2018

ORIENTATION/REORIENTATION HANDBOOK

Los Angeles County – Department of Health Services

MARTIN LUTHER KING, JR
OUTPATIENT CENTER

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

CONTRIBUTORS

Name	Department
Yolanda Vera	Hospital Administration
Jessica Kuo	Performance Improvement
Jessica Kuo	Risk Management
Erika Sweet, RN, NP	Employee Health Services
Samel Hardiman	Compliance Officer
Jessica Kuo	Clinical Quality and Safety Officer
Lessie Barber, RN	Nursing
John Thompson	Facilities Management
Gentamu McKinney	Infection Prevention and Control
Francisco Rea	Supply Chain Operations
Nina Vassilian, MPH, MCHES	Office of Diversity & Cultural Competency
Maria Elena Gaitan	DHS Human Resources
Laura Rinard, CPA	DHS Human Resources
La Tonya Calloway	DHS Human Resources

Produced by DHS Human Resources
Office of Regulatory Compliance

Publication Support
Irma Urzua

Revised
July 2018

Quick Reference

Martin Luther King, Jr.
Outpatient Center
1670 East 120th Street
Los Angeles, CA 90059

(424) 338-1000
General Line

DEPARTMENT	CONTACT PERSON	PHONE
Administration		(424) 338-1001
Chief Executive Officer	Yolanda Vera	(424) 338-1001
Chief Medical Officer	Ellen Lerner Rothman, M.D.	(424) 338-1501
Nursing Director	Lessie Barber, RN	(424) 338-1646
Chief Financial Officer		(424) 338-1001
Americans with Disability Act Coordinator	Samel Hardiman	(424) 338-2703
Clinical Social Work	Wendy Givens	(424) 338-1815
DHS Risk Management	Jessica Kuo	(424) 338-1001
Return To Work		(323) 914-7111
Dollarhide Health Center		(310) 763-2244
Emergency Preparedness Coordinator	Jessica Kuo	(424) 338-1001
Employee Assistance Program (EAP)		(213) 738-4200
Employee Health Services	Nursing Administration	(424) 338-2200
Environmental Safety Officer	Damena Bahiru	(424) 338-2648
Environmental Services	Collins Nwadiogbu	(424) 338-1001
Facilities Management	John Thompson	(424) 338-2620
Finance		(424) 338-1603
Health Information Management	Vanessa Crawford	(424) 338-1900
HIPAA Privacy Liaison	Samel Hardiman	(424) 338-2703
Human Resources	Regina Pierre	(424) 338-1686
Employee Relations		(323) 914-7132
Performance Management		(323) 914-8428
Payroll		(323) 914-8383
Infection Prevention and Control	Nursing Administration	(424) 338-1646
Information Desk		(424) 338-2378
Information Systems		(424) 338-1833
Enterprise Help Desk		(323) 409-8000
Language Center	Joseph Y. Huang	(424) 338-1001
Medical Administration		(424) 338-1501
Nursing Administration		(424) 338-1646
Patient Advocate		(424) 338-2713
Sheriff Department/Security		(424) 338-1234

Volunteer Services	Denise Gordon	(424) 338-1001

HOTLINES

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

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Welcome to the Martin Luther King, Jr. Outpatient Center and the Dollarhide Health Center where we strive as a team to provide the same quality health care we would want for ourselves and our loved ones.

The MLK Outpatient Center works in partnership with our other public and private campus and neighboring partners, including the private non-profit Martin Luther King, Jr. Community Hospital, the MLK Mental Health Urgent Care Center, our Department of Public Health's Center for Public Health, our Department of Mental Health outpatient programs at the Augustus Hawkins building, and our academic partners at the King/Drew Magnet High School and Charles Drew University.

This campus has a rich history and is now nationally recognized as a state-of-the-art way of operating a medical campus. It has a proud tradition of pioneering new and better ways to serve our patients and promote wellness. For example, it was the first site to open a recuperative care center where formerly hospitalized homeless patients can heal and be linked with housing. It is the first County-run campus to have a farmers' market. It is the first County medical campus to embrace care improvement teams, now a regular DHS practice, where front-line staff are actively engaged to improve patient care. It is one of the County's first sites to hire community health workers for its most complex hard-to-manage patients.

The Martin Luther King Jr. Outpatient Center is a County-run 136,500 square-foot four-story outpatient service facility, opened in 2014. It has approximately 70 clinical services including patient-centered medical homes for adults and children; co-located behavioral health services staffed by the Department of Mental Health (DMH); an urgent care center that operates 7 days a week/16 hours a day; a full range of specialty and subspecialty clinics, including dental services; an ambulatory surgery center; and a full range of diagnostic and ancillary services consisting of laboratory, radiology, rehabilitation, and pharmacy services that are available 7 days a week.

The Dollarhide Health Center provides quality primary pediatric and adult care; integrated wellness at the MLK Outpatient Center through the support of the DMH co-located clinic, women's clinic and diabetes education sessions led by the nursing team to ensure that patients understand their treatment plans and goals. Patients see the same provider at every visit. The service is patient-centered, coordinated and is provided in a caring and safe environment.

More campus innovations and improvements are on their way. A new community library, campus child care center, Willowbrook/Rosa Parks Metro transportation hub, and a new clinic to serve the full range of health, social and mental health needs of local at-risk youth, children and families are set to open soon. A new MLK Behavioral Health Center will also open in the building that housed the old hospital. A new Family Medicine residency program will soon begin, in partnership with our academic partners at Charles Drew University, where we will train our future medical champions.

This employee Orientation Handbook will provide you with general information regarding the Outpatient Center, Dollarhide Health Center, and other subject matter that all workforce must know. Take time to read and become familiar with all information contained within the handbook and use it as a reference guide. It is also important to make sure you understand and follow policies and procedures that govern the facility and your assigned work area.

With that, we welcome you to this historic and innovative community. By joining the MLK/Dollarhide team, you are serving a historic community that has given birth to countless renowned artists, doctors, nurses, lawyers, civil rights leaders, spiritual leaders, and scientists. No matter your job, you are part of this vibrant fabric. We welcome your ideas and passion so we can continue to improve and shine as a beacon in this community.

Yolanda Vera
Chief Executive Officer

MARTIN LUTHER KING, JR. OUTPATIENT CENTER

INTRODUCTION

The Martin Luther King, Jr. Outpatient Center (MLK OPC) is located at 1670 East 120th Street and can be accessed from 120th Street and south on Healthy Way. The facility is a state-of-the-art 136,500 square-foot four-story outpatient service building with connecting corridors to Leroy Weekes North Support Building. The MLK OPC is designed to improve patient experience and operating efficiency. The facility operates over 70 primary care and specialty care clinics including Pediatric HUB Clinic and OASIS Clinic to serve the health care needs of surrounding communities.

The MLK OPC was designed to obtain Leadership in Energy efficient and Environmental Designed (LEED) Silver certification. It has a Glass Curtain Wall along the front of the building, is furnished with new equipment and advanced technology. There are surveillance/security cameras in place to monitor campus activity. The facility is outfitted with fire rated elevators, wireless network access, and requires keycard/badge access.

PARKING

Patient parking is to the right of the entrance of the OPC in Parking Lot D, where there are spaces for hybrid and carpool vehicles along with electric vehicle charging stations. Additional patient parking is available directly across 120th Street in Parking Lot G.

Employee parking is available in Parking Lot C, and the adjacent structure, and lots E and F.

SIGNAGE DIRECTORY

Martin Luther King, Jr. Outpatient Center Building
1670 East 120th Street
Los Angeles, CA

1st Floor	2nd Floor	3rd Floor	4th Floor
Cashier	Blood Gas Lab	Ambulatory Surgery Center	Audiology
Lab Blood Draw Station	Cardiology Clinic	Gastroenterology (GI) Clinic	Dental Clinic/
Nuclear Medicine	Continuing Care/Functional	General Surgery/Breast Clinic	Oral maxillofacial Surgery
Orthopedic Clinic	Assessment Clinic	Neurology Clinic	Dermatology Clinic
Pharmacy	Echocardiography Lab	Renal Clinic	Diabetes Clinic
Radiology	EKG	Urology Clinic	Eye/Ophthalmology Clinic
Urgent Care	Endocrinology Clinic		ENT/Otolaryngology Clinic
	Hematology/Oncology Clinic		Physical Therapy
	Holter Monitoring		Rehabilitation
	Infusion Center		Speech Therapy
	Medical Home A Clinic		
	Medical Home B Clinic		
	- Behavioral Health		
	Nephrology Clinic		
	Post Hospital Discharge/		
	Continuing Care Clinic		
	Pulmonary Clinic		
	Pulmonary Function Lab		
	Stress Lab		
	Women's Clinic		

1ST FLOOR FEATURES:

* Clinic Modules A, B, and C
* Patient seating/waiting area
* Public restrooms (west of the building)
* East conference room number 1002
* Staff work areas are towards the back of the clinics
* Staff lounge with lockers & staff restrooms

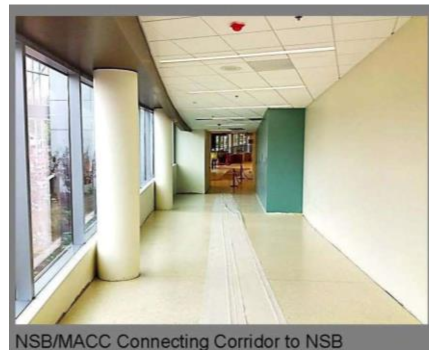
2ND FLOOR FEATURES:

* Clinic Modules A - F
* Patient seating/waiting area
* Public restrooms (west of the building)
* East Conference room number 2004
* West conference room number 2002
* West elevator lobby
* North side stairwell
* Staff entrance 2nd floor east breeze way
* South east service elevators lobby
* Staff lounge with lockers & staff restrooms

3RD FLOOR FEATURES:

- Ambulatory Surgery Center (ASC) Clinic Module A
- Public restrooms (west of the building)
- Patient seating/waiting area
- Surgery patient waiting area
- Surgery conference room number 3114
- West conference room number 3002
- Surgery staff lounge
- Staff work area are located towards the back of the clinics
- Staff lounge with lockers & staff restrooms
- Staff outdoor patio area
- Connecting corridor between MLK OPC and MLK CH

4TH FLOOR FEATURES:



NSB/MACC Connecting Corridor to NSB

- Clinic Modules A - F
- Patient seating/waiting area
- Public restrooms (west of the building)
- East Conference room number 4004
- West conference room number 4002
- West elevator lobby
- North side stairwell
- South east service elevators lobby
- Staff lounge with lockers & staff restrooms

LEROY WEEKES BUILDING/NORTH SUPPORT BUILDING

The MLK OPC includes 34,000 square-feet of renovation to the existing Leroy Weekes building housing administrative services and support departments.

1st Floor

- Biomedical Engineering
- Elder Abuse Program
- Environmental Services
- Health Information Management
- Human Resources
- Patient Financial Services
- Patient Services (Social Services, Interpreter Services, Patient Relations/Member Services)
- Sheriffs Dispatch
- Staff lounge

2nd Floor

- Administration
- Call Center
- Data Center
- Information Technology
- Medical Administration
- Nursing Administration

ELEVATOR AND STAIRS

There are five elevators and two stairwells available for patients, visitors, vendors and staff use. Elevators #1 and #2 are located on the southeast side of the building. Elevators #3 and #4 are located on the Northwest side of the building and are available for workforce members, patients, guests, and vendors.

Stairwell #1 is located on the northwest front of the building and is assessable to everyone. Stairwell #2 is located in the back on the southeast side of the building and is designated for workforce members to exit and for emergency use only.

LOCKERS

There is limited space in cabinets and drawers to store personal belongings in the clinic work areas. Therefore, employee lockers are located throughout the facility. Lockers will be assigned to workforce members within designated departments to store and safeguard their personal belongings during the work shift. Workforce members will be assigned a locker based on availability. If no locker is available, the workforce member will be placed on a wait list until a locker is available.

Each workforce member will complete a Locker Request Form and submit to his/her manager for locker assignment. A copy of the request form with the assigned locker number will be kept on file. When a workforce member is terminated or discontinues service at MLK OPC, he/she will be responsible for removing his/her contents from the assigned locker prior to the last day of employment/assignment. Any items left in the locker will be discarded.

MARTIN LUTHER KING, JR. OUTPATIENT CENTER

IDENTITY STATEMENT

A public safety outpatient clinic, owned and operated by the Los Angeles County Department of Health Services, to provide high quality, primary care and specialty services to the community we serve.

VISION

Martin Luther King, Jr. Outpatient Center will be the healthcare provider of choice for the communities we serve, while excelling in patient-centered care.

MISSION

To provide compassionate, high quality care that improves the health status of our patients, their families and the communities we serve.

VALUES

Excellence, Quality, Respect, Integrity, Teamwork, Diversity, Responsibility

TAGLINE

Patients First

LOS ANGELES COUNTY HEALTH AGENCY STRATEGIC PRIORITIES

September 29, 2015

Consumer Access to and Experience with Clinical Services

STRATEGIC PRIORITY*:* Streamline access and enhance customer experience for those who need services from more than one Department, including by promoting information-sharing, registration, care management, and referral processes, training staff on cross-discipline practice, and increasing co-location of services.

Goal 1: Consumer Access and Experience. Implement staff workflow processes and technical infrastructure necessary to ensure clients can access services in another Department without having to duplicate registration, financial screening, and eligibility/determination processes; where prudent, align Departments' financial policies governing eligibility and payment for services from self-pay individuals.

Goal 2: Housing and Supportive Services for Homeless Consumers. The goal is to link the homeless and those at risk of homelessness to appropriate health, housing and supportive services and to develop a consistent method for identifying and engaging homeless and those at risk for homelessness across the three Departments.

Goal 3: Overcrowding of Psychiatric Emergency Departments. Implement Agency-wide referral processes and technical infrastructure and train staff on protocols through which clients can be identified and referred directly to services in or funded by another Department.

Goal 4: Culturally and Linguistically Competent Programs. Ensure access to culturally competent and linguistically appropriate services and programs as a means of improving service quality, enhancing customer experience, and helping to reduce health disparities.

Goal 5: Diversion of Corrections-Involved Individuals to Community-based Programs and Services. Successfully divert corrections-involved persons with mental illness and addiction who may otherwise have spent time in County jail or State prison by placing them into structured, comprehensive, health programming and permanent housing, as tailored to the individual's unique situation and needs.

This strategic priority focuses on successful diversion of corrections-involved persons with mental illness and addiction who may otherwise have spent time in county jail or State prison by linking them to structured, comprehensive, health programming and permanent housing as tailored to the unique individual's situation and needs.

Goal 6: Expanded Substance Use Disorder Benefit. Substance Abuse Prevention and Control (SAPC). Maximize opportunities available under the recently approved Drug Medi-Cal waiver to integrate Substance Use Disorder (SUD) treatment services for both adults and youth into LA County's mental and physical health care delivery system.

Goal 7: Vulnerable Children and Transitional Age Youth. Improve the County's ability to link vulnerable children, including those currently in foster care, and Transitional Age Youth (TAY) to comprehensive health services (i.e., physical health, mental health, public health, and SUD services).

Goal 8: Chronic Disease and Injury Prevention. The overall objective of this priority is to align and integrate population health strategies with personal health care services so that County of Los Angeles clients can benefit from both the receipt of quality chronic disease management services and thrive in safe and healthy communities.

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: **http://www.lacounty.gov/strategic-plan-and-goals**

CUSTOMER SERVICE

CUSTOMER SERVICE PHILOSOPHY

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

- Personal Service Delivery
- Service Access
- Service Environment

PERSONAL SERVICE DELIVERY

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

Always:

- Introduce yourself by name and, when appropriate, **SMILE**.
- Treat our customers with courtesy and respect.
- Listen carefully and patiently to them.
- Be responsive to their cultural and linguistic needs.
- Explain procedures clearly.
- Be courteous when having telephone conversations.
- Take the extra step to assist customers.
- If a request cannot be met, explore and suggest other options.

SERVICE ACCESS

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

- Providing service as promptly as possible.
- Providing clear directions and service information.
- Reaching out to the community to promote available services.
- Involving patients' families in their service plan development.
- Following-up to ensure appropriate delivery of services.
- Responding to customer concerns immediately and following up within 24 hours.

SERVICE ENVIRONMENT

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

- Report any unsafe conditions to your supervisor.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our patients' health information.

TEAMWORK

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

EFFECTIVE WORKPLACE COMMUNICATION

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

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

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

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

KEY POINT

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

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 information format.

PRINCIPLES OF INTERDISCIPLINARY COLLABORATION

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

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

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

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

KEY POINT

Teamwork through effective communication, collaboration, and coordination of care across disciplines can result in 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 key to providing effective coordination of care. Up-to-date information about a patient's care, treatment or services, condition, expected outcomes and anticipated changes must be maintained to ensure appropriate care of the patient. Effective

coordination of care makes it possible for patients to feel secure in the knowledge that they are receiving appropriate and timely care. This is a necessary part of the process of developing patient trust.

CONFLICT RESOLUTION THROUGH TEAM BUILDING

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

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

KEY POINT

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

REMEMBER

PATIENT SAFETY PROGRAM

The DHS Patient Safety Program is under the direction and supervision of the DHS Director of Quality, Patient Safety, and Risk Management. The DHS Director of Quality, Patient Safety, and Risk Management works collaboratively with the DHS Patient Safety Committees as well as representatives from each facility in the areas of Patient Safety, Administration, Risk Management, Infection Control, Pharmacy, Environmental Health & Safety, Medicine, Nursing, Ancillary Services, and other groups as needed to coordinate safe patient care. If you provide patient care at any level, please pick up a copy of the Employee Patient Safety Handbook which is available on our DHS intranet.

If you need additional information on DHS patient safety activities, please visit the DHS Patient Safety Program website located under Clinical Resources, Quality Improvement, Risk Management & Patient Safety on the DHS Intranet. If you have any questions or would like to report any patient safety concerns, you can email them to patientsafety@dhs.lacounty.gov or call the DHS Patient Safety Hotline at (213) 989-7233 or (800) 611-4365.

JUST CULTURE

A Just Culture is one where accountability is fairly balanced between the DHS organization and the individual workforce members. It recognizes that adverse events and unanticipated outcomes are often the result of human error, or system failures, rather than the result of reckless or intentionally malicious behavior.

DHS strives to build, maintain, and support a Just Culture. A Just Culture is one in which safety is an individual and organizational priority and where errors, near miss events, adverse events, unsafe conditions, and system problems can be easily reported without retaliation, and are viewed as an opportunity to identify system and behavior changes that will improve the safety and quality of 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.

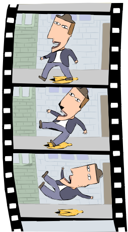
When indicated, Workforce members will be held accountable and appropriate corrective action taken. Actions will be consistent with Just Culture principles, AND with DHS Discipline Manual and Guidelines, County Civil Service Rules, and DHS policies and procedures. Workforce Members will not be held accountable for system flaws over which they have no control.

CREATE AND MAINTAIN A JUST CULTURE BY:

- Encouraging staff to recognize and report patient safety issues, and suggest ideas on how we can improve.
- Acknowledging that errors in health care occur and provide a supportive environment for the staff should an error occur.
- Viewing mistakes as opportunities to learn and 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.
- Staff is held accountable for reckless, dangerous behaviors even if no patient has been harmed.

PREVENTION OF FALLS

Prevention is the key factor to reduce injury from falls. It is crucial to know how to respond to a fall situation at the facility or in your work environment. If you work in a patient care environment at the facility, you must become aware of the facility's response mechanism. Prevention of patient falls is the responsibility of EVERY workforce member. Workforce members can be proactive by being aware of their surroundings and identifying risks for falls.



Definition

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor or 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.

All falls regardless of the type of fall must be reported in the Safety Intelligence TM (SI) Event Reporting System.

FALL PREVENTION MEASURES

General Safety Measures to Prevent Falls in the Outpatient Clinic Setting

- Maintain a safe, hazard-free environment (remove any obstacles from patient pathway and keep floors dry).
- Ensure adequate lighting.
- Use wheel locks when indicated.
- Keep beds, stretchers, gurneys in lowest, locked position with side rails up, as appropriate.
- Keep call light within reach, if applicable.
- Do not allow patients to sit on chairs with wheels or rollers.
- For patients with higher risk of falls, consider locating patient to an area that allows closer clinic staff observation.
- Be sure assistive devices (cane, crutches, etc.) are within reach of the patient.

General Fall and Injury Prevention Measures for Children

- Do not leave the child unattended when using equipment such as strollers, walkers, infant seats or swings.
- Do not allow the child to jump on the exam bed.
- Do not allow the child to run in the room or hallway.
- Do not allow the child to climb on clinic furniture or equipment.
- Specify the importance of wearing non-skid footwear.
- Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.

Refer to DHS Policy 311.101, DHS System-Wide Fall Prevention Program, for additional fall prevention measures.

IDENTIFICATION OF PATIENTS WITH FALL RISKS

Screening for fall risk may be applied across a clinic or be patient specific:

- Certain patient populations, settings and environments pose an 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 and staff education
  - Evaluation of previous year's fall data

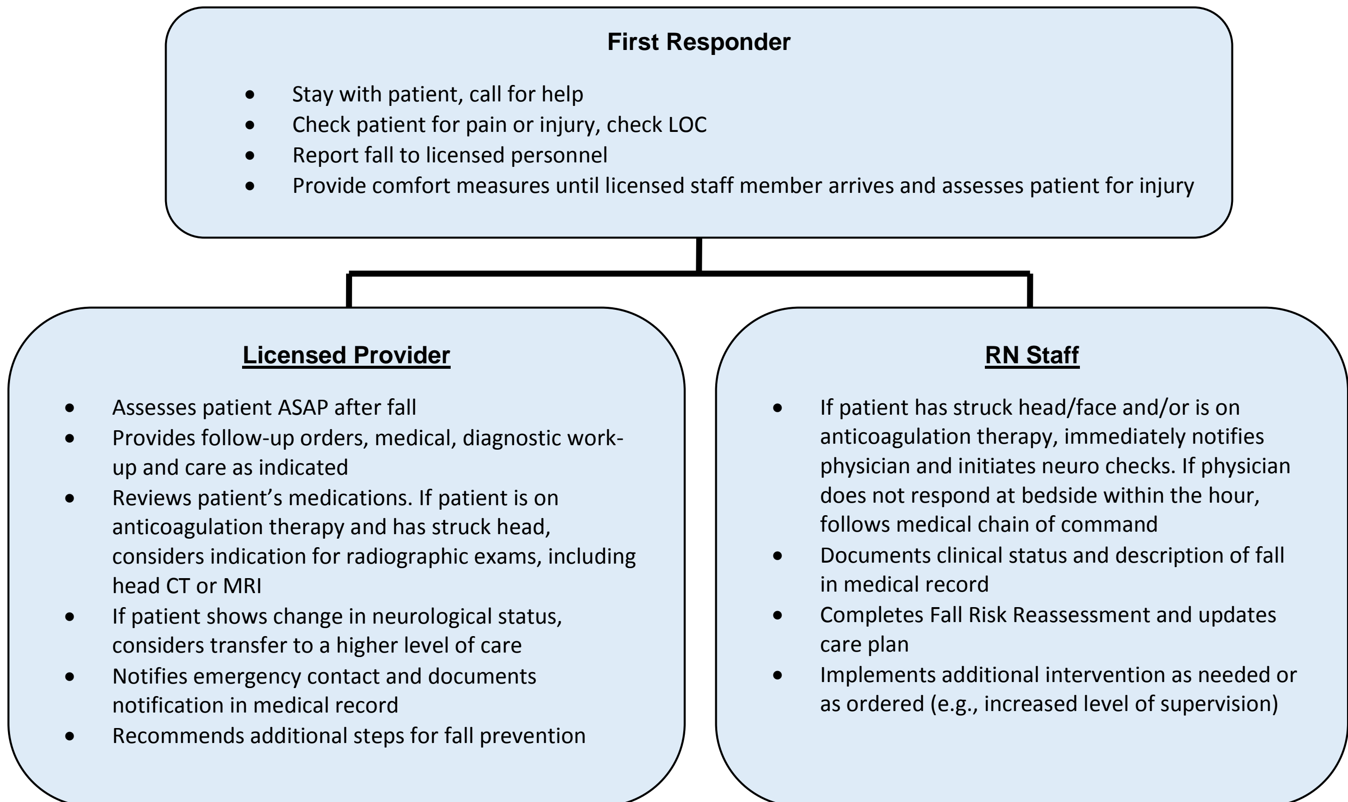
- Screen each adult and/or pediatric patient (over 1 year of age) for fall risk using the age appropriate screening tool:
  - Hospital-Based Outpatient Falls Screening Criteria (Adult)
  - Hospital-Based Outpatient Falls Screening Criteria (Pediatric)

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

FALL PREVENTION MEASURES FOR AT RISK OUTPATIENTS

Fall Event Procedure

In the event of a patient fall, initiate the Post Fall Evaluation and Management Algorithm.



Documentation

The first staff to witness or come on scene of the fall must complete an event notification report into the Safety Intelligence™ Event Reporting System before end of the shift. Submissions are aggregated for the purpose of Performance Improvement, Quality Control, monitoring, reporting, and benchmarking.

Outpatient Clinics 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

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.

DETERIORATING PATIENT CONDITION

RESPONDING TO THE DECLINE IN PATIENT CONDITION

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

If you are in a patient care area, immediately notify the patient's nurse. If you cannot determine which nurse to notify, please tell any doctor or nurse in the area that you are concerned about the patient/visitor. Check with your supervisor on your facility's response mechanism.

RESPONSE TEAM

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 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 for ensuring that he/she gives the highest level of care, and to immediately react upon emergencies, potential emergencies and/or incidents. Some facilities have a response team that assists with deteriorating patients.

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

- Acute change in level of consciousness, mental status, new seizure or prolonged seizure.
- Acute change in heart rate.
- Acute decrease in systolic blood pressure.
- Acute change in respiratory rate or effort.

- Acute decrease in oxygen saturation.
- Acute decrease in urinary output.
- Abnormal bleeding.
- Chest pain.
- You are concerned about the patient; “Something is wrong.”

If you are concerned that a patient is deteriorating, activate the facility response team (if applicable) right away, and explain what concerns you. The response team is set up to evaluate and stabilize patients who are deteriorating.

“READ-BACK”, “REPEAT-BACK” REQUIREMENTS

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

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result write down, then “read-back” the complete order or test result.

All values defined as critical by the laboratory are reported directly to a responsible licensed caregiver within the time frames established by the laboratory (defined in cooperation with the nursing and medical staff). When the patient’s responsible licensed caregiver is not available within the time frames, there is a mechanism to report the critical information to an alternative response caregiver.

Examples:

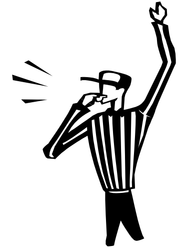
- ***Telephone Orders*** – while the licensed independent provider (NP, PA, MD) issues the order, the nurse enters the telephone order into the electronic health record. Before ending the telephone call, the nurse “reads back” the order to the provider to confirm that he/she understood and transcribed it correctly. The nurse 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 nurse 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 Test Results*** – When a caller provides a critical test result or value to the patient care area, as a licensed member of our service delivery team, you are required to “read back” the test result or value to the caller. Then, telephone the physician caring for the patient. The physician is also required to do a verification “read-back”.

UNIVERSAL PROTOCOL

DHS has adopted all components of the World Health Organization and Joint Commission’s Universal Protocol intended to prevent wrong site, wrong procedure and wrong person surgery or procedure. 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., endoscopy, interventional radiology, cardiac catheterization, and bedside procedures). You share in the responsibility of conducting this verification process in cooperation with the patient.

The three main components are:

1. **Pre-Operative/Pre-Procedure Verification** – Use a DHS Standardized Final Surgical Timeout checklist to ensure that all relevant documents are available and correct before sending a patient for an invasive procedure. We ensure that the patient's history and physical is present and current, that we obtained the patient's informed consent, and that the patient agrees to the planned surgery/procedure. If you find any information missing or any discrepancy, postpone the procedure until the information is clarified and/or corrected.
2. **Marking the Operative Site** – DHS requires site marking for all surgical sites/invasive procedures involving right/left distinction, multiple structures, or levels. Whenever possible, involve the patient in the marking process.
3. **"TIME OUT" –** Immediately before starting the procedure, all members of the service delivery team conduct a final verbal verification to confirm the following: correct identity of the patient, operative site and side, consent on the procedure to be done, correct patient position, availability of correct implants and any special equipment or special requirements. In the Operating Room (OR) and other dedicated procedure areas, the nurse documents the "TIME OUT" in ORSOS. In non-specialty areas (e.g., bedside procedures), the physician documents the occurrence of the "TIME OUT" in his/her procedure note.



MEDICATION MANAGEMENT

MEDICATION USE

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

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, contraindications, and the pharmacological effects of each medication that you prescribe to avoid adverse drug events. You are encouraged to review the formulary on an ongoing basis, and utilize formulary-approved medications when possible.

SAFETY TIPS FOR SAFE MEDICATION PRESCRIBING

Make your medication orders clear and complete by:

- Identifying your patient with **TWO** identifiers (***Patient Name and Date of Birth and/or Medical Record Number***)
- Including specific dose, route, frequency, and any instructions/parameters.
- When in doubt about a dose or a Formulary status of a medication, **PLEASE call your Pharmacist**.
- Not using range orders (Pharmacy will NOT accept ranges such as 1-2 tabs; q 4-6h in orders.).
- Qualifying orders as needed (e.g., PRN orders: PRN pain).
- Using weight-based dosing on all pediatric patients less than 40 kg of weight.

REMEMBER

When in doubt,
DO NOT ABBREVIATE!
Spell out the entire name or the drug.

Avoid the use of unapproved abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire name of the drug.

DANGEROUS ABBREVIATIONS

DO NOT USE! DANGEROUS ABBREVIATIONS

Make Patient Safety a Part of Your Patient Care Routine!

The abbreviations listed below **MUST NOT** be used in any patient order or clinical documentation.

DO NOT USE	USE INSTEAD	Potential Problem
U	Spell out "unit "	Mistaken as zero leading to 10-fold overdose, four, or cc
IU	Write "international unit"	Mistaken as IV (intravenous) or the number 10 (ten)
Q.D. or QD	Write "daily", "qday" or "q24hrs"	**Can be mistaken for QOD or QID**. The period after the Q or the tail of the "Q" can be mistaken for an "i" and make the order a QID.
Q.O.D.	Write "every other day" or "every 48 hours"	**Can be mistaken for QID**. The "O" can be mistaken as an "I" and make the order a QID.
Trailing zero Example: 1.0 mg	Write 1 mg Never write a zero by itself after a decimal point	If the decimal point is missed, it can be misread as 10 times the amount intended (e.g. misread as 10 mg)
Lack of leading zero Example: .1 mg	Write 0.1 mg Always use a zero before a decimal point	The decimal point can be missed, leading to a ten-fold overdose error in drug strength & dosage (e.g. misread as 1 mg)
MS, MSO_4 or $MgSO_4$	Spell out "m o r p h i n e" or "morphine sulfate" "Magnesium or magnesium sulfate"	Confused for one another. Can mean morphine sulfate or magnesium sulfate.

"LOOK-ALIKE/SOUND-ALIKE" MEDICATIONS

To further enhance medication safety, special attention should be given when administering one of these drugs to ensure that it is the correct drug. Be aware of the Look-Alike/Sound-Alike (LASA) Medication List. The "Tall-Man" lettering is used to differentiate look-alike/sound-alike drugs. The following strategies are implemented to minimize medication errors associated with LASA medications:

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

LOOK-ALIKE/SOUND-ALIKE MEDICATION LIST

#	Medication	Look-alike/Sound-alike
1.	**CARBOplatin** (antineoplastic)	**CISplatin** (antineoplastic)
2.	**clonAZEPAM** (anticonvulsant)	**ClonIDINE** (alpha-adrengeric agent)
3.	**DAUNOrubicin** (antineoplastic)	**DOXOrubicin** (antineoplastic)
4.	**DOPAmine** (andrenergic agonist)	**DOBUTamine** (adrenergic agonist)
5.	**ePHEDrine** (bronchodilator)	**EPINEPHrine** (alpha-beta agonist)
6.	**foLIC acid** (vitamin)	**foLINIC acid** (antidote)
7.	**hydromorPHONE** (narcotic analgesic)	**MORPHine** (narcotic analgesic)
8.	**hydrOXYzine** (anti-histamine)	**hydrALAZINE** (anti-hypertensive)
9.	**LAMIVudine** (anti-retroviral)	**LAMOtrigine** (antiepileptic)
10.	**LORazepam** (benzodiazepine)	**ALPRAzolam** (benzodiazepine)
11.	**SufSALAzine** (anti-inflammatory agent)	**SulfaDIAZINE** (antibiotic)
12.	**VinBLAStine** (antineoplastic)	**VinCRIStine** (antineoplastic)

MEDICATION DISPENSING

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

MEDICATION ADMINISTRATION

If you administer medication to patients, you are responsible for properly performing patient identification (using two identifiers per facility policy) and administering the correct medication and doses through correct route and technique.

ADVERSE DRUG REACTION REPORTING

Please report all adverse drug reactions (ADR) through the facility Safety Intelligence™ Event Reporting System and appropriate program specific forms, as needed. Provide the patient's name, medical record number, location, date of occurrence, name of the suspected medication, type of reaction, and your name. Signs and symptoms of an ADR include (but are not limited to): anaphylactic shock, hives, bleeding, itching, rashes, change of lab value, change of vital signs, or shortness of breath. Nausea, vomiting and diarrhea should also be reported. Remember, it is better to OVER report than UNDER report.

MEDICATION ERRORS

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems (including prescribing); order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.

Report all medication events, whether an actual medication error or an identified potential to lead to a medication error, through the facility Safety Intelligence™ Event Reporting System. Report all medication errors on the Safety Intelligence™ Event Reporting System and notify your manager/supervisor.

THE 6 RIGHTS OF PATIENT MEDICATION SAFETY

RIGHT	WAY IN WHICH TO COMPLY
RIGHT PATIENT	Use 2 forms of identification of patient.
RIGHT MEDICATION	Legibility of writing; diagnosis or purpose included; double read and "read back"
RIGHT DOSE	Legibility of writing; knowledge of dosage form, diagnosis or purpose for the medications; lab results.
RIGHT TIME	Legibility of writing; knowledge of dosage form; diagnosis or purpose for the medication; lab results.
RIGHT ROUTE	Legibility of writing; knowledge dosage form; diagnosis or purpose for the medication; lab results.
RIGHT DOCUMENTATION	Legibility of writing; document after each dose of medication is given; use correct medical terminology.

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

- Begin medical record entry with an identifier (e.g., Attending note, Cardiology Fellow note).
- Legibly sign and indicate provider identification number (and level of training for postgraduate physicians) on all entries. If signature is not readable, then it is required to print complete name and title in large uppercase letters with the provider identification number next to your signature (e.g., JOHN DOE, M.D. ID # 999999). Electronic signatures do not require a separate time or date if that information is automatically recorded by the system.
- All verbal orders must be validated/authenticated within 48 hours. The facility may accept verbal orders from a prescribing physician only in extreme emergencies, in the course of treatment, or during a surgical procedure. No verbal orders for high alert medications are allowed except for cases of code blue and rapid sequence intubation.
- Specify reason(s) when prescribing the medication on as needed (PRN) orders (i.e., conditions/symptoms, etc.)
- If a handwritten error is made while charting in a medical record, make the correction by drawing a line through the error and write the date, time, and initials above the error. Erasing or using "white out" is not allowed in a patient's medical record. If an error is made in the electronic medical record, follow procedures in accordance with established protocols.

MEDICAL RECORD REVIEW CHECKLIST

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

- ☐ All orders and progress notes must have legible physician signature and Provider/identification number. Electronic signatures do not require a separate signature if the information is automatically recorded by the system.
- ☐ Did the patient sign the consent to treatment?
- ☐ Was the H&P (history and physical) dictated or completed no more than 30 days prior to or within 24 hours of admission or for surgical admissions within seven (7) days before surgery?
- ☐ Are the telephone orders in the record? Is the read-back/repeat-back verification documented? Did the physician sign off on the orders within 48 hours?
- ☐ Are H&P and progress notes legible/organized and informative?
- ☐ Are all orders dated, timed and signed?
- ☐ Are allergies identified in the orders?
- ☐ Are any banned abbreviations used? If so, was the order clarified?
- ☐ Are the resident's orders and notes cosigned by the attending physician (when required)?
- ☐ Is there evidence of multidisciplinary care planning (e.g., SPD patients)?
- ☐ Is pain management well documented?
- ☐ Does the patient have an Advance Directive? If so, is there a copy in the record?
- ☐ Do all as needed (PRN) orders include indications?
- ☐ Was informed consent completed, including the interpreter attestation, if indicated?
- ☐ If this is a surgical case, was the pre-op checklist completed to confirm that all required documentation was present before surgery?
- ☐ If a procedure was performed was the operative report dictated immediately after surgery or within 24 hours after surgery?
- ☐ Was the handwritten postoperative report noted in the medical record immediately after surgical procedure, providing information until the dictated operative report reaches the medical record?
- ☐ Was the discharge record completed at the time of discharge?

SUICIDE PREVENTION

The suicidal thoughts, also known as suicide ideation, of individuals 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.

KEY POINT

Patients with suicide ideation or their family members should be given the number to the National Suicide Prevention Hotline

(800) 273-TALK (8255).

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.

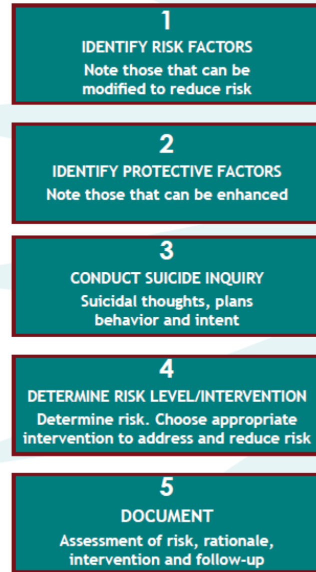
What are the risk factors?

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, and radiators, bed frames, window and door frames, ceiling fittings, handles, hinges and closures.

What are the risks?

The goal for our patients at risk of suicide or self-harm is to have a ligature free environment. Common ligature points include doors, hooks/handles, and windows. Common ligatures are belts, sheets, and towels, with a recent increase in the use of shoelaces.

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

Psychiatric patients receiving care in a hospital setting are at a higher risk, as are patients who demonstrate suicide ideation. These patients require increased vigilance and protection, such as one-on-one monitoring and continuous visual observation and removal of risky objects listed above. You may obtain the patient's permission to contact friends, family, and/or treatment centers if the patient screens positive for suicide ideation. If the patient refuses to provide consent and staff feel the patient may harm themselves or others, staff are permitted to make these contacts without consent. Contact your supervisor if you require guidance or assistance with a patient.

ADDITIONAL RESOURCES

- www.sprc.org
- www.stopasuicide.org
- National Suicide Prevention Lifeline **(800) 273-TALK (8255)**
- Caring for Adult Patients with Suicide Risk Quick Guide for Clinicians http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf
- 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

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

PATIENTS' RIGHTS

1. Patients have the right to quality care and treatment consistent with available resources and generally accepted standards.
2. Patients have the right to appropriate assessment and management of pain.
3. Patients have the right to formulate advance medical directives, which may include living wills, durable powers of attorney or similar documents portraying their preference.
4. Patients have the right to considerate and respectful care, with recognition of their personal dignity and consideration of the psychological, spiritual and cultural variables that influence their perception of illness.
5. Patients have the right, within the law, to privacy and confidentiality concerning medical care and their medical record. Privacy of patient medical records requires access to patient information only by individuals directly involved in their care, by individuals monitoring the quality of their care, or by individuals authorized by law or regulation. Patient privacy includes auditory and visual privacy during consultations, treatment and examinations. Patients have the right to be informed of and consent to the presence of any individuals during their visit for care and treatment.
6. Patients have the right to know at all times the identity, professional status and professional credentials of healthcare personnel, as well as the names of the healthcare providers primarily responsible for their care.
7. Patients have the right to an explanation concerning their diagnosis, treatment, procedures and prognosis of illness in terms that the patient can be expected to understand.
8. Patients have the right to have their visual, speech, hearing, language and cognitive impairments addressed. Interpreters will be provided at no charge to the patient.
9. Patients have the right to be provided, in non-clinical terms, information needed in order to make knowledgeable decisions regarding consent or refusal for treatment.
10. Patients have the right to care and treatment in a safe environment.
11. Patients have the right to an explanation of charges related to their healthcare.
12. Patients have the right to be informed of the facility's rules and regulations pertinent to patient and visitor conduct.
13. Patients have the right, without recrimination, to voice complaints regarding their care, to have those complaints reviewed, and when possible, resolved.
14. Patients and their families have the right, in collaboration with their physician, to make decisions involving their health care. This right applies to family and/or guardians of children and adolescents. The physician will include a discussion about potential benefits, risks, side effects and alternatives to the proposed procedure or treatment.
15. Patients, or their legally designated representative, have a right to access the information contained in their medical record, as allowed by law.
16. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.
17. Patients or their surrogate decision-maker, have the right to accept medical care or to refuse any drugs, treatment, or procedure offered by the facility. A physician shall inform the patient/surrogate of the medical consequences of such refusal.
18. Patients have a right to participate in the consideration of ethical issues surrounding their care, within the framework established by this facility.
19. Patients have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
20. Patients have a right to refuse and must give informed consent for the facility to make and use recordings, films, or other images of them for use other than identification, diagnosis, or treatment of their health issues.

PATIENTS' RESPONSIBILITIES

1. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. Patients have the responsibility to let their healthcare providers know whether they understand the treatment and what is expected of them.
2. Patients and/or their family members have the responsibility to ask the healthcare providers what to expect regarding their pain management and to participate in the discussions and decisions. Patients should ask for pain relief and notify the healthcare provider if the pain is not relieved.
3. Patients have the responsibility to be considerate of the rights of other patients and health facility personnel, to assist in the control of noise and to respect the property of other persons and of the facility.
4. Patients have the responsibility to comply with the medical treatment plan, including follow-up care recommended by the healthcare provider. Patients are responsible for reporting to the healthcare provider if they do not plan or refuse to follow the recommended treatment plan. This includes being on time for appointments and notifying the facility when appointments cannot be kept.
5. Patients have the responsibility to follow rules and regulations addressing patient conduct while in the facility.
6. Patients are encouraged to discuss their medical treatment concerns with the healthcare provider. If resolution does not occur, the patients or family members should discuss it with the Patient Advocate who will appropriately address those issues.
7. Patients are responsible for reporting whether they clearly comprehend a contemplated course of treatment and what is expected of them.
8. Patients are responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.

INTERPRETER SERVICES

It is the facilities responsibility to provide interpreter services for our Limited English Proficient (LEP) and non-English speaking patients. We do not require nor expect a patient to use family members or friends as interpreters. Bilingual Bonus staff can only assist with general information but not for medical interpreting unless the staff acting as an interpreter has been trained and assessed for interpreting, and this way becomes a qualified interpreter. It is prohibited to use minors as interpreters in any situation.

REMEMBER

Always check to ensure the patient's preference of written or spoken language is documented in ORCHID. We encourage you to use our network via the methods and equipment available to you.

The Health Care Interpreter Network (HCIN) is used for our interpreting needs. HCIN can be accessed over the telephone or through a Video Medical Interpretation (VMI) machine by dialing Ext. 81755. VMI machines are available on each floor, one per module, for a live session with an interpreter. Each exam room is equipped with a telephone that is pre-programmed to dial HCIN. Once HCIN is dialed, you are prompted to push a number for the language you need (i.e., 1- Spanish; 3-Cantonese, etc.). If your call is not answered by an HCIN interpreter, the call will automatically roll over to the contracted service – telephone interpreters. You will be asked for the access Code (62500).

Our in-house interpreter can be reached by calling (424) 338-1755. Services provided include:

- Interpretation service over the HCIN,
- Answers to questions regarding VMI equipment,
- Translation of documents from English to Spanish and Spanish to English,
- Scheduling appointments with HCIN for providers whose patients are in need of American Sign Language translation.

When requesting interpreting service to translate written documentation, you must complete a "Request for Translation" form that is found on the MLK OPC intranet. Follow the instructions provided or contact the Interpreter Office for detailed information. Translated material will be returned within 14 working days.

Interpreter Services are provided free of charge. Remember to always check to ensure the patient's preference of written or spoken language is documented in ORCHID.

TELEPHONE ETIQUETTE

Telephone etiquette is very important. You are the first impression a patient, staff member or other member of the public has of our facility. Using proper telephone etiquette when answering the telephone or making telephone calls, leaves callers with a favorable impression of you, and our facility. The following are some hints that will help make your phone conversation more effective:

- Speak clearly and slowly with confidence. Use your normal tone of voice, and avoid shouting or speaking loudly.
- Using phrases such as "thank you" and "please", which are essential to display a professional attitude and make the caller feel at ease.
- Listen to callers without interrupting.

IT'S TEAM WORK!

If you are transferring a caller to another area/unit, inform the receiver that the call you are forwarding is a transfer call and the reason for the transfer, if any. As we work together, we can provide great customer service to our customers.

ANSWERING CALLS

- Try to answer a call by the third ring and have your voicemail pick-up calls after four rings.
- Answer with a friendly greeting, stating your name and department/unit.
- Speak in a pleasant tone of voice.
- If the caller has reached a wrong number, be courteous and ask the caller who or what department or unit they are trying to reach. Before transferring the call, provide the caller with the telephone number to which you are transferring the call. If you are transferring the caller to the operator because you are unsure of the telephone number, let the caller know that they are being transferred to the operator.
- Use the Hold button. If you need to step away from the workstation, place the caller on hold. The last thing we want is for the caller to hear the background noise and/or discussions others may be having. Remember, don't leave the caller on hold too long or they may become upset or hang up. Periodically check in with the caller on hold if the wait time is extensive or offer to take their number and call them back with the answer. Don't forget to call them back.

HANDLING RUDE OR IMPATIENT CALLERS

- Stay calm. Try to remain diplomatic and polite. Getting angry will only make the caller angrier.
- Be patient and helpful. Always show a willingness to resolve the problem or conflict, and ask the caller how you can help him/her.
- Listen to what he/she has to say. Remember, their problems and concerns are important.
- If you are in a non-supervisory position: Offer to have your supervisor talk to the caller or ask for the caller's number where your supervisor can call him/her back.
- If you are a supervisor: Be willing to handle irate callers. Speak slowly and calmly. Be firm with your answers, but understanding. Sometimes the caller just wants someone in a supervisory capacity to listen to their story even if you are unable to resolve the issue.

ADVANCE HEALTH CARE DIRECTIVES

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

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

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

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

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

SERVICE ANIMALS

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

Service animal means any dog, or animal identified in the DHS policy, 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 measured to the shoulders and generally weigh between 70 and 100 pounds). However, the miniature horse must be trained to provide assistance to the individual with a disability and must be house broken.

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

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

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

  In these cases, the business should give the person with disability the option to obtain goods and services without having the animal on the premises.
- Businesses that sell or prepare food must allow service animals in public areas, even if state and local health codes prohibit animals on premises.
- Businesses are not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

If you have additional questions concerning ADA and service animals, please call DHS Risk Management at (323) 914-7122, or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

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

NEONATES (BIRTH TO 28 DAYS)

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

INFANTS (1 MONTH TO 12 MONTHS)

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

CHILDREN (1 YEAR TO 12 YEARS)

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

ADOLESCENTS (13 YEARS THROUGH 17 YEARS)

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

ADULTS (18 YEARS THROUGH 64 YEARS)

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

GERIATRICS (65 YEARS & OLDER)

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

PAIN ASSESSMENT AND REASSESSMENT

The distress of pain can be overwhelming. It can drain patients and their families: physically, emotionally, and financially. Pain interferes with healing. Pain has been described as anything from a slight twinge of discomfort to sharp, stabbing sensations. The International Association for the Study of Pain and the American Pain Society (APS) define pain as, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." In healthcare we use the following definition of pain: "Pain is whatever the patient says it is."

WHAT IS PAIN MANAGEMENT?

According to The Joint Commission Patient Rights standards, all patients have the right to effective pain management. The ultimate goal of pain management is to help patients be as comfortable and as pain-free as possible. Effective pain management consists of a multidisciplinary team approach to assessing, treating and educating the patient and their family regarding pain.

PAIN ASSESSMENT: PAIN IS THE 5TH VITAL SIGN

The first step to effective pain management is assessment. All patients are assessed for pain upon admission, with vital signs, and with painful procedures. Patients are also reassessed after any interventions. On admission, patients are educated on the use of the pain tool and a pain goal is established for optimal patient comfort/function. This goal may change at any time. There are a variety of methods to assess for pain.

PAIN INTERVENTION

The second step of the pain management processes is the intervention or treatment of pain. A pain rating ***greater*** than the patient's established ***goal*** indicates the need for pain intervention. Pain scores greater than 5-6 indicate the need for some intervention and scores of greater than 7 require intervention. Treatment of pain consists of more than just administering pain medication. Other interventions such as heat/cold packs, breathing exercises, relaxation techniques, and imagery can also be effective. The key to successful pain management is to involve the patient and family in the plan of care. Patients should be questioned regarding the effectiveness of pain interventions. Unrelieved pain or ineffective medication must be reported to the physician immediately.

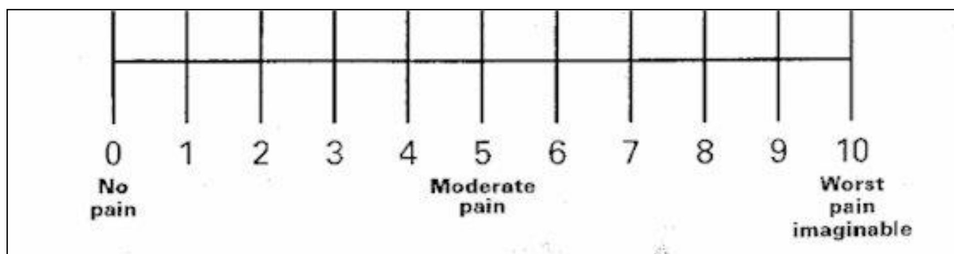
PATIENT EDUCATION

Patient education is an ongoing process in pain management. Patients must be educated in the use of the appropriate pain scale and the importance of prompt reporting of pain. They should be taught that pain will be assessed regularly, and that they should report pain any time they experience it. The patient must be instructed in the therapeutic effects of medications, the appropriate dosage, common side effects, and indications for contacting the physician or clinic.

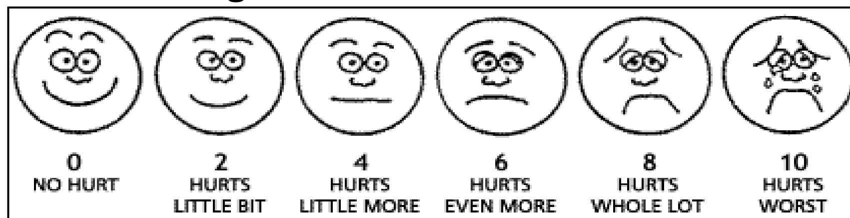
Remember that patients have a right to effective pain management. Include pain assessment as part of the overall assessment process. Be aware of ineffective pain management and take appropriate steps to notify the health care provider. Educate patients and their families about why pain management is so important.

PAIN SCALES

Wong-Baker Pain Scale

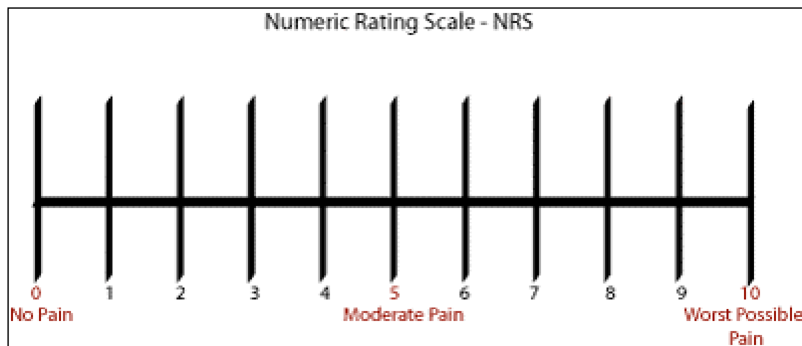


Wong-Baker FACES Pain Scale



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.*

Numeric Rating Scale - NRS



Riley Infant Pain Scale (RIPS) (Use for children < 3 years and those with MR/CP)

3 – 6 = Mild Pain **7 – 10 = Moderate Pain** **11 – 15 = Severe Pain**

There are four categories of behavior for this scale. Zero is equal to no pain and three is the worst pain. The “no pain” category indicators include neutral face/smiling, calm, sleeping quietly, no cry, consolable, moves easily. The “worse pain” category includes full cry expression thrashing/flailing, sleeping prolonged periods interrupted by jerking or no sleep, screaming/high-pitched cry, inconsolable, and screaming when touched or moved.

RILEY INFANT PAIN SCALE					
Behavior Category	**0**	**1**	**2**	**3**	**Score**
Facial	Neutral/Smiling	Frowning/ Grimacing	Clenched Teeth	Full Cry Expression	
Sleep	Sleeping quietly with easy respirations	Restless while asleep	Sleeps intermittently (sleep/awake)	Sleeping for prolonged periods of time interrupted by jerky movements or unable to sleep	
Verbal/Vocal	No cry	Whimpering, complaining	Pain, crying	Screaming, high pitched cry	
Consolability	Neutral	Easy to console	Not easy to console	Inconsolable	
Response to Movement/ Touch	Moves easily	Winces when touched/moved	Cries out when moved/touched	High pitched cry or scream when touched or moved	
Record score for each category in column to right, total in pain score.					

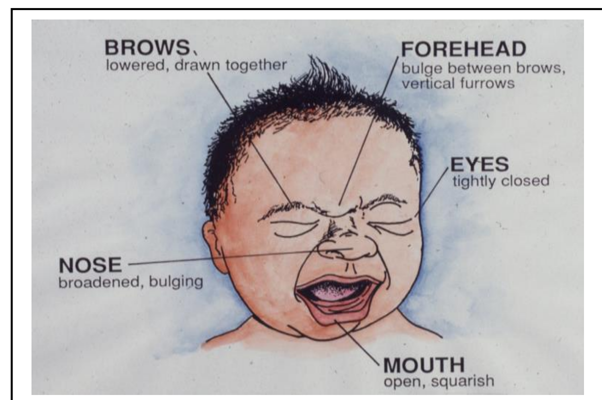
Premature Infant Pain Profile (PIPP) (All premature infants and term infants, 30 days)			
< 7 = No Pain	7 – 10 = Mild Pain	11 – 14 = Moderate Pain	≥ 15 = Severe Pain

PREMATURE INFANT PAIN PROFILE

Process	Indicator	0	1	2	3
Chart	Gestational age	36 weeks and more	32-35 weeks, 6 days	28-31 weeks, 6 days	<28 weeks
Observe infant 15 sec	Behavior state	Active/awake, eyes open, facial movements, crying (with eyes open or closed)	Quiet/awake, eyes open, no facial movements	Active/sleep, eyes closed, facial movements	Quiet/sleep, eyes closed, no facial movement
Observe baselines Heart Rate___________________ Oxygen Saturation_______________					
Observe infant 30 sec	Heart rate Max_________	0-4 beats/min increase	5-14 beats/min increase	15-24 beats/min increase	25 beats/min or more increase
	Oxygen saturation Min__________	0-2.4% decrease	2.5-4.9% decrease	5.0-7.4% decrease	7.5% or more decrease
	Brow bulge	None 0-9% of time	Minimum 10-39% of time	Moderate 40-69% of time	Maximum 70% of time or more
	Eye Squeeze	None 0-9% of time	Minimum 10-39% of time	Moderate 40-69% of time	Maximum 70% of time or more
	Nasolabial Furrow	None 0-9% of time	Minimum 10-39% of time	Moderate 40-69% of time	Maximum 70% of time or more

Scoring Method for the PIPP

1. Familiarize yourself with each indicator and how it is to be scored by looking at the measure.
2. Score gestational age (from the chart) before you begin.
3. Score behavioral state by observing infant for 15 seconds immediately before the event.
4. Record baseline heart rate and oxygen saturation.
5. Observe the infant for 30 seconds immediately after the event. You will have to look back and forth from the monitor to the baby's face. Score physiology and facial changes seen during the time and record immediately after the observation period.
6. Calculate the final score



FLACC (FACE, LEGS, ACTIVITY, CRY AND CONSOLABILITY) SCALE FOR PEDIATRICS

A behavioral scale used for scoring pain in young children, infant to 5 years. It consists of five categories: Face, Legs, Activity, Cry, and Consolability. The scale is used to quantify pain behavior in children who may not be able to verbalize their level of pain.

FLACC SCALE
SCORING

CATEGORIES	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to; distractible	Difficult to console or comfort

1. If the initial pain screening is ≥ 8 (or if the patient's clinical presentation warrants), clinic staff will immediately notify a provider. This immediate Reporting is documented on the progress note/e-charting.
2. A more detailed provider assessment of pain may include:
   a. Pain Intensity.
   b. Pain Location.
   c. Quality of Pain (i.e., sharp, dull, throbbing, shooting, aching, tearing).
   d. Onset, duration, variation and patterns.
   e. Present pain management regimen and effectiveness.
   f. Pain management history.
   g. Effects of pain (i.e., impact of activities of daily living, sleep, appetite, relationships with others, emotions, concentration).
3. When medication is administered or an intervention is conducted to relieve pain during the visit, the effectiveness will be documented afterwards.
   a. Medication administration for adults, infants, and children.
      - 15 to 30 minutes after parenteral drug therapy; and
      - 30 to 60 minutes after oral administration.
4. Patient pain is managed by the clinical service where the patient is present (if possible) or the patient will be referred to a more appropriate service.

INFECTION PREVENTION AND CONTROL

TRANSMISSION OF INFECTIOUS DISEASES

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

HEALTHCARE-ASSOCIATED INFECTIONS (HAI)

HAIs are infections transmitted within a health care setting. Ambulatory healthcare increasingly includes care to vulnerable patient populations. It is critical that all healthcare be provided under conditions that minimize or eliminate risks of HAI. Outbreaks in ambulatory care settings have been associated with breakdowns in basic infection prevention procedures. All healthcare settings, regardless of the level of care provided, must make infection prevention a priority.

STANDARD PRECAUTIONS

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

REMEMBER

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

HAND HYGIENE

Practicing good hand hygiene is the most important intervention in preventing the spread of infection. Hand washing consists of water, soap and friction for a minimum of 15 seconds. Use of alcohol-based hand sanitizer consists of taking a small amount of the product and vigorously rubbing the surface of your hands, including in between your fingers, under your fingernails, and around your thumbs until the hands are dry.

PROPER STEPS ON PERFORMING HAND HYGIENE

Washing Hands with Soap and Water

1. Wet both hands.
2. Obtain 2-3 “pumps” of soap in the palm of one hand.
3. Vigorously rub all surfaces of both hands.
4. Scrub for at least a ***full 15* seconds.**
5. Rinse well.
6. Dry thoroughly with paper towels.
7. Do not touch faucet/sink/counter.
8. Do not touch door knob with your clean, bare hands.
9. Keep paper towel in hand while opening door.
10. Discard towel in trash.

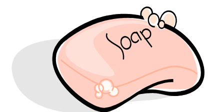
Using Alcohol-based Hand Sanitizer

1. Apply enough sanitizer to open palm.
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.

HAND HYGIENE SHOULD BE PERFORMED:

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

HANDS MUST BE WASHED WITH SOAP AND WATER:



- When hands are visibly soiled or contaminated.
- Before eating or preparing food.
- After using the restroom.
- After removing gloves if gloves are visibly soiled with blood or body fluids.
- After every 5-10 applications of the alcohol-based hand rub (follow the manufacturer’s guidelines).
- When contact with Clostridium difficile (c-diff), Bacillus anthracis (anthrax) or Norovirus is suspected.

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

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

REMEMBER

An alcohol-based hand rub is the recommended agent for all other hand antisepsis indications unless the hands are visibly dirty, or soiled with blood, body fluids, or after contact with C. difficile

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.

FINGERNAILS

Natural nails must be clean, with tips less than 1/4 inch long. If fingernail polish is worn, it must be in good condition, free of chips, and preferably clear in color. 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 fingernail 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.).

CLEANING AND DISINFECTION

Patient care equipment must be cleaned with a facility-approved detergent/disinfectant and follow manufacturers' instructions for appropriate contact time. Only clean equipment is stored in the clean equipment area.

Equipment will 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 removed. Only soiled equipment is stored in the soiled or "dirty area". If it is unclear whether patient care equipment has been cleaned, it must be cleaned before patient use.

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Individuals with signs and symptoms of a respiratory infection or a cough should:
    a. Cover the nose/mouth when coughing or sneezing.
    b. Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
    c. Wash hands or use alcohol-based hand sanitizer after having contact with respiratory secretions and contaminated objects/materials.
    d. Utilize the "Respiratory Hygiene Stations" which have been installed in the lobby areas and in the out-patient clinics to obtain masks and tissues if needed.

e. Sit at least three feet away, (if possible) from others in common waiting area.

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

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

TRANSMISSION-BASED/ISOLATION PRECAUTIONS

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

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

DROPLET	For patients known or suspected to be infected with pathogens transmitted by large respiratory droplets that travel short distances (<3 ft.) and are generated by a patient who is coughing, sneezing or talking, such as, Influenza, Bacterial Meningitis, Mumps, Scarlet Fever, Pertussis, and Rubella.
	PPE Needed: Surgical/barrier mask, gloves and gown.
AIRBORNE	For patients known or suspected to be infected with microorganisms transmitted by small respiratory droplets from person to person by the airborne route over long distances (less than or >3 ft.) such as, Measles, Tuberculosis, Severe Acute Respiratory Syndrome (SARS), Smallpox and Chickenpox. These patients must be placed in a negative pressure room with the door kept closed. If negative pressure room is not available, patient is to be placed in a private room with the door closed and is to be transferred to appropriate setting or sent home as appropriate as soon as possible.
	PPE Needed: N95 or PAPR respirator is required when entering the room.
CONTACT	For patients with known or suspected infections that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment. Infections such as MRSA, VRE, and C. difficile require the use of gown and gloves.
	PPE Needed: Gown and gloves.

- Patients with need for Droplet or Airborne Precautions and/or who are coughing are to wear a Surgical/Barrier Mask when in a room or enclosed area/building.
- Isolation Sign should be posted at the door of room or cubicle area.
- Notification is to be made to other Departments if patient on isolation precautions is sent to other areas, e.g., Lab, Radiology, EKG, etc. For Airborne or Droplet Isolation the patient should wear a surgical mask and be escorted to other department by a HCW.

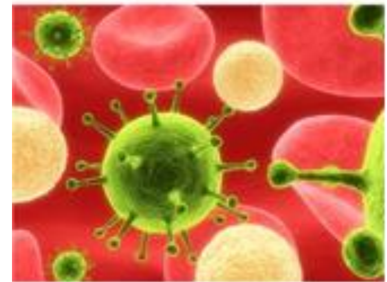
PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

PPE Guidelines:

- Must be applied prior to an anticipated exposure.
- Caution must be used not to contaminate the environment during patient care activities (i.e. during specimen collection and patient transport).
- Remove and discard at the conclusion of the activity prior to leaving the work area (except for the N95 respirator which must be discarded outside of the room).
- Single use only and are not to be used between patients.
- Hand hygiene performed after removal.
- Gloves:
    1. Do not substitute for hand hygiene.
    2. Must be changed between patients.
    3. Must be removed if damaged/torn/punctured.
    4. Must be worn when hands have any open areas, cuts, or abrasions.
- Disposable gown.

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN



The Cal-OSHA *California Code of Regulations, Title 8, Section 5193* requires that the Bloodborne Pathogens Exposure Control Plan be adhered to in all healthcare settings. The purpose of this plan is to minimize, if not prevent occupational exposure to blood or other potentially infectious materials (OPIM). All workforce members, who have the potential of occupational exposure to blood or body fluids, must practice Standard Precautions.

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

BLOODBORNE PATHOGENS

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

Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)

HBV and HCV cause serious liver disease. Some people are infected and have no symptoms. Infection may range from no symptoms at all to flu-like symptoms (nausea, vomiting and fever). Transmission of HBV and HCV

occurs primarily after exposure to blood or body fluids from a person who has acute or chronic HBV/HCV infections.

HBV and HCV are transmitted in four primary ways:

1. Sexual contact (e.g., unprotected intercourse).
2. Parenteral exposure (e.g., needle sharing, blood exposure or tattooing).
3. Perinatal exposure (may be transmitted from mother to fetus).
4. Recipient of blood/blood products (blood products used in healthcare are now tested for presence of bloodborne pathogens).

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

Human Immunodeficiency Virus (HIV)

HIV attacks the immune system and causes it to break down. A person infected with HIV may carry the virus without developing symptoms for years.
HIV is transmitted in four primary ways:

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

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

BLOODBORNE PATHOGEN EXPOSURE PREVENTION

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

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

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

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

Handling Blood and Body Fluid Spills

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

Exposure to Blood and Body Fluids

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

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

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

- Wash the exposed area and/or flush eye mucous membranes with water or normal saline for a minimum of two (2) minutes.
- Instruct the patient to remain for further instruction.
- Report the exposure to your supervisor.
- Go to the Emergency Department/Urgent Care/Employee Health for follow up.

SURGICAL SITE INFECTIONS

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

Prevention Strategies for Reducing the Incidence and Risk of SSIs

- Administer prophylactic antibiotics within 1 hour before surgery.
- Do not remove hair at the operative site unless the presence of hair will interfere with the operation; if you need to remove hair do not use a razor (instruct patient to not shave area prior to surgery).
- Use a chlorhexidine-based prep agent.
- Follow Hand Hygiene Policy.
- Apply aseptic techniques.

Report any SSI identified in clinic setting to Infection Prevention/Control office per facility protocols.

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.
- Use Standard Precautions with all patients (may or may not be known to have an MDRO).
- Ensure proper cleaning and disinfection of equipment and the environment.
- Use Contact Precautions for patients colonized or infected with MDROs.
- Educate patients and their families about MDROs and how to prevent their spread.

MDROs include (but are not limited to) the following organisms of MRSA & VRE:

- **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.
- **Vancomycin-Resistant Enterococci (VRE)**
  - Enterococci is a type of bacteria normally found in the intestines and female genital tract. Vancomycin-resistant enterococci (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.
- **Clostridium difficile (C. difficile)**
  - Clostridium difficile infection (CDI) is the most common cause of antibiotic associated diarrhea. Risk factors for CDI include prior or current antibiotic administration, gastric acid suppression, hospitalization, and advanced age. C. difficile can survive in the environment for long periods of time in a spore form and therefore may be difficult to kill with usual cleaning products.

Prevention Strategies for Reducing the Incidence and Risk of CDI

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

PREVENTING SHARPS INJURIES

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

Simple measures to reduce the risk of sharps injuries include:

DO

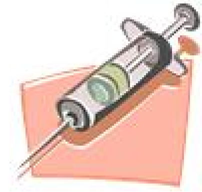
- Use and activate needle/sharps safety devices (e.g., safety needles, angel wings, point loc).
- Get help with uncooperative patients.
- Let falling objects fall.
- Dispose of sharps into covered, labeled, and ridged puncture resistant sharps container.
- Use tongs or brush & dustpan to pick up broken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

DO NOT

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

SAFE INJECTIONS PRACTICES

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



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

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

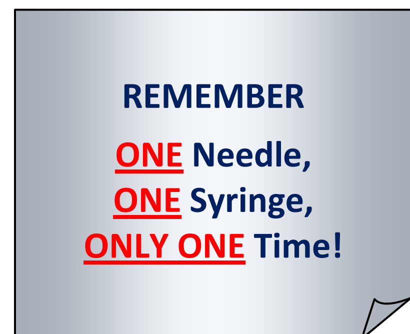
INJECTION SAFETY TIPS FOR PROVIDERS

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

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

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

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



For more information about sharps safety, please see:

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

VACCINATIONS

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

Workforce members may decline to accept a recommended vaccination by completing a mandatory vaccination declination form. If the workforce member later decides to accept the vaccination, it will be provided to them. Non-County workforce members should obtain vaccinations from their physician or licensed healthcare professional; services provide through DHS will be billed to their contractor/agency as appropriate

SEASONAL INFLUENZA

To comply with DHS Policy No. 334.200, as a condition of employment/assignment and continued employment/assignment, an annual influenza vaccination is mandatory for every workforce member who works in a DHS facility unless the workforce member completes and signs an informed declination form. A sticker will be affixed to the badge of the workforce member after he/she has received the influenza vaccination.

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

AEROSOL TRANSMISSIBLE DISEASE (ATD)

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 respirator mask for Airborne Isolation or a surgical mask for Droplet isolation if the patient is coughing or unable to wear the mask.

TRANSPORTING PATIENTS

Patients leaving the 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 for those employees with a significant exposure by Employee Health.

TUBERCULOSIS (TB)

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

TB precautions include the following:

- Annual TB screening for all workforce members who work or must perform duties inside a healthcare facility.
- Early triage and identification of TB suspects.
- Isolation of suspect and confirmed TB patients.
- Proper engineering and maintenance of negative pressure TB isolation rooms.
- TB Isolation room door is to be kept closed at all times when TB patient is in the room and an Airborne isolation sign posted on the door.
- TB patient wears a barrier or surgical mask when outside of isolation room and in enclosed area.
- Any workforce member who may provide direct patient care to respiratory isolation patients is to be fit tested and use an N95 respirator mask:
    - In a TB patient's isolation room.
    - During procedures that generate airborne secretions.
    - When caring for suspected or confirmed TB patient(s).
    - During vehicle transport of suspected or confirmed TB patients.
- Patients who have or are suspected of having TB should be placed in a negative pressure room where the air is vented to the outside. If such a room is not available, the patient should be placed in a private room with the door closed and an Airborne Isolation sign posted.

ACTIVE TB DISEASE

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

- Prolonged cough (2 or more weeks).
- Feel weak.
- Have a fever.
- Have unintended weight loss.
- Positive PPD may be present.
- Loss of appetite.
- Night sweats.
- Coughing up blood or have chest pain when coughing.
- This person can infect others unless he or she is taking the TB medicine as directed.

TB INFECTION (LATENT)

This person carries the TB germ, but:

- Does not look or feel sick or have signs or symptoms of TB disease.
- May have a positive TB skin test.
- Does not have active TB disease.
- Cannot infect others.

REMEMBER

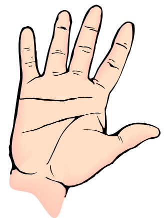
Practicing good hand hygiene is the most important intervention in preventing the spread of infection!

Preventative treatment is recommended for some people.

For additional information contact:

- Facility Infection Prevention & Control Department
- Facility Employee Health Services
- Facility TB Liaison Nurse

Remember
Infection Control – It's in Your Hands!



PROTECTION OF PATIENT AND CONFIDENTIAL INFORMATION

PRIVACY OF PATIENT INFORMATION (HIPAA)

Every patient has a right to privacy. To earn our patient's trust we must protect their health information. If the patients cannot trust us with their health information they will not want to be our patients. All requests for 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) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and California laws require us to protect the privacy and security of all patient health information. 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 given out.
- Give patients more rights and increases 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. This includes providing additional training for workforce members to assure patient information on computers is kept safe.

What is Protected Health Information and Personally Identifiable Information?

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

There is another form of personal information similar to PHI that we also need to protect; that is **Personally Identifiable Information** (PII). PII is information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

PHI	PII
• Physical or health condition of a patient • Services or treatment provided • Payment information • Information about past, current and future • Some examples include name, address, telephone number, and medical record number	• Can be used to identify a person, either alone or when combined with other PII • Some examples include name; home or business address; e-mail address; telephone, wireless and/or fax number; short message service or text message address or other wireless device address; instant messaging address; credit card and other payment information, and any demographic information.

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

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 and at their request. 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 can see it or to whom we can send it.
- Ask us to send their mail or call them at another address or telephone number.
- Request corrections to their health 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.

Use and Disclosure of Patient Information

- The patient's written permission is usually needed for us to use or disclose their health information to someone.
- The patient's permission is not needed if the use or disclosure is for treatment, payment, healthcare operations; or to certain agencies that protect the public.
- You may take pictures or video of patients for clinical or medical reasons, as permitted in the General Consent. Recording equipment must belong to the facility. Do not use your own personal equipment.
- Taking pictures or video of patients for any other reason, such as research, education, news media, or for the patient's family, friends or personal lawyer require written authorization from the patient.
- The authorization must describe the purpose and use of the pictures or video and list any restrictions the patient or his legal representative has placed on its use.
- 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

Safeguards

- Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients' PHI.
- Verify the identity of a patient with two patient identifiers before providing them with documents and/or medications. Make sure that all documents such as discharge summaries, clinic summaries, prescriptions belong to the patient.
- We must take reasonable ***safeguards*** or ***steps*** to make sure patient health information is kept private.

Incidental Disclosures

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

- Some activities we do for business reasons, such as calling out a patient's name in the waiting area or talking to a patient on the phone or in an area where others might hear are called ***incidental disclosures***.

<u>Disclosing Information to Spouses, Family Members, and Friends</u>

- Workforce members should use good professional judgment when disclosing health information to a patient in front of a spouse, family members or friends. If in doubt or to be sure, ASK.
- 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 this information if the patient says it is okay or when asked, does not object, or if the person is the patient's legal representative.
- You should only talk about current relevant information.

<u>Disclosing Information to the Media</u>

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

<u>Social Media</u>

- Do not post information about patients or work-related issues on social networking sites such as *Facebook, Twitter, Snapchat, Instagram, Google+, YouTube, Tumblr, WhatsApp*, etc.
- It does not matter if you are not using County equipment or 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.

Access to PHI

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

Inappropriate Access to or Disclosure of PHI

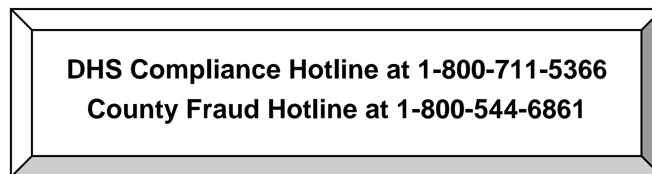
If you acquire, view, or access patient information that you do not need to do your job, or give patient information to someone who should not receive it you will violate DHS policies, HIPAA, HITECH, and/or the State law.

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.
- Never look at confidential or patient information "just because you want to know," even if you are not going to do anything with it. This includes famous people, close friends, neighbors, coworkers, and family members.
- All patient information is confidential and must be protected at all times.
- You are not allowed to look at your own patient information, access it through the facility HIM.

Reporting Possible Violations and Incidents

- 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 have to 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.
- If you falsely accuse someone on purpose you will be subject to discipline.
- If you report a violation and you were involved, you will still be subject to discipline.
- **You MUST report incidents or possible violations of patient information to your supervisor, the facility Privacy Manager at (323) 409-6100 or the DHS Privacy Officer at (213) 288-7730 and submit a Safety Intelligence™ Event report as soon as possible.**
- If you feel you need to report it somewhere else, you can report it to any of the hotlines listed below.


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

Fines and Penalties

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

SECURITY OF 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 kept on computers and electronic media. Examples of electronic media include:

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

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

- Developing policies and procedures,
- Making sure computers do not get stolen, and
- Ensuring workforce members do not share their passwords.
- You must review and comply with the County and departmental IT security policies.

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

- The County's computers and electronic devices belong to the County, and are to be used only for County business.
- You must protect all information created using County computers. Access to use a County computer is not a right. Your access may be modified or taken away at any time for abuse or misuse.
- DHS may log, review, or monitor any data you have created, stored, accessed, sent, or received, and these activities may be subject to audit.

REMEMBER

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

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

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, directly from the victim. These social engineering attacks go by some pretty interesting names: phishing, smishing, and vishing. They are designed to get you to willingly give up your personal information, mostly for their financial gain, or identity theft, etc.

How to guard against Social Engineering:

Illegal Activity	What Is It?	How to Guard Against
Phishing	Cybercriminals send familiar looking e-mails pretending to be a well-known and trusted bank, charitable organization, e-mail provider, IRS, or other official agency, even friends in need, asking you to click on a link to a fake website, download a malicious attachment, or reply to a fake request with your sensitive information. Sometimes making threats if you do not comply.	• Compare web address (URL) in link to web address in e-mail address, if different be suspicious (preferably go directly to site and do NOT click on the link). • Compare domain names (e.g., Facebook.com vs Facebook.badwebsite.com). • Look for unprofessional writing such as poor grammar and typos. • Most legitimate companies do not ask for personal information through e-mail. • Search the company name on the web to see if fraud alerts exist. • Call the company directly. • Consider if the threat is really reasonable.
Smishing (SMS Phishing)	Similar to Phishing but using 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.	• Search the Internet to find out more information. • Call the company to confirm their identity. • If you did not provide them a mobile number or it doesn't apply to you, DO NOT CLICK the link and delete the email.

Vishing (Voice Phishing)	A person posing to be from a legitimate company like a bank or technical support company calls to verify account information, claim virus on computer to gain access to data by remote access (your permission) or requiring the victim to download malicious attachment. For example, a fraudulent phone call from the IRS indicating that you owe back taxes, etc.	• Don't rely on Caller ID to identify fake callers – they can spoof their phone number to look like the real one (800 prefix instead of 888). • Wait a few minutes after the call to dial the company. The fake caller may be holding the line and when you dial you get connected back to the caller. • Do not provide personal information unless you initiated the contact and verify that the person you are interacting with is legitimate.
Ransomware	Ransomware typically infects a system through a malicious email 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 asking the user to pay a specific ransom to reclaim or reactivate the computer. Moreover, some ransomware-based applications also impersonate or disguise themselves as police or a government agency, claiming that the user's system is locked down for security reasons, and that a fine or fee is required to reactivate it.	• Beware of unexpected emails, especially if they contain links and/or attachments. • Be especially suspicious of any Microsoft Office email attachment that advises you to enable macros to view its content. Unless you are absolutely sure that this is a genuine email from a trusted source, do not enable macros and instead immediately delete the email. • Beware of emails that are unexpected or where the content does not appear to directly apply to you.

Four primary ways patient confidentiality is most often violated:

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

Privacy and Security Do's and Don'ts

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

- Verify that all documents provided to a patient belong to that patient. Use two patient identifiers process before providing a patient with documents, such as appointment reminders, discharge summaries, and eligibility packets.
- Immediately remove all PHI from printers, fax machines, and photocopiers.
- Place PHI in confidential bins or shredders.
- Talk about patients in a private place or speak quietly.
- Keep medical records and other documents that contain PHI out of public view.
- Close patient/exam room doors or draw curtains and speak softly when discussing patient care.
- Treat patient information as if it were your own.
- Report suspected patient privacy violations through the Safety Intelligence™ Event Reporting System AND by phone to the facility Privacy Manager at (424) 338-2703.
- Cover carts when transporting medical records so that patient names are not visible.
- Remove, if safe to do so, or secure PHI found in trash cans and report it to your supervisor and/or the facility Privacy Manager.
- Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside the DHS e-mail domain.
- Obtain permission to store e-PHI on a laptop or other portable device, or USB thumb/flash drive and make sure the device is encrypted.
- Store paper records and medical charts in locked rooms and locked cabinets.
- Access to computers or computer systems containing e-PHI must be restricted to authorized users.
- Position computer workstations and monitors away from public view.
- Log off the computer when you are away from the work area or when the computer is not in use.
- 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.

Privacy and Security Don'ts

- Don't provide PHI/PII to a vendor until you have verified that there is a signed BAA.
- Do not use a personal laptop to store PHI/PII or confidential information unless the laptop is encrypted and authorized by your supervisor.
- Don't access information about a patient unless you need it to do your job.
- Don't share confidential patient information with anyone who does not need to know it to do their job.
- Don't share passwords or your computer while logged on. You are responsible for all information viewed using your password.
- Don't store or save patient information on the computer's hard drive. All patient information must be stored on the network drives.
- Don't e-mail PHI outside of the County e-mail network without authorization.
- Don't send patient information through internet-based e-mail sites such as *Yahoo Mail, Google Mail, Hotmail,* etc.
- Don't use online web-based document sharing services (e.g., *Google Docs, Microsoft Office Live, Drop Box, Open-Office,* etc.) to store or share patient data.
- Don't post patient information or discuss patient care such as diagnosis, treatment, patient location, or other information that may be used to identify the patient on social networking websites (e.g., *Facebook, Twitter, Google+, YouTube, etc.).*
- Don't walk away from open medical records, lab results, etc. Make sure all medical records and lab results are placed in a secure location, out of public view.
- Don't discard documents or medical supplies that contain PHI in the trash.
- Don't store documents containing PHI in an area where it can be mistaken for trash.
- Don't store patient information on personal computers, notebooks, or other electronic devices.
- Don't forget to log off shared/public use computers and workstations.
- Never click on links in email from unknown or suspicious senders.

SHREDDER BINS

There are two (2) Console Recycle Bins per department in staff areas, Nursing, Registration, common areas assessable to workforce members and clinic work areas.

The off-white bins have 100-120 lbs. capacity. They are 36 inches high, 19 inches deep and 19 inches in width.

RISK MANAGEMENT

Risk Management involves the identification, evaluation, and reduction of the risk of injury to the patient, visitor, and workforce member. This section provides policies and procedures on how to report adverse events, sentinel events and near miss incidents, and responding to subpoenas and summons.

RISK MANAGEMENT GOALS

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

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

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

REPORTING CLOSE CALL/NEAR MISS, ADVERSE AND SENTINEL EVENTS

DEFINITIONS OF EVENTS:

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

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

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

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

- Unanticipated death or major loss of function, not related to the natural course of the patient’s illness or underlying condition.
- Suicide of any patient in a setting where the patient receives around-the-clock care or suicide of a patient within 72 hours of discharge.
- Unanticipated death of a full term infant.
- Abduction of any patient receiving care, treatment, or services.
- Infant abduction or discharge to the wrong family.
- Rape (by another patient, visitor or staff).
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

- Surgical or non-surgical invasive procedure performed on the incorrect patient or incorrect body part, or wrong procedure.
- Unintended retention of a foreign object in a patient after surgery or other procedure.
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

EVENT REPORTING PROCESS – SAFETY INTELLIGENCE™ EVENT REPORTING SYSTEM

If you are involved, witness or become aware of any event (adverse event, near miss, unsafe working condition, or medication error) you must report it using the Safety Intelligence™ Event Reporting System which can be found on your facility intranet.

You may enter an event from any computer in the facility. Please see the facility's policy and procedure for reporting events and documentation.

You must report events as soon after the event as possible. Check with your facility Risk Management office for consultation.

REMEMBER

You are required to report **sentinel events immediately at the time of the event to your supervisor.**

TIMELY REPORTING

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

- Complete an Event Notification Report on the Safety Intelligence™ Event Reporting System for all events without exception as soon as possible.
- **Sentinel events** (as defined above) must be reported **immediately** to your supervisor and entered into the Safety Intelligence™ Event Reporting System.
- Your supervisor is responsible for **immediate** notification of the facility Administrator of the Day and the Risk Manager.
- When in doubt, call the facility Risk Manager. Follow all calls by submitting an Event Notification Report in the Safety Intelligence™ Event Reporting System.
- In the case of power failure affecting the Safety Intelligence™ Event Reporting System downtown, use the paper Event Notification Reporting Form (HS-10).

REMEMBER

DO NOT MAKE COPIES of the Event Notification Report. Send all copies of the Event Notification Report to your facility Risk Management.

DOCUMENTATION – *A KEY DEFENSE*

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

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

Your documentation must include:

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

Make your documentation:

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

Correct errors in the medical record by:

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

SUBPOENA AND SUMMONS

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

If you receive a subpoena or summons relative to County business, notify your supervisor and contact your facility's Risk Management Office immediately. Additionally:

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

STAFF RIGHTS AND RESPONSIBILITIES

STAFF RIGHTS

This section discusses your rights and responsibilities as a workforce member. Included in this section are the DHS emergency protocol, compliance awareness and Code of Conduct; sexual harassment prevention, procurement process; your responsibilities for attending training and demonstrating competence; policies on maintaining professional credentials, background checks, smoke-free environment, substance abuse, , health screening, cultural and linguistic competency, workforce behavioral expectations, preventing and reporting of abuse/neglect, Safe Haven/Safely Surrender Baby Law, and Americans with Disabilities Act (ADA).

DHS COUNTY EMERGENCY PROTOCOL

All DHS personnel are considered Disaster Service Workers (DSWs). In accordance with State law and County Code provisions, public employees may be deployed to perform activities outside the course and scope of their regular employment. These activities promote the protection of lives and property or mitigate the effects of a disaster (such as earthquake, fire, flood, or other natural or man-made disaster). This designation is mandatory for all eligible County employees and requires DSWs to receive training on basic emergency management principles, take an oath, and sign an affirmation of allegiance card (also referred to as the affirmation of loyalty) and document specialized skills.

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

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.

In an effort to provide effective communications to employees during a disaster, DHS is entering contact information about its employees into Everbridge. Everbridge is a communications system that sends out mass alerts through e-mail, landline phone, cellular phone, and other communication devices to notify employees on events that may have an impact on services and/or employees as well as provide instructions on how to proceed or where to go for additional information.

BUILDING EMERGENCY COORDINATOR/COMMAND POST

Another mode of communication is the Building Emergency Coordinator (BEC). A BEC is located at each facility and is responsible for the development and implementation of the facility emergency plan. Designated BECs and alternates are assigned to each floor for each shift.

BECs are responsible for ensuring everyone on the floor is evacuated and accounted for should the need arise to evacuate the building. BECs can assign duties to staff as needed to assist in the evacuation. You must adhere to BEC directions, listen to their instructions and cooperate at all times. Workforce members should evacuate to their designated assembly area unless instructed otherwise by their BEC.

A Command Post is located in Conference Room 2G11 (location may change). The Command Post can be activated by Administration in the event of an emergency situation or when deemed necessary. Supervisors and managers will be notified to report to the Command Post in the event it is activated to receive important information, updates regarding emergent situations, and to receive special instructions for assignment of staff to designated areas to assist with emergency related activities.

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

ELEVATORS

Do not use elevators when evacuating the building for emergencies or disasters as they may become disabled and you could become trapped inside.

In the event someone becomes trapped in an elevator:

- Staff should attempt to communicate with the passenger(s) by any means available, including yelling through closed shaft doorways, if necessary. Assure the passenger(s) that they are safe in the elevator and inform them that help is on the way.
- Insist that the passenger(s) remain inside the elevator and not attempt to use access panels for escape, as the elevator may unexpectedly resume operation.
- Check all floors to visually verify that all of the shaft doors are closed.
- If a shaft door is found open do not attempt to close it, but block/cone off the elevator entryway to keep others away from the open shaft door.

EVACUATION CHAIRS

Evacuation chairs are located close to the top of each stairway. Please become familiar with the locations of these devices. The evacuation chairs are easy to operate and are used to transport individuals who are unable to walk safely down stairways.

DISASTER/EVACUATION PLAN

Disaster/Evacuation plans are posted on the wall on each floor of the Outpatient Center as and in off-site buildings as follows:

- 1st floor Lobby across from the Security desk by front entrance
- 1st floor Elevator Lobby next to elevator doors
- 1st floor Leroy Weekes/NSB adjacent to the East entrance (near HR)
- 1st floor Leroy Weekes/NSB adjacent to the West stairwell
- 1st floor Leroy Weekes/NSB adjacent to the North entrance (across from the Sheriff’s office)
- 2nd floor Elevator Lobby next to elevator doors
- 2nd floor Leroy Weekes/NSB adjacent to North stairwell (near Administration)
- 2nd floor Leroy Weekes/NSB adjacent to the West stairwell

- 3rd floor Elevator Lobby next to elevators
- 3rd floor adjacent to each of the 2 stairwells
- 4th floor Elevator Lobby next to elevators
- 4th floor adjacent to each of the 2 stairwells

Dollarhide:

- 1st floor Southwest corner (Main Entrance)
- 1st floor Northwest corner

Oasis:

- 1st floor Southwest corner (Main Entrance)
- 1st floor Northeast corner (Near medication room)

Pediatric Hub:

- 1st floor Southeast corner (Near Room E6)
- 1st floor Northeast corner (Near Room E18)
- 1st floor Main corridor (Near Children's waiting room)
- 1st floor Main corridor (Near Public Restrooms)
- 1st floor Southwest corner (Near Room A5)
- 1st floor Northwest corner (Near conference room)

Become familiar with these routes and evacuation plans in the event of an emergency or disaster.

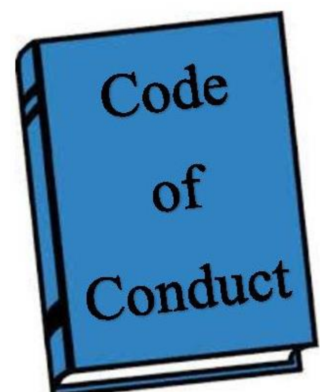
EMERGENCY CALL BOXES

Blue emergency call boxes are located throughout the parking lots. Emergency call boxes are activated by pushing the call button. The call box will automatically connect you to the on-site Sheriff's office. Each blue emergency call box is connected to the nearest video surveillance camera. The video surveillance camera will automatically focus on the call box area when the emergency call button is activated.

The emergency call boxes are not restricted to emergencies. They can be used to report suspicious incidents or people, or to request immediate assistance. Should you require assistance, push and release the call button, and state the reason for your call to the person who answers the call.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The DHS Compliance Program is a comprehensive strategy to prevent, detect and correct instances of unethical or illegal conduct. DHS is committed to conducting its business 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.



The Chief Compliance Officer located at DHS headquarters is responsible for directing the DHS Compliance Program. Each facility has a Local Compliance Officer who is responsible for implementing compliance-related activities at each of their

respective facilities.

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

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

- His/her supervisor or manager
- Local Compliance Officer
- DHS Audit and Compliance Division:

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

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

Please note that the Los Angeles County Fraud Hotline at (800) 544-6861 and website http://fraud.lacounty.gov/, operated by the Auditor Controller continue to be available to report fraudulent activity.

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

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.

FALSE CLAIMS ACT

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

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

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

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

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

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

Actions that violate the federal FCA include:

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

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

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

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

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

ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS

In addition to administrative procedures that may exist under a particular government program such as Medicare, federal law gives certain federal executive departments, such as the Department of Health and Human Services,

the right to impose administrative penalties (i.e., penalties that are not imposed by the courts) for false claims and statements. Other laws, not discussed below, allow the federal Office of the Inspector Attorney General to impose administrative penalties. Administrative penalties can consist of monetary penalties as well as exclusion from participation in federal healthcare programs. These penalties may be imposed, for a variety of offenses, which include violation of Medicare or Medicaid rules, kickbacks or other inappropriate behaviors as well as for false claims and statements.

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

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

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

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

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

The policy also describes the following state law provisions:

- Penal Code §72 – Makes it a crime to knowingly and deliberately submit a fraudulent claim to the government;
- Penal Code §550 – Makes certain types of improper claiming practices criminal acts;
- Welfare and Institutions Code §14123.2 – Imposes administrative fines for presenting or causing to be presented various kinds of improper claims to Medi-Cal;
- Welfare and Institutions Code §14123.25 – Allows civil monetary penalty to be imposed and/or a provider to be excluded from participation in Medi-Cal for improperly billing Medi-Cal or making improper calculations on a cost report; providers may also be excluded for a variety of other prohibited behaviors;
- Welfare and Institutions Code §14107 – Makes it a crime, under certain circumstances to submit or support false claims, or obtain an authorization with false documents, where the claim is to the Medi-Cal Program;
- Welfare and Institutions Code §14107.4 – Makes it a crime to submit false information in a cost report or to falsely certify a cost report;
- Business and Professions Code §810 – Makes it unprofessional conduct, punishable by the various licensing bodies, to make false claims under an insurance policy, or to create false or fraudulent supporting documents, among other prohibited behaviors;
- Health and Safety Code §100185.5 – Allows the California Department of Health Care Services, under certain circumstances, to suspend or disenroll from any program a provider who is suspended or disenrolled from another program it administers; and
- Labor Code §1102.5 – Protects employees from retaliation, employees who share non-privileged information about wrongdoing with the government.

Actions that violate the CFCA include:

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

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

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

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

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

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

COUNTY POLICY OF EQUITY

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

DISCRIMINATION

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

SEXUAL HARASSMENT

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

Facts about Sexual Harassment

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

UNLAWFUL HARASSMENT (OTHER THAN SEXUAL)

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

THIRD-PERSON HARASSMENT

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

INAPPROPRIATE CONDUCT TOWARD OTHERS

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

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

RETALIATION

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

EXAMPLES OF PROHIBITED ACTIVITIES (NOT A COMPLETE LIST)

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

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

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

- DHS Audit & Compliance:

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

- County Equity Oversight Panel:

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

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

RESPECTFUL WORKPLACE

DHS is committed to fostering a healthy and professional work environment free of bullying. The memo below discusses workplace bullying and your rights and responsibilities as a County workforce member.

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Chief Operations Officer

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

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

www.dhs.lacounty.gov

September 6, 2016

TO: All DHS Workforce Members

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **RESPECTFUL WORKPLACE**

The Department of Health Services (DHS) is committed to a professional and healthy workplace where all workforce members are treated with dignity and respect. Disrespectful and disruptive behavior, including workplace bullying, is not acceptable.

Through the labor-management partnership with SEIU Local 721 and the DHS Employee Engagement Survey, front-line staff raised concerns about workplace bullying to me and DHS' leadership team. Over the past few months, we have engaged in open and on-going dialogue on our shared goal for DHS to be both the Provider of Choice and the Employer of Choice. To achieve this, I believe we need to foster a workplace where employees feel respected and valued while they carry out DHS' important mission of caring for our patients. As a result of these discussions, we also agreed that it would be beneficial to define workplace bullying and this was done with the direct input of front-line staff.

Workplace bullying is the persistent, repeated, abusive mistreatment - whether covert or overt, indirect or direct, the threat of or actual threat - from others in a work setting that causes harm. Behaviors may be physical, verbal, or nonverbal.

Workplace bullying often involves an abuse or misuse of power that undermines an employee's dignity at work. Power dynamics between and among people are important to recognize, whether this may be worker to worker (abuse of social power), supervisor to worker (abuse of hierarchal power) or administrator to middle management (abuse of bureaucratic power).

Bullying is different from harassment and discrimination, which are prohibited under the County's Policy of Equity (CPOE). Harassment is offensive and unwelcome conduct which occurs because of an employee's protected status (sex, race, color, ancestry, religion, national origin, ethnicity, age [40 and over], disability, sexual orientation, marital status, medical condition or any other protected characteristic protected by state or federal employment law).

While bullying conduct is not illegal harassment, it is disruptive to the workplace and is not consistent with the high standard of professionalism and integrity that we expect of all staff. It is important to recognize the gravity of impact caused by bullying including, but not limited to, physical injury, aggravated physical and/or psychological conditions, mental illness, stress on outside relationships, lack of trust, low team morale, high attrition, poor quality services, reduced productivity, poor performance, and negative reputation of work setting.

All DHS Workforce Members
September 6, 2016
Page 2

RECOGNIZING WORKPLACE BULLYING

Bullying is present when there is a *pattern* of *persistent, repeated* mistreatment.

Behaviors may be exhibited in the following ways:

- Covert or overt: Subtle mistreatment and/or intimidation; not openly displayed; or apparent, blatant bully behavior; action taken against an employee for reporting or objecting to bullying behavior, including action taken by a manager or supervisor.
- Indirect or direct: Indirect bully behaviors through a subordinate; pitting a worker against another; or direct, one-on-one interaction.
- The threat of or actual threat: The threat of physical, verbal or nonverbal mistreatment; or the actual threat of inflicting physical, verbal or nonverbal harm.

Categories of bullying behaviors include:

- **Physical:** Spits, hits, pushes, throws charts or instruments. (Single or continued acts of physical aggression should be reported under DHS' Threat Management Policy, Policy #792).
- **Verbal:** Consistently gossiping about a worker with the intent to harm, shouting, swearing, name-calling, falsely accusing, demeaning, threatening to harm, taking down, being rude, insulting, humiliating, being offensive.
- **Nonverbal:** Intimidating body language, blocking a doorway, standing next to a worker watching their every move, unnecessary following, isolating, excluding, sabotaging, consistently setting up for failure, consistently providing negative performance evaluations with no basis.

The following would not meet the criteria of bullying conduct:

- A one-time incident
- A supervisor setting high yet reasonable work expectations
- Workplace decisions based on a legitimate business purpose

BUILDING A HEALTHY, PROFESSIONAL WORK ENVIRONMENT

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

- Honor DHS' mission and give the public, our patients, and your co-workers your best
- Display a professional demeanor at all times
- Communicate effectively and respectfully
- Be fair
- Support teamwork
- Build trust
- Strive to resolve conflict and disruptive behavior early on and at the lowest possible level

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.

MHK:ej

ACKNOWLEDGEMENT OF EMPLOYEE RESPONSIBILITIES

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 are 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, and retaliation.

It is the responsibility of every County employee to conduct themselves in a manner consistent with these laws and County policies. **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 or both.**

PROCUREMENT PROCESS

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

COUNTY AUTHORITY

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

DHS AUTHORITY

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

DHS FACILITY AUTHORITY

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

UNAUTHORIZED PURCHASES

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

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

TRAINING AND COMPETENCY

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

PROFESSIONAL CREDENTIALS (LICENSE / CERTIFICATION / REGISTRATION / PERMIT)

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

Primary source verification must be conducted during in-processing/onboarding, upon new assignment, promotion, professional credential renewal (prior to licensing expiration date), contract renewal (independent contractor), transfer to new work location, and during the performance evaluation process. 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 as a condition of employment that it has unlimited access to professional credentials

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

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

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

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

If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report to the facility medical administrator or DHS Human Resources Performance Management.

CRIMINAL BACKGROUND CHECKS

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

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

- Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) exclusions list on the OIG Internet website to ensure the workforce member has not violated any federal regulations pertaining to Medicaid or Medicare or any other healthcare related regulations.
- General Services Administration/System for Award Management (GSA/SAM) exclusions list to ensure the workforce member has not violated any administrative or statutory federal regulations, or is not listed as a suspected terrorist or person barred from entering the United States.
- Medi-Cal Suspended and Ineligible Provider List (S&I List) to ensure eligibility to participate in Medi-Cal programs.
- Medicare opt out list, workforce members cannot work for DHS if they have opted out of billing 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.

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

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

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

- Positions that involve the care, oversight, or protection of persons through direct contact with such persons.

- Positions having direct or indirect access to funds or negotiable instruments.
- Positions having direct or indirect access to confidential, sensitive, or protected health information, networks, or systems

SMOKING POLICY

Smoking is not permitted inside any DHS building, structure, or vehicle. Additionally, smoking shall not be permitted within 20 feet of main entrances, exits, and operable windows of any occupied building. Smoking is permitted only in the approved outdoor designated smoking areas, if any. Some DHS facilities have implemented a smoke-free environment. Check with your supervisor if your facility has implemented a smoke-free environment policy.

SUBSTANCE ABUSE

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

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

HEALTH SCREENING

All workforce members of DHS health facility service delivery teams as well as all students, volunteers, and non-DHS/non-County workforce members must have an initial and annual health screening including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease status, and/or any other medical tests, as required. **You and your supervisor** are responsible to comply with DHS policy, and ensure you obtain a health screening annually as a condition of continued employment/assignment. Documentation of annual health clearance is to be kept up-to-date in your area file. You may contact the facility Employee Health Services to find out when your health screening is due.

REMEMBER

You must complete your health screening annually.

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

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

CULTURAL AND LINGUISTIC COMPETENCE

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

WHAT IS CULTURAL AND LINGUISTIC COMPETENCE?

Cultural and Linguistic Competence: The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.
(Source https://www.ahrq.gov/professionals/systems/primary-care/cultural-competence-mco/cultcompdef.html)

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

WHY IS CULTURAL COMPETENCY IMPORTANT?

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

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

CULTURAL COMPETENCE

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

Culture and language may influence:

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

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

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

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

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

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

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

ROLE OF CULTURAL AND LINGUISTIC COMPETENCY IN DHS' TRANSFORMATION OF SERVICE DELIVERY

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

- ✓ Improved quality in the delivery of care.
- ✓ Patient safety compliance.
- ✓ Improved patient adherence with the medical regimen.
- ✓ Improved patient experience and customer satisfaction.
- ✓ Last, and equally important as each of the elements mentioned above, by ensuring cultural and linguistic competency, DHS is in a much better position in our efforts to become the **"Provider of Choice"** following Health Care Reform.

DHS-wide Language Data Report

All DHS hospitals, multi-service ambulatory care centers, and comprehensive health center facilities capture the ***"preferred language"*** of the limited English-proficient (LEP) patients. According to DHS' "Language Report" database for FY '11 – '12, DHS facilities provided healthcare services to a total of 1,335,133 patient visits with LEP skills, representing 53% of our total patient visits (2,517,319). During the same time period, a total of 678,309 unique patients sought healthcare services throughout DHS facilities, 349,933 (51.6%) of whom spoke

English and 328,376 (48.4%) spoke other than English. Furthermore, our patient utilization data indicated that over 86 languages were spoken by our LEP patients, including the top 12 languages that are heavily utilized, and therefore, are in much greater need for interpreter (voice/verbal) and translation (written) services. The top 12 languages are Spanish, Korean, Armenian, Tagalog, Mandarin, Cantonese, Vietnamese, Russian, Farsi, Thai, Arabic, and Khmer (Cambodian).

DHS Cultural Bill of Rights

We Believe in

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

DHS/Office of Diversity
Approved on October 30, 2001

WORKFORCE BEHAVIORAL EXPECTATIONS

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

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

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

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

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

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.

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

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

THREAT MANAGEMENT “ZERO TOLERANCE”

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

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

- Incidents involving a call of local law enforcement.

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

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

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

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

Licensed workforce members who violate the provisions of this policy may, depending upon the circumstance, be reported to the appropriate license, certificate, registration, or permit issuing agency/board.

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

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

IMMEDIATE DANGER OR IMMINENT THREAT OF VIOLENCE

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

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

NON-IMMINENT THREATS

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

1. On-site facility security personnel/L.A. County Sheriff's Department/local law enforcement.
2. A facility supervisor or manager.
3. The potential victim(s).

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

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

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

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

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

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

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

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

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

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

A workforce member determined to have violated this policy shall be subject to appropriate corrective action which may lead up to termination. The workforce member may also be subject to criminal and/or civil prosecution and reporting to the appropriate license, certificate, registration, or permit issuing board/agency. Non-County workforce members will be subject to termination of assignment and placed on the "Do Not Send" database.
Each DHS facility has a complaint/grievance process which must be followed to ensure appropriate actions are taken to provide the patient with adequate protections and that a timely investigation is completed.

REPORTING OF ABUSE/NEGLECT INCIDENTS

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

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

- **Child Abuse** includes emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years, including a newborn child where either mother or child has a positive toxicology screen as a result of mother's substance use/abuse. Workforce members are mandated to report incidents of suspected abuse to Department of Children and Family Services at 1-800-540-4000 immediately or as practicably as possible. A written report must be submitted within 36 hours of the telephone report, and may be submitted through their website at http://dcfs.lacounty.gov. Abuse that is sexual in nature also must be reported to law enforcement by calling the Los Angeles County Sheriff's Department or other local law enforcement agency within the jurisdiction of the incident.
- **Elder Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Workforce members are mandated to report incidents of suspected elder/dependent abuse immediately or as practicably as possible by calling the Elder Abuse Hotline at (877) 477-3646. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at https://fw4.harmonyis.net/LACSSLiveIntake/.
- **Dependent Adult Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals between the ages of 18-64. This includes individuals who are mentally or physically challenged. Workforce members are mandated to report incidents of dependent adult abuse by calling the Adult Abuse Hotline (877) 477-3646. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website https://fw4.harmonyis.net/LACSSLiveIntake/.
- **Domestic/Intimate Partner Abuse** involves any individual who has been abused by their intimate partner. Domestic/intimate partners are those individuals who are currently dating, married, cohabitating, or separated. The abuse includes physical violence, sexual assault, severe emotional distress and economic coercion. Domestic/intimate partner abuse must be reported if the patient is presenting to the facility for treatment of a current injury sustained through domestic/intimate partner abuse. Workforce members are mandated to report the violence as soon as practicably possible to local law enforcement or the Sheriff's Department at (310) 222-3311.

In addition, you may contact the facility 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 either was:

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

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

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

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

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

SAFELY SURRENDER BABY (SSB) 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 www.babysafela.org or call 1-877-BABY SAFE.

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

If an infant is surrendered to your facility, immediately call 9-1-1 for assistance.

AMERICANS WITH DISABILITIES ACT (ADA)

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

The ADA prohibits discrimination against any qualified individual with a disability in any employment practice. A qualified individual with a disability is a disabled person who meets legitimate skill, experience, education or other requirements of an employment position that he or she holds or seeks, and who can perform essential job functions with or without reasonable accommodation. Illegal use of drugs is not a disability covered by ADA. Persons who have a disability covered under ADA may be entitled reasonable accommodations that do not pose undue hardship to the department. Workforce members requiring an accommodation are referred to DHS Risk Management, Return to Work for review of needs and to initiate the interactive process for a reasonable accommodation. For specific information on reasonable accommodations, contact DHS Risk Management, Return to Work Unit at (323) 914-7122.

If you have a disability that is covered under the ADA and you are a qualified individual, you are entitled to reasonable accommodation. Please contact DHS Risk Management, Return to Work Unit at (323) 914-7122 for assistance.

ENVIRONMENT OF CARE

WORKFORCE SAFETY PROGRAM

It is our ongoing priority to provide a safe environment for our customers and workforce members. Our Safety Program looks for and identifies hazards through surveillance rounds and data collection. All identified hazards are investigated and acted upon by the facility Safety Council, Safety Committees, Safety Officers and/or the department/service managers. Address any concerns you have regarding safety to your supervisor, facility administration or 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.
- Complete an "Employee's Report of Unsafe Condition."
- Notify the Facility Safety Office. (*Can be Anonymous.*)
- Safety Intelligence™ Event Reporting System on the facility intranet.

SAFETY AWARENESS

With your personal safety at the forefront, here are some things to consider:

- **Try to spot trouble before it starts**: You can often spot trouble and head it off by staying alert. If you see something, say something. Add the Sheriff's phone number to your contact list in your cell phone (424) 338-2345.
- **Trust your feelings**: Your instincts (uncomfortable feelings, uneasiness, etc.) are important. If you do not feel safe, notify the Sheriff Department or local law enforcement to assist you with your situation.
- **Report suspicious activity**: Communication is critical to the Sheriff Department or local law enforcement's ability to keep your workplace safe. Much of their success relies upon a partnership with you, built on trust.

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

- Walking in groups when leaving the workplace after dark. Security will walk you out of or into the building when requested.
- Reporting suspicious activities to the Sheriff's Department or local law enforcement.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.
- In case of an emergency, call 9-1-1.
- Have your car keys in hand before entering the parking lot.

- When exiting the parking onto 120th Street, only a right turn is permitted. Staff risks being cited for failing to over traffic laws.
- Check your rear view mirror often when leaving to ensure you are not being followed.
- Always check-in and inform Security personnel if you are working during off-hours/after-hours. Provide them the location where you will be, and check-out with them when leaving the facility.

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.

Effective July 1, 2015, standardized paging codes were implemented at all DHS health care facilities.

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

BOMB THREATS

If you receive a bomb threat by telephone, **stay calm**. **Do not hang up**. Keep your voice calm and professional. Do not interrupt the caller and keep the caller on the line as long as possible. Signal a co-worker that you have received a bomb threat and have him/her initiate a facility code, if applicable, or call 9-1-1.

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

- When is the bomb going to explode?
- Where is the bomb?
- What kind of bomb is it?

- What does the bomb look like?
- What will cause the bomb to explode?
- Why did you place the bomb?
- What is your name?

Also, pay attention to details, such as:

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

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.

INFANT OR CHILD ABDUCTION

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

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

CHEMICAL SPILL/HAZARDOUS MATERIALS/HAZARD COMMUNICATION

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

1. The Safety Officer or the Hazardous Materials Specialist shall be the Hazardous Materials Spill Response Team Leader and shall coordinate all emergency response measures.
2. The first person at the scene shall immediately report the incident to the facility safety officer or in accordance to the facility procedures. He/she shall also notify the supervisor and all staff in the room that a spill has occurred.
3. The supervisor who is familiar with the material spilled/released through safety training, shall take the following actions until the Hazardous Materials Spill Response Team arrives at the scene:

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

REMEMBER

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

c. Remove injured or exposed personnel from the release site if condition permits safe removal.
d. Control the leak and the spread of the material.

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

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

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

RADIATION EXPOSURE

Use precautionary measures in caring for radioactive patients. All signs and safety measures are placed and removed by the Radiation Safety Office. Anyone providing direct care to patients who receive therapy with radionuclides must read and be familiar with the information on the Radiation Protection Guide.

1. Personnel radiation monitoring devices (film badges) must be worn only on the collar. Film badges must be returned to Radiation Physics Section in Radiology by the 20th of each month for accurate analysis and readings.
2. Safety, including radiation safety, is everyone's responsibility. Notify your supervisor immediately for all safety related issues.

REMEMBER

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

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

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

EMERGENCY PREPAREDNESS AND MANAGEMENT

What Is An Emergency (Disaster) Preparedness Plan?

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

What Is Considered A Disaster?

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

What Are Two Types Of Disasters?

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

In the event of a disaster, all workforce members are involved to some degree in the disaster plan. It is important that you know the plan, know what your role is and take disaster drills seriously. Check with your supervisor on your role during the event of a disaster.

Are You Prepared At Home For A Natural Disaster?

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

Handouts are available outlining what you should do at home to be prepared. For information go to:

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

EMERGENCY TRANSPORT (CARRIES)

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

EMERGENCY TRANSPORT-SAFELY

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

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

ONE-PERSON CARRIES

HIP CARRY

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

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

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

down

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

PACK STRAP CARRY

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

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

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

down

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

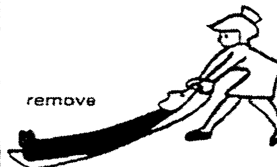
CRADLE DROP

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

2. Slide patient to edge of bed

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

remove



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

TWO-PERSON CARRIES

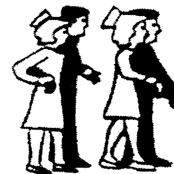
SWING

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

EXTREMITY

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

SEMI-AMBULATORY



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

FIRE/LIFE SAFETY

FIRE RESPONSE

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

R	**R**emove patients and others from immediate danger.
A	**A**larm – Activate nearest fire alarm pull station and the facility code, if applicable, or call 9-1-1.
C	**C**ontain – Close doors in fire area to prevent the spread of fire and smoke.
E	**E**xtinguish or Evacuate – Extinguish only if it can be done with one fire extinguisher.

Steps in the Use of the Fire Extinguisher

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

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

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

TYPES OF EXTINGUISHERS

Type A: Silver canister. Symbol A

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

Type B-C: Red canister. Symbols B C

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

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

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

Class D fires require special extinguishing agents and procedures.

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

KEY POINT

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

NOTE: **Health Centers – Dial 9-1-1 and refer to your Area Specific Policy and Procedure Manual.**

REMEMBER SAFETY FIRST even if the fire is small.

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

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

ELECTRICAL SAFETY

Before using any piece of electrical equipment, check:

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

Other points to remember:

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

Avoid using any electrical equipment if:

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

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

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

In order to report a mechanical emergency, mechanical failure, or the need for mechanical repair, contact your facility's Facilities Division.

REPORTING WORK RELATED INJURIES/ILLNESSES

You must immediately report any work-related injury, accident, or illness to your supervisor or the supervisor's designee. Even if you decline medical treatment, you are still required to report the incident to your supervisor or

the supervisor's designee. Failure to report an injury, accident, or illness may result in denial of benefits and progressive discipline up to and including discharge from County service or assignment.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

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

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

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

BODY MECHANICS

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

Why You Should Practice Good Body Mechanics

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

Maintaining Good Body Mechanics

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

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

GUIDELINES FOR DECREASING MUSCULOSKELETAL INJURY

General Guidelines for Maintaining Proper Body Mechanics During Activity

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

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

Reaching

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

Twisting/Turning

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

Standing

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

Sitting

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

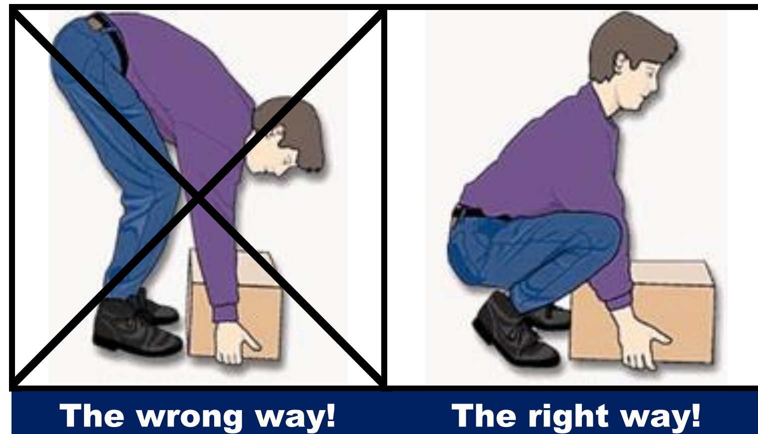
Patient Transfers

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

Equipment/Object Transfer

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

- If the item is too much for one person to handle, get help!



ERGONOMICS

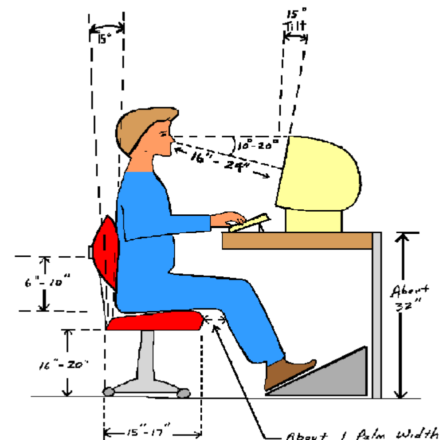
Ergonomic safety is achieved by adapting equipment, procedures and work areas to fit individuals. This helps to prevent injuries – and improve efficiency.

Common Causes and Types of Ergonomic Injuries

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

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:



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

RISKS FACTORS TO REMEMBER

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

TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

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

PERFORMANCE EVALUATION

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

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

NOTE

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

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

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

All managers and supervisors are expected to ensure performance evaluations are completed and fully executed on time. Managers and supervisors who fail to adhere to the performance evaluation policy and procedures will be subject to disciplinary action in accordance with DHS Policy 747, Disciplinary Action. MAPP managers/supervisors are subject to monetary penalties for late submissions of MAPP evaluations.

Managers and supervisors shall refer to DHS Human Resources Procedure 780.000 for additional information on the performance evaluation process.

All managers and supervisors are required to attend performance evaluation training and, if applicable, MAPP orientation and goal writing training as determined by, offered by or coordinated through DHS Human Resources or the Los Angeles County Department of Human Resources.

COMPETENCY ASSESSMENT

Competency is the application of knowledge, skills, and behaviors that are needed to safely, effectively and ethically perform the duties and expectations of the workforce member's job in accordance with the scope of practice and/or as determined by a specific set of criteria or standards.

Competency is measured in a variety of ways, which includes but is not limited to; possession of current and valid professional credentials, criminal background clearance, clearance of federal and state exclusions lists, and skills validation.

All DHS workforce members who hold a direct or indirect patient care position and are assigned to DHS hospitals and health facilities are required to demonstrate competency in their job responsibilities as required by the standards of their profession, state and federal laws and regulations, and/or accreditation agencies.

All DHS workforce members who hold a direct or indirect patient care position and are assigned to hospitals and health facilities are required to maintain and enhance their job skills, and maintain their professional credential(s), by attending mandatory training and continuing education courses in accordance with the requirements of their professional credential(s), the applicable California Business & Professions Code, the hospital and/or facility, and Los Angeles County.

All 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.

All DHS workforce members mentioned above must participate in the Department's ongoing competency assessment and skills validation process.

Workforce members holding direct and indirect patient care positions who are not performing the essential duties of the position due to a temporary accommodation associated with the employee's medical work restrictions (e.g. work hardening) must still maintain competencies in core functions and appropriate licensure, certification, registration or permit.

Each clinical department head/ancillary division chief is responsible for establishing and providing competency standards and a job description for each workforce member who holds a direct or indirect patient care position and is assigned to a DHS hospital and/or health facility where care, treatment or services are provided on behalf of Los Angeles County.

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

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. You must follow your work schedule, including observing your lunch and break times. Your supervisor will explain the attendance requirements for your work area. **Lunch and break times cannot be combined.**

PROFESSIONAL APPEARANCE

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 in an effort to promote a positive and professional image and to ensure the delivery of safe patient care.

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

All clothing must be professional and consistent with our business atmosphere, health care standards, and workplace safety and must not interfere or detract from our mission. It must be appropriate to the type of work being performed and take in consideration the expectations of our patients and customers served. Your photo identification badge must be worn at all times while on duty and in County-facilities. Do not obscure your photo or name on your identification badge. Workforce members failing to wear or produce their ID badge while on the premises may be reported by security personnel to Human Resources (HR) and/or their facility Executive Staff member for corrective action. Workforce members must immediately report a lost or stolen ID badge to the on-site Sheriff's Department personnel. Deputies are available to take a report. Workforce members are also required to pay for the lost or stolen ID badge at the Cashiers Office and take the receipt to HR. HR will require a written affidavit attesting to the disposition of the badge before a replacement ID badge is issued

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

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES)

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

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

FAMILY AND MEDICAL LEAVE ACT (COUNTY EMPLOYEES)

The Department of Health Services (DHS) is required to comply with the provisions of FMLA, thereby, DHS must designate FMLA leave whenever applicable to any eligible employee (including temporary and part-time employees).
Under FMLA and CFRA an eligible employee is one who meets the following criteria:

- Has completed an aggregate of 12 months of County service, which need not be consecutive

AND

- Has worked at least 1,250 hours during the 12-month period immediately preceding the first day of leave.

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

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

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

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

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

NOTE

See DHS Policy No. 756.6 for detailed guidelines.

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

- The care of a domestic partner with a serious health condition

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

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

Management's determination must be based on the information received from the employee or the employee's spokesperson in the event the employee is unable to communicate directly.

An employee on an approved medical leave of absence is subject to the provisions—and limitations—of DHS Policy 740.000 in relation to all (non-conflicting) outside employment or activity. As part of this process employees are responsible for appropriately disclosing outside activity, subject to the provisions mentioned above, that may adversely impact or interfere with existing medical limitations and/or restrictions. Outside activities subject to approval include, but are not limited to: outside employment; expert witness testimony; volunteer activity; and performance of charity medical relief.

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, OR STALKING

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).

Employees may use vacation, personal, unpaid or compensatory time to cover the leave. Leave for medical reasons may be covered by sick leave or in accordance with Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) guidelines.

All information pertaining to leave of absence of an employee covered under this policy is confidential and shall only be disclosed at the authorization of the employee or as required to assure the employee's safety or to address administrative issues.

DHS must engage in a timely, good faith, and interactive process with the employee to determine effective reasonable accommodations, taking circumstance in consideration, should they be requested by the employee (e.g. adding or changing locks, changing the employee's work phone or schedule, transferring or reassigning the employee, or changing work location/space). Employees may also take advantage of the Employee Assistance Program for counseling or other assistance including referral assistance.

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, his/her immediate family or registered domestic partner.

Any employee who feels that he/she has 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.

PAYROLL (COUNTY EMPLOYEES)

TIME REPORTING

Each employee is held accountable for complete and accurate time reporting on a daily basis. Falsification, tampering with and/or failure to properly complete time collection documents by employees or supervisors shall be cause for appropriate disciplinary action which could include discharge.

DHS uses eHR web-based timesheets (TIMEI) for documenting and recording time worked and time off although when necessary a key punch card or paper timesheet may be used when directed by DHS Payroll. Each employee shall accurately and timely record time worked and time absent from work in increments of no less than 0:15 (15 minutes), complete the TIMEI document and submit it as directed within the time period specified by payroll and management.

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

Timesheets are to be submitted as directed by management and Payroll. Each year, payroll publishes a calendar for submission and approval of time-sheets. Employees are reminded to be diligent in submitting their timesheets on time to avoid delayed paychecks, bonuses and/or accrued compensatory time such as overtime.

Each employee can attend eHR time collection training. Check with your supervisor to schedule the eHR time collection training. For more information, you may also check DHS Time Collection website from the DHS Enterprise Intranet at http://myladhs.lacounty.gov.

HOLIDAYS

Only monthly employees, permanent or temporary are eligible for paid leave for holidays. Currently, the Board of Supervisors has approved 12 annual holidays:

- New Year's Day – January 1st
- Martin Luther King Jr.'s Birthday – Third Monday in January
- Presidents' Day – Third Monday in February
- Cesar Chavez Day – Last Monday in March
- Memorial Day – Last Monday in May
- Independence Day – July 4th
- Labor Day – First Monday in September
- Columbus Day – Second Monday in October
- Veterans Day – November 11th
- Thanksgiving Day – Fourth Thursday in November
- Friday after Thanksgiving – Fourth Friday in November
- Christmas – December 25th

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

If a holiday falls on an employee's regular day off, permanent full-time and permanent part-time employees will accumulate holiday time based on their Title Sub (to a maximum of 8 hours). For 40-hour week employees, holiday time is accrued at 8 hours. There is no limit to how long an employee can carry over the time, but

management has the option of paying the employee for unused holiday time after two years have elapsed from the date the time was earned.

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

The eHR application keeps up with holidays and codes them on the online timesheet. Coding of the time worked on a County holiday requires a determination as to whether the employee's position is a POST position. A POST position is characterized by duties that must be performed at regular intervals regardless of holidays or other regular days off. Such positions are normally found in areas that provide 24-hour coverage every day of the year. An employee assigned to a POST position is a **shift** employee.

A **shift** employee who works a County holiday as part of his/her standard work schedule will code his/her time sheet as regular hours worked, and accrue Holiday time based on their Title/SubTitle (to a maximum of 8 hours) to be taken at a later date upon approval. If a shift employee is off on a Holiday, and said Holiday fulfills or completes the employee's standard work schedule, then the employee will get paid for the Holiday, but will not accrue Holiday time.

A **non-shift** employee who works on a County holiday will get paid for the Holiday and will code his/her time sheet as overtime hours worked. However, if a Holiday falls on an employee's regular day off (RDO), he/she will accrue the fractional number of Holiday hours as indicated by their Title Sub. The accrued Holiday time can be used as time off at a later date.

Any part-time non-shift or shift employee employed on a monthly basis shall be allowed paid leave for each holiday in an amount equal to the item subfractional amount indicated by County Code.

TIME OFF REQUESTS

Employees must follow the directions of their manager/supervisor regarding the submission of time off requests. Requests for time off should be submitted as soon as possible/practical so as to allow time for the manager/supervisor to evaluate staff coverage. This includes vacation, jury duty, witness duty and any other reasons for time away from work.

If an employee needs to request time off with less than three (3) working days written notice, the employee must submit an emergency request in writing to his/her supervisor stating what type of leave he/she is requesting and the reason for the request. Written proof or verification of the emergency may be requested by the employee's manager/supervisor for any occasion on which the employee must be absent from work for an emergency. Written proof or verification must be submitted to the manager/supervisor upon the employee's return to work. Managers/supervisors shall provide a response to the request in a timely manner.

- If the emergency is sudden and the employee has not yet reported to work, the employee is to personally call his/her manager/ supervisor, or designee. The employee should state the nature of the emergency and the type of time he/she will be requesting to cover the absence, subject to the manager's/supervisor's approval.
- If the employee is not physically able to notify his/her supervisor, he/she should ensure someone notifies his/her supervisor as soon as practical. When practical, the employee is expected to give an estimated return to work date to his/her supervisor. If the employee does not provide an estimated return to work date, the supervisor may ask the employee for an estimated return date or ask the employee to call in on a regular basis until a return date is identified. An employee must make every reasonable effort to inform his/her supervisor.
- If the emergency is sudden and the employee is on duty, he/she must speak to the manager/supervisor immediately to obtain permission to leave work and the amount and type of time to be used. The employee may not leave the work area without first reporting to his/her manager/supervisor or designee.

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

- For absences of three (3) consecutive work days, the medical certification, if requested, must be provided to the employee's immediate supervisor on the first day the employee returns to work.

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

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

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

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

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

An employee who, without prior authorization or notification, is absent or fails to work his/her regularly assigned duties for three (3) consecutive regular working days or two (2) consecutive regularly scheduled on-duty shifts, is considered to have resigned from County service, unless the employee resumes his or her regularly assigned duties at the commencement of the next regular working day or on-duty shift, per County Code 5.12.020. Employee will be subject to release from employment due to voluntary resignation by job abandonment once applicable due process requirements are complete.

SICK LEAVE

Sick Leave, as used in DHS Policy 756.5, Use of Sick Leave Benefits, refers to paid leave for an employee's absence on a relatively short term basis when he/she or the employee's child, parent, spouse, or domestic partner is ill or injured. The term Sick Leave does not include:

- Absences that have been designated as Family Leave, such as an extended absence for the employee's own serious health condition; and
- Absences for illnesses and injuries deemed compensable as work related; nor
- Absences for disabilities approved for coverage by Megaflex's Short Term Disability Plan, since such absences must be medically certified and are subject to review and approval by a third party.

To be eligible to earn Full (and Part-Pay) Sick Leave, non-MegaFlex employees must be on one of the following SubTitles: Full-time, Permanent ("A" or "N"), Monthly Recurrent ("B"), Monthly Temporary ("M" or "O" Title Subs) and Part-time Daily or Permanent Part-time, as long as the part-time is at 1/2time or more ("C", "D", "E", "U", "V", "W", "X", "Y", or "Z").

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

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

Employees do not earn Sick Leave for:

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

The total amount of Full-Pay Sick Leave earned by each eligible full-time employee each year is defined in the County Code or his/her Bargaining Unit and years of County Service. Full-Pay Sick Leave accrual for each year begins January 1st or when an employee enters County service, and ends each year when the employee reaches the maximum number of hours specified for his or her class or Bargaining Unit and years of service, or at the end of the year. The accrual begins over again each January 1st.

Sick leave at full pay may be used for:

- An absence resulting from injury, illness, disability, or pregnancy including childbirth or related medical condition;
- Medical or dental care scheduled in advance, such as physical examinations, dental examinations, or eye examinations for glasses or contact lenses. Using Sick Leave for these purposes requires prior supervisory approval, when practical;
- Under the California Kin Care Law, an employee is entitled to use that amount of Sick Leave the employee earns in any calendar year during a six-month period to attend to the illness or injury of a child, parent, spouse, or domestic partner.

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

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

Personal Leave

Non-MegaFlex employees (on a 40-hour work week) who earn Sick Leave may use up to a maximum of 96 hours per calendar year of his or her Sick Leave as Personal Leave as allowed by County Code. Personal Leave is defined as any leave, taken for personal reasons, which does not interfere with the public service mission of the department. Prior supervisory approval must be obtained by an employee before he or she can use Sick Leave as Personal Leave, unless the need to use Sick Leave and Personal Leave arose due to an unforeseen situation or other emergency.

Personal Leave may also be used to care for a spouse (including a domestic partner), child, or parent who is ill. In this case, prior supervisory approval may not always be feasible, but it should be obtained when the need to give care is anticipated.

Part-Pay Sick Leave

At the beginning of each calendar year, employees who are eligible to accrue Full-Pay Sick Leave as described above and who have completed six months or more of continuous service are entitled to receive various amounts of Part-Pay Sick Leave hours, at either 65% or 50% pay. The amount an employee receives is based on the employee's length of service. Unused Part-Pay Sick Leave from any year does not carry over to the following year. Part-Pay Sick Leave is used to cover an extended sick leave. Refer to DHS Policy 756.5 for more information on use of part-pay.

Other Sick Leave Provisions

An employee may carry over unused 100% Sick Leave that he or she has earned during the year, there is no limitation to the amount an employee may accrue.

Certain employees who, for a period of six months, do not use any Sick Leave for any reason, including personal reasons, may sell back to the County some number of days of Full-Pay Sick Leave; most employees may sell back three days, but some Bargaining Units have negotiated a different number of days. Consult County Code Section 6.20.030 and applicable MOU for specified number of days. Sick leave buy back occurs each January and July for the previous six month period.

Upon termination from County service, full-time, permanent employees with at least five years of continuous service are paid for one-half of their unused Full-Pay Sick Leave to a maximum of 90 days (720 hours); for 56-hour employees, 135 days (1080 hours).

Sick Leave Reporting

Absences for which using Sick Leave is appropriate may be either scheduled or unscheduled.

Family School Partnership Act for County Employees

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.

SCHEDULED ABSENCES

A scheduled Sick Leave absence is any absence, either for a full or a partial workday, that is approved in advance by an employee's supervisor. Such absences are usually for medical or dental office visits, treatments, etc., which can be scheduled in advance. Employees should notify their supervisors as soon as they have scheduled an appointment and submit his or her request in writing.

UNSCHEDULED ABSENCES

Unscheduled absences due to sickness or injury of either the employee or a family member can occur at any time. An employee who needs to be absent because of sickness must immediately notify his or her supervisor of the absence.

The employee must personally notify his or her supervisor or designee of the absence as much as possible in advance of the employee's shift. An employee assigned direct patient care related responsibilities in an inpatient setting must notify management at least two (2) hours prior to his/her scheduled work hour/shift.

An employee assigned direct patient care in an outpatient setting, or non-patient care related responsibilities must notify management 30 minutes prior to the start of the employee's scheduled work hour/shift.

It is the employee's responsibility to call in. Calls will not be accepted from anyone on behalf of the employee except in those cases where the employee is incapacitated and unable to call in. In the event an employee cannot call his/her manager/supervisor (such as hospitalization, accident, physically unable, etc.) a report will be

accepted from a representative. However, the employee must make personal contact with the manager/supervisor as soon as possible.

When practical, the employee is expected to give an estimated return to work date to his or her supervisor. If the employee does not provide an estimated return date, the supervisor may ask the employee for an estimated return date or ask the employee to call in on a regular basis until a return date is identified.

An employee must make every reasonable effort to inform his or her supervisor when he or she is aware that a previously-specified expected return date will not be met, and provide a new date. See "Time Off Request" section above for absences exceeding three (3) workdays.

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

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

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

MEGAFLEX

MegaFlex employees do not accrue Vacation, or Full-Pay (or Part-Pay) Sick Leave. In lieu of Vacation and Sick Leave, a MegaFlex employee earns or purchases two kinds of annual leave: Non-Elective and Elective Leave. A MegaFlex employee can earn up to 100 hours of Non-Elective Leave per year, periods of absence without pay will affect the accrual of this leave. MegaFlex employees will earn from four up to five hours of Non-Elective Leave each pay period, depending upon the years of service, to a maximum of 100 hours. This leave may be carried over to the following year and can be accumulated up to a maximum of 480 hours. Megaflex employees can purchase up to 20 days of Elective Leave each year during the annual plan benefit.

MegaFlex employees can use unused Full-Pay Sick Leave that they earned before they entered MegaFlex when they are sick, but they cannot use that Full-Pay Sick Leave for "Personal Leave" as described before for non-MegaFlex employees. MegaFlex employees who are not sick may not use Sick Leave, and must use any other accrued leave available to them before using Elective Leave. If they are not sick, and accrued Sick Leave is the only leave available to them other than Elective Leave, then they may use Elective Leave (with supervisory approval).

Megaflex participants must use all non-elective annual leave days and any banked and available compensatory time off, vacation, holiday and/or (when sick) sick leave before using any of the elective annual leave purchased for the year.

A MegaFlex employee may not use Non-Elective or Elective Leave without prior supervisory approval; with a supervisor's approval it can be used for any purpose.

Under California Kin Care Law, a MegaFlex employee may use up to five days (40 hours) of Non-Elective Leave for this purpose.

Although MegaFlex employees do not earn Part-Pay Sick Leave, a MegaFlex employee with a serious illness may qualify for the Short Term Disability plan provided by the MegaFlex cafeteria plan.

SALARIES

County employees are paid on a semi-monthly basis on the 15th and 30th. Taxes and most deductions are split and deducted twice a month. Some deductions such as medical, dental and life will be deducted on the 15th of the month. Employees who elect to be paid through direct deposit will receive their paycheck stubs online. Employees must complete the direct deposit form and submit it to Payroll Services to enroll in direct deposit. Employees who elect to receive paper paychecks will also be able to see their paystubs online.

EMPLOYEE PAY STATEMENTS (PAYSTUBS)

Paystubs are available online through the eHR application. Paystubs can be printed or saved to an approved USB thumb drive. To view paystubs online the employee must log into the eHR application and choose “Paystub Viewer.” Paystubs are usually available to view/print within two business days before payday. Current and historical paystubs and W-2’s can be viewed and downloaded. A tutorial on how to read your paystub can also be found under the “Paystub Viewer” tab. Select “Help/Information” tab on the left of the screen to view the tutorial.

WORK HOURS/WORK WEEK

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

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

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

Management shall ensure that the scheduling and taking of rest periods shall not interfere with essential workload coverage nor adversely affect the ability of the facility/organization to accomplish its mission.
The number of work hours per day and week may vary based on employee agreement of an alternate work schedule.

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

OVERTIME

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

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

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

SALARY INCREASES

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

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

General Step Pay Plan

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

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

Step Anniversary Date

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

Step Advances and Salary Adjustments

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

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

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

Management Appraisal and Performance Plan

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

There are two levels of MAPP participants, Tier I which includes the department head and his or her direct reports and Tier II other high-level staff positions. Tier I MAPP participants' merit increases are based on recommendations by the Department Head and approved by the CEO. Tier II MAPP participants' step advances are also approved by the CEO. MAPP participants must be rated "competent" or above to receive a merit increase or step advance. At a certain level, Tier II MAPP participants must receive an "exceeds expectations" rating to advance to the top pay steps.

VACATIONS

To be eligible to earn Vacation Leave, non-MegaFlex employees must be on one of the following SubTitles: Full-time, Permanent (“A” or “N” Title Subs), Monthly Recurrent (“B”), Monthly Temporary (“M” or “O”) and Part-time Daily or Permanent Part-time, as long as the part-time is at 1/2 time or more (“C”, “D”, “E”, “U”, “V”, “W”, “X”, “Y”, or “Z”).

Vacation Leave for non-MegaFlex employees who are entitled to earn this leave, is earned and accrued each pay period based on certain hours recorded in each pay period. This accrual process begins for new employees upon appointment to an eligible job. There is no waiting period or minimum service requirement before accrual begins.

Vacation Leave that has been earned in one pay period can be used in the next pay period, unless the employee has less than one year of service. For new employees, Vacation that is earned is held in reserve until the employee completes one year of service, at which time the earned Vacation may be used. The amount of Vacation an employee may earn each pay period or each calendar year increases as the employee reaches certain milestones of County service.

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

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

Vacation Years of Service	40-Hour Employees Vacation Annual Maximum Hours	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

Employee Vacation leave requests should be submitted in writing far enough in advance to provide supervisors time to consider coverage, per departmental requirements. Supervisors will provide instruction on when and how to submit vacation requests.

An employee may carry over unused and accrued Vacation to the following year. Such carried-over Vacation is called “Deferred” Vacation, while Vacation that is earned during the current year is called “Accrued” Vacation. At the end of the year, an employee may have some Deferred Vacation and some Accrued Vacation still remaining; these two are combined at the beginning of the following year and become the new year’s Deferred Vacation balance. There is a limit (320 hours for most employees) to the amount of vacation that can be deferred. At the end of December of that year, any Vacation in excess of 480 hours (320 hours deferred and 160 hours current) will be paid the following January.

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

MEGAFLEX EMPLOYEES

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

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

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

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

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

BEREAVEMENT LEAVE

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

For employees represented by SEIU local 721 and non-represented employees, this provision also includes brother-in-law, sister-in-law, great-grandfather, and great-grandmother.

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

Definitions of Working Days for Bereavement Leave Purposes

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

Bereavement Leave for Full time, Permanent Employees

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

In addition, represented employees are allowed to use other paid or unpaid leave if the employee has to travel over 500 miles.

Bereavement Leave for Temporary Monthly Employees

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

Monthly Permanent 9/10 Time Employees (RN's or Title Sub D)

Such employees are allowed 24 hours for each qualifying occasion.

USE OF BEREAVEMENT LEAVE

Bereavement Leave need not be taken on three consecutive working days. For example, if an employee takes two working days of Bereavement Leave at the time of death, he/she may take a third day later to attend the business affairs of the deceased. Any additional time that may be needed beyond the three working-day limit must be charged to Vacation, Personal (Sick) Leave, Compensatory Time Off (CTO), or Holiday time with prior management approval. **Bereavement leave must be taken within a one-year period from the death of the family member. Bereavement leave can only be taken in full shift increments.**

In the event that two or more qualifying family members die at the same time, the employee receives three working days for each qualifying family member.

If a qualifying family member dies while an employee is already off work and using (100% paid leave benefit) Personal Leave, CTO, Holiday time, or Vacation Leave, the employee may substitute the allowed amount of Bereavement Leave in lieu of the foregoing leave types. Except, when the employee is using part pay sick leave, this leave should not be interrupted with bereavement leave.

The foregoing provisions also apply to Title Sub D employees whose leave is defined in hours rather than working days.

PROOF OF BEREAVEMENT

The Employee must complete and submit to his/her supervisor a Bereavement verification slip with attached proof of bereavement and travel within 30 days following his/her return to work. Copies of the Bereavement verification slip and proof of bereavement and or travel must then be forwarded to Payroll. Failure to provide this will result in the employee using his/her own leave benefits to cover absence taken as bereavement leave.

Acceptable evidence to document the death of a qualifying family member for the purpose of Bereavement Leave include:

- Death Certificate.
- Obituary Notice.
- Letter from attending physician, clergyman, or mortician attesting to the death and identifying relationship to the deceased.
- Funeral program.

NOTE

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

PROOF OF TRAVEL

If an employee is required to travel a minimum of 500 miles one way, the employee will be eligible to receive two additional working days of Bereavement Leave. In order to qualify for these additional days the employee must provide proof of travel. The following are acceptable evidence of travel 500 miles or more:

- Train, airline, bus or boat ticket or boarding pass.
- Gasoline or credit card receipt showing date(s) of purchase and city(ies).
- Hotel/Motel lodging receipt.
- Other.

NOTE: Destination must be most direct from point A to point B.

JURY DUTY

County employees summoned to serve as jurors will be granted jury duty leave. An employee must notify his/her supervisor as soon as he/she receives a jury duty summons and provide the supervisor with a copy of the summons. All employees in a permanent position (full-time or part-time) who are ordered to serve on a jury shall be allowed the "necessary time to be absent from work" at his/her regular pay. "Necessary time to be absent from work" means the amount of time required to fulfill jury duty service, including travel time. It does not include any time in which the employee is "on call" or when his/her presence is not required. Due to extended work days associated with a 9/80 or 4/40 schedule, employees may be required to return to work following release from court.

Employees who are not on a permanent position shall receive a maximum of two days (16 hours) of pay in any one year if they have completed at least 200 days of active service in the prior calendar year. Employees who do not meet this requirement shall receive a maximum of one working day (8 hours) with pay per year. The leave is not accumulated. Exceptions to this may be defined in applicable Memoranda of Understanding.

Service on any California State (Superior) or Federal Court is covered by Jury Duty Leave. Service on any County's criminal grand jury is covered, but service on a civil grand jury is not covered, because such service is entirely voluntary. An employee may serve on a County grand jury, if the employee's department approves an unpaid leave of absence, but the employee does not receive his or her regular pay or Jury Duty Leave.

County employees are not eligible for jury duty fees, but do receive their regular earnings while on jury duty. Employees may receive mileage reimbursement, beginning on the second day of service, which does not have to be returned to the County.

USE OF JURY DUTY LEAVE

Employees serving jury duty on their regular day off (RDO) are on their own time for that day. Jury duty served on a RDO is not work time for overtime or any other purpose.

If an employee becomes ill during jury service and is excused by the Court from jury duty for that period of time, the absence is charged to Sick Leave.

All employees assigned to night or weekend schedules must convert to a five-day, 40 hour daytime work schedule during jury duty.

Employees who work alternate work schedules may or may not need to convert to a regular five day, 40 hour shift for jury duty, as follows:

- **Non-Represented Employees**
  Permanent, monthly-temporary and monthly-recurrent, non-represented employees assigned to other than a five day, 40-hour day shift schedule may, at the discretion of each County department head,

remain on that schedule while serving jury duty. This includes employees whose positions are covered by or exempt from Fair Labor Standards Act (FLSA) requirements.

- **Represented Employees**
  Requirements for represented employees are in their respective Memoranda of Understanding (MOU).

PROOF OF JURY DUTY SERVICE

An employee summoned to jury duty must submit a copy of the jury duty certification form(s) obtained from the court to his/her supervisor AND Payroll Services upon return to work. It is the employee's responsibility to obtain proof of jury service from the court. If proof of jury service is not submitted to the supervisor the employee may not be granted jury duty leave.

VEHICLE TRIP REDUCTIONS - RIDESHARING

DHS sites employing 100 or more employees are required to participate in the County Rideshare Program. This includes programs with aggregate number of employees situated in a leased building. The purpose of the Rideshare Program is to reduce traffic congestion and pollution resulting from air emissions from vehicles used to commute between home and work. It is also required per County agreement with the South Coast Air Quality Management District (SCAQMD).

Sites required to participate in the County's Rideshare Program have an assigned Employee Transportation Coordinator (ETC) responsible for promoting Rideshare, facility-specific benefits and incentives available to employees that participate in a Rideshare mode as well as conducting the annual Rideshare survey. All employees who arrive to work at the site between the hours of 6 AM to 10 AM are mandated to participate in the survey. The survey not only signifies to SCAQMD how the County is performing in meeting its requirements but also provides valuable information to the County and facility ETCs on the needs of the employees and the effectiveness of Rideshare incentives. Individual employees may elect via the survey to receive a RideGuide that provides them with alternative methods of commuting to work and assists with finding Rideshare partners for vanpools and carpools. The information provided in the survey and the RideGuide is handled confidentially.

There are a number of programs provided through the County to enhance Rideshare:

Telework: Want to work at home? If your work assignment allows it and it is approved by your supervisor, you can work at home and leave the commute behind. Telework is a management option and you and your supervisor must attend training and sign an agreement.

Guaranteed Ride Home (GRH): Afraid you won't be able to get home in an emergency? Employees that Rideshare are eligible for a "guaranteed ride home" in emergency situations.

Alternative Work Schedules (Compressed Work Week): A management option, working a 4/40 or 9/80 work schedule can reduce traffic and air pollution. Discuss this option with your immediate supervisor or manager.

Flexible Work Schedules: Rideshare doesn't fit your schedule? Employee work schedule can be flexed 15 minutes (instead of the normal 8 a.m. – 4:30 p.m. work day, the schedule can be flexed to 8:15 a.m. – 4:45 p.m.) to allow an employee who takes public transportation to arrive to work on time.

Commuter Benefit Plan: Save money by enrolling in the County's Commuter Benefit Program. Elect to purchase your bus, train, vanpool fare using pre-tax dollars which lowers the amount of 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. Refer to the CEO Rideshare Website for more information.

A rideshare mode includes: Vanpool, Carpool, Public Transit, Metro Light Rail, Metrolink, Telework, and don’t forget walking and bicycling.

For additional information on your particular site’s Rideshare Program contact your site ETC. For general information on the County Rideshare Program, visit the County CEO Rideshare Website at http://rideshare.lacounty.gov/

CLEAN AIR PARTNERS

TAKE PRIDE, SHARE THE RIDE!

POST TEST

1. Medication errors or near misses should be reported to:
   a. Manager/Supervisor
   b. Co-worker and tell them to keep it a secret
   c. Safety Intelligence™ Event Reporting System before the end of shift
   d. A and C
   e. None of the above

2. Which of the following choices is not a fall prevention step?
   a. Keeping hallways clear of obstacles
   b. Screening patients for fall risk
   c. Leaving wheelchairs, beds, and gurneys unlocked
   d. Documenting a patient's fall history

3. When responding to a fall victim, the workforce member should:
   a. Leave the victim to find help
   b. Lift the patient off the ground
   c. Immediately call for help and remain with the victim
   d. Avoid entering the event in the Safety Intelligence Event Reporting System to prevent litigation

4. Proper hand washing with soap, water, and friction takes:
   a. 10 seconds
   b. 15 seconds
   c. 20 seconds
   d. 25 seconds

5. Patients have rights that include which of the following?
   a. Patients have the right to quality care and treatment consistent with available resources and generally accepted standards.
   b. Patients have the right to appropriate assessment and management of pain.
   c. Patients have the right to refuse services/treatment.
   d. Patients and their family have the right, in collaboration with their physician, to make decisions involving their health.
   e. Patients have the right to choose or change their physician.
   f. All of the above

6. Which of the following choices IS NOT a violation of the HIPAA Security Rule?
   a. Reading through a fax left on the countertop
   b. Sharing access codes/passwords with other co-workers
   c. Looking at a FAX cover sheet to find out to whom it was sent and delivering it to that person
   d. Sharing the patient personal medical record information with friends and family members

7. If you encounter malfunctioning medical equipment, you should take what action?
   a. Use the equipment until you get a new one and report it to your supervisor.
   b. Immediately remove the equipment from the clinical area, tag the equipment "Out of Order," and report it to your supervisor.
   c. All of the above
   d. None of the above

8. As a condition of continued employment/assignment, you are responsible for obtaining a health screening:
   a. Every six months
   b. Every year
   c. Every other year
   d. Every two years

9. Whose responsibility is it to protect patient information?
   a. DHS Privacy Officer
   b. Departmental Information Security Officer
   c. Workforce members
   d. A and B only

10. The code for child abduction is Code Pink.
    a. True
    b. False

11. Universal Protocol was developed to prevent wrong site, wrong surgery/procedure and wrong person errors.
    a. True
    b. False

12. Just Culture recognizes that adverse events and unanticipated outcomes are often the result of reckless or intentionally malicious behavior, rather than the result of human error, or system failures.
    a. True
    b. False

13. At minimum, all staff must use at least two (2) patient identifiers whenever ordering or providing any treatments or procedures, as well as when ordering or administering medications.
    a. True
    b. False

14. All of the following are signs and symptoms that a patient's condition is deteriorating, EXCEPT:
    a. Acute changes in mental status
    b. Acute change in heart rate
    c. Uncontrolled bleeding
    d. Improving systolic blood pressure

15. All workforce members are expected to enter an online event report for which of the following?
    a. Near Miss Events
    b. Sentinel Events
    c. Healthcare Acquired Conditions
    d. All of the above

Martin Luther King, Jr. Medical Campus

1. MARTIN LUTHER KING Jr. OUTPATIENT CENTER
2. HOSPITAL SERVICES BUILDING (HSB)
3. FACILITIES MANAGEMENT / CENTRAL PLANT
4. LEROY WEEKES/NORTH SUPPORT BUILDING
5. ANCILLARY BUILDING
6. MARTIN LUTHER KING Jr. COMMUNITY HOSPITAL MAIN LOBBY
7. MARTIN LUTHER KING Jr. COMMUNITY HOSPITAL
8. AUGUSTUS HAWKINS PSYCHIATRIC AND CLINICAL SCIENCES BUILDING
9. PARKING STRUCTURE-STAFF ONLY
10. MLK MENTAL HEALTH URGENT CARE/EXODUS
11. GENESIS BUILDING
12. OASIS CLINIC
13. JARON J. GAMMONS SOUTHWEST AREA PEDIATRIC HUB
14. INTERNS & RESIDENTS BUILDING
15. H. CLAUDE HUDSON CONFERENCE CENTER
16. FIRE STATION
17. SUPPLY CHAIN OPERATIONS
18. ACUTE UNIT (OLD MACC)
19. MARTIN LUTHER KING Jr. CENTER FOR PUBLIC HEALTH

FACILITY PARKING LOTS

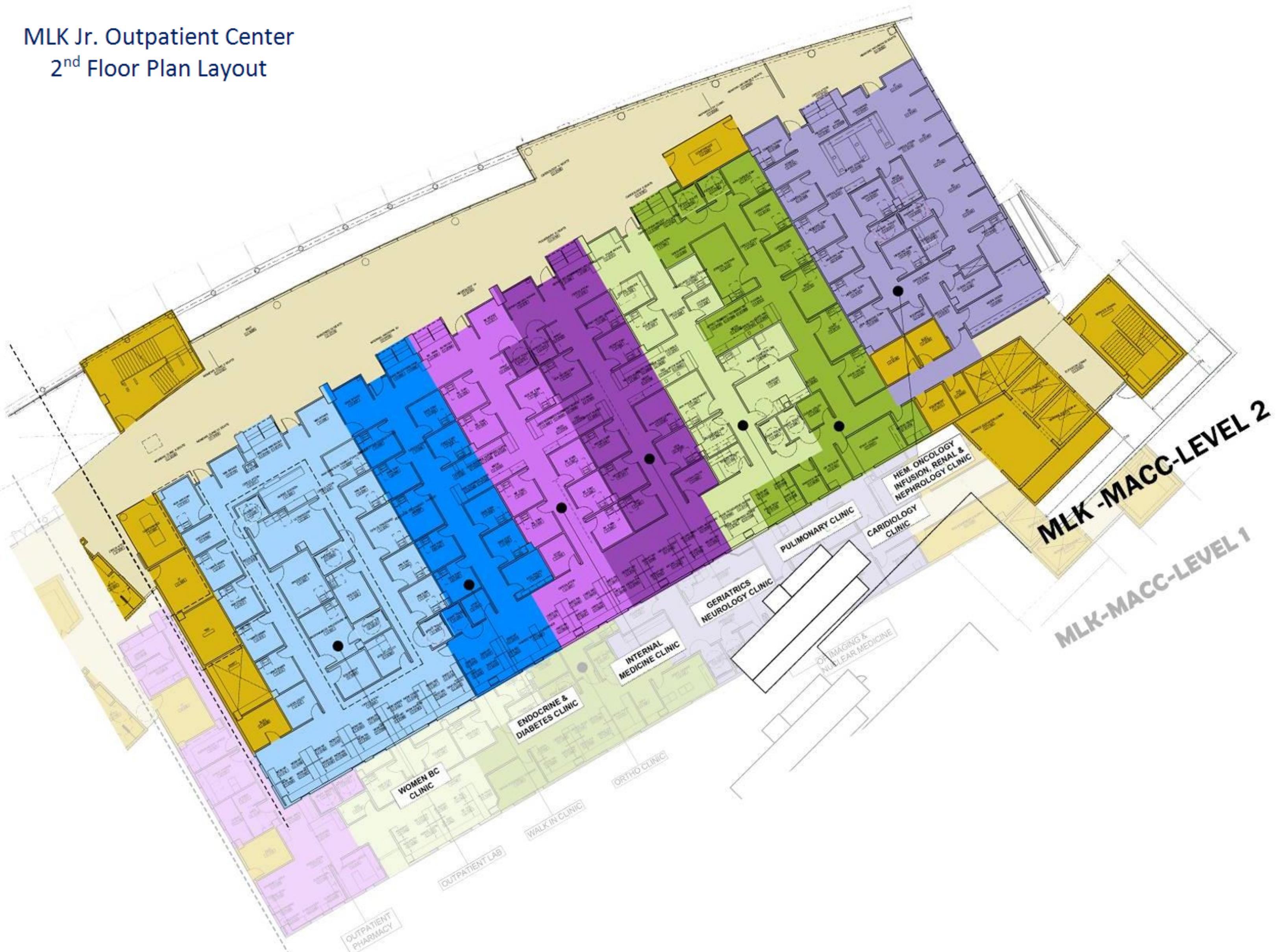
DESIGNATED PARKING *

- LOT A – MLK COMMUNITY HOSPITAL STAFF (182 SPACES)
- LOT B - SHARED: MLK HOSPITAL STAFF (103 SPACES)/EXODUS STAFF (25 SPACES)
- LOT C – SHARED MLK OPC WORKFORCE/MLK COMMUNITY HOSPITAL STAFF (288 SPACES)
- LOT D – PATIENT/VISITOR FOR MLK OPC CLINICS AND MLK COMMUNITY HOSPITAL (302 SPACES)
- LOT E – MLK OPC STAFF & MLK OPC TENANTS (210 SPACES)
- LOT F – MLK OPC STAFF (121 SPACES)
- LOT G – PATIENT & VISITORS PARKING (208 SPACES)
- LOT H – OPEN PARKING (5 SPACES FOR APLA DENTAL)
- PARKING STRUCTURE – MLK OPC STAFF, LAC+USC, DMH, OTHER TENANTS (479 SPACES)

FACILITY FLOOR PLANS

MLK Jr. Outpatient Center
1st Floor Plan Layout

MLK Jr. Outpatient Center
2nd Floor Plan Layout



MLK Jr. Outpatient Center
3rd Floor Plan Layout

MLK Jr. Outpatient Center
4th Floor Plan Layout

MLK -MACC-LEVEL 4
MLK -MACC-LEVEL 3
MLK -MACC-LEVEL 2
MLK-MACC-LEVEL 1

PT/OT/ST/ CLINIC
DENTAL CLINIC
ENT CLINIC
EYE CLINIC
DERMATOLOGY CLINIC
COMMUNITY HEALTH PLAN

Provided By:

County of Los Angeles
Department of Health Services
Human Resources
Office of Regulatory Compliance
5555 Ferguson Drive, Suite 200-01
City of Commerce, CA 90022
Tel: (323) 914-8001

On-Site Human Resources
Publication Support

Christina R. Ghaly, MD
Acting Director
Department of Health Services

DHS Mission

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

Board of Supervisors
County of Los Angeles

Hilda Solis	Mark Ridley-Thomas	Sheila Kuehl	Janice Hahn	Kathryn Barger
First District	Second District	Third District	Fourth District	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.