DHS employee's contacts and obtain copies of e-mail and any attachments that may contain patient, employee and/or confidential data.

The following ten-step examination process can help identify a possible phishing e-mail:

1. External Tag: If you receive an e-mail from someone that appears to be a colleague or a Departmental Executive, and the e-mail is tagged with the yellow banner indicating the e-mail was generated outside of the County, beware! This **MAY** be a phishing attempt. Look for additional suspicious signs.

2. "From" Line: Check the spelling of the sender's e-mail address and verify the e-mail address by hovering your mouse/pointer over it; misspelling is likely an indicator of a spoofed e-mail.

3. "To" Line: Check to see if you know other people in the "to" line.

4. Hyperlink: Avoid clicking the hyperlink if the URL does not match the text. Hover your mouse/pointer over a hyperlink to see the destination URL before you click on it.

5. Time: Consider the time you receive the e-mail and compare it with the normal time you receive similar e-mail. E-mail sent in the middle of the night might be phishing.

6. Attachments: Avoid opening attachments you are not expecting.

7. Subject: Phishing attempts often use scare tactics to prompt immediate actions, such as "Change password immediately". Validate the source before you take any action.

8. Content: Check grammar and spelling; if they are incorrect, confirm the legitimacy of the message before clicking on the links or downloading any files.

9. Trust: Check if the source appears to be a known and trusted individual.

10. If the e-mail seems suspicious, **report it** through the **PAB** 🐟 **button.**
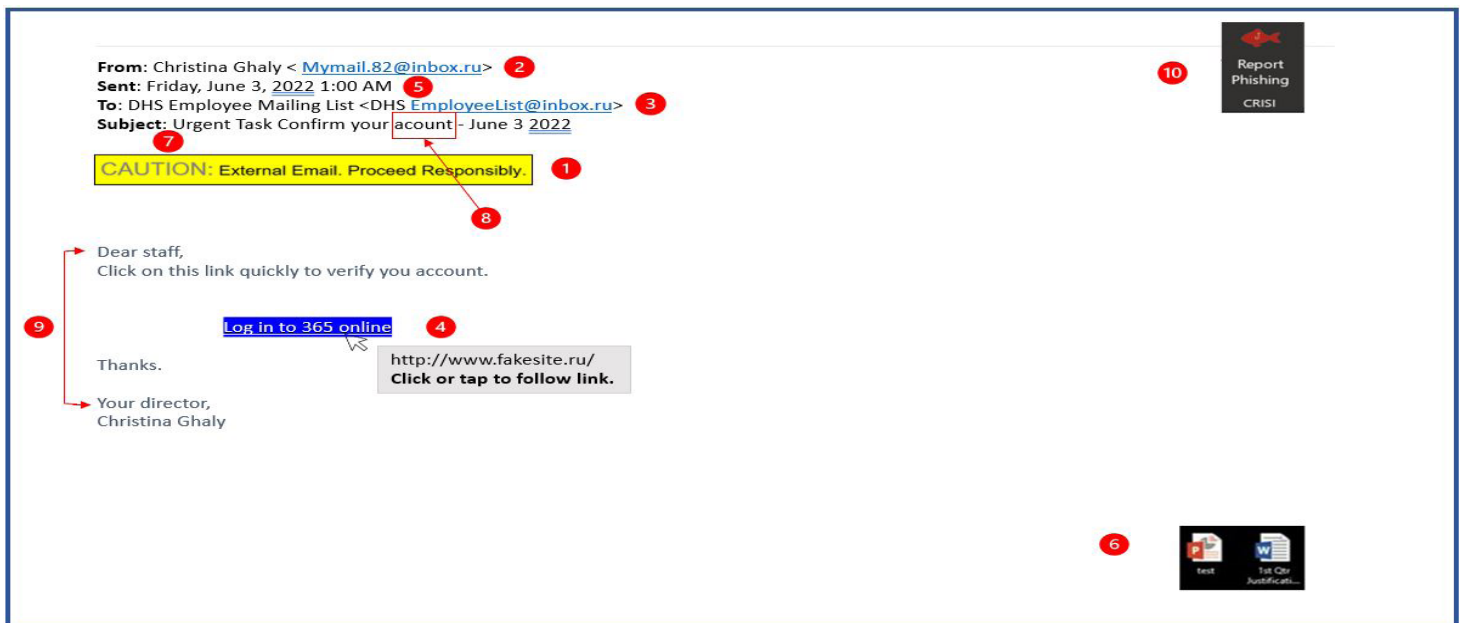
If the e-mail is SPAM, you may block the sender's e-mail address to avoid future junk e-mail.
Right-click a message from the sender you want to block, and then click Junk > Block Sender.

Ransomware typically infects a system through a phishing e-mail containing a malicious e-mail attachment, an infected software download, and/or visiting a malicious website or link. Once ransomware infects a system, it locks it down and the user's files are encrypted, or the user is restricted from accessing the computer's key features. The ransomware will send pop-up windows demanding the user to pay a specific ransom to reclaim or reactivate the computer.

If you are not sure about the e-mail's legitimacy, verify with the sender by other means of communication, such as a phone call. If in doubt, report the e-mail via the " 🐟 " button or contact DHS Enterprise Help Desk at Helpdesk@dhs.lacounty.gov or at (323) 409-8000 so that one of their experts can validate its legitimacy for you. Please DO NOT seek other colleagues' opinions by forwarding the e-mail. Doing so will help the threat actor distribute the malware to a larger audience making it much more difficult to contain.

Smishing and vishing are other types of social engineering. Similar to phishing, smishing uses text messages on mobile devices. Some examples are: chances to win a gift card from a major retailer by entering some personal information; signing up to be part of a product test group; a text indicating some form of credit card transaction and a link to confirm. DO NOT CLICK the link; and make sure to delete the text.

Vishing (voice phishing) can include a person claiming to be from a legitimate company, like a bank, healthcare entity or technical support company. The person may call to verify account information, or claims a virus is on your computer to gain access to data remotely (with your permission), or instructs you to unknowingly download a malicious attachment. For example, a fraudulent phone call from the IRS indicating that you owe back taxes, etc.

Do not provide personal information unless you initiated the contact and verify that the person you are interacting with is legitimate.

WORKING REMOTELY

Working away from the office requires the same level of security awareness as if in an office and does not exempt you from following our policies. The way you access, store, and transfer confidential data must align with our current guidelines. You are prohibited to download or install any software on work devices. It is your responsibility to know if you're allowed to access our organization's network with a personal device and to what extent. Working from home makes you no less of a target for cybercriminals.

Ways to improve security while working remotely include:
- Keep your personal and work accounts separate. Keep all personal activity on your personal devices. Never store PHI/ Restricted Information on your personal device(s).
- Shred or destroy sensitive documents using a cross-cut shredder.
- Do not leave documents containing PHI/Restricted Information or mobile devices unsecured. Do not leave these in plain view or in your vehicle overnight.
- Lock the door of your workspace if you have a dedicated room for your office. It will help keep out intruders as well as children, friends, family and pets who like to cause trouble.
- If you do not have an office, try to work in the same spot and if possible, limit other people's access to that area. Always lock your screen and other devices if you step away, and lock up papers and removeable media, such as USB drives.
- Password-protect your Wi-Fi (never use default passwords).
- Use strong passwords and lock your device(s) when not in use.
- Use discretion when working in public areas, such as coffee shops with free unsecure Wi-Fi. Avoid handling confidential information over an unsecure Wi-Fi that is vulnerable to hackers.

INSIDER THREATS FOR END USERS

An insider threat is a threat that comes from within DHS or the County. Insider threats are authorized users, such as employees and contract staff who wittingly or unwittingly expose sensitive data or otherwise undermine our efforts to improve and maintain security.

Ensure your access is not obtained by unauthorized parties. NEVER share your login credentials, keys, or badges. ALWAYS utilize strong, unique passwords for every account, lock systems when not in use, and refrain from granting access to restricted workplace areas. If you suspect that you've been granted unnecessary access to systems or data, don't assume it was intentional. Instead, consult management and report the incident.

CLOUD SERVICES

Cloud services is the on-demand availability of data storage that allows users to access and share files from anywhere with internet connectivity. The County of Los Angeles utilizes Microsoft OneDrive as its cloud services provider. The use of any other cloud services provider such as Dropbox, Amazon Web Services (AWS), and Google Drive are strictly prohibited and a violation of DHS Policy 935.20, Acceptable Use of County Information Technology Resources.

PRIMARY WAYS PATIENT CONFIDENTIALITY IS MOST OFTEN VIOLATED BY WORKFORCE MEMBERS:

- Accessing medical information about a family member, friend, coworker, or high-profile patient without a work-related justification.
- Not locking or logging off the computer when stepping away. Everything done under your credentials is your responsibility.
- Speaking with a patient about their illness in front of a family member without giving the patient a chance to agree or object.
- Lost or stolen unencrypted flash/thumb drive, laptop, or other portable device containing patient information (i.e., leaving your laptop in your vehicle leaves it at risk of getting stolen).
- Removing PHI from the facility and not properly securing it in a safe place. This increases the risk of inappropriate disclosure and even worse, loss or theft (e.g., taking documents with PHI home and leaving them in your car which gets vandalized).
- Working remotely in an unsecure work location or not locking your computer when stepping away.
- Storing documents containing confidential or patient information on a personally owned device.

REPORTING POSSIBLE VIOLATIONS AND INCIDENTS

- Do not hesitate to report suspicious behavior. It's important to remember that malicious activity may affect the entire organization or our patients' privacy. Timely reporting is the best way to combat threats and reduce risk.
- You must report anything a workforce member does that might be against DHS Policy, or federal or state laws.
- If a workforce member peeks at a patient's medical record we must report it even if the workforce member did not tell anyone, or the patient was not harmed. It is still considered a violation.
- You will not be retaliated against for reporting a suspected or actual violation in good faith. You may stay anonymous. If you choose to report anonymously, you should provide as much detail about the potential violation as possible. Otherwise, it may be difficult for the department to conduct a thorough investigation.
- If you falsely accuse someone on purpose, you will be subject to discipline.
- If you report a potential violation in which you were involved, you will still be subject to discipline.
- You MUST report incidents or potential violations of patient information to your supervisor, the facility Privacy Manager or the DHS Privacy Officer and submit a Safety Intelligence™ (SI) Event report as soon as possible.
- Other methods of reporting potential violations are to the following hotlines:

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

- Report potential security incidents involving electronic data, suspicious computing activities, or identification of malware to the Enterprise Help Desk (EHD) at: Helpdesk@dhs.lacounty.gov or at (323) 409-8000.
- Report potential phishing e-mail using the Report Phishing Button " ◂ " (RPB or PAB) located on your e-mail banner. Never click on the link or open suspicious attachments.

FINES AND PENALTIES

- Use good judgment when working with patient information.
- Violations may not only result in discipline but can result in fines against the DHS facility involved. If guilty of a violation, you may also be fined and sentenced to prison.
- Anyone with a professional credential may also be reported to the issuing board or agency for investigation.

PRIVACY AND SECURITY DO'S AND DONT'S

As a DHS workforce member, it is very important that you safeguard patient health and confidential information. Here are some privacy and security do's and don'ts to help you remember some key points.

PRIVACY AND SECURITY DO'S
1. Respect patient privacy and their information and only access, view, or use information needed to do your job.
2. Verify that all documents provided to a patient belong to that patient. Use at least two patient identifiers (additional identifiers if necessary) before providing a patient with medications or documents, such as appointment reminders, discharge summaries, and eligibility packets. When verifying, ask the patient to provide their personal information rather than you asking them if they are the correct patient.
3. Delete e-mail and attachments containing PHI/PII when no longer needed to do your job. Empty your recycle or trash folder regularly and delete no longer needed pictures, files, attachments and e-mail from your desktop, laptop, or phone's mailbox.
4. Delete files and pictures containing PHI/PII from MS Teams and OneDrive when no longer needed to do your job.
5. Immediately remove all PHI from shared printers, fax machines, and photocopiers.
6. When faxing PHI, be sure to verify if the recipient and phone number are correct and when possible, verify if the recipient received the fax.
7. Discard PHI in secure shredder bins (HIPAA bins) or use cross-cut shredders.
8. Discuss patient care in a private place or speak quietly.
9. Keep medical records and other documents that contain PHI out of public view.
10. Close patient/exam room doors or draw curtains and speak softly when discussing patient care.
11. Treat patient information as if it were your own.
12. Report suspected patient privacy violations through the Safety Intelligence™ (SI) Event Reporting System AND by phone to the facility Privacy Manager in a timely manner to comply with privacy policies and regulations.
13. Report suspected security incidents to the Enterprise Help Desk via e-mail at helpdesk@dhs.lacounty.gov or by phone (323-409-8000).
14. Use the " ◂ " (RPB or PAB) button to report potential phishing e-mail.

PRIVACY AND SECURITY DO'S

15. Remove, if safe to do so, and secure PHI found in trash cans and report it to your supervisor and/or the facility Privacy Manager.
16. Only use your dhs.lacounty.gov e-mail to send or discuss patient information and encrypt e-mails to be sent outside the DHS e-mail domain.
17. Obtain permission to store e-PHI on a laptop, USB thumb/flash drive or other portable device, and make sure the device is encrypted.
18. Store paper records and medical charts in locked rooms and locked cabinets.
19. Restrict access to computers or computer systems containing e-PHI to authorized users only.
20. Verify the recipient(s) e-mail address(es) before sending communications especially if PHI, employee PII or other confidential information is contained in the e-mail. Do not solely rely on auto-populated names in Outlook.
21. Encrypt e-mail sent outside of the County that contain PHI/PII or confidential information.
22. Always be careful when using public computers and public Wi-Fi because it's not secure.
23. Always password protect your home Wi-Fi (change from the factory password that comes with equipment).
24. Position computer workstations and monitors away from public view or use a privacy screen.
25. Log off the computer when you are away from the work area, even if you're coming right back, or when the computer is not in use.
26. If a patient requests a restriction regarding sharing information, such as diagnosis and/or treatment, with family and/or others, document the request and make sure the treatment team is aware of the request.

PRIVACY AND SECURITY DON'TS

1. Don't access information about a patient unless you need it to do your job (even if you personally know the patient).
2. Don't share confidential patient information with anyone who does not need it to do their job.
3. Don't provide PHI/PII to a vendor until you have verified with your Privacy Manager that there is a signed Business Associate Agreement.
4. Don't use a personal laptop, notebooks, or other electronic devices to store PHI/PII or confidential information unless authorized by your supervisor and the device is encrypted.
5. Don't store or save patient information on the computer's hard drive. All patient information must be stored on the network drives.
6. Don't share passwords or your computer while logged on. You are responsible for all actions and information viewed while logged in with your credentials.
7. Don't store your password(s) under the monitor, keyboard or inside your unlocked desk.
8. Don't reuse the same password for multiple accounts.
9. Don't use short and simple or personal passwords that are easy to guess (e.g. 1234567890, abcde1234, kid's names, pet's name, birthdates, etc.).
10. Don't forget to log off shared/public use computers and workstations when you are done or briefly stepping away.
11. Don't e-mail PHI outside of the County e-mail network without authorization.
12. Don't send and discuss patient information or conduct County business through internet-based e-mail sites such as Yahoo Mail, Google Mail, Hotmail, etc.
13. Don't use online web-based document sharing services (e.g., Google Docs, Microsoft Office Live, Drop Box, Open-Office, etc.) to store or share patient data.
14. Don't post patient information or discuss patient care such as diagnosis, treatment, patient location, or other information that may be used to identify the patient on social networking websites (e.g., Facebook, Instagram, Twitter, YouTube, etc.).
15. Don't take photos and videos of patients for patient diagnosis and treatment with your personal cellular telephone unless you use the secure Microsoft Teams platform, which has replaced HIPAABridge.
16. 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.
17. Don't discard documents or medical supplies that contain PHI in a trashcan.
18. Don't store documents containing PHI in an area where it can be mistaken for trash.
19. Never click on links in e-mail from unknown or suspicious senders. This could be a phishing e-mail.
20. Don't remove documents containing PHI/PII from the facility unless you have been authorized to do so.
21. Don't forget to remove documents containing PHI from your pockets or from your personal belongings before leaving the workplace; secure or discard it appropriately.
22. Don't access unsecure sites or view confidential information when using public Wi-Fi.
23. Don't permanently store sensitive information in your e-mail.
24. Don't burn CD's/DVD's that contain PHI without encrypting.
25. Don't leave CD's/DVD's that contain PHI unattended.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The DHS Compliance Program is a comprehensive strategy to prevent, detect and correct instances of unethical and/or illegal conduct. DHS is committed to conducting its business in a manner that facilitates quality care, excellence, integrity, respect for patients and colleagues, and 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.

A significant element of the DHS Compliance Program is the DHS Code of Conduct, which is our guide to appropriate conduct and behavior. 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, volunteers and consultants. Each workforce member has a personal responsibility to comply with the Code of Conduct and must sign an acknowledgement stating that they will abide by the Code of Conduct and understand that non-compliance with the Code of Conduct can subject them to appropriate corrective action up to and including discharge from County service or termination of assignment.

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

• Your supervisor or manager
• Local Compliance Officer
• DHS Audit and Compliance Division

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 and website, operated by the Auditor-Controller, continues to be available to report fraudulent activity.

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

Workforce members are required to complete Compliance Awareness Training within 60 days of their start of service. The DHS Orientation/Reorientation training offered at each facility will provide annual refresher training thereafter. This training provides workforce members with a better understanding of the Code of Conduct and their role in the Compliance Program.

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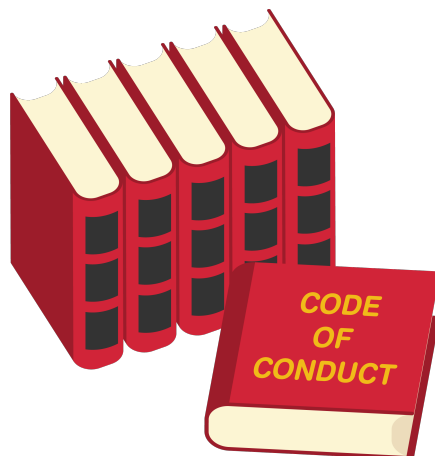
FALSE CLAIMS ACT

The False Claims Act (FCA) is a federal law with the intent to prevent fraud, waste, and abuse in the healthcare industry. Submission of false claims, statements, or records to federal health care programs can result in huge fines and penalties up to three times the amount of the false claim, plus a civil penalty of $5,500 to $11,000 and the cost of the civil action. The law is 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. Violators can submit false claims either actually knowing it is false or with "reckless regard". The FCA provides workforce members with "whistleblower protections" with respect to reporting wrongdoing. Reporters can also, under certain circumstances, bring suit against the violator and be rewarded with a portion of the recovery. Whistleblowers cannot be discharged, demoted, or retaliated against for reporting or participating in an investigation or lawsuit. California has a similar false claims law.

PROCUREMENT PROCESS

Department of Health Services workforce members do not have independent authority to purchase supplies, equipment or services, or commit County funds.

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

Specific delegated signatory authority has been established for the purchase and approval of procurement requests. Workforce members should contact their facility Supply Chain Operations Division if they have any questions regarding the procurement process or acceptance of goods or services.

CONDITIONS OF EMPLOYMENT

The purpose of this section is to provide workforce members with the conditions of employment set forth by the County and DHS. Below you will find information on the Americans with Disabilities Act (ADA), professional credentials, criminal background checks, the Disaster Service Worker (DSW) program, mandatory reporting of abuse, and reporting suspicious injuries.

TITLE I OF ADA - EMPLOYMENT

DHS is firmly committed to equal employment opportunity for persons with disabilities in compliance with the Americans with Disabilities Act (ADA) as well as state law. The ADA prohibits discrimination against persons with disabilities during the application process and in all phases of employment. DHS is required to interact with disabled employees to identify reasonable accommodations that will enable them to perform the essential functions of their jobs and to enjoy equal benefits and privileges of employment. These accommodations might include removing architectural barriers, adjusting a work schedule, and making changes to equipment.

The Department will provide a reasonable accommodation for the known physical or mental disability of a qualified employee or applicant, unless doing so would pose an undue hardship or direct threat to the health or safety of the individual or others.

If you feel you need an accommodation for a disability, inform your supervisor, departmental personnel officer or reasonable accommodation coordinator immediately. Requests for accommodation will be evaluated on a case-by-case basis. If you request an accommodation, it is essential that you participate fully in the interactive process to address your request. This participation may include, but is not limited to, providing medical documentation, meeting with specialists, and identifying restrictions and possible accommodations.

If you have a disability that is covered under the ADA and you are a qualified individual, you are entitled to reasonable accommodation. Please contact DHS Disability Management & Compliance and Protected Leaves at (323) 914-6365 for assistance.

EQUAL EMPLOYMENT OPPORTUNITY

The Equal Employment Opportunity policy exists to provide equal employment opportunity to all qualified persons, regardless of age (40 and over); ancestry; color; ethnicity; religious creed (including religious dress and grooming practices); denial of family and medical care leave; disability (including mental and physical disability); marital status; medical condition (cancer and genetic characteristics); genetic information; military and veteran status; national origin (including language use restrictions); race (including traits historically associated with race - which includes but is not limited to - hair texture and protective hairstyles); sex (including pregnancy, childbirth, breastfeeding, and medical conditions related to pregnancy, childbirth, or breastfeeding); gender (including gender identity and gender expression); sexual orientation; and any other characteristic protected by state or federal law.

In developing our equal employment opportunity policy, the Department of Health Services (DHS) is committed to:

- Recruiting, hiring, training, and promoting persons in all job classifications without regard to any non-job-related characteristics.
- Ensuring that promotional decisions are made in accord with equal employment opportunity requirements by imposing only valid, job-related requirements for promotional opportunities.
- Ensuring that all personnel actions relating to compensation, benefits, transfers, terminations, training, and education are administered in a non-discriminatory manner.
- Ensuring that no employment practice exists which discriminates against any employee or applicant in any aspect because of sexual harassment from a manager, supervisor, client, or fellow employee.
- Providing a work environment free from harassment and/or other discriminatory practices for all employees.
- Providing a work environment that complies with federal and state statutes regarding disability and providing an interactive process for those having a disability that limits a major life activity.

PROFESSIONAL CREDENTIALS (LICENSE/CERTIFICATION/REGISTRATION/PERMIT)

A workforce member (County employee or contract staff) whose position requires a current valid professional credential to perform the duties of their position shall produce evidence of license, certification, registration and/or permit to Human Resources upon entering County service or assignment.

It is the responsibility of the workforce member to renew all required professional credentials or other requirements and to ensure the professional credential is kept in good standing with the appropriate issuing board or agency. Failure to comply with professional credential requirements may subject the workforce member to corrective action, which may include discharge/release from County service or assignment.

Primary source verification is required to ensure staff are qualified to provide treatment, care, and services as well as demonstrate to regulatory/accreditation agencies that DHS verifies those qualifications. Some credentialing agencies allow members to block access to online credentialing records. DHS requires unlimited access to review professional credentials.

If you are required to maintain a current professional credential to perform your job, it is your responsibility to provide a copy of a renewed 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.

If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report the behavior by notifying your supervisor or the DHS Human Resources Performance Management Unit.

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

CRIMINAL BACKGROUND CHECKS

All candidates selected for hire, promotion or transfer from another department, and potential contract/volunteer/student staff, as specified in DHS Policy 703.1, will participate in a criminal background check. The criminal background check will include Live Scan fingerprinting, 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 during onboarding and monthly through several federal and state exclusion/suspension lists that identify individuals excluded from participating in federal and state health care programs. **DHS is prohibited from hiring or maintaining relationships with individuals and entities that have been excluded/suspended or have opted out of Medicare.**

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.

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

Failure to report may result in disciplinary action, including discharge or termination from assignment. DHS HR PM will review the charges/conviction to determine if a job nexus exists. All information reported to DHS Human Resources will only be released on a "need-to-know" basis as required to determine a job nexus.

DISASTER SERVICE WORKER/DHS COUNTY EMERGENCY PROTOCOL

The State of California Disaster Service Worker Volunteer Program (DSWVP) was created as the result of legislation to provide worker's compensation benefits in the event a Disaster Service Worker (DSW) volunteer is injured while performing authorized disaster service duties.

All persons employed by the state, any county, city, or public district (public employees), excluding aliens legally employed, are Disaster Service Workers (Gov. Code, § 3101). Public employees may be activated by their organization to perform disaster services and are eligible for benefits and liability protections.

NOTE: A public employee performing disaster work outside their regular job **AND** without pay, is eligible for state DSW program benefits (Code, § 3211.92(b)). Registration is required with an Accredited Disaster Council, authorized designee, or Cal OES.

In addition, Los Angeles County Code (2.68.060) designates all officers and employees of the County a part of the "County Emergency Organization," and can be activated to perform disaster services outside their regular duties. County employees aid the public in the event of an emergency or disaster.

All DHS employees are required to complete the new Disaster Service Worker Awareness training on TalentWorks. The DSW training does not apply to non-County workforce members.

WHAT TO DO WHEN A DISASTER OCCURS

When initially alerted, stay calm, ensure your personal safety, and evacuate if instructed to do so. Confirm the safety of your family and property. Once the personal safety of your family is verified, employees should assist in the County's disaster response.

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

A Building Emergency Coordinator (BEC) is located at each facility with 10 or more employees and is responsible for the development and implementation of the building emergency plan. Listen for instructions from your BEC and/or supervisor regarding steps to take during a disaster or evacuation.

Employees who require assistance evacuating may request assistance by completing a "Voluntary Request for Reasonable Accommodation" form and submitting it to your supervisor/manager, or the facility on-site HR Office or the Department ADA Coordinator.

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REPORTING OF ABUSE/NEGLECT INCIDENTS

The State of California Penal Code mandates that health care practitioners report incidents of suspected or identified child abuse/neglect, and elder or dependent adult abuse/neglect. Any mandated reporter (all workforce members) who fails to report abuse may be found guilty of a misdemeanor punishable by imprisonment or a fine.

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

CHILD ABUSE

Emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years, including a newborn child where either mother or child has a positive toxicology screen as a result of mother's substance use/abuse. Workforce members are mandated to report incidents of suspected abuse to Department of Children and Family Services Child Abuse Hotline immediately or as practicably as possible. A written report must be submitted within 36 hours of the telephone report and may be submitted through their website at http://dcfs.lacounty.gov. Abuse that is sexual in nature also must be reported to law enforcement by calling the Los Angeles County Sheriff's Department or other local law enforcement agency within the jurisdiction of the incident.

ELDER ABUSE

Physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals. Reports can be submitted for Older Adults (60 yrs and older) and for Dependent Adults (18-59 yrs old) with a disability. Workforce members are mandated to report incidents of suspected elder abuse immediately or as practicably possible by calling the Elder Abuse Hotline at 1-877-477-3646. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

DEPENDENT ADULT ABUSE

Physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals Reports can be submitted for Older Adults (60 yrs and older) and for Dependent Adults (18-59 yrs old) with a disability. This includes individuals who are mentally or physically challenged. Workforce members are mandated to report incidents of dependent adult abuse by calling the Dependent Adult Abuse Hotline. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

DOMESTIC/INTIMATE PARTNER ABUSE

Any individual who has been abused by their domestic/intimate partner. Domestic/intimate partners are those individuals who are currently dating, married, cohabitating, or separated. The abuse includes physical violence, sexual assault, severe emotional distress and economic coercion. Domestic/intimate partner abuse must be reported if the patient is presenting to the facility for treatment of a current injury sustained through domestic/intimate partner abuse. Workforce members are mandated to report the violence as soon as practicably possible to local law enforcement or the Sheriff's Department.

NOTE

Contact the Clinical Social Work Department for assistance with evaluations, reporting forms and referrals.

REPORTING SUSPICIOUS INJURIES

A SUSPICIOUS INJURY INCLUDES ANY WOUND OR OTHER PHYSICAL INJURY THAT 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 their professional capacity or within the scope of their assignment, who 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 practicable. Section 11160 requires the reporter to make a written follow-up report within two (2) business days to the same local law enforcement agency. If the suspicious injury is to a patient/inmate, per Los Angeles County Board of Supervisor's (BOS) mandate, it must be reported to Los Angeles County Sheriff's Department Internal Affairs Bureau or the Captain of the jail facility where the patient/inmate is housed.

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.

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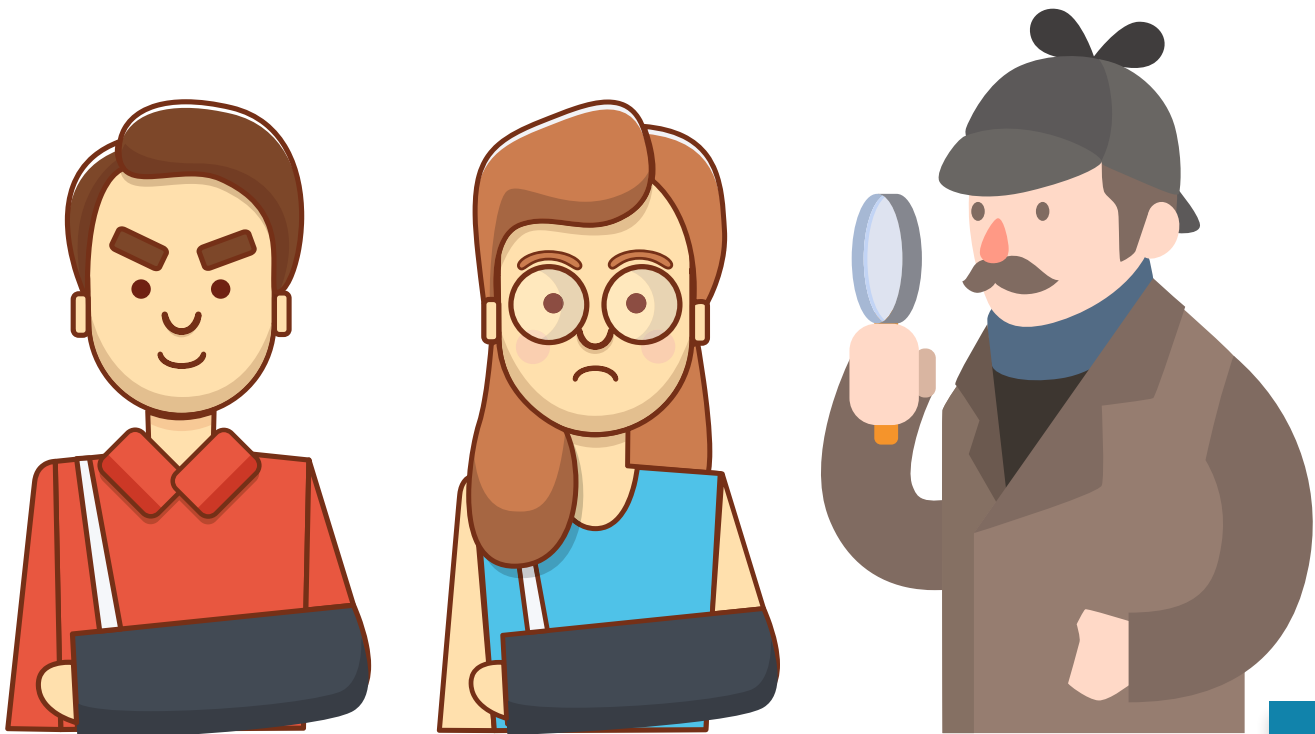
OUTSIDE EMPLOYMENT

Upon hire, and annually thereafter, all workforce members are required to complete and submit an Outside Employment form notifying DHS of outside employment activities, if any.

DHS workforce members wishing to engage in outside employment activities may do so by completing the Outside Employment form located on LA County Workplace and obtaining approval. The workforce member must disclose the outside employer, duties, and number of hours worked per week. Outside employment cannot exceed 24 hours per week. Outside employment activities cannot conflict with County duties and cannot be worked during County time or by using County property.

See DHS Policy 740 for more information, such as special conditions for physician post-graduates and appeal process in the event of denial.

CONFLICT OF INTEREST

A conflict of interest exists if a workforce member (WFM) uses their official position to influence a governmental decision in which they have a financial interest. This includes participating in the contracting process. Such practices are prohibited under state law.

A WFM has a financial interest in a decision if the decision has a material financial effect on the WFM, the WFM's immediate family, or on:
- Any business entity in which the WFM has an investment of $2,000 or more in which he or she is a director, officer, partner, trustee, employee or manager;
- Real property in which the WFM has a direct or indirect interest worth $2,000 or more including leaseholds (month-to-month leases are not considered leaseholds);
- Any source of income to the WFM totaling $500 or more in value provided to, received by, or promised to the WFM within the previous 12 months (includes community property in the interest of the spouse or registered domestic partner);
- Any business entity in which the WFM holds a position, including executive and management; or
- Any donor of a gift totaling $590 or more in value provided to, received by, or promised to the WFM within 12 months prior to the decision being made.

In addition to the list above, there are additional state statutes and regulations which further define a financial interest. Any WFM who believes they may have a financial interest in a decision should immediately discuss the matter with their supervisor.

WFMs cannot be involved in the decision to transfer or refer a patient to a private facility in which the WFM has a financial interest.

It is the WFM's responsibility to report any potential conflict of interest situations using the Conflict of Interest form. Certain executive level positions and positions with significant influence and involvement with contracts, financial, and other government decisions related to County business are required to annually complete a Form 700, Statement of Economic Interests. The Form 700 is a public document that discloses the financial interests of the positions involved in decision making and makes sure decisions made are in the best interest of the public entity as well as serves as a reminder to those making decisions about conflicts of interests.

See DHS Policy 740, the DHS Human Resources Operations Section, or DHS Compliance Division for more information.

EMPLOYEE ORGANIZATIONS (UNION REPRESENTATION)

DHS is committed to fostering positive relationships with our labor partners. There are 18 unions representing LA County employees. In 2015, the Alliance for Health Integration (Department of Health Services, Department of Public Health, and Department of Mental Health) partnered with several unions to create the Labor Management Transformation Council (LMTC). The County's unique partnerships with our labor partner strengthens staff involvement and brings positive change to DHS.

Some of the changes that have come out of our labor partnership include:

- Standardized emergency codes across DHS
- Employee engagement survey
- Just Culture policy
- Training in Microsoft Office applications
- Customer service training
- Distribution of care packages to front line staff during Covid-19 pandemic
- Continuous performance improvement efforts
- Involvement of front-line staff in decisions involving system transformation

Employee organizations (labor unions) include employees of the County. One of their main purposes is to represent employees in their relationship with the County, such as in negotiations regarding benefits, leaves, Memorandum of Understanding (MOU), and other working conditions. Employee organizations also provide a variety of external benefits to their members which may include life insurance, legal services, recreation discounts, and optional health-, dental-, or vision-related services. Refer to the table below for information on labor unions and memberships.

There are several unions that represent County employees, including those that are part of the Coalition of County Unions, independent unions, and SEIU. Most DHS employees are represented by SEIU Local 721; other labor unions include, but are not limited to, AFSCME, and UAPD. County positions are divided into different categories of Bargaining Units. These Bargaining Units correlate with a specific labor union. Check the profile on your timesheet to determine your Bargaining Unit. New staff will be given information on the union representing their classification, if any, upon hire. If you have questions, please contact your supervisor/manager or the local HR office.
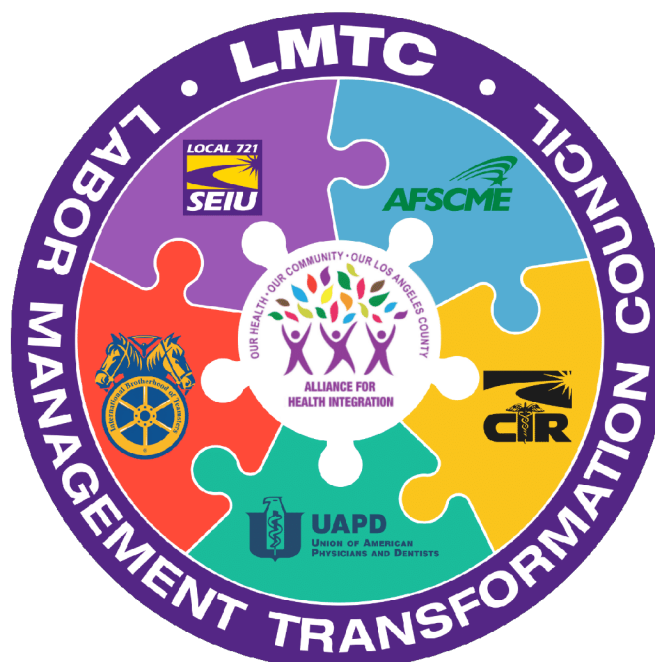
Labor Union	Address & Phone	Website
Service Employees International Union (SEIU) Local 721 Bargaining Units: 105, 111, 112, 121, 122, 201, 211, 221, 222, 311, 312, 341, 342, 431, 432, 711, 722, 729	1545 Wilshire Boulevard, Suite 100 Los Angeles, CA 90017 (877) 721-4968	https://www.seiu721.org/
American Federation of State, County, and Municipal Employees (AFSCME) Council 36 Local 119 Bargaining Unit: 421 Local 1271 Bargaining Unit: 321 Local 2712 Bargaining Unit: 721 Local 3511 Bargaining Unit: 724	3375 E Slauson Ave Vernon, CA 90058 (213) 487-9887	https://www.afscme36.org/
Coalition of County Unions (CCU) California Association of Professional Employees, MEBA, AFL-CIO (CAPE) Bargaining Units: 501, 502, 511, 512	3018 East Colorado Blvd, Ste. 200 Pasadena, CA 91107 (626) 243-0340	https://capeunion.org/
Coalition of County Unions, Los Angeles County Building & Construction Trades Council, AFL-CIO (BCTC) Bargaining Units: 411, 412	1626 Beverly Boulevard Los Angeles, CA 90026 (213) 483-4222	http://laocbuildingtrades.org/
Coalition of County Unions, International Union of Operating Engineers, Local 501, AFL-CIO, (IUOE) Bargaining Units: 401, 412	2405 West Third Street Los Angeles, CA 90057 (213) 385-1561, Ext. 113	https://local501.org/ca/
Coalition of County Unions (CCU) Committee of Interns & Residents (CIR)-SEIU Bargaining Unit: 323	1545 Wilshire Blvd, Suite B02 Los Angeles, CA 90017 (213) 236-2212	https://www.cirseiu.org/
Coalition of County Unions (CCU) Union of American Physicians and Dentists (UAPD), AFSCME, AFL-CIO Bargaining Units: 301, 324, 325	316 W. 2nd Street Ste. 500 Los Angeles, CA 90012 (800) 504-8273 (310) 398-4038	https://www.uapd.com/
Teamsters Local 911 Public, Prof., & Medical Employees Union	9900 Flower Street Bellflower, CA 90706 (562) 595-4518	http://www.teamsters911.com/

CUSTOMER SERVICE

CUSTOMER SERVICE PHILOSOPHY

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

- 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.
- Responding to customer concerns immediately and following up within 24 hours to ensure appropriate delivery of services.

SERVICE ENVIRONMENT

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

- Report any unsafe conditions to your supervisor or the Los Angeles General Medical Center Safety Officer.
- 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 customer service strategy 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:

A	Acknowledge	• Make eye contact. • Smile. • Stop what you are doing, so that your patient or visitor knows they are important. *Example: "Good morning, Ms. Jones."*
I	Introduce	• Welcome. • State your name. • State your role in the patient's care. *Example: "Welcome to Los Angeles General Medical Center. My name is Jane. I am Dr. Smith's Nurse and will be assisting her with your exam today."*
D	Duration	• Explain how long a procedure will take. • Explain how long an interaction will take. • Explain how long it will take to get test results back. *Example: "Dr. Smith ordered an x-ray procedure for you today, to make sure your finger is not broken. The procedure takes about 15 minutes to complete. Go to the Medical Imaging Department to check-in and when you are done, come back to this office to get your result."*
E	Explanation	• Explain the test or procedure. • Explain any post-procedure instructions. *Example: "Ms. Jones, I will be taking an x-ray image of your finger with this machine. The machine will produce an image of your bone and will allow us to see if your finger is broken. Do you have any questions for me?"*
T	Thank You	• Let patients know you have enjoyed working with them. • Thank them for entrusting us with their healthcare needs. *Example: "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."*

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 healthcare setting is teamwork. Teamwork is achieved through a shared vision, positive attitudes, mutual respect, effective sharing, and application of skills by each team member. Key components 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 settings, including formal (as in a meeting), informal (as in a hallway), two-way or multi-way (as in a group). Ineffective communication can lead to failed patient outcomes (patient harm, pain), medical errors, increased medical and malpractice costs, reduced patient trust, decreased staff satisfaction and retention, and poor productivity and motivation. Barriers to effective communication which include language, age, skill level, poor listening and verbal skills, negative attitudes, time constraints, cultural differences, etc., can lead to misperception, inaccurate messages, embarrassment and failed outcomes. Good communication skills can be learned, practiced, and continuously improved.

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

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

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

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

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

PRINCIPLES OF INTERDISCIPLINARY COLLABORATION

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

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

Example 1: A Physical Therapist schedules to see the patient at 9:00 a.m. When they tell the RN about this, they discuss the patient's need for medication prior to the therapy appointment. The RN contacts the physician to discuss the patient's medication needs. The physician sees the patient for reassessment and to discuss the patient's condition and concerns and then renews the medication order.

Example 2: The environmental service worker collaborates with the nurse or their 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.

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

COORDINATION OF CARE

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

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

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

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

CONFLICT RESOLUTION THROUGH TEAM BUILDING

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

• Learn to respect the ideas, suggestions, processes, and contributions of all members of the team, however varied and diverse. For example, physicians, pharmacists, nurses, social workers, and psychologists have been educated to view and process problems in various ways. Each one may have a unique and different perspective on the problem.
• Acknowledge and appreciate other disciplines' processes and contributions to ensure that thorough and complete care planning is patient-focused, 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.

THE JOINT COMMISSION'S FOCUS ON PATIENT SAFETY AND QUALITY

The Joint Commission has been a global driver of quality improvement and patient safety in health care. They believe that all people should always experience the safest, highest quality and consistently excellent health care service from all organizations under their purview. DHS' focus in the preparation for re-accreditation is to use The Joint Commission standards for achieving and maintaining efficient and effective systems to support safe and high-quality patient care.

DHS hospitals are proud and privileged to be recognized as accredited through The Joint Commission. This accreditation signifies a commitment to providing the safest and highest quality of care possible to our patients and community.

DHS Hospitals are on a triennial survey track, but the process for quality improvement and patient safety does not end with the survey, as they must continually improve and maintain compliance standards. Activities such as responding to any deficiencies (Requirements for Improvement (RFIs)) identified during the survey, conducting self-reviews (Focused Standards Assessment (FSA)) at 12 months and 24 months after the survey to ensure RFIs are addressed, ensuring National Patient Safety Goals are met, and reviewing revised standards and elements of performance assist with survey readiness, but most importantly, we are ensuring that we meet the standards of safety and quality in patient care.

The Joint Commission surveys are unannounced. Not only are they conducted on the triennial track, but also at various times during the interim years due to patient complaints/concerns, to review compliance with new standards, and to follow up with these issues.

SURVEY PROCESS

When a surveyor or team of surveyors visit a facility, they spend a large amount of time conducting tracers: individual tracers, system tracers, and accreditation program tracers. Tracers allow the surveyors to follow the care, treatment, and services provided to several patients and identify deficiencies in one or more steps in the healthcare process.

INDIVIDUAL TRACER ACTIVITY

Individual tracers are designed to "trace" the care experience that a patient had while receiving services from DHS. It is a way to analyze DHS' system of providing care, treatment or services using actual patients. Patients selected for these tracers will likely be in high-risk areas or whose diagnosis, age, or type of services received may provide the best method of evaluating DHS' processes and practices.

SYSTEM TRACER ACTIVITY

System tracers evaluate the system or process and how they work together, and the coordination of communication among disciplines and departments in the process. They focus on data management, infection control and medication management.

ACCREDITATION PROGRAM-SPECIFIC TRACERS

These tracers focus on important issues relevant to DHS such as clinical services offered and high-risk, high-volume patient populations. The goal is to identify risk points and safety concerns involving different levels and types of care, treatment, or services.

Reference(s):

"Tracer Methodology Fact Sheet." The Joint Commission, www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-tracer-methodology/.

WHAT TO DO DURING A SITE VISIT FROM A REGULATORY/ACCREDITATION AGENCY

1. Greet and welcome surveyor(s) to your facility.

2. Ensure your work badge is visible.

3. If you are asked questions by a surveyor, answer those specific questions only. If you do not know the response to a question, please do not guess. Inform them you will obtain the appropriate response and will get back to them.

4. Display the awesome work you do each day!

KEY POINT

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

ACCREDITATION PARTICIPATION REQUIREMENTS (APR 09.02.01)

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

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

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

Online:	https://www.jointcommission.org/report_a_complaint.aspx
Mailing Address:	Office of Quality and Patient Safety
	The Joint Commission
	1 Renaissance Boulevard
	Oakbrook Terrace, IL 60181

The Joint Commission

Safety or quality of care concerns/complaints may also be made through the workforce member's supervisor, or the facility Risk Manager.

LOS ANGELES GENERAL MEDICAL CENTER PATIENT SAFETY PLAN

The Los Angeles General 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 Plan. The purpose of the Plan is to ensure that Los Angeles General Medical Center is in compliance with current patient safety standards as required by The Joint Commission's National Patient Safety Goals and standards.

JUST CULTURE

DHS strives to build, maintain, and support a Just Culture. A Just Culture is one in which safety is an individual and organizational priority, where accountability is fairly balanced between the DHS organization and the individual workforce members.

In a Just Culture, errors, near miss events, adverse events, unsafe conditions, and system problems can be easily reported without retaliation. These are viewed as an opportunity to identify system and behavior changes that will improve the safety and quality of the care and services we deliver. Workforce members will not be punished or retaliated against for reporting an error, near miss, adverse event, system problem, safety or quality concern.

A Just Culture recognizes that adverse events and unanticipated outcomes are often the result of human error or system failures rather than reckless or intentionally malicious behavior. Workforce members will not be held accountable for system flaws over which they have no control.

However, when indicated, workforce members will be held accountable for reckless, dangerous behaviors and appropriate corrective action taken, even if no patient has been harmed. Actions will be consistent with Just Culture principles, AND with the DHS Discipline Manual and Guidelines, County Civil Service Rules, and DHS policies and procedures.

Create and Maintain a Just Culture by:

- Encouraging staff to recognize and report patient safety issues and suggest ideas on how we can improve.

- Acknowledging that errors in health care occur and provide a supportive environment for staff should an error occur.
- Viewing mistakes as opportunities to learn and to identify system failures.
- Focusing on designing/re-designing systems that will ultimately prevent mistakes.
- Partnering with patients and their families and letting them know how much we appreciate their active participation in making their care as safe as possible.

LGBTQ+ INCLUSIVE CARE

Los Angeles GeneralMedical Center

The lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patient population has historically experienced discrimination on many levels which have directly contributed to identifiable and disproportionately high health disparities. Unfortunately, this discrimination is experienced by the LGBTQ+ community while accessing and receiving healthcare as well. Los Angeles General Medical Center is committed to providing equitable and inclusive care without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

To this effect, we have developed and implemented policies that serve to guide practice and protect our LGBTQ+ patients. Inclusive to these efforts are extensive guidelines/policies that direct transgender medical care. Protective policies are also extended to workforce members that identify as LGBTQ+. Cumulatively, these policies encourage a healthy and equitable work environment and one that is safe and welcoming to our LGBTQ+ patient population.

The Joint Commission and California state law requires healthcare practitioners to be culturally competent with regards to information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities. This includes the respective fulfillment of continuing education requirements. Our Los Angeles General Medical Center LGBTQ Committee actively encourages and promotes the enhancement of awareness and clinical skills through contemporary education and events.

As an Equal Opportunity Employer, DHS supports our existing workforce members that identify as LGBTQ+ and acknowledges that this entity is a valuable resource with regards to reducing discrimination and improving LGBTQ+ Inclusive Care.

KEY POINT

Our LGBTQ Committee promotes equity through education, community engagement, enforcement of inclusion policies, and facilitates a safe and welcoming environment for all.

NATIONAL PATIENT SAFETY GOALS

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

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.

(H) = Hospital   (A) = Ambulatory Health Care   (L) = Laboratory

Healthcare Organization			
	Identify Patients Correctly		
(H) (A) (L)	NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.	
	Improve Staff Communication		
(H) (L)	NPSG.02.03.01	Get important test results to the right staff person on time.	
	Use Medicines Safely		
(H) (A)	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.	
(H) (A)	NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.	
(H) (A)	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. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.	
	Use Alarms Safely		
(H)	NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.	
	Prevent Infection		
(H) (A) (L)	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.	
	Identify Patient Safety Risks		
(H)	NPSG.15.01.01	Reduce the risk for suicide.	
	Improve Health Care Equity		
(H) (A)	NPSG.16.01.01	Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.	
	Prevent Mistakes in Surgery		
(H) (A)	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.	
(H) (A)	UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.	
(H) (A)	UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.	

The exact language of the National Patient Safety Goals can be found at www.jointcommission.org.

KEY POINT

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

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 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 Los Angeles General Medical Center Rapid Response Teams (Code Blue Team and Airway Team). Registered nurses in the areas covered by the Rapid Response Teams have been trained in how and when to activate the teams. In other areas, nurses may call the patient's doctor, call a Code Blue or Code White, or call 9-1-1, in response to a change in patient condition. This is why notification of the patient's nurse is the first step 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 the area covered by those teams a paramedic ambulance may be dispatched via 9-1-1 (See Los Angeles General Medical Center 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 Los Angeles General Medical Center, it is important to 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!**

Freepik

AT LOS ANGELES GENERAL MEDICAL CENTER:

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

FALL PREVENTION AND RESPONSE

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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 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 need assistance.

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

Prevention

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

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

TIPS FOR PREVENTING FALLS

Environmental

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

Inpatients

- Check for "Fall Alerts" for inpatients such as "fall risk" wristband, fall precaution sticker on patient's chart, signage, etc.
- Ensure bed and wheelchair brakes are locked.
- Ensure patients have non-skid footwear.
- Keep bed side rails raised during patient transport.
- Keep bed rails raised when child is not attended by adult.
- Ensure personal items and call button are within patient's reach.
- Orient patient and family to the patient's room environment and bathroom facilities.
- Assist patient in transfers or ambulation, as needed.

RESPONSE

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

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

Process for obtaining medical assistance:

1. Notify your supervisor/manager.
2. Dial Ext. 111 to activate the Man Down code.
3. Document the incident via Safety Intelligence™ (SI) Event Reporting System 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 Mobile Intensive Care 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 or the facility Risk Manager.

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) Event Reporting System**. Patterns and risks leading to falls can be identified and processes can be developed to improve the safety of the environment. Workforce members without access to the 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. 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.

SUICIDE PREVENTION

The suicidal thoughts of individuals, also known as suicide ideation, is often left undetected by healthcare providers. As the suicide rate continues to climb in the United States, it is critical for staff to detect suicide ideation and take steps to help prevent suicide.

DETECTING SUICIDE IDEATION

Who is at risk for suicide?
Suicide may affect certain groups more than others, however, it is important to know that suicide can affect anyone. Knowing the risk factors is a better indicator of risk than the patient's demographic information. A patient may not disclose suicide ideation therefore it is important to know and detect the risk factors.

What are the risk factors?
The risk factors include, but are not limited to, the following:
- Family history of suicide
- History of abuse or other trauma
- Previous suicide attempts
- Self-inflicted injury
- Alcohol or drug abuse
- Depression, bipolar disorder, or other psychiatric disorders
- Serious illness, pain, or physical limitations
- Social isolation, aggression, or antisocial behavior
- Discharge from psychiatric facilities or other change in treatment
- Access to firearms/lethal weapons
- Triggering events, such as loss of relationship or job

Not every individual who exhibits one or more of these symptoms will attempt suicide, in fact, most do not. However, identifying these risk factors in a patient will allow you to take appropriate steps to refer the patient to a provider for screening, risk assessment, and treatment. If you suspect a patient is having suicide ideation, notify your supervisor.

SAFE-T

SAFE-T stands for **S**uicide **A**ssessment **F**ive-step **E**valuation and **T**riage.

These are the five steps:

1. **Risk Factors:** Know the risk factors (see above for a list of risk factors).
2. **Protective Factors:** Protective factors include the ability to cope with stress, religious beliefs, frustration tolerance, a feeling of responsibility to children or other loved ones, positive relationships and social support. Although protective factors can be enhanced, they may not counteract acute risk.
3. **Suicide Inquiry:** Conduct a suicide inquiry and ask specific questions about suicide ideation, any plans they may have, including timing, locations, past or aborted attempts, rehearsals, and self-injury.
4. **Risk Level/Intervention:** After completing steps 1-3 assess the risk level and reassess as the patient or the environment changes.

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

5. **Document:** Document results of the assessment and include a justification. There should also be a treatment plan to address/reduce the current risk and a follow up plan. Parents and guardians should be included in treatment plans involving youth.

LIGATURE RISK

Each and every patient who walks through our doors has the right to receive "effective and caring service" in a safe environment free of safety risks. This includes patients at risk for suicide or those who may harm themselves or others.

DEFINITION:

A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, radiators, bed frames, window and door frames, ceiling fittings, handles, hinges and closures. Common ligatures are belts, sheets, and towels, with a recent increase in the use of shoelaces.

WHAT ARE THE RISKS?

The goal for our patients at risk of suicide or self-harm is to have an environment free of ligatures and ligature points.

Other risks to look out for include furniture or anything that can be thrown or moved, sharp objects, areas where the patient isn't visible to staff, plastic bags, tubing or other medical equipment or supplies that can be used for suffocation or strangulation, windows that open or are breakable, harmful medications, accessible light fixtures, and non-tamper proof screws.

WHAT YOU CAN DO TO MINIMIZE RISK

Patients with psychiatric issues in a hospital setting may be at higher risk for suicidal ideations and should be screened and monitored as appropriate to their level of risk. As with any person that demonstrates suicidal ideation, they may require a mental health referral/evaluation, greater vigilance, and protection, such as periodic check-ins, one-to-one monitoring, and removal of potentially dangerous objects, as listed above.

ADDITIONAL RESOURCES

- Call **988** Suicide & Crisis Lifeline
- Means Matter from the Harvard T.H. Chan School of Public Health: https://www.hsph.harvard.edu/means-matter/
- Mental Health Environment of Care Checklist from the U.S. Department of Veterans Affairs: https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

KEY POINT

Employees or patients with suicide ideation, or their family members, should be given the number to the 988 Suicide & Crisis Lifeline.

References:

- Detecting and treating suicide ideation in all settings. (2016, February 24). Sentinel Event Alert.
- Clarification of Ligature Risk Policy. (2017, December 8). Memo from Department of Health & Human Services, Centers for Medicare & Medicaid Services.
- SAFE-T Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals. (2009). Education Development Center, Inc. and Screening for Mental Health, Inc.

PATIENTS' RIGHTS AND SERVICES

This section explains Los Angeles General 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, Baby-Friendly Initiative, organ/tissue donation, and the Emergency Medical Treatment and Active Labor Act (EMTALA).

PATIENTS' RIGHTS

To ensure that you are protecting our patients' rights, Los Angeles General 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 Los Angeles General 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 the Physician, Nurse, Social Worker, or Chaplain. You can also call (323) 409-4906, 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 Los Angeles General Medical Center have both rights and responsibilities. Each patient is given a **Welcome to Los Angeles General 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 Work Department.

- Patient Advocates are available at Los Angeles General 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 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.
  - Los Angeles General Medical Center Admissions and Clinical Social Services staff inform patients of their options concerning AHCD's.
  - Patients can fill out an AHCD document or give oral direction to a physician, who will document the directive in the patient's medical record and complete appropriate documentation.

If a patient comes to you with a complaint about any part of their medical care or treatment, refer them to the accountable supervisory staff to resolve the complaint at the first level of care whenever possible. Complaints that cannot be resolved at the first level will be referred to Administration at (323) 409-2800. Patients may contact the Patient Relations Department directly with a complaint.

PATIENTS' RESPONSIBILITIES

- Patients must provide information that is as accurate and complete as possible about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- Patients have the responsibility to report unexpected changes in their condition to the doctor or health care team member.
- Patients are responsible for informing the doctor or health care team member when patient expectations or a proposed treatment plan are not understood.

- Patients are responsible for cooperating with the agreed-upon treatment plan recommended by the doctor or health care team member and following the instructions.
- Patients are responsible for keeping appointments and, when unable to do so for any reason, notifying the responsible practitioner or the facility (hospital/clinic).
- Patients are responsible for accepting 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.
- Patients are responsible for providing financial information as necessary to qualify for health care benefits and fulfill financial obligations not covered by insurance.
- Patients are responsible for requesting health information and/or education as needed.
- Patients are responsible for being 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.
- Patients are responsible for being respectful of the property of other persons and of the facility.

PATIENT ADVOCATE

The Patient Advocate helps ensure that patient rights are protected. If a patient, family member or visitor comes to you with a complaint about any part of their hospital visit, clinic appointment or emergency room visit, make every attempt to resolve the issue or refer them to your supervisor or designee immediately. If the problem cannot be resolved in your department or is not related to your department, the Patient Advocate will assist to resolve the problem.

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

For inpatients, the Patient Advocate and Guest Services Department is located on the second floor of Inpatient Tower Room 2N115.

For outpatient concerns, a Patient Advocate is available in the Clinic Tower, Room A6A.

For Emergency Room concerns, a Patient Advocate may be reached.

LANGUAGE ACCESS SERVICES

WHAT YOU NEED TO KNOW

- The majority of our patient encounters are with patients who have a preferred language, other than English (OLAI 2022 by the Numbers).

- Patients and families have a right to receive care in their preferred language.

- DHS is committed to ensuring that patients are provided care in their preferred language for better patient care.

- Here are the resources available to support Language Access:

    o   Qualified Interpreters, including Qualified Sign Language Interpreters

    o   Qualified Translation for vital patient information written in other languages

    o   Aids and Alternative Formats (auxiliary aids and different formats, such as large print, audio, and accessible electronic formats)

Department of Health Services
Office of Language Access and Inclusion (OLAI)
Calendar Year 2022 by the Numbers

1.3M Patient Visits
Non-English Preferred Language

57K

Face-to-Face
Interpretation Encounters

662K

Phone Interpretation
Encounters
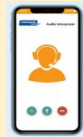
27K

LLS Insight (Interpreter)
App Encounters
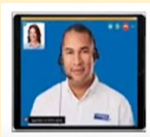
21K

Video Interpretation
Encounters

150

LLS Virtual Desktop Infrastructure
(VDI) Encounters

85
DHS Healthcare Interpreters

Top Ten Languages

Other 3%

English 46%

Spanish 51%

Other:
Korean
Tagalog
Mandarin
Armenian
Cantonese
Vietnamese
Russian
Arabic
(<0.05% each)
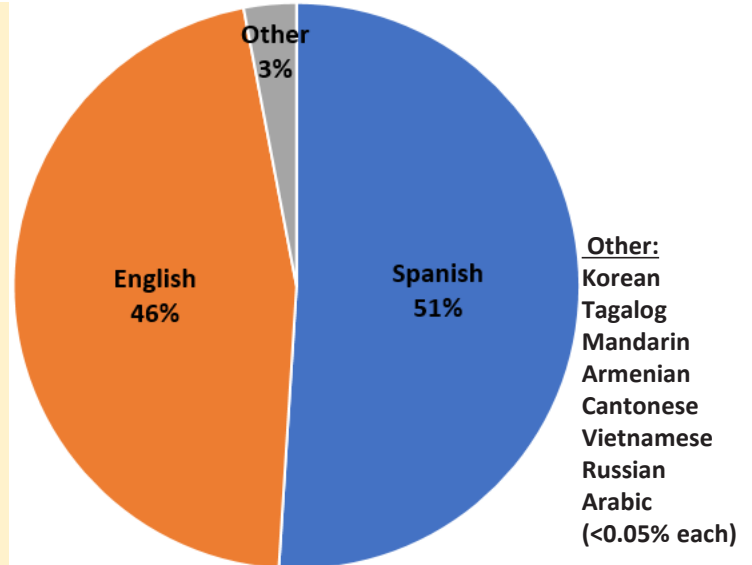
767K*
Interpretation Service Encounters

221K*
Interpretation Service Hours

4.4/5
Average Satisfaction Rating

225
System-wide Document Translations

3.8K
Bilingual Bonus Recipients

e-mail: Olaifeedback@dhs.lacounty.gov

*Of note, "Interpretation Services" include Qualified Healthcare Interpretation Services provided by vendors through telephonic and video remote interpretation, as well as services provided by DHS Healthcare Interpreter staff only. The data above reflects services utilized across DHS medical centers, health centers, and programs. Updated: 3/15/2023.

LANGUAGE SERVICES REQUIREMENTS

Federal laws require that we provide Language Assistance Services (LAS) to Non-English Language Preferred (NELP) patients and patients with communication disabilities, and/or their legal representative(s) to ensure equal access to our healthcare services 24 hours a day, 7 days a week as aligned with site operations.

Qualified Interpretation Services, as well as Written Translation and other Effective Communication Services are provided at no cost. Services are accurate, are provided timely, and protect patient privacy.

Review DHS Policies on Language Access below:

- DHS Policy 318: Language Access - Interpretation Services
- DHS Policy 318.001: Translation of Written Materials
- DHS Policy 318.002: Effective Communication with Persons with Disabilities

LANGUAGE ACCESS LAWS AND REFERENCES

DHS complies with applicable federal civil rights laws and regulatory requirements.

https://jeenie.com/news/language-access-laws-comprehensive-guide/

ACCESSING QUALIFIED LANGUAGE SERVICES

Based on regulations, Qualified Language Services include individuals trained in Healthcare Interpretation [e.g., Healthcare Interpreters (HCI)], Translation, and Certified Bilingual Staff.

In general:

1. HCIs are available to assist staff with interpretation for clinical conversations, and

2. Certified Bilingual Staff are available to provide direct communication with patients in the scope of their assigned job.

Patient safety data shows that relying on family members or untrained bilingual staff to interpret can lead to medical errors. That is why **it is important to work with qualified language services for clinical conversations**.

Qualified Interpretation Services can be offered and provided through various ways including Face-to-Face Interpreters, Telephonic/Audio Interpretation Services, and Video Remote Interpretation (VRI) services. The type of Interpretation Service chosen depends on the nature of the visit, patient's needs/preference(s), as well as the readily available services in the language needed.

IMPORTANT INFORMATION ABOUT FRIENDS AND FAMILY SERVING AS INTERPRETERS

A patient may not be asked to bring their own interpreter. With the exception of medical emergencies until a qualified interpreter is available:

1. You should not have family or friends interpret for clinical conversations.

2. Minor children cannot interpret for their families.

IDENTIFYING AND CAPTURING PREFERRED LANGUAGE

A patient's Preferred Language should be captured/verified in the patient's Electronic Health Record (EHR) at each visit. It is the responsibility of the staff who interact with the patient to ensure that the Non-English Language Preference and interpretation needs are accurately noted in the EHR.

DOCUMENTING LANGUAGE SERVICES

The method used to provide language services, including if services were refused, must be documented in the EHR when a healthcare member speaks to a patient about their clinical care.

For additional information, please visit Office of Language Access and Inclusion or your Language Center.
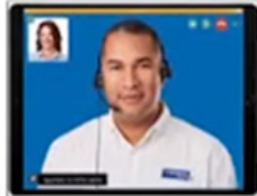
freepik.com

LA GENERAL LANGUAGE CENTER: (323) 409-5533		
Business Hours from 8:30 A.M. to 10:00 P.M.		
How to Request Language Services		
Face-to-Face Interpreting Services	To schedule a face-to-face interpreter for any language (including sign language), call the Language Center at (323) 409-5533 during business hours from 8:30 A.M. to 10:00 P.M.	
Video Remote Interpretation (VRI) Services, including American Sign Language (ASL) Interpreting Services Top Languages available on-demand 24 hours/7days a week	Refer to the laminated cards on the Video Remote Interpretation (VRI) equipment for details regarding VRI Services. If not available, call the Language Center at (323) 409-5533.	
Telephonic/Audio Interpreting Services Over 240 languages available on-demand 24 hours/7 days a week	Dial "0" for the operator and request an interpreter or dial ext. 93600 from any in-house phone. For personal phone access, dial (323) 409-3600	
LanguageLine Insight (Interpreter) App Over 240 languages available on-demand 24 hours/7 days a week	To access the app on personal smartphones, click here for instructions. To access the app Virtual Desktop Infrastructure click here to review the user guide.	
TTY or CRS	Call the Language Center to obtain information about the following: • TTY (teletypewriter) Devices or the California Relay Service (CRS) [available for the deaf, hard of hearing, or speech disabled patients] • Locations of Public TTY/TDD machines/pay phones • Speech to Speech (STS) Relay Service for patients with speech disabilities	
Written Translation	Contact the Language Center for assistance with Written Translation.	

FEDERAL LAW: SECTION 1557 – AFFORDABLE CARE ACT

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 I of the Act or its amendments. **Entities subject to Section 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, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.**

Section 1557 of the Affordable Care Act includes prohibitions on gender identity discrimination as a form of sex discrimination, enhances language assistance for people with limited English proficiency, and requires effective communication for individuals with disabilities.

Section 1557 has been in effect since its enactment in 2010 and the US Department of Health and Human Services (USHHS) Office for Civil Rights has been enforcing the provision since it was enacted.

KNOW THE RIGHTS THAT PROTECT INDIVIDUALS WITH DISABILITIES FROM DISCRIMINATION

US HHS Office for Civil Rights Commemorates the American with Disabilities Act's 30th Anniversary:

On July 26, 1990, President George H.W. Bush signed the Americans with Disabilities Act into law. This landmark civil rights law is a critical part of the HHS Office for Civil Rights' (OCR) disability non-discrimination work, along with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act.

What is Section 504?

Section 504 is part of the Rehabilitation Act of 1973, a federal law that protects individuals from discrimination based on disability. Under this law, individuals with disabilities may not be excluded from or denied the opportunity to receive benefits and services from certain programs.

What is Title II of the Americans with Disabilities Act?

Title II of the Americans with Disabilities Act (ADA) is another law that prohibits disability discrimination. It applies to all state and local government agencies and offers protections similar to Section 504.

DHS NONDISCRIMINATION NOTICE

The Los Angeles County Department of Health Services (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of language, culture, size, gender, sex, sexual orientation, gender identity or expression, socioeconomic status, physical or mental ability or disability.

To whom do these laws apply?

Section 504 applies to entities that receive financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (HHS). These entities include many hospitals, nursing homes, mental health centers and human service programs. The Office for Civil Rights (OCR) at HHS ensures that entities receiving federal financial assistance comply with these laws. Title II of the ADA applies to all state and local government agencies, whether or not they receive federal financial assistance.

What does Effective Communication for Persons Who Are Deaf or Hard of Hearing entail?

Effective communication with a qualified person who is deaf or hard of hearing is communication that allows the person an equal opportunity to participate in, and enjoy the benefits of a service, program, or activity. This can mean communicating with a patient or their companion through lip-reading, written notes, or a Sign Language interpreter. It is important to ask the deaf or hard of hearing person what works best for them. (Source: This requirement is found at 28 C.F.R.Section 35.160(a), and for more clarity on public entities' obligations toward companions who have disabilities, see 28 C.F.R. Part 35, Appendix A.)

DHS:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

To obtain language access services, contact your local DHS facility's Language Center at (323) 409-5533.

SPIRITUAL NEEDS OF PATIENTS

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

Emergency chaplains are available 24 hours a day through referrals by nurses at any unit. Chaplains (available in English, Spanish, Korean, and Chinese) will attempt to visit every patient, every few days. Weekly visits also include a person of the Jewish, Islamic and Jehovah's Witness faith. Referrals to the Chaplaincy program may be made by having a nurse call or by *ORCHID* request. For an urgent request, a nurse can page the appropriate emergency chaplain.

Chaplaincy services offered include: Pastoral care visits, spiritual and grief counseling, Holy Communion/Anointing of the Sick, Confession, spiritual literature, Sunday worship services, Bible study (staff), prayer and spiritual support groups. Chapels are located in Inpatient Tower, 2nd floor. Chaplains are members of various hospital committees such as Ethics, Organ Donation, Cancer, I Can Cope, etc. Chaplains often are a part of the interdisciplinary team and participate in patient care meetings/rounds such as discharge planning and/or end of life issues.

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ADVANCED HEALTH CARE DIRECTIVES

The Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give directives regarding health care decisions. The AHCD allows patients to determine whether or not they want life-sustaining treatment if terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so. Los Angeles General Medical Center Nursing 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 Los Angeles General Medical Center intranet. Staff MUST ensure a copy of the AHCD is in the medical record.

If you are directly involved in the care of a patient who wishes to execute an AHCD, or to discuss this option, please contact the Clinical Social Work Department or the patient's physician. Remember patients who are of sound mind can change their mind at any time regarding AHCDs.

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

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

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

SERVICE ANIMALS

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

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

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

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

- Businesses may ask if an animal is a service animal and ask what tasks the animal has been trained to perform, if it is not obvious, but cannot require special ID cards for the animal or ask about the person's disability.
- The service animal must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.
- People with disabilities who use service animals cannot be charged extra fees, isolated from other patrons or treated less favorably than other patrons. However, if a business normally charges guests for damage that they cause, a customer with a disability may be charged for damage caused by their service animal.
- A person with a disability cannot be asked to remove their 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 a disability the option to obtain goods and services without having the animal on the premises.
- Businesses that sell or prepare food must allow service animals in public areas, even if state and local health codes prohibit animals on premises.
- Businesses are not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

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

Violators of the ADA can be required to pay monetary damages and penalties. If you have additional questions concerning ADA and service animals, please call the HR Manager and ADA Coordinator at (747) 210-3313, DHS Risk Management at (323) 914-6365, or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

BABY-FRIENDLY INITIATIVE

INTRODUCTION

Baby-Friendly USA, Inc. is the U.S. authority for the implementation of the Baby-Friendly Hospital Initiative ("BFHI"), a global program sponsored by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). The initiative encourages and recognizes hospitals and birthing centers that offer an optimal level of care for breastfeeding mothers and their babies, based on the Ten Steps to Successful Breastfeeding.

WHY BREASTFEEDING MAKES A DIFFERENCE

Importance of Exclusive Breastfeeding
Exclusive breastfeeding provides optimal nutrition and health protection. WHO recommends breast milk as the natural first food for babies. It provides all the energy and nutrients that the infant needs for the first six months of life. Exclusive breastfeeding reduces infant mortality due to common childhood illness such as diarrhea or pneumonia, and helps for a quicker recovery during illness.

Breastfeeding Offers an Unmatched Beginning for Our Children
Human milk provides the optimal combination of nutrients and antibodies necessary for each baby to grow healthy. Scientific studies have shown us that breastfed children have fewer and less serious illnesses.

Mothers Who Choose to Breastfeed are Healthier
Recent studies show that women who breastfeed enjoy lower risks of breast and ovarian cancer, anemia, and osteoporosis.

Families Who Breastfeed Save Money
In addition to the fact that breast milk is free, breastfeeding saves on health care costs and time lost to care for sick children.

Communities Reap the Benefits of Breastfeeding
Research shows that there is less absenteeism from work among breastfeeding families. Families who breastfeed have more money available to spend on goods and services, thereby benefiting the local economy.

The Environment Benefits When Babies are Breastfed
Scientists agree that breast milk is the best way to nourish our babies, and may protect babies from some of the effects of pollution. Since there is no waste in breastfeeding, each breastfed baby cuts down on our pollution and garbage disposal problems.

LOS ANGELES GENERAL MEDICAL CENTER RECEIVES BABY FRIENDLY DESIGNATION

In April 2012, Los Angeles General Medical Center became one of the first facilities in the nation to receive from Baby-Friendly USA the prestigious international recognition as a Baby-Friendly® birth facility. Los Angeles General Medical Center had its Baby-Friendly redesignation site visit in June 2017.

UPDATES TO THE GUIDELINES AND EVALUATION CRITERIA AT LOS ANGELES GENERAL MEDICAL CENTER

- Medications and information on use of Radioisotopes acceptable for breastfeeding can be found:
  - LactMed: Drugs and Lactation Database at https://www.ncbi.nlm.nih.gov/books/NBK501922/
  - Medications and Mother's Milk (2010), a book by Thomas Hale
- Community Resources
  - Women Infant Children (WIC) program
  - La Leche League (LLL)
- Los Angeles General Medical Center Community Resources
  - Los Angeles General Medical Center Breastfeeding Support Group
  - Los Angeles General Medical Center Outpatient Lactation Clinic
  - Los Angeles General Medical Center Prenatal Breastfeeding Class
- When a mother needs help for breastfeeding, ancillary staff should notify the nurse assigned to the patient.

Further information about the U.S. Baby-Friendly Hospital Initiative may be obtained by contacting:

Baby-Friendly USA, Inc.
Phone: (518) 621-7982
Fax: (508) 484-1716
E-mail: info@babyfriendlyusa.org
Web: www.babyfriendlyusa.org

ORGAN/TISSUE DONATION

Los Angeles General 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).

REMEMBER

All potential organ/tissue donors must be referred to the OneLegacy 24-hour donor referral line at (800) 338-6112

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

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

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.

It is our ongoing priority here at Los Angeles General Medical Center to provide a safe environment for our customers, visitors, 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.

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
    •   Notify the Safety Office (*Can be anonymous*)
    •   Safety Intelligence™ (SI) Event Reporting System on the Los Angeles General Medical Center SharePoint site

FACILITY SAFETY OFFICER

The Los Angeles General Medical Center facility Safety Officer oversees the following areas: General Hospital Building, Clinic Tower, Inpatient Tower, Diagnostic & Treatment Building, Interns & Residents Building, Rand Schrader Clinic, Outpatient Department, and Psychiatric Services at the Augustus Hawkins Mental Health Center.

Los Angeles General Medical Center: (323) 409-7485
DHS Health, Safety & Environmental Unit: (323) 409-7514

DHS EMERGENCY CODES

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

LOS ANGELES GENERAL MEDICAL CENTER HOSPITAL EMERGENCY CODES

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

DHS STANDARDIZED EMERGENCY CODES

Code	Description
CODE BLUE	Adult Medical Emergency
CODE WHITE	Pediatric Medical Emergency
CODE RED	Fire
CODE GOLD	Mental Health/Behavioral Response
CODE GRAY	Combative Person
CODE SILVER	Person with a Weapon and/or Active Shooter and/or Hostage Situation
CODE GREEN	Patient Elopement
CODE PURPLE	Child Abduction
CODE PINK	Infant Abduction
CODE ORANGE	Hazardous Material Spill/Release
CODE YELLOW	Bomb Threat
CODE RAPID RESPONSE	Urgent Medical Attention to Inpatients
CODE ASSIST	Urgent Medical Assistance to Outpatients, Visitors, and Staff
CODE TRIAGE ALERT	Potential Disaster
CODE TRIAGE INTERNAL	Internal Disaster
CODE TRIAGE EXTERNAL	External Disaster

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

AUGUSTUS F. HAWKINS FAMILY MENTAL HEALTH CENTER EMERGENCY CODES

AUGUSTUS F. HAWKINS – CALL EXT. 4512

	CODE BLUE	Adult Medical Emergency
	CODE WHITE	Pediatric Medical Emergency
	CODE RED	Fire
	CODE GOLD	Mental Health/Behavioral Response
	CODE GRAY	Combative Person
	CODE SILVER	Person with a Weapon and/or Active Shooter and/or Hostage Situation
	CODE GREEN	Patient Elopement
	CODE PURPLE	Child Abduction
	CODE PINK	Infant Abduction
	CODE ORANGE	Hazardous Material Spill/Radiation Incident
	CODE YELLOW	Bomb Threat
	CODE RAPID RESPONSE	Urgent Medical Attention to Inpatients
	CODE ASSIST	Urgent Medical Assistance to Outpatients, Visitors, and Staff
	CODE TRIAGE ALERT	Limited Activation of Key Personnel for Incident
	CODE TRIAGE INTERNAL	Activate Emergency Operations Plan – Internal Incident

SECURITY

The Los Angeles County Sheriff's Department provides Los Angeles General 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 Los Angeles General 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 Los Angeles General 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 Los Angeles General Medical Center and provide weapons screening and workforce member badge checks.

SAFETY AWARENESS

In the interest of protecting yourself and your personal property, please leave valuables such as expensive jewelry, 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:

- Do not prop doors open or keep doors from latching.
- Walking in groups when leaving the workplace after dark.
- Reporting any suspicious activities to the Sheriff's personnel.
- Locking your vehicle.

BOMB THREATS (CODE YELLOW)

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

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

- 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?
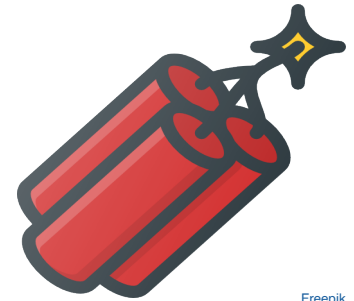
Freepik

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

WEAPONS

Workforce members shall not carry a prohibited weapon of any kind while in the course and scope of performing their job, whether or not they are personally licensed to carry a concealed weapon. Workforce members are prohibited from carrying a weapon anywhere on County property or at any County-sponsored function. Prohibited weapons include any form of weapon or explosive restricted under local, state, or federal regulation. This includes all firearms, illegal knives, or other weapons prohibited by law. Violations may result in any or all of the following:
- Arrest and prosecution for violations of pertinent laws
- Immediate removal of the threatening individual from the premises pending investigation
- Disciplinary action up to and including discharge from County service or assignment

The Sheriff's Department and contract security guards will strictly enforce all weapons related laws.

WORKPLACE VIOLENCE

To protect our workforce members from an act of violence or threat of violence that occurs at our work site, Los Angeles General Medical Center has a Workplace Violence Prevention Plan. The County of Los Angeles has a "zero tolerance" policy that addresses workplace violence and violent behavior. Violation of this policy may result in disciplinary action up to and including discharge from County service or assignment. If you observe violence or signs of violent behavior, notify your manager or supervisor and the facility security officers. Please refer to DHS policy on workplace violence for further information.

What is Workplace Violence?

"Any act of violence or threat of violence that occurs at the work site."

The Crisis Cycle

Workplace violence doesn't occur without warning. It is usually the third or fourth stage in the Crisis Cycle. Knowing the different stages will allow you to better identify and address potential danger.

1st Stage of Crisis - Anxious Person

Anxious person – defined by a notable change/increase in behavior. Behaviors include: pacing, finger tapping, wringing hands, asking questions, appearing distracted or withdrawn, and increase in vital signs (heart rate, blood pressure, respiratory rate). **Staff response** should be supportive with an empathic, nonjudgmental approach. Examples include: listening, offering reassurance, providing information, and utilizing therapeutic considerations such as:

- Personal space - an area surrounding the body that varies from person to person. Invasion of personal space increases anxiety for everyone and decreases safety. Staff can honor personal space by maintaining at least a leg's length away.
- Kinesics - the non-verbal message transmitted by the motion and posture of the body. Staff can decrease anxiety and send a positive message by maintaining an open body posture, interested facial expression, non-threatening gestures, offering eye contact, and by smiling (depending on the situation).
- Paraverbal communication - the vocal part of speech, excluding the actual words used. Staff should speak with a smooth, calm, and reassuring voice. The voice volume should be controlled and appropriate for the setting.

"Calming words" and a "positive attitude" have the power to calm anxiety, so be aware of your tone of voice, choice of words, and body language.

2nd Stage of Crisis - Defense Person

Defensive person – defined by a loss of rationality; sometimes referred to as the verbally abusive stage. Behaviors include: yelling, screaming, belligerent language including the use of profanities, and challenging authority. **Staff response** should focus on taking control of a potentially escalating situation by setting limits that are simple, clear, reasonable, enforceable, non-challenging, and non-threatening. Staff members should remain calm, start with positive choices, allow the defensive person to blow off steam, remove the audience, and avoid power struggles.

3rd Stage of Crisis - Person in Crisis

Person in crisis – defined by the total loss of rational control that results in a physical acting-out episode. This is sometimes referred to as the physically abusive stage. Behaviors include: engaging in dangerous actions and not responding to verbal interventions, hurting self or others, placing patient or others in imminent danger such as hitting, kicking, biting, grabbing, pulling, choking or throwing objects. **Staff response** should focus on avoiding solo intervention, using non-harmful personal safety techniques to escape, and activating the appropriate emergency code. Physical intervention is used as a last resort when alternative measures have been considered and are ineffective. Alternative measures include: continued verbal intervention, setting limits, offering anti-anxiety medication, and continued observation.

4th Stage of Crisis - Tension Reduction

Tension reduction – defined by the decrease of physical and emotional energy where the individual begins to regain control of their emotions; sometimes referred to as the post-crisis stage. Behaviors include: apologizing, crying, withdrawing, sleeping, and expressing feelings of remorse. **Staff response** should be focused on building a therapeutic rapport with the individual and avoid blaming the individual for their actions. This is accomplished by debriefing with the individual to discover what happened from their perspective, identifying triggers, and contracting on strategies to avoid the behavior in the future. This debriefing can be performed using the acronym "**COPING**":

Remember **"COPING"**
COPING is the steps to remember when talking to the individual in crisis:

Control – make sure the individual is calm
Orient – orient individual to what just happened
Patterns – What things triggered the crisis
Investigate – what needs to change to prevent a crisis
Negotiate – Contract to make changes
Give – give back control to the individual

Avoiding Physical Harm

Most violent behavior is preceded by warning signs. The following cues are indicators of impending violence:

Verbal Cues
•   Speaking loudly, yelling, swearing or using a threatening tone of voice

Non-verbal or Behavior Cues
•   Poor hygiene or symptoms of intoxication and/or drug abuse
•   Aggressive or threatening posture
•   Arms crossed on chest or clenched fists
•   Heavy breathing, pacing or agitation
•   A scared look or a fixed stare
•   Thrown objects or sudden changes in behavior

Incident Reporting

To report violent incidents to law enforcement call the Los Angeles County Sheriff's Department at ext. 3333.

Report all workplace violence incidents in the Safety Intelligence™ (SI) Event Reporting System!

Workplace Violence Emergency Codes

Code Gold– Called when there is an emergent issue with a patient's mental state and there is the potential to bring harm to themselves or others. A **Behavioral Response Team** (BRT) will respond in ER, a second team to Inpatient situations. Assist the team as directed. All other buildings must call **Code Gray** for assistance.

Code Silver– Called when there is a person with a weapon, active shooter and/or hostage situation.
•   **Notify** - Warn others of the situation.
•   **Escape** - Evacuate if it is safe to do so.
•   **Hide Out** - Seek cover/protection. Assist patients in seeking shelter/protection.
•   **Take Action/Fight** - Only as a last choice.

Code Gray – Called when there is a combative person or situation.
•   **Contact security or the Los Angeles County Sheriff's Department at ext. 3333.**
•   Assist victims(s) and remain calm and non-combative. Diffuse the situation if possible.
•   Clear the area of non-involved persons.

Dress with Safety in Mind

•   Remove anything you are wearing that can be used as a weapon or grabbed by someone.
•   Avoid wearing earrings, stethoscope, necklaces or other items that can be pulled.
•   Glasses, keys or name tags dangling from cords/chains can be hazardous. Use breakaway safety cords or lanyards.
•   Long hair should be put up or tucked away so that it can't be grabbed.

Remember **"STAMP"**
STAMP stands for the five visible elements of behavior that can indicate a person's potential or likelihood for becoming violent.
Staring and eye contact
Tone and volume of voice
Anxiety
Mumbling
Pacing

As the risk of violence increases, the number of observable **STAMP** cues will typically increase.

Awareness, Vigilance, Avoidance, Defense, and Escape Principles (AVADE)

Awareness, Vigilance, Avoidance, Defense, and Escape principles (AVADE) is a new workplace violence prevention training model that has three levels of trainings assigned in TalentWorks based on role and work setting. AVADE training is specific to healthcare settings and provides specialized techniques on how to identify, prevent, and mitigate the risk of violence.

- **Level I**: Is a web-based training that is completed via TalentWorks. This 60-minute course covers the fundamentals of AVADE and is for all DHS workforce members.

- **Level II**: Is an in-person interactive training for workforce members with direct patient contact. This training provides knowledge on basic self-defense techniques for intervening in violent incidents that cannot be otherwise deescalated. This 4-hour training requires completion of the Level I online training as a pre-requisite and is not applicable to everyone.

- **Level III**: Is the most advanced level of training and is for workforce members who meet selective criteria for requiring advanced training. This 8-hour in-person training combines Level II and III curriculum and only requires completion of Level I training as a pre-requisite. Advanced Level III techniques may include responses to attempted lethal force, attacks against employees, defensive take-down responses, and healthcare specific restraint techniques designed to mitigate patient harm. This training is not appropriate for everyone and will only be assigned to workforce members who meet very selective criteria.

For more information, visit Workforce Violence Prevention - Home (sharepoint.com)

Workplace Violence Prevention Resources

Employee Assistance Program (EAP)

Licensed mental health professionals are available to assist employees and their dependents with personal or situational stress that interferes with their well-being, day-to-day functioning and carrying out their job responsibilities.
https://employee.hr.lacounty.gov/employee-assistance-program/

Department of Mental Health

24/7 ACCESS Hotline
Free, confidential mental health information, referrals to service providers and crisis counseling.
(800) 854-7771
http://dmh.lacounty.gov

Safety Office

If there are questions on workplace violence, contact the Safety Office or
e-mail safetyhotline@dhs.lacounty.gov.

INFANT/CHILD ABDUCTION (CODE PINK/PURPLE)

When a Code Pink or Code Purple is called, all available staff members are required to immediately cover exits in their areas and report 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.

HAZARDOUS MATERIALS/HAZARD COMMUNICATION

Whenever there is an actual release or spill of a hazardous material or waste, the following emergency procedures shall be placed into effect in accordance with 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 initiating 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 Safety Data Sheet (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.
b. Ingestion – Drink a lot of water but do not induce vomiting.
c. Skin Contact – Flush the affected area with water for 15 minutes.
d. Inhalation – Remove victim to fresh air.

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

Hazard Pictograms on Labels

FLAMMABLE	**OXIDIZER**	**EXPLOSIVE**
FATAL/TOXIC	**CORROSIVE**	**COMPRESSED GAS**
HEALTH HAZARD	**ENVIRONMENT**	**IRRITANT/SENSITIZER/TOXIC**

KEY POINT

You must know the names of the hazardous materials that you work with or may come in contact with in your work area.

RADIATION EXPOSURE

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) 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.

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.

REMEMBER

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

EMERGENCY AND DISASTER MANAGEMENT

Emergency Management (EM) involves the planning, preparedness, and response activities for emergency and disaster events, internal or external, which affect the Los Angeles General Medical Center and Los Angeles County as the Operational Area.

The Los Angeles General Medical Center has a comprehensive Emergency Management Program (EMP). Primary responsibility for the development and oversight of the EMP falls to Hospital Leadership, the Office of Emergency Management (OEM), and the Emergency Management Committee (EMC), which is chaired by the Emergency Management Officer (EMO) and reports to Executive Leadership. They strategize and approve EM activities, facilitate in executing EM scope of work, and facilitate compliance with EM mandates, including:

- Regulatory EM requirements for:
  - Office of the Assistant Secretary for Preparedness and Response (ASPR): Hospital Preparedness Program
  - National Fire Protection Association (NFPA): NFPA 99 Health Care Facilities Code, 2012 Edition
  - Centers for Medicare & Medicaid Services (CMS): 42 CFR Part 482
  - California Department of Public Health (CDPH): Title 22, 24
  - The Joint Commission: EM Chapter
  - County of Los Angeles / Department of Health Services
- Conducting and publishing the annual Hazard Vulnerability Analysis
- Developing, reviewing, and revising the Emergency Operations Plan
- Conducting 2 drills per year, at a minimum
- Ensuring Hospital Command Center (HCC) readiness 24/7, Hospital Incident Command System (HICS) compliance, and National Incident Management System (NIMS) implementation activities

Emergency Operations Plan:

The Emergency Operations Plan (EOP) establishes operational procedures and guidelines for potential or actual emergencies that fall on a continuum of disruptive to disastrous, that can adversely impact the organization's ability to provide care or adversely impact the environment of care itself, or that can result in a sudden, significantly changed or increased demand for the organization's services.

The EOP is an all-hazards plan. It also contains Incident Response Plans (IRP) for specific events, including: earthquakes, evacuations, power failure, and water emergencies. The plan is to be implemented at any time deemed necessary to manage an incident, for internal/external disasters, healthcare emergencies, patient surge, a multi-casualty/mass casualty incident (medical, trauma, chemical, biological, radiological, nuclear, or high yield explosives), or when needs are greater than resources. This plan will remain in effect until that time the event and its effects are resolved and the medical center can return to normal operations.

The EOP is activated via the hospital emergency code: Code Triage [Internal/External]. EOP activation then necessitates establishing the Hospital Command Center and implementing the Hospital Incident Command System, which is the standardized management tool for incidents. Authority to activate the EOP includes Executive Leadership, Administrator on duty, and the EMO.

The EOP can be accessed via the intranet homepage under Departments > Administrative Services > Emergency Management.

The Hospital Command Center phone number is (323) 409-1443.

Departments may have internal Emergency Response Plans (ERP) for department-specific procedures to follow in the event of an emergency or disaster. Staff should be familiar with these. Contact your supervisor for more details.

Communications:

Code Triage notification will come from the Telephone Office and the Enterprise Help Desk (EHD). The Telephone Office will provide overhead paging and desktop VOIP phone speakers systems. The EHD will provide notification via Outlook Broadcast Notification and the Everbridge Notification System.

The facility has usual and redundant modalities that may be implemented during an emergency or disaster, including: overhead paging, desktop VOIP phone speaker paging, telephone system (e.g., analogue red phones, digital lines, and VOIP wired/wireless lines), Everbridge notification system, Outlook e-mail, Microsoft Teams, VMED28 radio, ReddiNet, HAM radio, and satellite phone. Additional options during an emergency may include the use of runners and personal cell phones.

Staff Responsibilities:

During an incident, all staff are required to report to their duty station and direct line of authority. This includes: County, non-County; administrative, medical, nursing, and ancillary workforce members; Residents and Fellows in meetings, grand rounds, on call, or on elective leave. Staff may be held-over and/or called-in as needs dictate.

During an incident, all departments/units/services shall implement their respective unit-/service-based procedures or ERP's, if available. The department/unit/service supervisors or managers shall evaluate their specific area's operational status, staffing needs, and available personnel, and relay the information to their department director. This information is forwarded to the HCC via their respective Operations branch.

Non-essential services or day-to-day functions not directly related to the emergency response may be suspended for the duration of the incident, if necessary. Space may be flexed/re-purposed. Personnel may be redeployed/reassigned to different locations. Personnel may be required to perform duties not related to their normal assignment (but not above their capability). Just-in-time training may be necessary. The overseeing unit or service will be responsible for this function.

Resources and Supplies:

Each unit or service will obtain and/or replenish needed resources and assets through their normal procedures, including but not limited to: personnel, supplies, equipment, pharmaceuticals, Environmental Services (EVS), and Laundry Services.

Should standard methods be insufficient, the department/unit/service supervisor or manager will place a request with the HCC/Logistics Section. The Logistics Section will then assist in obtaining the requested resource or asset. Their function will be to:

- Provide support to other sections.
- Acquire resources from internal/external sources.
- Activate existing MOUs, contracts, and vendor agreements.
- Employ standard and emergency procurement and contracting procedures.
- Work closely with Supply Chain Operations to obtain and replenish hospital stock.
- Work closely with Supply Chain Operations and the Planning Section to forecast future needs.
- Communicate needs with the Medical Alert Center or DHS Department Operations Center. The Liaison Officer may assist.

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 from unnecessary injury.

Although you may need assistance using the "Swing" and "Extremity" carries, 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

TWO-PERSON CARRIES

HIP CARRY

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

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

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

DOWN

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

PACK STRAP CARRY

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

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

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

DOWN

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

CRADLE DROP

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

2. Slide patient to edge of bed
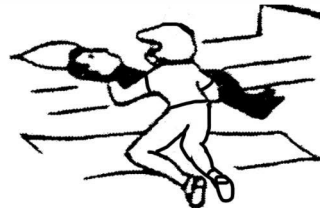
3. On both knees, slide patient down your chest to blanket. Or on one knee, lower their legs then their body, to blanket.

REMOVE

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

SWING

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

EXTREMITY

1. Patient must be sitting on the edge of the bed.
2. One nurse hugs patient from behind, grasping their own wrist.
3. The other nurse stands between patient's legs, and lifts them from behind their knees.

SEMI-AMBULATORY

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

FIRE/LIFE SAFETY

FIRE RESPONSE (CODE RED)

The acronym **SAFE** refers to steps you should take at the Los Angeles General Medical Center in the event of a fire.

S	**S**afety of Life/Close Doors (remove patients and others from danger).
A	**A**ctivate alarm and call emergency operator at Ext. 111.
F	**F**ight the Fire (optional).
E	**E**vacuate.

STEPS IN THE USE OF THE FIRE EXTINGUISHER

The acronym **PASS** refers to the proper use of the fire extinguisher and stands for:

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

CLASSIFICATION OF FIRES

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

TYPES OF EXTINGUISHERS

Extinguisher Type	Canister Color	Symbol	Description
A	Silver	A	Pressurized water tank used for wood, paper, cloth (Class A) fires. Do not use on flammable liquids or electrical fires.
B-C	Red	B-C	Contains either carbon dioxide or dry chemical, which smothers the fire; used for flammable liquids (Class B) or electrical (Class C) fires.
A-B-C	Red	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 combustible metal (i.e. magnesium, sodium, potassium, lithium etc.) fires require special extinguishing agents and procedures.			
Class K fire extinguishers were developed for deep fat fryers in commercial cooking operations. It uses wet chemicals that extinguishes the fire by removing the heat of the fire triangle. It can be found in commercial kitchens.			

Image by: Freepik

MRI – Special Consideration

Only non-magnetic fire extinguishers can be used in the Magnetic Resonance Imaging (MRI) area because MRI equipment uses magnetic waves that cause safety concern when magnetic/metallic object is present.

A 5 lb. fire extinguisher will empty in less than one minute.

NEVER re-hang an extinguisher once it has been discharged, even if it is only for a few seconds. Notify Facilities 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 (e.g., "Out of Order"). Report all medical equipment and utilities malfunctions to your supervisor and the Clinical Engineering Department. When there is an equipment malfunction, do not leave a patient unattended. In life-threatening emergencies involving medical equipment, send a co-worker to get a replacement from the nearest location. When a device failure or operator error results in serious negative consequence to a patient, you must inform Risk Management as soon as possible (within 24 hours) and immediately impound the device. You must also submit an event report via the Safety Intelligence™ (SI) Event 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).
- Inspection sticker with proper date.

Verify LIFE

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

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

Other points to remember:

- Keep long cords coiled and out of way of traffic.
- Unplug all electrical equipment that is not in use.
- Keep chargeable batteries plugged in.
- 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 only (e.g., ventilators and balloon pumps).

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.

> **REMEMBER**
> Report all medical equipment and utilities malfunctions to your supervisor and the Clinical Engineering Department.

ERGONOMICS

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

COMMON CAUSES AND TYPES OF ERGONOMIC INJURIES

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

RISKS FACTORS TO REMEMBER

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

TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

1. **Recognize** the force or strain placed on your body caused when you grip, push, pull or lift heavy materials. Think about ways to minimize these strains or avoid some of these movements. Be aware of pain or numbness in the neck, shoulders, arm, wrist, fingers and back. Immediately, report any work-related injuries to your supervisor.
2. **Alternate** tasks to use different muscles and to give you time to recover. Pace yourself.
3. **Use** eyeglasses, if needed. Remember uncorrected vision problems can cause eyestrain. Remember to blink and look away from the monitor frequently to decrease strain on your eyes.
4. **Use** tools in a safe and appropriate manner. Keep your worksite safe and clean. Do not use unsafe tools, remove them and report them.
5. **Report** any worksite safety concerns to your supervisor. This will help your manager identify harmful patterns or environmental conditions so that necessary changes may be made.
6. **Ergonomic worksite evaluations** are available through the Safety Office. To request an evaluation, please notify your supervisor, then go to https://lacounty.sharepoint.com/sites/dhs-ergonomics and fill out the self-assessment form.
7. **Keep** yourself fit with regular exercise, proper diet, and manage your daily stress.

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:

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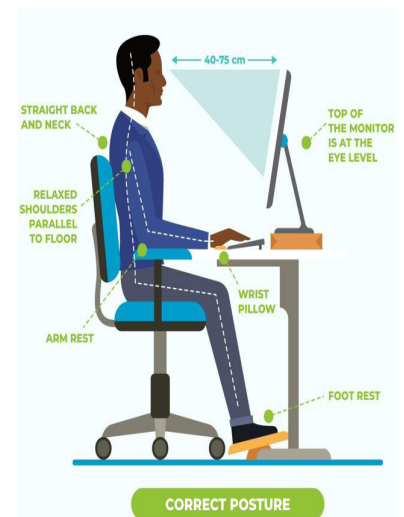
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PERFORMANCE IMPROVEMENT

The mission of the Los Angeles General Medical Center Performance Improvement Program is to facilitate, support and train teams of medical and all other Los Angeles General Medical Center staff in adopting the management system, culture, tools and methodologies based on learned principles, adapted to the Los Angeles General Medical Center 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 Quality Improvement (QI) training.
- Foster a culture where key performance indicators are used daily.

PURPOSE

The purpose of the Los Angeles General 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?)
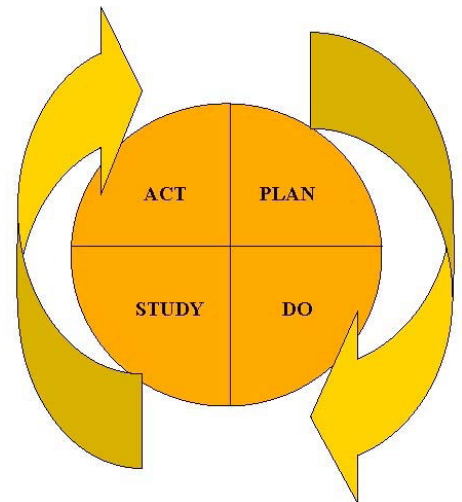
PERFORMANCE IMPROVEMENT ACTIVITIES

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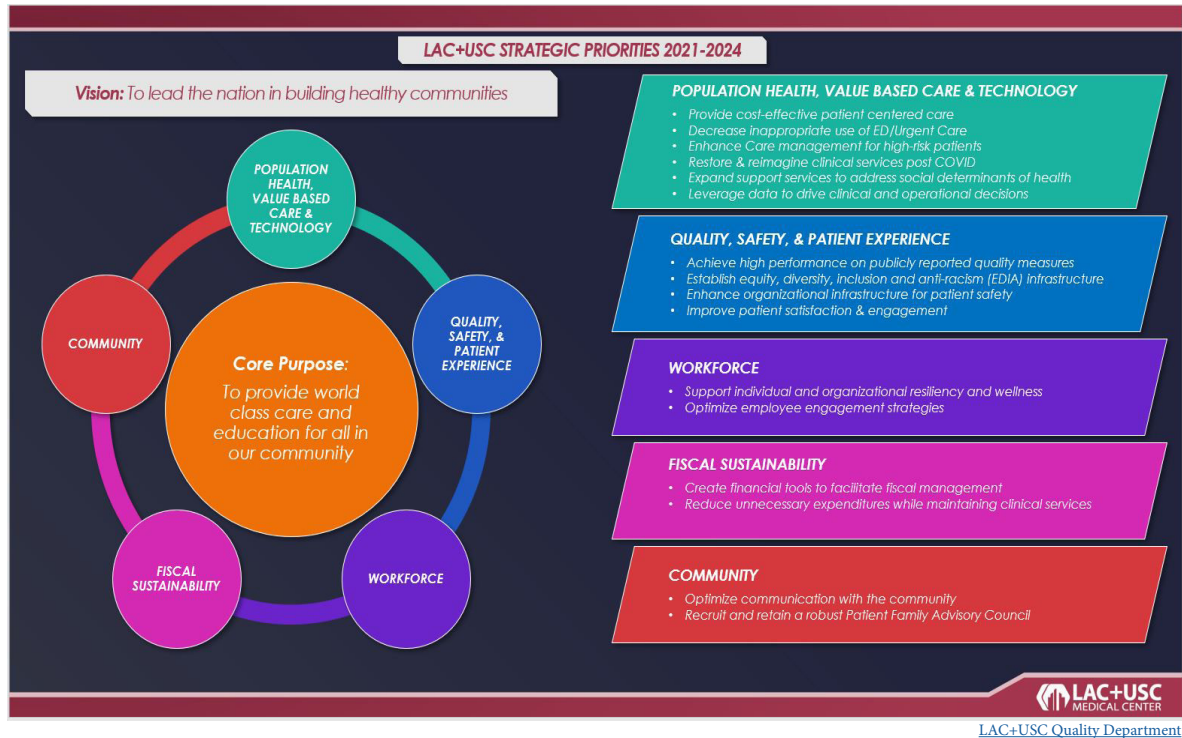
LOS ANGELES GENERAL MEDICAL CENTER DATA COLLECTION

Los Angeles General Medical Center regularly collects data and reports on performance of patient safety issues. Data are benchmarked with other academic medical centers or other appropriate settings to drive performance and continuously improve. Some samples of data collection include:

- Falls
- Hospital Acquired Pressure Injuries (HAPI)
- Restraints
- Hospital Acquired Infections (CLABSI/CAUTI)

Los Angeles General Medical Center participates with other Safety Net organizations and programs in activities to improve performance around population health measures, including:

- Breast Cancer Screening
- Colon Cancer Screening
- Readmissions
- Antibiotic Stewardship
- Medication Reconciliation
- Patient Experience

LOS ANGELES GENERAL MEDICAL CENTER QUALITY ACADEMY & QUALITY TOOLBOX

Los Angeles General Medical Center also conducts Performance Improvement training through its Quality Academy Program (QAP). This program provides didactic and experiential training for multidisciplinary groups of 40-50 participants twice yearly. Each participant completes a strategically important QI project in their work location while learning the essential skills of performance improvement, including the Model for Improvement (IHI), Lean methodology, and PDSAs.

The QAP acts to build individual capability and organizational capacity for performance improvement. This education is supplemented with Quality Toolbox Workshops, held each month and focusing on performance improvement tools applicable in a variety of settings. Staff are encouraged to attend these educational sessions.

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, near miss incidents, documentation of all care and how to respond 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 or 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

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

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

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

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

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

1. Surgery performed on the wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability from contaminated drug/device/or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

7. Patient death or serious disability associated with use/function of a device in a way other than as intended. "Device" includes but is not limited to: a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Death or serious disability associated with patient disappearance for more than 4 hours (excludes adults who have competency or decision-making capacity).
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. Patient death or serious disability associated with medication error, including but not limited to: an error involving the wrong drug, the wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient Death or serious disability related to hypoglycemia, the onset of which occurs while the patient is being cared for in a hospital.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. Stage 3 and 4 ulcers acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. Patient death or serious disability from spinal manipulation therapy performed at the health facility.
19. Patient death or serious disability associated with electrical shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in the health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in the health facility.
24. Any instance of care ordered or provided by someone impersonating a physician, nurse, pharmacist, or licensed health care provider.
25. Abduction of a patient of any age.
26. Sexual assault of a patient within or on the facility grounds.
27. Death or significant injury of patient or staff from physical assault that occurs within or on the grounds of the facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

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™ Event Reporting System, a web-based, DHS-wide system accessible from the Los Angeles General Medical Center intranet webpage.

Sentinel event: A patient safety event (not primarily related to the natural course of the [patient's] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).
   •   **Severe harm**: An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continual physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.
   •   **Permanent harm**: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline.

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.
   •   Discharge of infant to the wrong family.

- Abduction of any patient receiving care, treatment or services.
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services.
- Sexual abuse/assault or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital or while providing care or supervision to patients.
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
- Invasive procedure, including surgery on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure regardless of the type of procedure or the magnitude of the outcome.
- 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.

Los Angeles General 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) Event Reporting System.

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 <u>and</u>
- Safety Intelligence™ (SI) Event Reporting System <u>or</u>
- Patient Care Statement of Concern form - available in all departments or from the Risk Management Office.

> ## REMEMBER
> Risk Management must be immediately notified when an Adverse Event or a Sentinel Event occurs. See Los Angeles General Medical Center 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 Los Angeles General Medical Center Policy No. 303.

REPORTABLE UNUSUAL OCCURRENCES

Title 22 requires the reporting of occurrences to the California Department of Public Health, 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.

A workforce member who encounters such an occurrence must immediately notify their direct supervisor and complete the Reportable Unusual Occurrence form. The workforce member must submit a Safety Intelligence™ (SI) Event Reporting System report within 24 hours of the occurrence (see Los Angeles General Medical Center Policy No. 303.1).

TIMELY REPORTING

When you become aware of an event involving a patient, visitor or staff that may result in a claim or lawsuit against the County or one of its workforce members, the event must be reported to your department supervisor and the Risk Manager using the following steps (Los Angeles General Medical Center Policy No. 300):

- Safety Intelligence™ (SI) Event Reporting System
- 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 Los Angeles General Medical Center Policy No. 300).
- The Risk Management Office can be reached during business hours or through the Telephone Operator after hours.
- When in doubt, call the Risk Manager. Follow-up with all calls by submitting a Safety Intelligence™ (SI) Event Reporting System 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 Los Angeles General Medical Center Policy; there is a possibility that you may be disciplined for failure to report.

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.

> ### REMEMBER
> **Do not** make copies of the SI reports or refer to the SI report in the patient's medical records.

DOCUMENTATION - A KEY DEFENSE

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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.

In a timely manner, document in the medical record all care, treatment given, and changes in the patient's condition. **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. Such issues can be reported to Hospital Administration or recorded in the Safety Intelligence™ (SI) Event Reporting System or Statement of Concern form, as appropriate.

YOUR MEDICAL RECORD DOCUMENTATION MUST INCLUDE:

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

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.
- Do not write the word "error".

CORRECTIONS/EDITS TO THE ELECTRONIC MEDICAL RECORD

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.

SUBPOENA AND SUMMONS

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 that person 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. 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.
- DO NOT ACCEPT LEGAL DOCUMENTS OR SUBPOENA ON BEHALF OF ANOTHER PERSON OR DEPARTMENT.
- DO NOT ACCEPT ANY LEGAL DOCUMENT THAT IS NOT ADDRESSED TO YOU.
- Keep the original envelope that the notice came in.
- Bring the documents to the Risk Management Office (IRD Room 904) or fax.

Contacting Risk Management

Hospital Risk Manager's Office can be reached by telephone or contact the Hospital Telephone Operator during after-hours.

INFECTION PREVENTION AND CONTROL PROGRAM GOALS INCLUDE:
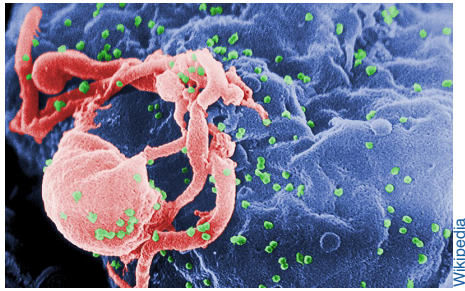
- Preventing the transmission of infection to patients, visitors and workforce members.
- Providing a safe work environment.
- Improving patient care.
- Complying with regulatory requirements.

Infections can be spread through direct or indirect contact when infectious organisms enter the body or blood stream through the eyes, nose, mouth, or skin (cuts, punctures, rashes, wounds, or burns).

Infections can also be spread through frequently touched items, instruments, and articles that come in contact with the patient and/or the environment. It is impossible to know who is infected and who is not. Therefore, it is important to follow Standard Precautions and consider **ALL** blood and body fluids from **ALL** persons as potentially infectious.

Processes that reduce the risk for transmission:

- Standard Precautions
- Transmission-Based Precautions

STANDARD PRECAUTIONS

Standard Precautions are designed to protect the workforce member from bloodborne pathogens and prevent the transmission of infectious agents between the workforce member and patients. Standard Precautions are based on the principle that all blood, body fluids, non-intact skin (including rashes), secretions, excretions (except sweat), and mucous membranes may contain infectious agents.

Standard Precautions include:

- Hand hygiene (before and after every contact with a patient or their immediate environment)
- Respiratory hygiene/cough etiquette
- Appropriate use of Personal Protective equipment (PPE) - gloves, gowns, masks, and eye protection, depending on the anticipated exposure
- Preventing sharps injuries
- Safe injection practices
- Waste disposal
- Cleaning and disinfection

Practicing good hand hygiene is the most important intervention in preventing the spread of infection. Hand washing utilizes water, soap and friction. Use of alcohol-based hand sanitizer (ABHS) consists of taking a small amount of the product, sufficient to cover both hands and all fingers, and rubbing the surface of your hands, including in between your fingers, fingertips, cuticles, wrist, and around your thumbs. Isopropyl Alcohol is used in a healthcare setting.

NOTE:

CDC recommends using ABHS with 70% Isopropyl Alcohol in a healthcare setting.

HAND HYGIENE

USE ALCOHOL-BASED HAND SANITIZER

Amazon

- Before starting your work on each unit
- Prior to going into and after leaving a patient room if your work involves touching the patient or anything in the room
- After touching objects that multiple people touch (i.e., telephones and door knobs, equipment, bed, etc.)
- After handling high-touch surfaces (i.e., telephones, door knobs, equipment, bed, etc.) or anything in the patient's immediate area
- Before leaving work
- Before touching a patient
- During patient care when moving from a contaminated body site to a clean body site
- After contact with a patient's intact skin (e.g., when taking blood pressure, lifting a patient)
- Before donning (putting on) and after removing gloves (if gloves not visibly soiled with blood or body fluids

HANDS MUST BE WASHED WITH SOAP AND WATER

sndcdn

- When hands are visibly soiled or contaminated
- After using alcohol-based hand sanitizer 5-10 times (per manufacturer's guidelines)
- After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, wound dressing or contaminated surfaces
- Before eating or preparing food
- After using the restroom
- After direct contact with a patient that is known or suspected to have Clostridium difficile (C. diff), Bacillus anthracis (anthrax), Norovirus, or any item/substance that may be contaminated with these pathogens

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

PROPER STEPS ON PERFORMING HAND HYGIENE	
Using Alcohol-Based Hand Sanitizer	**Washing Hands with Soap and Water**
1. Apply enough alcohol-based hand sanitizer to open palm to fully cover hands and wrists 2. Rub hands together palm to palm 3. Rub in between and around fingers 4. Rub back of each hand with palm of other hand 5. Rub fingertips of each hand in opposite palm 6. Rub each thumb clasped in opposite hand 7. Rub each wrist clasped in opposite hand 8. Keep rubbing hand surfaces until hands are **dry**	1. Wet both hands with clean running water 2. Apply adequate amount of soap in palm of hand 3. Rub soap all over both hands, including wrists, between fingers and under fingernails 4. Scrub for at least a **full 20** seconds 5. Rinse soap from hands thoroughly under clean running water 6. Dry hands completely using a clean paper towel 7. Use another clean paper towel to turn off faucet and discard 8. **Do not** touch faucet/sink/counter with clean hands 9. **Do not** touch door knob with clean hands 10. Use clean paper towel to open door 11. Toss towel in the trash

Training video available on TalentWorks: - Hand Hygiene - Soap/Water and Alcohol-Based Hand Sanitizer

FINGERNAILS

Natural nails must be clean, with tips less than ¼ inch long. If fingernail polish is worn, it must be in good condition, free of chips, and preferably clear in color. Hand jewelry with stones and crevices should not be worn as germs are difficult to remove from crevices and stones 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 patient care equipment, supplies, food, specimens, or medications.

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

ENVIRONMENTAL PRACTICES

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

REMEMBER

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

RESPIRATORY HYGIENE/COUGH ETIQUETTE

Respiratory hygiene and cough etiquette have been promoted by the Centers for Disease Control and Prevention (CDC) as strategies to contain pathogens 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 or 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.
- WFMs should observe Droplet Precautions and Standards Precautions when assisting or examining a patient with symptoms of a respiratory infection.

INDIVIDUALS WITH SIGNS AND SYMPTOMS OF A RESPIRATORY INFECTION SHOULD:

- Cover their nose and mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
- If you don't have a tissue, then cough or sneeze into your upper sleeve or elbow, NOT your hands.
- 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 six feet away, if possible) from others in common waiting areas.

WORKFORCE MEMBERS: PRECAUTIONS TO MINIMIZE EXPOSURE TO RESPIRATORY DROPLETS

- Workforce members should wear a medical-grade face 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 Transmissible Pathogen must wear a **NIOSH-certified respirator with rating of at least N95 or a Powered Air Purifying Respirator (PAPR) or Controlled Air Purifying Respirator (CAPR)**, if potential for exposure is increased due to the 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.
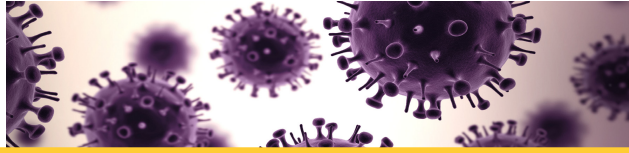
COVER YOUR COUGH

Stop the spread of germs and keep others from getting sick.

Cover your mouth and nose with a tissue when you cough or sneeze. Throw the tissue in the trash.

If you don't have a tissue, **cough or sneeze into your upper sleeve or elbow.** Don't sneeze into your hands.

You may be asked to **wear a facemask** to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water aren't available, use alcohol-based hand sanitizer.

Los Angeles County Department of Public Health www.publichealth.lacounty.gov

10/19

County of Los Angeles Public Health

Centers for Disease Control and Prevention

PERSONAL PROTECTIVE EQUIPMENT (PPE)

The purpose of the PPE is to protect the workforce member (WFM) and patients from exposure to infectious agents. To be effective, PPE must be used correctly.

Centers for Disease Control (CDC) have produced technical specifications for PPE, which includes the following:

- Gloves
- Gown
- Mask or respirator
- Face shield or goggles

<u>When to use the following PPE:</u>

- **GLOVES**: When touching blood, body fluids, secretions, mucous membranes, nonintact skin, excretions, contaminated items, and/or working with certain cleaning solutions or chemicals.

- **GOWNS**: Used during procedures and patient care activities when contact of clothing/exposed skin with blood/body fluids or secretions is anticipated.

- **MASK/RESPIRATOR**: Used when there is potential for exposure to airborne contaminants. Used during patient care activities likely to generate splashes or sprays of blood, body fluids secretions, or excretions. Types of face masks:

  - Surgical and medical/procedural masks
  - N95 Respirator
  - CAPR/PAPR
    - Controlled Air Purifying Respirator (CAPR): is a proprietary version of a PAPR, which fulfills all of the same functions; reusable device and battery operated; requires training
    - Powered Air Purifying Respirator (PAPR): A low breathing resistance reusable device with high level of protection against aerosols or particles; requires training

First Image: CAPR
Second Image: PAPR

Note: Surgical masks and medical/procedural masks may be used in clinical settings.

- **FACE SHIELD/GOGGLES:** Used during patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

<u>Donning (putting on) and Doffing (removal) of PPE:</u>

- **Donning** – There is a sequence to putting on PPE. The procedure for putting on PPE should be tailored to the specific type of PPE.

- **Doffing** – There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Remove GOWN and GLOVES before exiting the patient's room. Perform hand hygiene before and after exiting the patient room. Remove the N95 or CAPR/PAPR/Elastomeric Respirators and the face shield/goggles AFTER leaving the patient's room.

<u>Sequence for Donning (Putting on) PPE:</u>

1. **Gown:** Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back; fasten in back of neck and waist.

2. **Mask or Respirator**: Secure ties or elastic bands at middle of head and neck; fit flexible band to nose bridge; fit snug to face and below the chin; perform seal check before each use of the N95 Respirator.

3. **Face Shield/Goggles**: Place over face and eyes, and adjust to fit.

4. **Gloves:** Extend to cover wrist of isolation gown.

**USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND
LIMIT THE SPREAD OF CONTAMINATION**

- Keep hands away from face.
- Limit surfaces touched.
- Change gloves when torn or contaminated.
- Perform hand hygiene.

<u>Sequence for Doffing (Removal) PPE:</u>

Option 1: Remove gloves first. Ensure glove removal does not cause contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove). Perform hand hygiene if self-contamination occurs while removing gloves.

Remove gown second. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding forceful movements. Reach up to the shoulders and carefully pull gown down and away from the body. Roll the gown down without the hands touching the outside of the gown. Dispose in trash receptacle.

Option 2: Remove gown and glove (together). Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands. While removing the gown, fold or roll the gown inside-out into a bundle. As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Dispose of the gown and gloves in the trash receptacle.

1. **Perform hand hygiene.**

2. **You may now exit patient room.**

3. **Perform hand hygiene.**

4. **Carefully remove face shield or goggles.** Grab the strap and pull upwards and away from head. Do not touch the front of face shield or goggles.

5. **Remove and discard respirator (or mask if used instead of respirator)**. Do not touch the front of the respirator or mask.

    - **Respirator**: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.

    - **Mask**: Carefully untie (or unhook from the ears) and pull away from face without touching the front.

6. **Perform hand hygiene after removing the respirator/face mask and before putting it on again if your workplace is practicing re-use.**
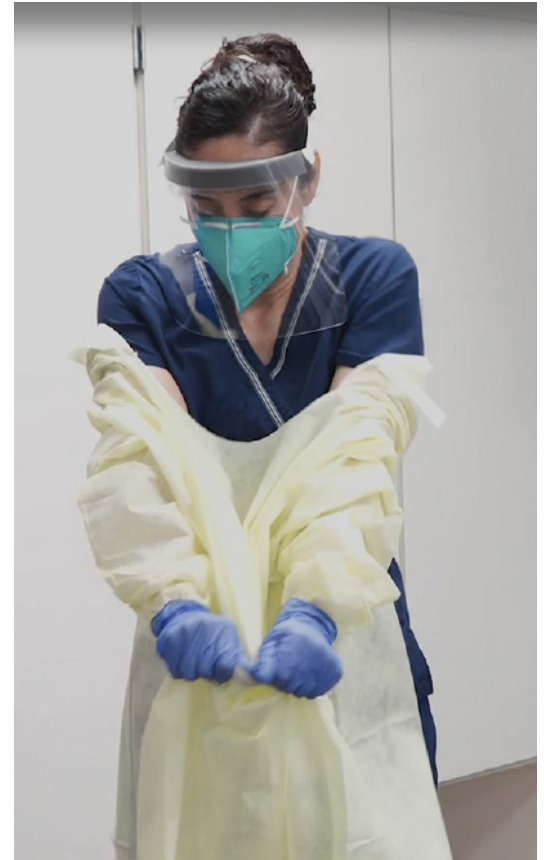
Note:
Doffing with an Anteroom: Exit patient's room and remove PPE in Anteroom. Without Anteroom: Remove gown and gloves in patient room, then exit patient room. Remove remaining PPE outside of patient room.

> **TRAINING VIDEO AVAILABLE FOR ALL WORKFORCE MEMBERS
> ON TALENTWORKS**
>
> <u>Donning and Doffing Personal Protective Equipment N95 Seal Check</u>

PREVENTING SHARPS INJURIES

Injuries can occur while handling or passing a sharps device, recapping a device, manipulating a device in a patient, colliding with coworkers, transferring potentially infectious material between containers, or during disposal, clean up, or decontamination of used equipment. Injuries can also occur from sharps left in unusual places, like laundry, mattresses, tables, trays, or other surfaces. Any workforce member handling sharps devices or equipment such as scalpels, needles for sutures, hypodermic needles, blood collection devices, or phlebotomy devices is at risk.

SIMPLE MEASURES TO REDUCE THE RISK OF SHARPS INJURIES

DO	DO NOT
✓ Let falling objects fall ✓ Activate sharps safety devices before disposal into sharps containers ✓ Immediately after use, dispose of sharps into covered, labeled, and rigid puncture-resistant sharps container ✓ Use tongs or brush & dustpan to pick up broken glass ✓ If tongs are not available, pick up the needle/syringe with the needle pointed away from fingers and body; carefully put it into sharps container. ✓ Practice safe handling techniques ✓ Hold trash bags away from your body ✓ Replace sharps disposal container when ¾ full. Never overfill. ✓ Ensure all sharps drop into the sharps disposal container and do not remain on the tilt lid. ✓ Prepare to use the device immediately before exposing the sharp ✓ Organize equipment at the point of use ✓ Have adequately lit workspace	× Hurry or take shortcuts × Reach into disposal or waste container × Touch broken glass × Overfill sharps container × Carry loose sharps in your pockets × Use hands or feet to push down waste in container × Never bend, recap, or break needles or sharps

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, cannula that replace needles, and, where applicable, intravenous delivery systems:

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

INFECTION CONTROL REQUIREMENTS DURING BLOOD GLUCOSE MONITORING AND INSULIN ADMINISTRATION

- Fingerstick devices should never be used for more than one person.
- Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared.
- Insulin pens and other medication cartridges and syringes are for single-patient-use only and should never be used for more than one person.

INJECTION SAFETY TIPS FOR PROVIDERS

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

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

- Medications packaged as single-use vials must never be used for more than one patient.
- Medications packaged as multi-use vials shall be assigned to a single patient whenever possible. Once punctured, the vial must be labeled with a beyond use date of 28 days or the manufacturer's expiration date, whichever comes first, and disposed of by that date. Vaccines are exempt from the 28-day limit unless otherwise indicated by the manufacturer.
- Bags or bottles of intravenous solution must not be used as a common source of supply for more than one patient.
- Absolute adherence to proper infection control practices must be maintained during the preparation and administration of injected medications.

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

For more information about sharps safety, please see:
www.cdc.gov/sharpssafety & www.cdc.gov/injectionsafety/one-and-only.html

WASTE DISPOSAL

The facility maintains appropriate handling and storage areas for hazardous materials and waste that are designed to minimize the possibility of contamination of food, clean and sterile goods, or contact with staff, patients or visitors. Be aware of the various types of hazardous materials and waste, and their appropriate measure of disposal.

WASTE	CONTAINER	CONTENTS
SHARPS WASTE CONTAINER		• Any device that is sharp at the time of disposal; such as needles, scalpels, razor blades, broken glass, glass slides, glass pipettes, trocars, staples, empty ampules • All empty syringes and empty medication vials • Guide wires • Replace container at 3/4 full
PHARMACEUTICAL WASTE (NON-RCRA)		• Acceptable non-RCRA pharmaceutical waste: partial IVs, unused pills, partial vials, sponges soaked in liquid medications • Sharps, needles, syringes and vials with remaining medications • No hazardous (RCRA) pharmaceuticals (see "black bucket" below) • No free flowing liquids are allowed in containers (no wasting or pouring of medications into the container); place entire syringe, entire partial IV bag into the container
HAZARDOUS PHARMACEUTICAL (RCRA) - BLACK BUCKET		• Warfarin, nicotine (gum, patch, lozenge), dandruff shampoo or lotion, cough syrup/elixir (containing more than 24% alcohol) iodine, hydrochloric and acetic acid, phenol, multi-dose vaccines • Chemotherapy IV bags & tubing that have moving liquid when moved or tilted • Radioactive waste • Mercury-filled devices, batteries, blood pressure cuffs & gauges, and thermometers
CHEMOTHERAPY WASTE		• Disposal of supplies used to administer chemotherapy • Empty chemotherapy sharps & glass bottles • Gowns & gloves used to administer chemotherapy • Chemotherapy IV bags & tubing that have no moving liquid when moved or tilted • Bedpan/urinal used by patients on chemotherapy
BIOHAZARD WASTE		• Infectious waste; including blood and blood products, items containing blood, infectious body fluids, bloody gloves, blood saturated dressing, any body-fluid containing blood, cultures, viruses, bacteria and live vaccines • Hemodialysis products • Bag and IV tubing containing blood products • Suction canister with secretions or body fluids • Hemovacs • Chest tube drainage units • Replace container at 3/4 full
REGULAR TRASH		• Gloves, gowns, masks, etc. that do not have blood or blood by-products • Masks • Non-bloody dressings • Tube feeding bags • Patient's bedside trash • Chux & paper towels

WASTE	CONTAINER	CONTENTS
REGULAR TRASH Cont.		• Empty IV bags (place HIPAA blackout label over PHI) • Empty IV piggyback bags • Empty foley catheter bags • Empty tubings • Non-regulated medical waste
UNIVERSAL WASTE CONTAINER		• Batteries that do not have blood or blood by-products * for OR use only; use disinfectant wipes to clean batteries before disposal
PLACENTA WASTE CONTAINER		• For placenta transport only
RADIOACTIVE WASTE		• Radioactive waste must be properly labeled • The Radiation Safety Office must be called to remove this waste to the designated area, where it must be monitored by qualified staff, until its safe and appropriate terminal disposal

Images by Cascade Healthcare Solutions; MedOnTheGo; Grainger; Uline.

For additional information contact:

• Your manager or supervisor
• Department of Infection Prevention and Control
• Employee Health Services

CLEANING AND DISINFECTION

Patient Care Equipment managed by patient care units or services must be cleaned with a hospital-approved detergent/disinfectant and follow manufacturers' instructions for appropriate contact time. All disinfectants and cleaners must be approved by the hospital Infection Control Committee prior to use. It is the responsibility of each workforce member to know the appropriate contact/kill time for the product being used to disinfect surfaces or equipment. Only clean equipment is to be stored in the clean equipment area. Clean linens should be kept covered.

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

REMINDER

Follow the guidelines for PDI wipe "dwell/contact kill time"

Super Sani-Cloth
2 MINUTES

Sani-Cloth Bleach
4 MINUTES

Sani-Cloth AF3
3 MINUTES

CLEANING, DISINFECTION, AND/OR STERILIZATION OF ENVIRONMENT AND PATIENT CARE EQUIPMENT:

Cleaning: Removal of visible soil and impurities (e.g., cleaning solutions).
Low-Level Disinfection: Elimination of most pathogenic microorganisms, except bacterial spores (e.g., disinfectant wipes).
High-Level Disinfection: Complete elimination of all microorganisms except bacterial spores (e.g., Trophon machine, Metricide, OPA, Automated Endoscope Reprocessing machine).
Sterilization: Destroys or eliminates all forms of microbial life (e.g., autoclaving).

CATEGORIZATION OF INSTRUMENTS/ITEMS ACCORDING TO THE DEGREE OF RISK FOR INFECTION ITEM DURING USE:

Critical: Items used in sterile tissue or the vascular system that pose a high risk for infection if contaminated with any microorganism. Usually require sterilization.
•   Examples: Surgical instruments, cardiac catheters, implants, and ultrasound probes used in sterile body cavities.
Semi-critical: Items that contact mucous membranes or non-intact skin. Minimally require high-level disinfection.
•   Examples: Ultrasound vaginal probes, cystoscopes, urinary catheters, esophageal manometry probes, endoscopes, laryngoscopes, respiratory therapy and anesthesia equipment.
Non-critical: Items that come in contact with intact skin but not mucous membranes. Usually require low-level disinfection.
•   Examples: Blood pressure cuffs, crutches, computers, gurneys, and wheelchairs.

INFECTION CONTROL FOR COMPUTERS

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

Image by Freepik

DO
✓ Perform Hand Hygiene prior to using device.
✓ Clean and disinfect device regularly between users or when visibly soiled or contaminated with blood.
✓ Clean device before moving to another patient room.
✓ Remove devices from patient room following use; this includes isolation rooms.
✓ Keep computer at least 3 feet from sink.
✓ Use wipes approved for computer screens.

DO NOT
× Lay a device on a patient bed or any furnishings in the patient room.
× Place food or drinks on any mobile cart or in any wall unit.
× Use gloves during computer use.
× Pour water over keyboard or other equipment to clean.

TRANSMISSION-BASED PRECAUTIONS

Transmission-Based Precautions prevent the transmission of a known infection between patients, healthcare personnel, and visitors. Transmission of infection within a health care setting requires three elements:

•   Source of infectious microorganisms
•   Susceptible host
•   Means of transmission for the microorganisms from source to new host

A variety of Infection Prevention and Control measures are necessary to reduce and prevent the transmission of microorganisms in the health care setting. These measures make up the fundamentals of Transmission-Based Precautions. When a patient is suspected or diagnosed of having an isolatable infection, he/she will be placed in the appropriate Transmission-Based Precautions. Workforce members entering the patient area are to follow posted instructions.

GENERAL TRANSMISSION-BASED PRECAUTIONS ARE DESCRIBED IN THE TABLE BELOW:

Transmission-Based Precaution	Description	Minimum PPE for Staff
Contact	• Pathogens are transmitted by direct contact with an infected or colonized patient • Transmission may also occur via indirect contact with contaminated environment	• **Gloves** • **Gown** *Use additional PPE if indicated according to the task being performed (e.g., goggles or face shield)*
Droplet	• For pathogens transmitted by large respiratory droplets (>5 microns) that can be generated by a patient coughing, sneezing, or talking • Some droplet-borne pathogens may also be transmitted by direct/indirect contact and will also require Contact Precautions	• **Medical/Surgical Mask** *Use additional PPE if indicated (e.g., gown, gloves, goggles or face shield)* *Patient wears a medical/surgical mask when outside the room*
Airborne	• For pathogens transmitted by small airborne droplets (<5 microns) over long distances • Some Airborne pathogens may also be transmitted by direct/indirect contact and will require a combination of Airborne and Contact Precautions (i.e., COVID-19 when an aerosol-generating procedure is occurring)	• **N95 Respirator** (or) • **PAPR** (Powered Air Purifying Respirator) (or) • **CAPR** (Controlled Air Purifying Respirator) *Use additional PPE if indicated (e.g., gown, gloves, goggles or face shield)* *Patient wears a medical/surgical mask when outside the room*
Special	• For suspected or confirmed COVID-19 cases • Includes all of the components of both **Contact** and **Airborne** Precautions, with the addition of Eye Protection	• **Gloves** • **Gown** • **N95 Respirator** (or PAPR/CAPR) • **Eye Protection (**goggles or face shield) *Patient wears a medical/surgical mask when outside the room*

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

Note: If a patient is MRSA positive ONLY as a result of a nasal or groin screening culture (colonized), then the patient does NOT need to be placed into Contact Precautions.

Exposure to Blood and Body Fluids

If you are exposed to blood or body fluids, **IMMEDIATELY**:

- Wash the puncture site and cuts with soap and water.
- Rinse nose or mouth with clean water.
- Flush eyes with clean water/saline.
- Report the exposure to your supervisor.
- Complete the Bloodborne Pathogens Post Exposure Packet.
- Complete an Industrial Accident (IA) forms/packet.
- Go to Employee Health Services (EHS) or the Emergency Department (if EHS is closed) for follow-up.
- Submit a Safety Intelligence™ (SI) Report of exposure event.

VACCINATIONS

Hepatitis B vaccine is provided free of charge for DHS workforce members at risk of exposure to blood and/or other potentially infectious materials per their job duties. Workforce members must have evidence of immunity to Varicella (Chickenpox) and MMR (measles, mumps and rubella) to work inside of a healthcare facility. Tdap (tetanus, diphtheria, and acellular pertussis) vaccines are recommended.

Workforce members declining to accept a non-mandatory vaccination must complete a mandatory vaccination declination form. If the workforce member later decides to accept the vaccination, it will be provided to them. Non-County workforce members should obtain vaccinations from their physician or licensed health care professional or per employer/school; services provided through DHS will be billed to their contractor/agency as appropriate.

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RESPIRATORY VIRUS SEASON, SEASONAL INFLUENZA, AND COVID-19

To comply with DHS Policy No. 334.200, as a condition of employment/assignment, an annual influenza and an up-to-date COVID-19 vaccination is mandatory for every workforce member who works in a DHS facility unless the workforce member completes and signs an informed declination form. A sticker will be affixed to the DHS photo identification badge of workforce members who have received the influenza and COVID-19 vaccination. Compliance with annual mandatory vaccinations shall be required by November 1st of each year.

Influenza and COVID-19 vaccination is available to all workforce members at no charge. All workforce members who have not been vaccinated by November 1st must wear a mask during the duration of the Respiratory Virus Season, regardless of submitting a signed declination. If the workforce member later decides to accept the vaccination, it will be provided to them.

AEROSOL TRANSMISSIBLE DISEASE (ATD) PLAN

The Cal-OSHA California Code of Regulations, Title 8, Chapter 4, Section 5199 requires that all healthcare settings adhere to an ATD Plan. An Aerosol Transmissible Disease (ATD) or Aerosol Transmissible Pathogen (ATP) is a disease or pathogen that is transmitted by aerosols, which requires either Droplet or Airborne Isolation. The complete list of Aerosol Transmissible Disease/Pathogens which require Airborne or Droplet Isolation can be found in the Infection Control Policy Manual.

EARLY IDENTIFICATION

Efforts to identify suspected or confirmed ATD infectious patients will begin as soon as the patient enters the facility. Patients should be assessed for ATD symptoms when they enter the facility. If a cough or other symptoms are present, a surgical mask will be placed on the patient. Patient is to be placed in **Airborne** or **Droplet** Isolation during the time he/she is in the facility.

WORKFORCE MEMBER PRECAUTIONS

Workforce members are to wear a NIOSH approved N95 or greater respirator mask for Airborne Precautions or a surgical mask for Droplet Precautions if the patient is coughing or unable to wear the mask.

TRANSPORTING PATIENTS

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

EXPOSURES

An "ATD Exposure Incident" is defined as an event in which a patient or employee sustains a substantial exposure to an ATD case without having had the benefit of all applicable and required control measures (i.e., respiratory protection, isolation, treatment). An employee who is exposed is to notify their supervisor as soon as possible (within 24 hours preferred). The supervisor who becomes aware of an exposure is to notify Employee Health and Infection Control and provide a list of employees suspected to have had an exposure. Exposed employees will be notified as soon as possible of potential exposures. A post-exposure evaluation will be conducted by Employee Health for those employees with a significant exposure.

TUBERCULOSIS (TB)

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

TB precautions include the following:

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

ACTIVE TB DISEASE

This person can infect others unless he or she is taking the TB medicine as directed. Signs of illness are usually present and may include the following:

- Prolonged cough (2 or more weeks)
- Feel weak
- Have a fever
- Have weight loss
- Loss of appetite
- Night sweats
- Coughing up blood or have chest pain when coughing

LATENT TB INFECTION (LTBI)

This person carries the TB germ but does not look or feel sick and cannot infect others.

If you have been told that you have LTBI and have not had prior treatment, it is strongly encouraged for you to complete treatment with a recommended regimen, including short-course treatments, unless a contraindication exists.

PANDEMIC INFLUENZA PLAN

Pandemic influenza usually arises from a novel or new virus strain that is different from commonly occurring seasonal influenza. 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.

> Seasonal influenza and COVID-19 vaccine is available to you at Employee Health.

CLINICAL INFORMATION

- Affects people of all ages. Typically, those at greatest risk of severe complications of influenza are infants, young children, elderly adults, pregnant women, and individuals with chronic disease although these risk groups may differ according to the circulating influenza strain.
- Incubation period and duration of viral shedding may vary depending on the novel strain.
- Symptoms may include fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Gastrointestinal symptoms may also be present, such as nausea, vomiting, and diarrhea.
  - Up to 30% of people with influenza have no symptoms, allowing transmission to others.
  - A person can be infected and spread the virus before they become sick.

TRANSMISSION

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

INFECTION PREVENTION AND CONTROL

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

- Respiratory hygiene and cough etiquette
- Standard Precautions and use of personal protective equipment (for workforce members and patients)
- Transmission-based Precautions

Guidelines may be amended as more is learned about the infectivity of the pandemic virus.

WORKFORCE MEMBER GUIDANCE FOR COVID-19

Key Points about COVID-19

Prevention Tips:

- Avoid close contact with people who are:
  - Sick
  - COVID-19 positive or Person Under Investigation (PUI) with no evidence of symptoms (asymptomatic)
- Practice physical separation (social distancing) >6 feet apart from each other
- Wear your medical-grade face mask to prevent the spread of COVID-19
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Avoid touching your eyes, nose and mouth
- Clean and disinfect frequently touched objects and surfaces
- Perform hand hygiene often with hand washing (soap/water) or ABHS (<u>see page 99</u>).

Definition of a Close Contact:

A "close contact" is any of the following people who were exposed to an "infected person"* while they were infectious:

- An individual who was within 6 feet of the infected person for a cumulative total of 15 minutes or more over a 24-hour period.
- An individual who had unprotected contact with the infected person's body fluids and/or secretions; for example, being coughed or sneezed on, sharing utensils or saliva, or providing care without wearing appropriate protective equipment.

*An infected person is anyone with COVID-19, or who is suspected to have COVID-19, and considered to be infectious from 48 hours before their symptoms first appeared until they are no longer required to be isolated. A person with a positive COVID-19 test but no symptoms is considered infectious from 48 hours before their test was taken until 10 days after their test.

Workforce Member Guidance for COVID-19 Self-Monitoring, Exposures and Work Restrictions

It is important to monitor your health for signs and symptoms of COVID-19. Symptoms of COVID-19 are similar to the symptoms exhibited by the flu and or other respiratory illnesses and can include:

- Fever and/or Chills
- Cough
- Difficulty breathing or shortness of breath
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Diarrhea
- Congestion or runny nose
- See references for further information

<u>**IF ANY OF THESE SIGNS/SYMPTOMS DEVELOP, THEN DO NOT COME TO WORK!**</u>

Note: This list does not include all possible symptoms of COVID-19. Some people with COVID-19 **DO NOT** have symptoms. With symptoms seek COVID-19 Testing: If negative, WFM may return to work when they have been absent of fever for minimum of 24 hours without use of fever reducing medicine.

The Department of Health Services (DHS) recommendations for COVID-19 include:

- If you are sick, you are required to stay home.
- If symptoms appear at work, immediately notify your supervisor and request to leave work, leave the patient care/work area and notify Employee Health Services (EHS). Click <u>HERE</u> for your local EHS contact information.
- Self-isolate at home and follow your healthcare provider's order and directions.
- If you test positive for COVID-19 outside of DHS you must report the results to Employee Health Services and your supervising manager within 24 hours or prior to coming to your next shift, whichever comes first.
- Confidentiality of Medical Information Act (CMIA) is in place for your protection. All efforts are made to protect the privacy of all workforce members.
- All workforce members should self-monitor for symptoms consistent with COVID-19.
- If you are a WFM with a confirmed known exposure to a patient(s) with confirmed COVID-19, you will be evaluated by Employee Health Services.

Note: Contact Patient Investigation for COVID-19 falls under each facility's specific Policy and Procedure for Aerosol Transmissible Disease Exposure Control Plan. When there is a possible exposure, Infection Prevention and Control (IPC) performs an
exposure analysis. This should be done within 48 hours of becoming aware of the potential exposure.

Affected department(s) are identified by IPC. Notification to these departments is done either by IPC or Employee Health Services (EHS) per facility. Staff are instructed to present or call EHS for exposure evaluation. Employee Health Services will perform the exposure evaluation and, based on risk, determine if work restrictions are required.

What else is DHS doing to assure a safe workplace during the COVID-19 pandemic?

In accordance with AB 685, DHS is committed to maintaining a safe workplace for our employees, which includes prohibiting discrimination, harassment, and retaliation of any kind in accordance with state and federal laws. The department does not tolerate harassment or retaliation against any worker for disclosing a positive COVID-19 test result, diagnosis, exposure, or order to quarantine or isolate, for raising any related concerns, for filing for leaves, or for raising concerns about workplace safety or employee health. In addition, AB 685 requires timely notification to workforce members (WFMs) of workplace cases of COVID-19 and the steps that can be followed if the WFM spent time in the work area of the possible cases. An e-mail notification/blast will be sent out when there is a reported case and recipients will be advised of steps to be taken if they were in those work areas.

Return to Work Guidelines

Return to work guidelines have been developed with guidance from the Department of Health Services Infection Prevention and Control Medical Directors. Contact your local Employee Health Services with any questions.

- If a workforce member has been off due to illness but has not been tested (we encourage the workforce member to get tested whenever possible), or tested negative for COVID-19, they can return to work when the following criteria have been met:

  - They have been fever-free for at least 24 hours without use of fever-reducing medication; and
  - Respiratory symptoms (e.g., cough, shortness of breath) have improved; and
  - Have a negative Ag test 24hrs prior to, or on the day of return to work (i.e. must have a negative test on day 5 or day 6)
  - Workforce member must continue to wear a medical-grade face mask while at work

- If a workforce member has tested positive for COVID-19 and was directed to care for themselves at home, they can return to work when the following criteria have been met:

  - They have been fever-free for at least 24 hours without use of fever-reducing medication; **and**
  - At least 11* days have passed since symptoms first appeared; **and**
  - Other symptoms have improved; **and**
  - Workforce member must continue to wear a medical-grade face mask while at work
  - See the Workforce Member Guidance for COVID-19 for more information, such as guidelines for vaccinated individuals.

  *Note: at least 20 days have passed since symptoms first appeared for workforce members who are severely immuno-compromised (on chemotherapy for cancer, untreated HIV infection with CD4 lymphocyte count <200, combined primary immunodeficiency disorder and/or receipt of prednisone >20mg/day for more than 14 days).

REMINDER: The Department of Health Services encourages you to review COVID-19 Expected Practices on an ongoing basis, as they may change during this COVID-19 Pandemic period. You may access the Expected Practices on the intranet.

KEY POINTS TO REMEMBER (ALL STAFF)

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

LEADERSHIP

- Our mission, vision and values statements are included in various training programs. In addition to the definitions contained in this handbook, the hospital makes the mission, vision, and values statements available in wallet-size for easy attachment 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.
- 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 Program 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 Los Angeles General Medical Center workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.
- Los Angeles General 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 Los Angeles General 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 DHS 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 annually.

- The County of Los Angeles has established a "zero tolerance policy" for any conduct that could possibly be interpreted as harassing, offensive or inappropriate in the workplace.
- 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

- Los Angeles General Medical Center Patients' Rights and Responsibilities are posted throughout the medical center for reference.
- Each patient is given a Welcome to the Los Angeles General 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 at the Los Angeles General 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.
- Los Angeles General Medical Center 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.
- 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

- **Sentinel even**t: A patient safety event (not primarily related to the natural course of the [patient's] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).
  - **Severe harm**: An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continual physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.
  - **Permanent harm**: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline.
- If you become aware of a sentinel event or a near miss, you must report it immediately.

Report events in one of the following ways:

- Direct supervisor **AND**
- Safety Intelligence™ (SI) Event Reporting System **OR**
- Patient Care Statement of Concern

     OR contact:

- Hospital Risk Manager's Office at (323) 409-6657
- Pharmacy to report Adverse Drug Events on the Safety Intelligence™ (SI) Event Reporting System
- Medical Administration at (323) 409-6734
- Patient Safety Officer at (323) 409-3156

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 Los Angeles General Medical Center:
  - **Code Blue means Adult Medical Emergency**
  - **Code White means Pediatric Medical Emergency**
  - **Code Red means Fire**
  - **Code Gold means Mental Health/Behavioral Response**
  - **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/Release**
  - **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 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.
- You can use alcohol-based hand sanitizer before direct contact with patients, after contact with a patient's intact skin, after contact with inanimate objects in a patient's area, after removing gloves (not visibly soiled with blood or bodily fluids), and before leaving work.
- 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, Los Angeles General 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.

PRIVACY OF PATIENT INFORMATION (HIPAA)

Protecting Patients' Rights to Personal Privacy

- Protect the privacy of Personally Identifiable Information (PII) as well as Protected Health Information (PHI).
- 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 team is aware of the request.
- Make sure all documents belong to the patient and use the two identifier process before providing patients with

- Treat confidential information as if it were your own.
- Report suspected HIPAA violations by means of an entry in the Safety Intelligence™ (SI) Event Reporting System <u>AND</u> by phone to the facility Privacy Manager at (323) 409-6100.
- 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.
- Los Angeles General Medical Center uses the following safeguards to protect patient-specific information:
  - Requires Compliance Awareness 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 Desktop Infrastructure (VDI).
  - 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, Los Angeles General 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.
- Los Angeles General 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.

IF YOU ARE
CLINICAL STAFF,
PLEASE **CONTINUE TO**
THE NEXT SECTION (PAGE 120)
OF THIS HANDBOOK

CLINCAL ORIENTATION CHECKPOINT (CLINICAL STAFF ONLY)

This section should be completed by all clinical workforce members who provide care, treatment or services to patients. This includes direct and indirect patient care, such as the <u>examples</u>* listed here:

Registered Nurses	Diagnostic Ultrasound Technicians
Licensed Vocational Nurses	EEG Technicians
Nursing Attendants	Lab Assistants
Physicians	Medical Technologists
Dentists	Pharmacists
Respiratory Care Practitioners	Pharmacy Technicians
Occupational Therapists	Nuclear Medicine Technologists
Radiologic Technologists	Phlebotomy Technicians
Physical Therapists	Recreation Therapists
Speech Pathologists	Clinical Social Workers
Rehabilitation Therapy Technicians	Surgical Technicians
Licensed Physical Therapy Assistants	Dental Assistants
Nurse-Midwives	Dental Hygienists
Certified Nurse Anesthetists	Registered Dietitians
Physician Assistants	Occupational Therapy Assistants
Nurse Practitioners	Cardiac Monitor Technicians
Certified Medical Assistants	

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

BLOODBORNE PATHOGEN CONTROL PLAN

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

Bloodborne 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 a 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

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).
- Ventilator Associated Pneumonia (VAP) (optional at this time)
- Central Line Associated Blood Stream Infections (CLABSI) (all inpatient)
- Surgical Site Infections (SSI) related to deep soft tissue and organ space
    - AFL procedures and NHSN procedures
- Multi-Drug Resistant Organism (MDRO) infections:
    - Vancomycin-Resistant Enterococci (VRE) in the blood
    - Methicillin-Resistant Staphylococcus Aureus (MRSA) in the blood
    - Clostridium difficile (C. *difficile)*
- Central Line Insertion Practices (CLIP)
    - All Intensive Care Unit (ICU) including Pediatrics Intensive Care Unit (PICU) and Neonatal Intensive Care Unit (NICU)

Facilities implemented bundles to reduce HAI. 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
- Catheter checklist at the time of CVC insertion - Hand hygiene before catheter insertion or manipulation - Antimicrobial impregnated catheters - Catheter cart or central line kit - Maximal sterile barrier precautions during insertion. - Including cap, mask, & sterile gown, gloves, large drape - Antiseptic for skin preparation - Chlorhexidine based for older than 2 months - Povidone-iodine solution for infants less than 2 months	- Daily documentation of line necessity; remove nonessential catheters - Do not routinely replace central line catheter unless there are clear indications for replacement. - Replace administration sets as per protocol. - Bathe daily with a chlorhexidine-based bath (> 2 MONTHS). - Disinfect catheter hubs, connectors and injection ports before accessing the catheter. - Dressing changed and site care as per policy

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.

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

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.

PATIENT CARE PRACTICES

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

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

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

NEONATES (BIRTH TO 28 DAYS)

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

INFANTS (1 MONTH TO 12 MONTHS)

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

CHILDREN (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 6-12).
- Use simple, concrete terms when talking to younger children.
- Allow younger children to keep security object (e.g., blanket, toy), if possible.
- Give praise, rewards, and clear rules. Encourage older children to ask questions.
- Use toys and games to teach the child and reduce fears.
- Always explain what you will do before you start; be age appropriate in language used/choice of words. Involve older children in care and offer choices whenever possible.
- Provide for the safety of the child. Do not leave the child unattended.
- Use equipment and supplies specific to the age and size of the child.

ADOLESCENTS (13 YEARS THROUGH 17 YEARS)

- Treat the adolescent more as an adult than a child. Avoid authoritarian approach and show respect.
- Explain procedures using simple terms and correct terminology to adolescents and parents.
- Consider the importance of the adolescents' peer group.
- Provide for privacy.

ADULTS (18 YEARS THROUGH 64 YEARS)

- Be supportive and honest.
- Respect the patient's personal values.

- Support the person in making health care decisions.
- Recognize commitments to family, career, and community.
- Address age-related changes.

GERIATRICS (65 YEARS & OLDER)

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

PAIN ASSESSMENT AND REASSESSMENT

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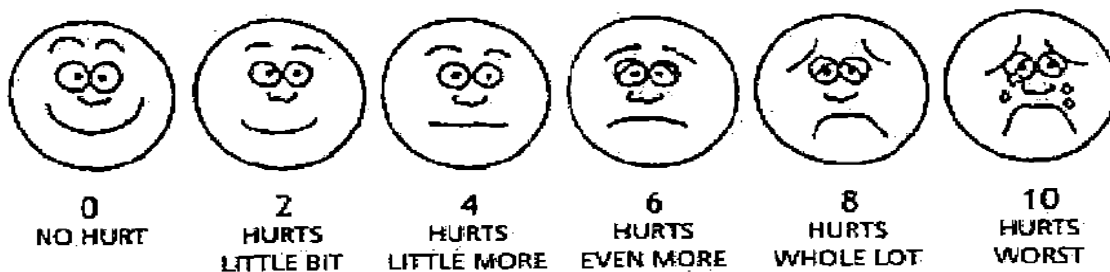
From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: **Wong's Essentials of Pediatric Nursing,** *6/e, St. Louis, 2001, P. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.*

Pain is a common experience for a majority of our patients. Los Angeles General Medical Center supports every patient's right to have their 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 as indicated. On initial complaint of pain, a comprehensive assessment is performed. Los Angeles General Medical Center uses an appropriate pain assessment tool to assess, reassess, and document pain ratings so that we can compare these ratings over time.

Pain is a very subjective experience. Because the patient is the best judge of the intensity of their pain and the effectiveness of its treatment, most of the assessment tools we use at Los Angeles General 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:

Mild Pain	1 – 3
Moderate Pain	4 – 6
Severe Pain	7 – 10

FLACC SCALE

The FLACC Pain Scale can be used for scoring pain in (a) children up to 5 years of age, (b) patients who are developmentally delayed, (c) children who have difficulty understanding a FRS and/or FACES Pain Scale who are greater than 5 years of age, and (d) patients who may not be able to verbalize the presence/severity of pain or who are non-communicative.

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

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

THE N-PASS

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

Pat Hummel MA, RNC, NNP, PNP, APN/CNP & Mary Puchalski MS, RNC, APN/CNS

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	Within baseline or normal for gestational age	↑ 10-20% from baseline SaO_2 76-85% with stimulation – quick ↑	↑ > 20% from baseline $SaO_2 \le$ 75% with stimulation – slow ↑ Out of sync with vent

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8/14/01)

Premature Pain Assessment
+ 3 if < 28 weeks gestation / corrected age
+ 2 if 28-31 weeks gestation / corrected age
+ 1 if 32-35 weeks gestation / corrected age

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's response to stimuli is normal for their gestational age
- Desired levels of sedation vary according to the situation
  - "Deep sedation" → score of -10 to -5 as goal
  - "Light sedation" → score of -5 to –2 as goal
  - Deep sedation is not recommended unless an infant is receiving ventilatory support, related to the high potential for apnea and hypoventilation
- 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

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 their gestational age to compensate for their limited ability to behaviorally or physiologically communicate pain
  - Total pain score is documented as a positive number (0 → +10)
- Treatment/interventions are indicated 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

Pavulon/Paralysis

- It is impossible to behaviorally evaluate a paralyzed infant for pain
- Increases in heart rate and blood pressure 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

Scoring Criteria

Crying / Irritability

-2 → No response to painful stimuli, e.g.:
  - 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 → Not irritable – appropriate crying
  - Cries briefly with normal stimuli
  - Easily consoled
  - Normal for gestational age

+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

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 → Relaxed hands and feet – normal palmar or sole grasp elicited – appropriate tone for gestational age

+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$_2$ Saturations

-2 → Any of the following:
  - No variability in vital signs with stimuli
  - Hypoventilation
  - Apnea
  - Ventilated infant – no spontaneous respiratory effort

−1 → Little spontaneous movement, arouses briefly and/or minimally to any stimuli:
- Opens eyes briefly
- Reacts to suctioning
- Withdraws to pain

0 → Behavior and state are gestational age appropriate

+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 (inappropriate for gestational age or clinical situation, i.e. post-operative)

−1 → Vital signs show little variability with stimuli – less than 10% from baseline

0 → Vital signs and/or oxygen saturations are within normal limits with normal variability – or normal for gestational age

+1 → Any of the following:
- HR, RR, and/or BP are 10-20% above baseline
- With care/stimuli infant desaturates minimally to moderately (SaO_2 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_2 < 75%) and recovers slowly (> 2 minutes)
- Infant is out of synchrony with the ventilator – fighting the ventilator

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 → Face is relaxed at rest but not lax – normal expression with stimuli

+1 → Any pain face expression observed intermittently

Brows: lowered, drawn together
Forehead: bulge between brows, vertical furrows
Eyes: tightly closed
Cheeks: raised
Nose: broadened, bulging
Nasolabial fold: deepened
Mouth: open, squarish

Facial expression of physical distress and pain in the infant
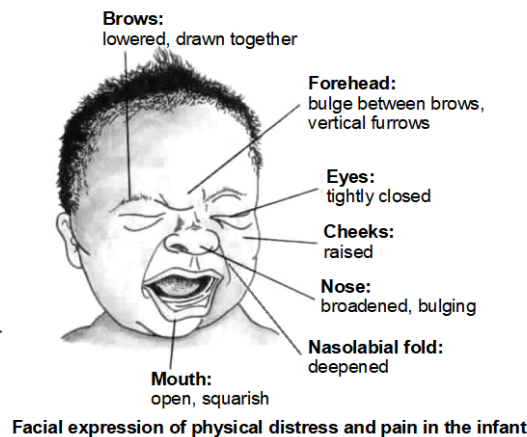
We value your opinion.
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INTERVENTION/TREATMENT PLAN FOR PAIN

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 in the Clinic Record/Progress Note for outpatients.

The patient is reassessed for the effectiveness of the intervention/treatment and the pain score or physiological and/or behavior signs of pain are documented within one hour in the reason column of the Medication Administration Record (MAR) for inpatients, or in the 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 the "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 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

PAIN MANAGEMENT GUIDELINES FOR DHS PROVIDERS

ASSESSING PAIN

The assessment of pain is fundamental to identifying the source(s) of pain and developing a safe and effective pain management plan.

PAIN HISTORY AND PHYSICAL EXAM

Assess:

- Primary areas of pain
- Patient's ranking of types of pain where pain #1 is the most bothersome, pain #2 is the next most bothersome, etc.
- Quality of pain

This demonstrates to patients that we prioritize their most bothersome regions of pain and that we are targeting their therapy for maximum effectiveness and minimum risk.

Examine:

- Skin, wounds (if any), and other anatomy of the area(s) the patient describes experiencing pain

Physical exam allows for an in-depth assessment of pain and demonstrates to patients that we are committed to a comprehensive evaluation of their pain.

GOALS FOR PAIN MANAGEMENT

Elicit from the patient what their functional goals are.

The goal of pain management is to avoid iatrogenic harm while optimizing pain control. Share patient goals to maximize function. Participate in therapeutic activities such as physical therapy, community engagement, and quality of life. Once a patient's functional goals are identified, determine how pain treatment advances the patient toward achieving these goals. Adjust treatments that do not improve patient functional goals.

THREE MAJOR TYPES OF PAIN

Nociceptive pain is typically from incisions, fractures, or physical injury like strain or inflammation. This includes muscle pain (myofascial tenderness on palpation), joint pain (pain with weight bearing or joint loading, morning stiffness), etc.

Neuropathic pain can be from any insult to the nervous system: nerves that are cut, pinched, irritated, or otherwise traumatized, or physiologic insults like brain injury, stroke, or diseases like multiple sclerosis. Quality is typically burning, shooting, tingling, numbness, pins and needles (paresthesias), allodynia, and hypersensitivity.

Centralized pain is typically from an insult to the central nervous system (brain or spinal cord injury, significant mental illness like severe depression, anxiety, or PTSD). It's important to have behavioral health expert collaboration to work on pain/stress coping strategies like distraction or deep breathing, recognizing pain triggers, cognitive behavioral therapy, etc.

Complex chronic pain may require multiple coping strategies. One may start as acute nociceptive pain and develop into chronic centralized pain. It is not uncommon for patients with significant dysfunction with complex chronic pain to overlap with depression, insomnia, PTSD, anxiety and substance-use disorders. Address these co-occurring issues comprehensively, along with aggressive pain management, for optimal improvement in patients' health.

TREATMENT PLANNING

A multi-modal approach that includes medications, physical therapy and other modalities, and minimally invasive interventions should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities improves outcomes. Patients with chronic pain that is poorly responsive to standard treatments should be assessed for undiagnosed or undertreated behavioral health issues including substance use disorder.

Treatment includes the following five broad categories:

- Restorative Therapies
- Interventional procedures
- Behavioral health approaches
- Complementary and integrative health
- Medications

RESTORATIVE THERAPIES

- E-Consult: Physical Therapy
- E-Consult: Occupational Therapy
- E-Consult: The Wellness Center
    - Indoor and outdoor physical activities including fitness trails, jogging paths, exercise areas and fitness equipment are available.

INTERVENTIONAL PROCEDURES

- E-Consult: Pain Procedures
- E-Consult: Pain Management (non-malignant) for questions about which approaches might be appropriate for your patient

BEHAVIORAL HEALTH APPROACHES

- Order: Specialty Referral to Social Work to refer the patient for a behavioral health assessment
- E-Consult: Addiction Medicine for support of assessment and diagnosis of substance use disorders; DHS Addiction Medicine Consult line 8am to Midnight everyday including weekends: (213) 288-9090
- E-Consult: Mental Health for psychiatric consultation

COMPLEMENTARY AND INTEGRATIVE HEALTH

- E-Consult: The Wellness Center
    - Acupuncture, massage, movement therapies (such as yoga and tai chi) are available

MEDICATION MANAGEMENT:

Topicals: Always offer wherever feasible.

- **Lidocaine cream or patches** are available OTC at 4% strength (Salonpas, Aspercreme for example), or Rx strength is 5%. Apply 3-4g to painful areas four times a day – numbing, helpful for both nociceptive and neuropathic pain.
- **Voltaren gel (Diclofenac) 1%** is available OTC or Rx. Apply 3-4g to painful areas thrice a day if taking oral NSAIDs too, or four times a day if no oral NSAIDs– anti-inflammatory, helpful primarily for nociceptive pain.

Oral non-opioid analgesics:

- If no hepatic failure, Acetaminophen (Tylenol) is safe and effective. Typically most patients tolerate 1000mg thrice a day standing or as needed. Limit to maximum 2,000mg daily for hepatic insufficiency.
- If no renal insufficiency or other contraindication, **Ibuprofen (Advil/Motrin)** 600-800mg thrice a day with food as needed is helpful for nociceptive pain. If there is history of GERD/stomach irritation, consider instead **Meloxicam** 7.5mg twice a day with food as needed or even **Celecoxib (Celebrex)** 100mg twice a day with food as needed.

If there is significant objective muscle tightness or myofascial pain, muscle relaxants can be considered. Muscle relaxants do cause drowsiness, increase fall risk, and potentiate other sedatives including alcohol. Caution in starting these medications and monitor closely. These medications should be avoided in the elderly or patients with polypharmacy. Recommend starting with low dose just at bedtime at first to assess for side effects.

- **Cyclobenzaprine (Flexeril)** 5-10mg every night at bedtime to start may help with sleep initiation. If tolerated (watch for drowsiness, dizziness), can increase to 5-10mg thrice a day as needed. This is serotonergic, so caution if patient is on more than two serotonergic agents for risk of serotonin syndrome.
- **Methocarbamol (Robaxin)** 500-1000mg thrice a day as needed is usually well tolerated, tends to cause less drowsiness, can be up-titrated to maximum 8000mg/day.
- **Tizanidine (Zanaflex)** 2-4mg thrice a day as needed (watch for orthostatic hypotension, can be helpful if patient has HTN).
- **Baclofen** 5-10mg thrice a day as needed – usually first line for spasticity associated with central nervous system injury, can also be helpful for neuropathic pain.

Neuropathic analgesics:

- For neuropathic pain, and even nociceptive pain as a strategy to minimize opioid requirements, the first-line neuropathic analgesic is gabapentin. Note: Gabapentin is not available in Correctional Health Services formulary.

Gabapentin is usually started at 300mg every night at bedtime x 3-7 days to assess for side effects (can cause drowsiness/dizziness), then increased to 300mg twice a day x 3-7 days, then increased to first goal dose of 300mg thrice a day. If this causes a lot of drowsiness but is helpful, increase the nighttime dose to goal dose of 900mg every night at bedtime only. As tolerated, can increase in a similar fashion to 600mg thrice a day, which maximizes gabapentin's bioavailability. If creatinine clearance is 30-59 mL/min, recommend twice a day dosing up to goal dose 600mg twice a day. Maximum safe dose is 3600mg/24 hours (1200mg thrice a day) but usually past 800mg thrice a day there is limited benefit to dose increases.

The second-line neuropathics of choice are **duloxetine (Cymbalta)** and **nortriptyline (Pamelor)**, and they can be helpful for mood too.

- **Duloxetine (Cymbalta)** can be started at 20-30mg daily x 3 days then uptitrate as tolerated to 20-30mg twice a day (max dose for neuropathic pain). This medication does not tend to cause drowsiness but can cause GI upset or dizziness. This is serotonergic, so caution if patient is already on multiple serotonergic medications.
- Alternatively, **nortriptyline (Pamelor)** is usually started at 10mg every night at bedtime, then after 7 days to assess for effectiveness or side effects, can uptitrate to 20mg every night at bedtime as first goal dose. Caution for drowsiness, dry mouth, dizziness, confusion, bladder retention. Can continue to uptitrate to lowest effective dose, max safe dose is 150mg/24 hours. This is serotonergic, so caution if patient is already on multiple serotonergic meds.
- Nortriptyline tends to have fewer side effects than **amitriptyline (Elavil)**, though amitriptyline has more evidence for efficacy in neuropathic pain associated with spinal cord injury. These medications should be avoided in the elderly > 65 years old.

If a patient has had no effectiveness with maximum dose gabapentin, a second-line neuropathic, AND a muscle relaxant, (or can't try some of these because of allergies or other contraindication) then insurance companies will consider covering **pregabalin (Lyrica)**, which requires prior authorization.

- **Pregabalin (Lyrica)** typically works best in patients with complex neuropathic pain like after spinal cord injury or phantom limb pain after amputation. If starting pregabalin, wean gabapentin to at least half their previous dose, then start Lyrica at about 50-100mg twice a day. Caution for drowsiness, leg swelling. After 3 days, as tolerated, can stop gabapentin and increase pregabalin to max dose 600mg/day (so 200mg thrice a day or 300mg twice a day).

An "out of the box" third-line analgesic that has most benefit in complex neuropathic or centralized pain and/or depression is ketamine.

- **Ketamine** is an NMDA receptor antagonist that can be helpful in depression and complex chronic pain, but it is primarily used in the peri-operative setting as an adjunct to anesthesia. It can be used in the outpatient setting, but compounded capsules are not covered by insurance and there are very few ketamine infusion programs that accept insurance.

SLEEP AIDS

- **Melatonin** *3-6mg every night at bedtime is a natural sleep aid that can help facilitate sleep quality/duration with minimal side effects.*

- **Trazodone** *50-100mg every night at bedtime is a sleep aid. It can cause orthostasis, particularly in the elderly. It can also cause priapism in men.*

- *If melatonin and trazodone are contraindicated or ineffective,* **diphenhydramine (Benadryl 25-50mg)** *is also a common sleep aid, though can cause anticholinergic symptoms including cognitive problems especially in the elderly. Can also use other anti-histamines like* **hydroxyzine or even cyproheptadine. Cyproheptadine** *is also a serotonin blocker used for the treatment of serotonin syndrome.*

- **Nortriptyline (Pamelor) and amitriptyline (Elavil)** *are commonly dosed at night and can be helpful for neuropathic pain, mood, and sleep.*

- If someone has a lot of drowsiness on **gabapentin or pregabalin**, it's recommended to keep the daytime doses low twice a day and then just increase the night time dose, which can help with sleep (example: Gabapentin 100mg every morning, 100mg every evening, 300mg every night at bedtime).

Hypnotics (such as zolpidem, eszopiclone, and zaleplon) have been used as short term sleep aids and **benzodiazepines** have been used for brief episodic anxiety, insomnia, and muscle spasticity management. They generate physical dependence, and are dangerous in combination with other sedating medications. They are not recommended for long term use for any condition and increase risk of death when combined with opioids and other central nervous system depressants.

OPIOIDS and OPIOID SAFETY

Opioids can be appropriate for acute trauma or pain (e.g. motor-vehicle accident, sickle cell crisis), acute post-operative pain, and pain from terminal illness such as malignancies. Aside from terminal pain, all patients should be counseled that they should not need opioids after the expected healing period (usually 3-10 days and generally not more than 14 days). After that, the risks of opioids almost always outweigh the benefits. Opioids are not indicated for chronic (longer than 3 months), non-terminal pain. Opioids shut down the pain-signaling pathway, and after their effects wear off, the pain returns because opioids do not address cause of pain. Opioids can also trigger the pain system to become more sensitive – a condition known as opioid induced hyperalgesia.

- DHS expected practices are to not offer treatments when harm outweighs benefit. Explain to patients opioid-associated risks including increased risk of death, overdose, dependence and hyperalgesia, and interference with other pain management treatments. Non-opioid treatments are safer and better address the inflammation and nerve irritation that are physiologic causes of pain. Structured & validated opioid risk tools exist, such as the ORT: https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf

For high-risk situations (active concurrent substance use disorders, history of overdose on prescribed opioids, diversion behavior, and respiratory insufficiency), there is no benefit that would outweigh the harm of continuing opioids. Transition these patients to buprenorphine-naloxone (Suboxone) as their opioid analgesic strategy of choice. Buprenorphine is a schedule III opioid partial agonist that is categorically safer than all other opioids. It has analgesic properties and thus a wide therapeutic index for pain management. Usual dosing for analgesia is buprenorphine-naloxone 2-0.5mg to 8mg-2mg tablet thrice a day.

Risk factors for problems related to opioid use include:

- Chronic disease: risk of opioid use disorder is 30%
- History of mental health issues: depression, anxiety, bipolar disorder, schizophrenia, suicidal behaviors
- Social instability and trauma such as history of sexual abuse
- Personal history of substance use (including alcohol, tobacco use, illicit drugs, and prescriptions), any history of overdose
- Risk factors for oversedation such as concomitant sedatives, benzodiazepine use, taking > 50 MME/day
- Family history of substance abuse (including alcohol, illicit drugs, and prescriptions)
- Risk factors associated with decreased respiratory function such as obesity, COPD, asthma, OSA
- Risk factors associated with poor metabolic clearance such as advanced age, liver or kidney disease
- Structured & validated opioid risk tools exist such as the ORT: https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf

Safer opioid strategies in chronic pain management:

- Avoid starting opioids for chronic non-terminal pain.
- Practice naloxone (Narcan) co-prescribing and education (indications for use, calling 911, administer second dose if effects wane).
- For patients already on opioids, we recommend evaluation for tapering the opioid dose down or discontinuous opioids at each visit. Evaluate all patients on chronic opioids for opioid misuse and/or diversion.
- Set a brief time-limited goal for use of opioids, with specific evaluation of functional improvements. If there is no improvement of functional goals on opioids, stop the opioids. Use lowest effective dose. The maximum recommended daily opioid dose is 50 MME (e.g. Oxycodone 40mg/day).
- If choosing to prescribe opioids for chronic pain, consider abbreviated prescriptions e.g. 3-7 days for new acute pain.
- Implement safeguards such as random urine drug screens (UDS) to ensure compliance both that patient is taking prescribed opioid and not taking illicit medications. Note urine fentanyl test is a unique order. Practice **naloxone (Narcan)** co-prescribing and education (indications for use, calling 911, administer second dose if effects wane).
- Minimize risky combinations, avoid co-prescription of benzodiazepines and other potentially sedating medications.
- CURES report checks: use first 1-3 letters of first and last names plus date of birth to capture all versions of patients' names.
- For high-risk situations (active concurrent substance use disorders, history of overdose on prescribed opioids, diversion behavior, and respiratory insufficiency), there is no benefit that would outweigh the harm of continuing opioids. Transition these patients to **buprenorphine-naloxone (Suboxone)** as their opioid analgesic strategy of choice. Buprenorphine is a schedule III opioid partial agonist that is categorically safer than all other opioids. It has analgesic properties and thus a wide therapeutic index for pain management.
- Some providers find that Pain Treatment Agreements can facilitate difficult conversations and preserve a therapeutic relationship between patient and care team. There is no evidence to support the outcome based clinical benefit of Pain Treatment Agreements (Controlled Substance Prescription/Opioid Contracts).
- Consult Pain Management for advice, education, and support: eConsult to Pain Management (non-malignant) for patients in ambulatory settings.

Tapering Opioids

It is easier to taper down long acting opioids (such as methadone or morphine OR) on a patient's regimen first and subsequently transition to short acting opioids as an initial milestone. Long acting opioids such as methadone, oxycodone extended release, and morphine sulfate extended release are generally only appropriate for patients with terminal pain.

- Reduce the daily dose by 10-20% each week to month to minimize physical withdrawal and psychological anxiety about changes in opioids. Individualize the pace of tapering.
- Encourage splitting tabs in half and replacing breakthrough opioid doses with breakthrough non-opioid strategies.
- For further guidance on tapering, please see "Addiction Medicine and Pain Medicine – Opioid Taper".
- Send an eConsult to Pain Management (non-malignant) if there are specific questions about tapering opioids.

PATIENTS WITH SUBSTANCE USE DISORDERS

Opioid use disorder commonly co-occurs with chronic pain. If a patient has an opioid use disorder, the first line treatment is to initiate sublingual buprenorphine-naloxone, which can be dosed thrice a day to four times a day to address pain. Instructions for initiating buprenorphine/naloxone are discussed in the Addiction Medicine – Medication Management of Opioid Use Disorder in Ambulatory Care Settings.

An X-waiver is not required to prescribe buprenorphine-naloxone for the indication of pain. Ensure that the indication of pain is documented in the ORCHID order in the instructions for the pharmacist field to clarify the indication for this buprenorphine-naloxone.

An X-waiver is required to prescribe buprenorphine-/naloxone in ambulatory settings for the indication of opioid use disorder. E-mail buprenorphine@dhs.lacounty.gov to obtain an X-waiver. In the ORCHID order's field for instructions for the pharmacist, providers who prescribe buprenorphine-naloxone for the indication of opioid use disorder must include their X-waiver number and the diagnosis of opioid use disorder (F11.20).

For patients with alcohol, tobacco, and other co-occurring substance use disorders, see the DHS Clinical Care Library section on Addiction Medicine to review and implement DHS expected practices related to the treatment of these conditions: http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx

If there are non-urgent questions about appropriate use of medications for alcohol, tobacco, and/or opioid use disorder, use the eConsult: Addiction Medicine – Medications for Addiction Treatment.

- For urgent questions about appropriate use of medications for treatment of alcohol, tobacco, and/or opioid use disorder, including during a clinical visit: DHS Addiction Medicine Consult line, 8am to Midnight everyday including weekends, (213) 288-9090.

PATIENT FOOD SERVICES/NUTRITION SERVICES

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.

freepik.com

DIET ORDERS

Patient meal service includes meal delivery and hospitality services, operated by Morrison Healthcare Food Service, Inc. Each meal is delivered according to the time schedule (see table below).

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 a physician's order form will automatically cancel all previous diet orders written.

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. 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
BREAKFAST	7:00AM - 8:30AM	6:10AM	9:15AM
LUNCH	11:00AM - 12:30PM	9:30AM	1:15PM
DINNER	5:00PM - 6:30PM	12:15PM	7:15PM

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

In an effort to improve communication among care providers, Los Angeles General Medical Center has several processes in place to confirm the accuracy of orders issued over the telephone for urgent/emergent situations, 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 licensed independent provider (NP, PA, MD) issues the order, the registered nurse (RN) enters the telephone order into the electronic health record. Before ending the telephone call, the RN "reads back" the order to the provider to confirm that he/she understood and transcribed it correctly. The RN will document the phrase "Telephone Order issued by" or the abbreviation "T.O. by" followed by the provider's printed full name and provider identification number. The electronic telephone order will be automatically routed to the issuing provider, to be signed as soon as possible, and no more than 48 hours later.
- *Verbal Orders* – It is not always feasible to do a formal "read back" for a verbal order (e.g., during a code blue or in surgery). In such circumstances, a "repeat back" is an acceptable means of confirming the accuracy of the order. When able, the RN will enter the verbal order into the electronic medical record. The order must include the date, time, specific order, ordering provider's name and the communication type selected as "Verbal with Read Back." The electronic verbal order will be automatically routed to the issuing provider, to be signed as soon as possible, and no more than 48 hours later.
- **Critical Laboratory Values/Results** – Los Angeles General 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 for critical laboratory values from 11:01 p.m. to 6:59 a.m. (2301-0659 hour), the performing laboratory staff will handle notification per Los Angeles General 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

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 they give the highest level of care, and to immediately react upon emergencies, potential emergencies and/or incidents.

SIGNS AND SYMPTOMS

Depending upon your scope and/or level of practice, these are some of the warning signs that a patient's condition 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's condition is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. The patient's nurse will assess the situation and call for additional assistance, if needed. 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

Prevention of patient falls is the responsibility of <u>**EVERY**</u> 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 is 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 OF A FALL

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor of extension to the floor (e.g., trashcan or other equipment) with or without injury to the patient. All types of falls are 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 that occurs while a patient is engaging in purposeful actions as a result of a rehabilitation therapy session (i.e., high challenge balance activities, fall recovery, etc. with therapist) that has the intent of challenging a patient's balance or attempting 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 be 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

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

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

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

OUTPATIENT FALL PREVENTION MEASURES	
For ALL Patients	**For AT-RISK Patients**
• Maintain a safe, hazard free environment (remove any obstacles from patient pathway). • Ensure adequate lighting. • Use wheel locks when indicated. • Keep beds, stretchers, gurneys in lowest, locked position. • Keep call light (as applicable) within reach. • Identify and manage areas of concern during Environmental Safety Rounds. • Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.	• Ensure "Fall Risk" alert arm band is in place. • Provide education to patient/family regarding fall risk determination. • Place "at-risk" patients identified as needing assistance on exam table only at time of examination, with staff present. • Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so). • Offer wheelchair if appropriate. • Be sure assistive devices (cane, crutches, walkers, wheelchairs, etc.) are within reach of the patient. • Assist patients walking with medical equipment (wound vac, IV, etc.). • Alert subsequent provider that patient is a fall risk. Notify appropriate professional for focused fall reduction interventions and patient/family education.

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.

INPATIENTS

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

Assessment/Reassessment

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

Health Services
LOS ANGELES COUNTY

Attachment 3

Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Humpty Dumpty Scale and Prevention – Inpatient Program

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.

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 Limitations	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 ICU Patients Sedated and Paralyzed), Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/ Diuretics, Narcotic	3
	One of the Meds Listed Above	2
	Other Medications/None	1
	Total	

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

2. Patients 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 in addition to Level 1 interventions.
High Risk	Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients in addition to Level 1 and 2 interventions.

- When a patient is identified as moderate or high risk for falls, the nursing staff will initiate a plan of care related to the patient's identified risk factors and place a colored "fall risk" alert arm band on the patient.
- Place a sign at the entrance to the patient's room and/or head of the patient's bed.
- Place a fall precaution sticker on front of patient's chart.

Pediatrics	
Low Risk	Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and "General Fall Prevention Interventions for All Children" will be implemented for these patients.
High Risk	Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for High Risk for the duration of their hospitalization.

- If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a falls risk reassessment may be performed and documented to justify the discontinuation of the high risk for falls identification and implementation of Falls Prevention Measures.
- If, in the nurse's judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures.

Initiation of Plan of Care

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

Fall Prevention Measures

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

Adults

Level 1
Low Risk
Score: 0 – 24
	• The patient's risk for falls will be discussed with interdisciplinary team members.
	• Provide patient/family education related to fall prevention.
	   • Purpose and importance of fall/injury prevention measures
	   • Use of call light
	   • Maintain bedrails in appropriate position
	   • Safe ambulation/transfer techniques
	   • Importance of wearing non-skid footwear
	   • Reporting environmental hazards to nursing staff (e.g., spills, cluttered passages)
	• Family/ significant others may assist with fall reduction strategies once fall management training is completed. (**Note:** staff remains responsible for overall safety of patients even with family in attendance).
	• Perform intentional rounds.
	• Orient patient to surroundings and hospital routines.
	• During exchange of patients between staff, hand off communication should include fall risk level, supervision provided, and observation of unsafe behaviors.
	• Set the bed in the lowest position with brakes locked.
	• Place personal belongings within reach on the bedside stand/table.
	• Reduce room clutter. Remove unnecessary equipment and furniture.
	• Provide non-skid (non-slip) footwear.

Level 2 **Moderate Risk** **Score: 25 – 50**	• Attach fall prevention stickers to the front of the medical record. • Place a sign at the entrance to the patient's room and/or head of the patient's bed. • Offer toileting, minimally, every 2 hours. • Activate the bed alarm and wheelchair seat belt alarm, if appropriate.
Level 3 **High Risk** **Score: 51 and higher**	• Increase frequency of nursing rounds based on patient need. • Collaborate with interdisciplinary team for therapy schedule/ activities. • Cohort patients, when possible. • Restraints are discouraged, however, if needed, apply per Hospital Specific Restraint Policy. • Provide continuous in-person observation with a trained staff member as needed for safety reasons. • Place the patient in a room or area where they can be easily observed. • Offer toileting, minimally, every 2 hours. • Stay with patient at all times while toileting out of bed. • Refusal by patient for direct observation during toileting must be documented in the patient's medical record, as applicable. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.). • Notify the appropriate licensed professional of patient's refusal.

Pediatrics

General Fall Prevention Measures	Children can fall because of developmental, environmental and situational risks.
	The following strategies shall be implemented for all children:
	• Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
	• Leave crib side rails up at all times unless an adult is at the bedside.
	• Bed type and size shall be determined based on child's developmental and clinical needs.
	• Instruct patient/parent on how to prevent falls in the hospital setting:
	   • Maintain side rails in appropriate position.
	   • Maintain crib rails up.
	   • Do not allow the child to jump on the bed.
	   • Do not allow the child to run in the room or hallway.
	   • Do not allow the child to climb on hospital furniture or equipment.
	   • Explain the importance of wearing non-skid footwear.
	   • Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.
	   • Notify nursing staff of environmental hazards (e.g., spills, cluttered passages).
	   • Supervise the child's activities (e.g. walk next to the child and provide support as strength and balance are regained).

Fall Prevention Measures for High Risk	- Consider locating the child closer to nursing station for closer observation. - Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion and pain. - Offer assistance with toileting, minimally, every 2 hours while awake. - Stay with child at all times while toileting out of bed. - Refusal by the child's parent/guardian for direct observation during toileting must be documented in the patient's medical record. - Notify the appropriate licensed professional of child's parent/guardian's refusal. - Provide calming interventions and pain relief. - Accompany patient with ambulation. - Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications). - Set bed alarms, as appropriate, to alert when child is exiting the bed. - Evaluate need for and encourage family to remain at the child's bedside. - Assess need for continuous in-person observation with a trained staff member, as needed, for safety reasons. - Provide patient/family education related to fall prevention (in addition to education related to general injury prevention above): - Purpose and importance of fall/injury prevention measures - Use of call light/maintaining bedrails in appropriate position - Safe ambulation/transfer techniques - Instruct family of pediatric patients to inform the nurse and/or physician if the child seems to be less coordinated than usual, or complains of dizziness or feeling weak. - Instruct family of pediatric patients that until the child regains their strength, someone should walk alongside him/her to provide support and protection in case he/she loses their balance.

Post-Fall Procedure

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

Post-Fall Evaluation and Management Algorithm

First Responder
- Stay with patient. Call for help.
- Check patient for pain or injury, check LOC
- Report fall to licensed personnel.
- Provide comfort measures until licensed staff member arrives and assesses patient for injury

Licensed Provider:
- Assesses patient asap after fall
- Provides follow-up orders, medical, and diagnostic work-up, and care as indicated
- Reviews patient's medications. If patient is on anticoagulation therapy and has struck head, consider indication for radiographic exams, including head CT or MRI
- If patient shows change in neurological status, considers transfer to a higher level of care.
- Notifies emergency contact and documents notification in medical record
- Recommends additional steps for fall prevention

RN Staff:
- If patient has struck head/face and/or is on anticoagulation therapy, immediately notify physician, and initiate neuro checks. If physician does not respond at bedside within the hour, follow medical chain of command.
- Documents clinical status and description of fall in medical record
- Completes Fall Risk Reassessment and updates care plan
- Implements additional intervention as needed or as ordered. (e.g., increased level of supervision)

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

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

DOCUMENTATION

Outpatient	Inpatient
For patients at risk for falls, staff will document the following on appropriate outpatient record: • Falls screening • Fall risk • Fall prevention measures and patient education provided	The RN will document the following on the appropriate forms: • Using the appropriate Fall Risk Assessment Tool, document the initial assessment and ongoing reassessments. • Patient/family education related to falls • Ongoing safety precautions • Any fall incident, related assessments, and notification of physician/family

EMERGENCY DEPARTMENT (ED)

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

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

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

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

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

Pediatrics Interventions
1. Assist with ambulation.
2. Move patient to allow closer nursing observation.
3. Place the patient directly on bed (or on gurney).
    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 child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
    c. 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

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

UNIVERSAL PROTOCOL

Los Angeles General Medical Center has adopted all components of Joint Commission's Universal Protocol intended to prevent wrong site, wrong procedure and wrong person surgery or procedures. The Universal 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** – Los Angeles General Medical Center uses a DHS Standardized Final Surgical Timeout 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** – Los Angeles General 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 Los Angeles General Medical Center, 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 their procedure note.

Use of the Universal Protocol is required for procedures for non-OR settings, including bedside procedures. Pre-procedure verification of relevant documents and informed consent is necessary. Site marking must be done for any procedure that involves laterality, multiple structures or level, when there is not an obvious wound or lesion. All those who will be participating in the procedure conduct a DHS Standardized Non-OR Procedural Time Out before the start of the procedure.

The ASK NICE mnemonic captures the core components of the Time Out: A – announce time out/allergy check, S – specimen, K – "K"orrect patient, procedure, site/laterality, N – needed equipment, I – informed consent, C – coagulation status, E – expiration date "call out" when supplies and medications are opened. Attestation of performance of a Time Out, including the date and time, is documented in the electronic medical record. In non-specialty areas (e.g., bedside procedures), the provider documents the occurrence of the "TIME OUT" in their procedure note.

MEDICATION MANAGEMENT

Freepik

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 Los Angeles General Medical Center.

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. Los Angeles General Medical Center encourages you to review the formulary on an ongoing basis, and utilize formulary-approved medications.

SAFETY TIPS FOR SAFE MEDICATION PRESCRIBING

All prescriptions should be prescribed and/or documented in ORCHID 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 severe, mild, moderate 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.
- Avoiding the use of unapproved abbreviations. When in doubt, do not abbreviate. To prevent any confusion, spell out the entire name of the drug.

Medication Storage Safety Tips:

✔ Do not store food with medications.
✔ Different medications should NOT be stored in the same bin.
✔ Medication for discharged patients should not be stored and must always be returned to the pharmacy.

PROHIBITED/UNSAFE ABBREVIATION LIST: DO NOT USE

Make Patient Safety a Part of Your Patent Care Routine!

The following abbreviations/symbols are **unacceptable** at Los Angeles General Medical Center and shall **NOT** be used for patient medication orders:

🚫 PROHIBITED & UNSAFE	✔ SAFE & ACCEPTABLE	RATIONALE
Drug Name Abbreviations **$MgSO_4$** **MSO_4** **MS**	Use the complete spelling for drug names. Magnesium sulfate Morphine sulfate	Helps reduce misinterpretation. 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 a "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.
Prohibited only for medication related notations **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: 0.2mg	***Always*** 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, please refer to the ISMP list of look-alike, sound-alike (LASA) medications. 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.

The following strategies are implemented at Los Angeles General Medical Center to minimize medication errors associated with LASA medications:

- Tall man lettering is used to describe LASA drugs on medication labels, Medication Administration Record (MAR).
- LASA drugs are separated where drugs are stored and labeled with a cautionary sticker.

Prescribers are encouraged to include the indication for use when prescribing LASA medications.

LOOK-ALIKE/SOUND-ALIKE MEDICATION LIST

CARBOplatin (antineoplastic)	**CISplatin** (antineoplastic)
clonAZEPAM (anticonvulsant)	**ClonIDINE** (alpha-adrengeric agent)
DAUNOrubicin (antineoplastic)	**DOXOrubicin** (antineoplastic)
DOPAmine (andrenergic agonist)	**DOBUTamine** (adrenergic agonist)
ePHEDrine (bronchodilator)	**EPINEPHrine** (alpha-beta agonist)
foLIC acid (vitamin)	**foLINIC acid** (antidote)
hydromorPHONE (narcotic analgesic)	**MORPHine** (narcotic analgesic)
hydrOXYzine (anti-histamine)	**hydrALAZINE** (anti-hypertensive)
LAMIVudine (anti-retroviral)	**LAMOtrigine** (antiepileptic)
LORazepam (benzodiazepine)	**ALPRAzolam** (benzodiazepine)
SufSALAzine (anti-inflammatory agent)	**SulfaDIAZINE** (antibiotic)
VinBLAStine (antineoplastic)	**VinCRIStine** (antineoplastic)

MEDICATION DISPENSING

Before dispensing medications, the pharmacists must review all medication orders for appropriate indication, dose, route, frequency, and drug/allergy interactions. The pharmacist utilizes the patient'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 AND BAR CODE SCANNING

If you administer medication to patients, you are responsible for properly performing patient identification (using two identifiers, e.g., **Patient Name and MRUN**, per hospital policy). Use the Medication Administration Record (MAR) in ORCHID to review and document medication administration. Bar Code Scanning is used for proper identification of patients and medications.

PATIENT'S OWN MEDICATIONS

Patients should not bring 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.

ADVERSE DRUG REACTION (ADR) REPORTING

All adverse drug reactions need to be documented in the MAR in the patient's allergy/side effects profile. Once documented it must be reported in the Safety Intelligence™ Event Reporting System by the end of the shift of occurrence or when 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™ (SI) Event Reporting System.

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

Los Angeles General 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. 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. The team is composed of licensed and non-licensed staff and is under the direction of a Registered Nurse.

Training

All members of the BRT receive specialized training in non-violent crisis intervention, less restrictive alternatives and restraint application. Team members must 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

- Call Ext. 111
- Request to activate "Code Gold"
- Provide your name, location and extension
- Operator will overhead page and activate the BRT's group pager
- Operator will notify the Sheriff personnel of "Code Gold"
- Operator calls requesting ward to verify BRT's response

DOCUMENTATION

When documenting on each restraint and/ seclusion episode: **REMEMBER JAAC**

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

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

- 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. Los Angeles General 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.

KEY POINTS TO REMEMBER (CLINICAL STAFF)

PROVISION OF CARE

- Know the characteristics of each population group that you serve.
- Los Angeles General Medical Center supports every patient's right to have their pain assessed and treated promptly, effectively, and for as long as the pain persists.
- Know that "Code Blue" means adult cardiac (or cardiopulmonary) arrest, and "Code White" means pediatric cardiac or cardiopulmonary arrest.

PATIENT SAFETY

- Use "READ-BACK" procedures to ensure important information is accurately communicated and recorded.
- Los Angeles General 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 Los Angeles General Medical Center Fall/Injury Prevention Program.
- Universal Protocol **applies to all surgical and nonsurgical invasive procedures** and establishes a process for preventing wrong site 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 Los Angeles General Medical Center Safety Intelligence™ (SI) Event 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.
- Los Angeles General Medical Center will dispatch a Behavioral Response Team (BRT) for a "Code Gold" emergency.
- Los Angeles General 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.
- Los Angeles General 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.

KNOWLEDGE CHECK

1. Your DHS photo Identification badge must be worn above the waist at all times while on duty and in County facilities.

   a.   True
   b.   False

2. Employees may spend time on non-County related activities during County working hours as long as it doesn't impact your County related work.

   a.   True
   b.   False

3. If you need to be excused from certain aspects of patient care that conflict with your cultural values, ethics, and religious beliefs, you must:

   a.   Speak with your supervisor.
   b.   Submit a request to be excused from that aspect of patient care.
   c.   Do nothing. DHS will not excuse anyone from any aspect of patient care.
   d.   A and B

4. Implicit Bias, which is defined as having an unconscious, hidden, or unknown preference, <u>only</u> occurs in healthcare.

   a.   True
   b.   False

5. The Notice of Privacy Practices is provided to patients during the following:

   a.   DHS is not required to provide it to patients.
   b.   DHS staff provide it to patients during their first encounter with us.
   c.   A patient may request a copy at any time.
   d.   Both B and C

6. If the press or news media request information about one of our patients, you must:

   a.   Call the PIO or Privacy Manager to report it and do not provide any infromation.
   b.   Provide the Information.
   c.   None of the above.

7. It is okay to post work-related issues on social networking sites as long as you do not use County equipment.

   a.   True
   b.   False

8. Under the False Claims Act:

   a.   Whistleblowers may face demotion or termination.
   b.   Whistleblowers are protected.
   c.   Reporters are prohibited from bringing a lawsuit against the violator.

9. You must notify your supervisor within ___ hours of being notifed that disciplinary action is being brought against your professional credential.

    a. 16
    b. 24
    c. 32

10. If you are asked a question by a surveyor during a site visit from a regulatory/accreditation agency such as The Joint Commission and you do NOT know the response, do NOT guess, and inform them you will obtain the appropriate response.

    a. True
    b. False

11. The DHS Emergency Code for fire is:

    a. Code red
    b. Code blue
    c. Code yellow
    d. Code green

12. All DHS employees must take the following Awareness, Vigilance, Avoidance, Defense, and Escape Principles (AVADE) training:

    a. Level I
    b. Level II
    c. Level III
    d. All of the above

13. You should adjust your workstation so that:

    a. Your monitor is above eye level.
    b. Your feet are dangling.
    c. Light is aimed at the task and not your screen.
    d. None of the above.

14. Standard Precautions include:

    a. Hand hygiene
    b. Safe injection practices
    c. Waste disposal
    d. All of the above

15. It is okay to clean a keyboard and other computer equipment with water.

    a. True
    b. False

16. To comply with applicable policies, and as a condition of employment, DHS staff must be up-to-date with the following vaccines, or complete a declination form:

    a. Influenza vaccine only
    b. COVID-19 vaccine only
    c. Both influenza and COVID-19 vaccines
    d. None of the above

LOS ANGELES GENERAL MEDICAL CENTER
2051 Marengo Street
Los Angeles, CA 90033

(323) 409-1000

Los Angeles General Medical Center Administration

Chief Executive Officer	Jorge Orozco	(323) 409-2800
Chief Operations Officer	Edgar Solis	(323) 409-3501
Chief Medical Officer	Brad Spellberg, MD	(323) 409-6734
Chief Nursing Officer	Nancy Blake, RN	(323) 409-6747
Chief Financial Officer	Efrain Munoz	(323) 409-6871
Chief Information Officer	Gary Hanna	(323) 409-2691

A

Augustus Hawkins	Nursing Office	(424) 338-2555
Admission/Bed Control	Al Castillo	(323) 409-5321
Allied Universal Security	Robert Evans	(323) 409-3304
Anesthesiology	Marie Pecson	(323) 409-8581
Appointment Center	Behnaz Hekmatnia	(323) 409-2316

C

Chaplains: Spiritual Care	Father Chris Ponnet	(323) 409-4715
Clinical Engineering Department		(323) 409-5053
Clinical Social Work	Inez Beckon-English, LCSW	(323) 409-5253
College of Nursing & Allied Health	Vivian Branchick, RN	(323) 409-5911
Command Center	Christopher Celentano, MD	(323) 409-1443
Compliance Officer	Angela Baca-Cooper	(323) 409-4242
Cultural and Linguistic Center	Claudia Mata	(323) 409-5533
Critical Lab Value	Shawn McGowan, RN	(323) 409-5390

D

Decedent Affairs	Estela Inouye	(323) 409-7161
Diagnostic Services	Daniel Amaya	(323) 409-7291
Dietary	Elizabeth Toushin	(323) 409-6901
Dietitian Office		(323) 409-6979
Hospitality Supervisor		(323) 409-1742
To Order Meals		(323) 409-6906
Director, Language Access and Inclusion	Dr. Erika Flores Uribe	(323) 226-6937

E

Emergency Services	Victor Pena	(323) 409-1945
Emergency Services	Shelia Mallet	(323) 409-6808
Employee Assistance Program		(213) 433-7202
Employee Health Services	Shawn McGowan, RN	(323) 409-5236
Epidemiology/Infection Control	Paul Holtom, MD	(323) 409-6705

F

Facility Accreditation/Policy Management/ Licensing	Victoria Walsh, RN	(323) 409-6370
Facility Management	Ruben Aguayo	(323) 409-6451

G		
Graduate Medical Education	Lawrence Opas, MD	(323) 409-6931
H		
Health Information Management (HIM)	Kimberly Rawls	(323) 409-6911
Health, Safety & Environmental	General Line	(323) 914-7514
HIPAA Compliance Coordinator	Jacqueline Anderson	(323) 409-6100
HIPAA Security Coordinator	Sedik Shamoradian	(323) 409-6265
Human Resources	Monique Ortega	(323) 409-2300 160HR@dhs.lacounty.gov
DHS Classification/Compensation		(213) 288-7000
DHS Employee Relations		(323) 914-6362
DHS Health, Safety & Environmental	General Line	(323) 914-7514
DHS HR Administration	Marilyn Hawkins	(323) 914-5000
DHS HR Operations		(213) 288-7000
DHS Payroll		(213) 288-7000
DHS Performance Management		(323) 914-6361 PMU@dhs.lacounty.gov
DHS Privacy Officer		(213) 288-7730
DHS Recruitment & Examination		(213) 288-7000
DHS Regulatory Compliance	Sharon Robinson	(213) 288-7000
DHS Risk Management	Catherine Mathers	(323) 914-6350
Disability Management & Compliance	Michelle Merino	(323) 914-6365
Claims & Litigation	General Line	(323) 914-6364
DHS Time Collection	Help Desk	(323) 914-8922
I		
Infection Prevention & Control	Paul Holtom, MD	(323) 409-6645
Information Systems	Gary Hanna, CIO	(323) 409-2691
General Public Information		(323) 409-1000
IT Help Desk	Roman Villalta	(323) 409-8000
IT Information	Gary Hanna	(323) 409-6866
Pager Operator	Kinly Kao	(323) 409-4906
Patient Information	Claudia Mata	(323) 409-5800
Internal Medicine Services	Steven Prieto	(323) 409-4513
L		
Labs and Pathology	Christina Russo	(323) 409-1315
Blood Bank	Christopher Tuma	(323) 409-1319
Core Lab	Margarita Montano	(323) 409-7146
Cytology	Christina Russo	(323) 409-1315
Frozen Section	Christina Russo	(323) 409-1315
Microbiology	Leang Tea	(323) 409-7050

M	Managed Care	Behnaz Hekmatnia	(323) 409-2316
	Medical Administration	Brad Spellberg, MD	(323) 409-6734
	Specialty Care Services (Medical Director)	Wei-An (Andy) Lee, DO	(323) 409-5181
	Medical Library Resources	Mahbubul Karim	(323) 409-7006
N	Nursing Administration	Annie Marquez, RN	(323) 409-6747
	Nurse Epidemiologists		(323) 409-6645
	Nurse Recruitment & Retention	Paul Holtom, MD	(323) 409-4664
O	Outpatient Administration	Behnaz Hekmatnia	(323) 409-2316
P	Palliative Care	Eve Cruz, RN	(323) 409-8532
	Parenteral and Enteral Nutrition Service		(323) 409-6901
	Patient Access Center	Behnaz Hekmatnia	(323) 409-2316
	Patient Appointment Line		(323) 409-1000
	Patient and Guest Relations	Claudia Mata	(323) 409-6959
	Patient Resource Center		(323) 409-4004
	Patient Relations Department		(323) 409-6959
	Patient Representative Emergency Room concerns		(323) 409-1612
	Patient Representative outpatient concerns		(323) 409-1612
	Patient Safety Coordinator	Sonny Aberin	(323) 409-2797
	Pediatrics/VIP		(323) 409-8662
	Pharmacy	Steven Dohi	
	Clinic Tower	Catherine Bell/Wilbert Ho	(323) 409-6763
	Inpatient	Kevin Weissman	(323) 409-7552
	OPD	Sandy Leem	(323) 409-5092
	Outpatient	Beatrisa Bannister	(323) 409-4280
	Privacy Manager	Jacqueline Anderson	(213) 409-6100
	Psychiatric Services	Gwendolyn Cooper	(323) 409-5551
	Public Information	Concepcion Castro	(323) 409-6899
Q	Quality Improvement	Laura Sarff, RN	(323) 409-2815
R	Radiation Safety Office		(323) 409-7855
	Radiology, Administration	Daniel Amaya	(323) 409-7291
	Intervention Radiology	Efrain (Frank) Carranza	(323) 409-7266

CT	Valerie Martinez	(323) 409-1764
Mammography	Rosalina Valle	(323) 409-1949
MRI	Mina Oveissi	(323) 409-7235
Nuclear Medicine	Lynn Jacobs	(323) 409-4112
Ultrasound	Efrain (Frank) Carranza	(323) 409-7266
General Radiology	Francisco Valle	(323) 409-2238
Inpatient Holdings Area		(323) 409-7234
Registration Area		(323) 409-7252
Regulatory Affairs	Ramon Sanchez	(323) 226-3679
Rehabilitation Services	Louise Wall, PT, DPT	(323) 409-5096
Revenue Management	Jose Chavez, Jr.	(323) 409-7773
Risk Management	Claudia Aguirre, RN	(323) 409-6657
Risk Management Fax		(323) 226-5923
Safety Officer	Sajid Yerunkar	(323) 409-6451
Supply Chain Operations	Dolores Gonzalez	(323) 409-3340
Surgical Services	Marie Pecson	(323) 409-8581
TB Control	Rebecca Park	(323) 409-7962
Volunteer Services	Gabriela Hernandez Gonzalez	(323) 409-6945
Women's Services	Angela Baca	(323) 409-3017

S

T

V

W

HOTLINES

Child Abuse	(800) 540-4000
DHS Compliance/HIPAA	(800) 711-5366
DHS Patient Safety	(213) 288-SAFE (7233)
Domestic Violence/Intimate Partner	(800) 978-3600
Elder Abuse/Adult Abuse	(877) 477-3646
Fraud (LA County)	(800) 544-6861
Allied Universal Security Services	(323) 409-3333
Patient Safety	(323) 409-SAFE (7233)
Poison Control	(800) 411-8080
Safely Surrendered Baby	(877) 222-9723
Suicide & Crisis Lifeline	988
Suicide Prevention Lifeline LGBTQ	(800) 273-8255
U.S. Department of Justice Civil Rights Division ADA Information Line	(800) 514-0301

Los Angeles General
Medical Center

North

Map not to scale

Streets and Locations

Chicago Street.
Chicago Street
Zonal Avenue
N. Cummings Street
N. Cummings Street
Marengo Street
Brittania Street
Pomeroy Street
Kingston Street
San Bernardino Freeway
N. State St.
N. State St.
Marengo Street
Mission Road
Sichel St.
Circle Drive
Golden State Freeway
To Hollywood Freeway

Buildings

P12
P7
P9
P5
P10
P14
P5P21

EMPLOYEE HEALTH (IRD)
CARES THRIFT SHOP
OUTPATIENT CLINICS (OPD) **B** **2**
INPATIENT TOWER (Hospital, IPT) **H** **3**
Loading Dock
Patient Drop-off Pick-up
Courtyard
DIAGNOSTIC & TREATMENT (D&T)
HISTORIC GENERAL HOSPITAL
THE WELLNESS CENTER
CLINIC TOWER (CT) **A** **1**
Patient Drop-off Pick-up
TRAILER 126
TRAILER 17
LA COUNTY CHILD DEVELOPMENT CENTER
Coroner's Office
RAND SCHRADER CLINIC **C**

101
5
10

Map Legend

A Clinic Tower (CT)
B Outpatient Building (OPD)
H Inpatient Tower, Hospital (IPT)
Diagnostic & Treatment Tower (D&T)
Rand Schrader Clinic (C)
Employee Health (IRD)
Visitor/Patient Parking
General Hospital
LA County Child Development Center
Emergency
Elevator
Information Desk
Pharmacy

Smoke & Tobacco Free Campus

NO HIT ZONE
Healthy Kids • Caring Communities

BabySafeLA.org
BABY SAFE SURRENDER

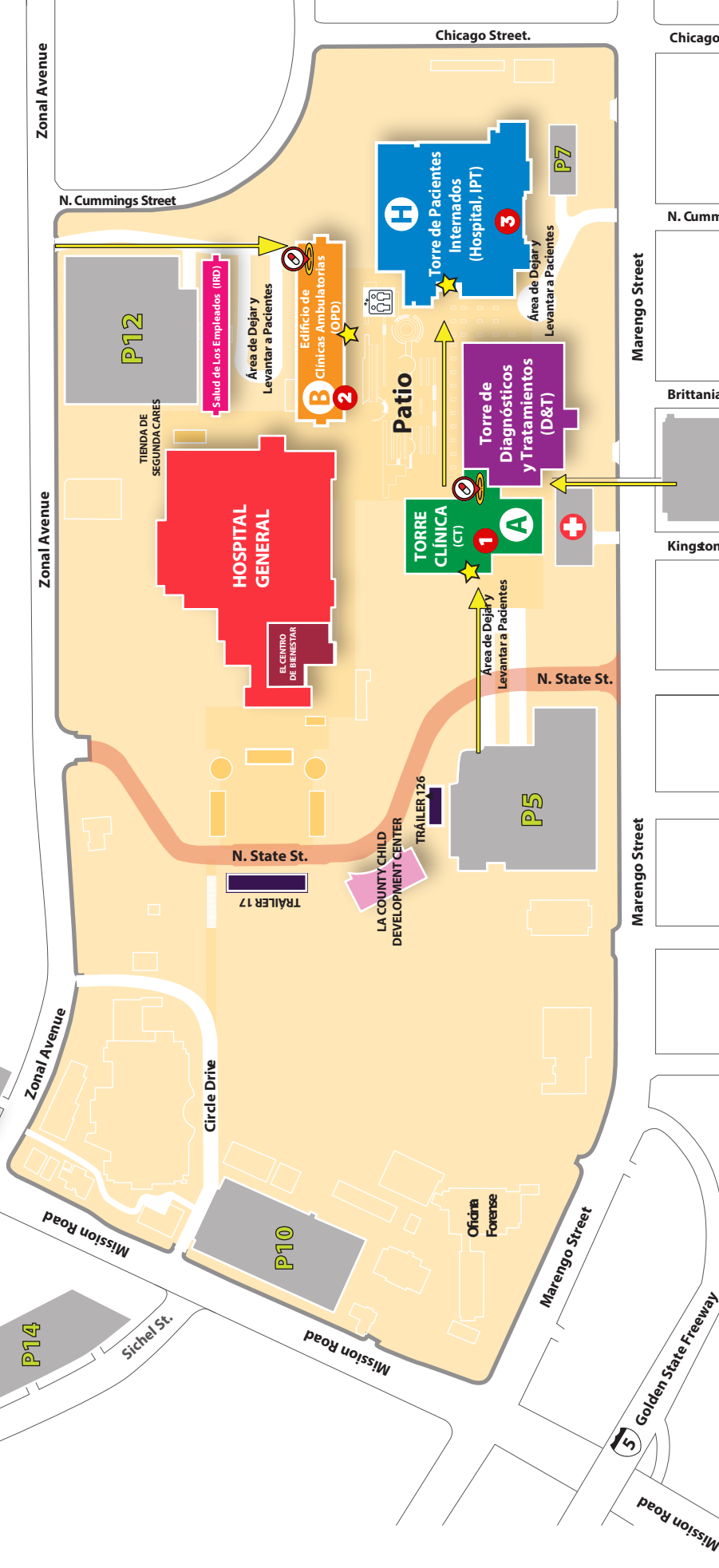**2051 MARENGO ST, LOS ANGELES, CA 90033 (323) 409-1000**
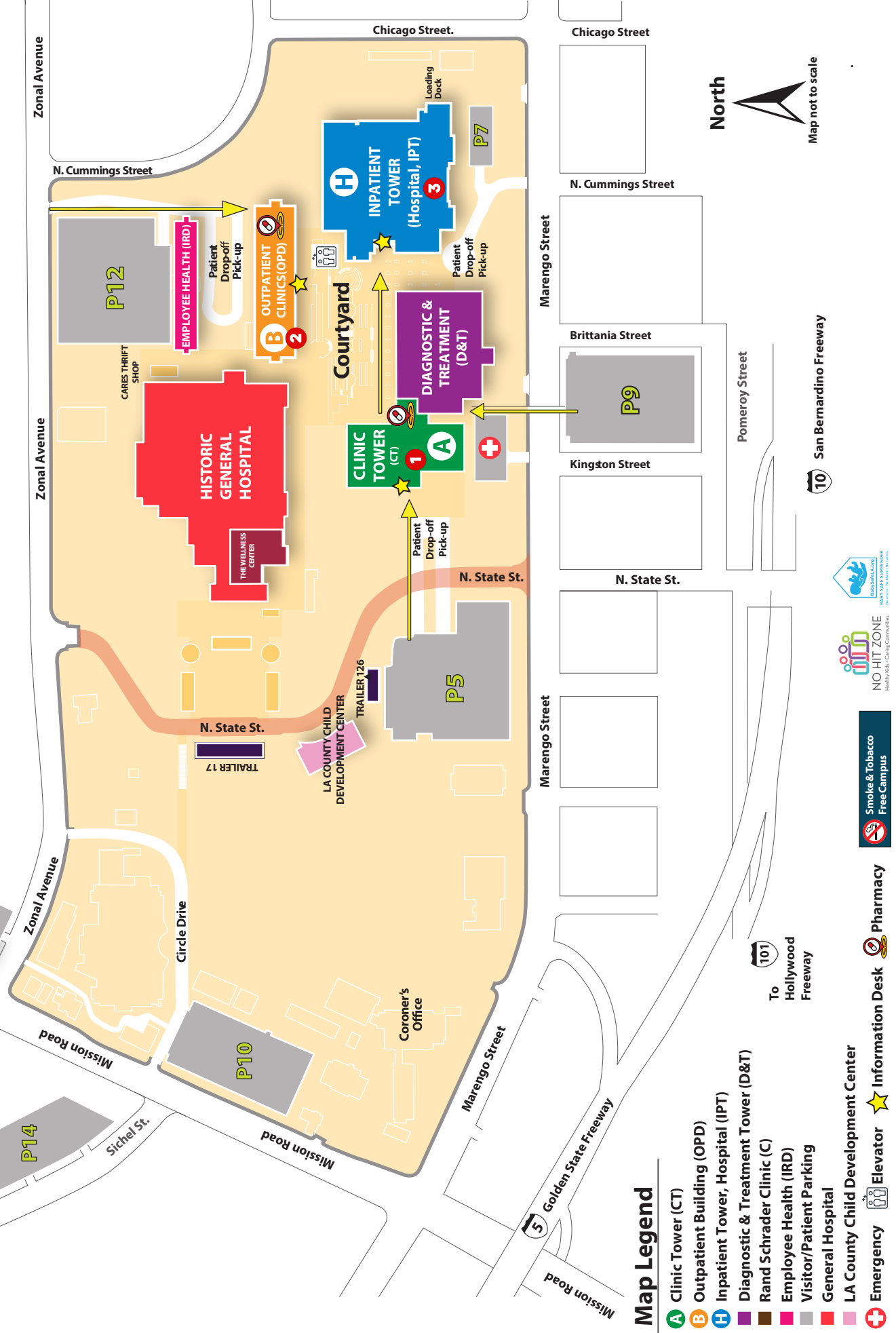
Los Ángeles General
Centro Médico

Servicios Financieros & Preguntas sobre facturas del Paciente Horas hábiles 7:00 am - 5:00 pm Lunes a Viernes

Para programar una cita con el personal de estos servicios o para obtener asistencia con su factura, solicitar Medi-Cal o cualquier otra pregunta sobre asistencia financiera y elegibilidad, llame al (323) 409-6361 o puede ir personalmente a alguno de nuestros tres centros:

1. **Edificio A:** Clínica Torre – 1er piso, en Ventanillas K y L
2. **Edificio B:** Pacientes Ambulatorios – 2ndo piso en 2p47 y 2p48
3. **Edificio H:** Hospital Pacientes Ingresos: 2nd piso – consulta sobre facturas

Streets and locations
- Chicago Street.
- Zonal Avenue
- N. Cummings Street
- Marengo Street
- Brittania Street
- Kingston Street
- Pomeroy Street
- N. State St.
- Circle Drive
- Mission Road
- Sichel St.
- Golden State Freeway
- San Bernardino Freeway
- To Hollywood Freeway 101
- Freeway 5

Buildings
- CLÍNICA RAND SCHRADER (C)
- P5P21
- P12
- P14
- P10
- P7
- P9
- P5
- HOSPITAL GENERAL
- EL CENTRO DE BIENESTAR
- TIENDA DE SEGUNDA CARES
- Salud de Los Empleados (IRD)
- Área de Dejar y Levantar a Pacientes
- Edificio de Clínicas Ambulatorias (OPD) (B) 2
- Torre de Pacientes Internados (Hospital, IPT) (H) 3
- Área de Dejar y Levantar a Pacientes
- Torre de Diagnósticos y Tratamientos (D&T)
- Patio
- TORRE CLÍNICA (CT) (A) 1
- LA COUNTY CHILD DEVELOPMENT CENTER
- TRÁILER 126
- TRÁILER 17
- Oficina Forense

Norte
Mapa no a Escala

NO HIT ZONE — Healthy Kids · Caring Communities

BabySafeLA.org — BABY SAFE SURRENDER

Smoke & Tobacco Free Campus

2051 MARENGO ST, LOS ANGELES, CA 90033 (323) 409-1000

Map Legend
- (A) Torre Clínica (CT)
- (B) Edificio de Clínicas Ambulatorias (OPD)
- (H) Torre de Pacientes Internados (IPT / Hospital)
- Torre de Diagnósticos y Tratamientos (D&T)
- Clínica Rand Schrader
- Salud de Los Empleados (IRD)
- Estacionamiento Para Visitantes
- General Hospital
- Centro del Desarrollo de Niños del Condado de Los Angeles
- Emergencia
- Farmacia
- Elevador
- Mostrador de Información

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

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The purpose of this handbook is to provide the Los Angeles County Department of Health Services (DHS) workforce members with the resources and regulatory/procedural information that applies to them. All DHS workforce members are governed by these standards, which you should read and be familiar with.

THIS HANDBOOK IS PROVIDED BY:

Health Services
LOS ANGELES COUNTY

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Human Resources, Office of Regulatory Compliance
5701 S. Eastern Ave, Suite 400, City of Commerce, CA 90040
Telephone: (323) 914-6460

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Director, Department of Health Services

DHS MISSION

To advance the health of our patients and our communities by providing extraordinary care.

Board of Supervisors, County of Los Angeles

Hilda L. Solis, First District
Holly J. Mitchell, Second District
Lindsey P. Horvath, Third District
Janice Hahn, Fourth District
Kathryn Barger, Fifth District

COUNTY MISSION

Establish superior services through inter-Departmental and cross-sector collaboration that measurably improves the quality of life for the people and communities of Los Angeles County.