Welcome to Olive View-UCLA Medical Center!

On behalf of all of your colleagues here, I want to welcome you to the Olive View-UCLA Medical Center team. You are joining a diverse and dynamic group of over 3,000 professionals who are committed to our mission to put patients first and provide patient-centered care with the respect and compassion we would want for our loved ones. We care for a multi-ethnic, multi-cultural, and multi-lingual patient population. Our staff reflects this diversity and work diligently to deliver services in a way that addresses the special needs of our clients.

This is a particularly exciting time at Olive View, as we continue our journey to be recognized nationally as a model integrated health system in patient care, education, research and innovation. Among other areas of focus, we are working on initiatives to improve the patient experience and to increase access to ambulatory care. These efforts will strengthen our reputation as a provider of choice, as well as continue to serve the health care needs of the community.

Olive View-UCLA Medical Center is a teaching hospital with a host of primary and specialty clinics located on a 230-acre campus. Collectively, we provide care and services to over 12,000 inpatients, 66,000 emergency room patients, 5,000 mental health patients and 210,000 outpatient visits each year. We also play a major role in the training of future physicians, nurses and other health care providers. Finally, through our affiliation with the Education & Research Institute (ERI), we continue to explore and create novel treatments and therapies that are advancing health care delivery not just locally, but worldwide.

I am pleased that you have chosen to join our team and made the commitment to provide quality health care services to our family, friends, neighbors and everyone who comes to us for care in their time of need. We look forward to including you on the journey to achieve our vision and mission.

This handbook provides information regarding Olive View-UCLA, Department of Health Services, and Los Angeles County policies. Please take the time to thoroughly read and review these policies. If you have any questions or need additional information, please talk with your supervisor or contact Human Resources.
Equity, Diversity, Inclusion, and Anti-Racism

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

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

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

GOALS: Population Health Management/Value Based Care, Quality and Patient Experience, Workforce Optimization, Fiscal Sustainability
Hilda L. Solis  
Supervisor, First District  
Population: 1,967,029*  
Square Miles: 246  
Room 856  
213-974-4111  
Fax #: 213-613-1739  
solis.lacounty.gov  
E-mail: FirstDistrict@bos.lacounty.gov

Janice Hahn  
Supervisor, Fourth District  
Population: 1,971,639*  
Square Miles: 440  
Room 882  
213-974-4444  
Fax #: 213-626-6941  
hahn.lacounty.gov  
E-mail: FourthDistrict@bos.lacounty.gov

Holly J. Mitchell  
Supervisor, Second District  
Population: 1,977,349*  
Square Miles: 162  
Room 866  
213-974-2222  
Fax #: 213-680-3283  
mitchell.lacounty.gov  
Email: HollyJMitchell@bos.lacounty.gov

Kathryn Barger  
Supervisor, Fifth District  
Population: 1,946,135*  
Square Miles: 2,807  
Room 869  
213-974-5555  
Fax #: 213-974-1010  
kathrynbarger.lacounty.gov  
E-mail: Kathryn@bos.lacounty.gov

Sheila Kuehl  
Supervisor, Third District  
Population: 1,956,453*  
Square Miles: 431  
Room 821  
213-974-3333  
Fax #: 213-625-7360  
supervisorkuehl.com  
E-mail: Sheila@bos.lacounty.gov

Map of the Five Supervisory Districts in the County of Los Angeles

As of July 26, 2022

Public Affairs, Chief Executive Office, Room 358, Hall of Administration, Los Angeles, CA 90012 • Phone (213) 974-1311 • http://lacounty.gov
Olive View – UCLA Medical Center is a state-of-the-art hospital that serves much of the San Fernando Valley and the Antelope Valley, with out-patient clinics that provide primary care and hospital services for those who need specialty care or surgery. The hospital has a strong affiliation with the David Geffen School of Medicine at UCLA, the 10th best school of medicine in the country as ranked by U.S. News and World Report. Olive View-UCLA offers residency programs in 22 specialty areas and also operates an on-campus School of Nursing. The facility is a national leader in clinical research to improve quality of care.

ON-SITE SERVICES

- Emergency Medicine
- Urgent Care
- Psychiatric Emergency Room
- Medical/Surgical Inpatient
- Vascular Surgery
- Pediatrics Inpatient
- Suspected Child Abuse Clinic
- Obstetrics and Gynecology
- Psychiatric Inpatient (Locked Ward)
- Intensive Care
- Step-Down
- Telemetry
- 7 Operating Suites
- Respiratory Care
- Inpatient and Outpatient Pharmacy
- 3 Operative Delivery Rooms
- Radiology, including UTZ, CT, MRI
- Nuclear and Interventional Radiology
- Ancillaries including RT, PT, OT, ST, Nutrition
- Neonatal Intensive Care
- Medicine Specialties
- Plastic Surgery
- Cardiac Catheterization
- Thoracic Surgery
- Podiatry
- Ear, Nose, and Throat
- Ophthalmology
- Neurology
- Pathology, including FNA
- Clinical Social Work
- Primary Care and Specialty Clinics
- Orthopedic Surgery
- Infectious Disease/Tuberculosis Unit
- Dialysis

OFF-SITE SERVICES (BY REFERRAL)

- Chronic Dialysis
- Neurosurgery
- Neuropsychiatric (Testing)
- Cardiovascular Surgery
- Cardiothoracic Surgery
- Acute Rehabilitation
- Allergy & Immunology
- Allergy Testing
- Photo Therapy
- MOHS Surgery

TEACHING PROGRAMS SPONSORED BY OLIVE VIEW

- Medicine
- Rheumatology
- Nephrology
- Hematology/Oncology

TEACHING PROGRAMS SPONSORED BY GREATER LOS ANGELES

- Psychiatry

TEACHING PROGRAMS SPONSORED BY UCLA

- Emergency Medicine
- Radiology
- Surgery
- Cardiology
- Orthopedics
- Podiatry
- Pediatrics
- Gastroenterology
- Anesthesiology
- Pulmonary
- Obstetrics
- Gynecology

AFFILIATION WITH SEVERAL NURSING AND ALLIED HEALTH SCHOOLS
<table>
<thead>
<tr>
<th>PAGE</th>
<th>SECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>1</td>
<td>Hospital History</td>
</tr>
<tr>
<td>2</td>
<td>True North</td>
</tr>
<tr>
<td>3</td>
<td>Los Angeles County Alliance for Health Integration Priorities and Objectives</td>
</tr>
<tr>
<td>4</td>
<td>Los Angeles County Strategic Plan</td>
</tr>
<tr>
<td>5</td>
<td>Paychecks</td>
</tr>
<tr>
<td>5</td>
<td>Employee Pay Statements</td>
</tr>
<tr>
<td>5</td>
<td>County Paid Holidays</td>
</tr>
<tr>
<td>6</td>
<td>Vacation and Sick Leave Accrual</td>
</tr>
<tr>
<td>6</td>
<td>Family School Partnership Act</td>
</tr>
<tr>
<td>7</td>
<td>Bereavement Leave</td>
</tr>
<tr>
<td>7</td>
<td>Jury Duty</td>
</tr>
<tr>
<td>8</td>
<td>Family Medical Leave Act</td>
</tr>
<tr>
<td>9</td>
<td>Time Off to Vote</td>
</tr>
<tr>
<td>9</td>
<td>Personal leave for Victims of Domestic Violence</td>
</tr>
<tr>
<td>9</td>
<td>Retirement</td>
</tr>
<tr>
<td>10</td>
<td>Additional Employment Benefits</td>
</tr>
<tr>
<td>10</td>
<td>Lactation Accommodation</td>
</tr>
<tr>
<td>11</td>
<td>Respectful Workplace</td>
</tr>
<tr>
<td>11</td>
<td>Health Screening</td>
</tr>
<tr>
<td>12</td>
<td>Smoking Policy</td>
</tr>
<tr>
<td>12</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>12</td>
<td>Body Mechanics</td>
</tr>
<tr>
<td>14</td>
<td>Reporting Work Related Injuries/Illnesses</td>
</tr>
<tr>
<td>14</td>
<td>Injury and Illness Prevention Program (IIPP)</td>
</tr>
<tr>
<td>14</td>
<td>Employee Assistance Program (County Employees)</td>
</tr>
<tr>
<td>14</td>
<td>Vehicle Trip Reduction - Rideshare</td>
</tr>
<tr>
<td>16</td>
<td>DHS Wellness and Resilience Site</td>
</tr>
<tr>
<td>18</td>
<td>Competency Assessment</td>
</tr>
<tr>
<td>18</td>
<td>Performance Evaluation</td>
</tr>
<tr>
<td>18</td>
<td>Management Appraisal and Performance Plan (MAPP)</td>
</tr>
<tr>
<td>19</td>
<td>Professional Appearance</td>
</tr>
<tr>
<td>19</td>
<td>Time Reporting</td>
</tr>
<tr>
<td>19</td>
<td>Attendance/Tardiness</td>
</tr>
<tr>
<td>20</td>
<td>Workforce Behavioral Expectations</td>
</tr>
<tr>
<td>20</td>
<td>Acknowledgement of Employee Responsibilities</td>
</tr>
<tr>
<td>21</td>
<td>County Policy of Equity (CPOE)/ Sexual Harassment/Gender Non-Discrimination</td>
</tr>
<tr>
<td>23</td>
<td>Nepotism</td>
</tr>
<tr>
<td>23</td>
<td>Staff Rights in Patient Care</td>
</tr>
<tr>
<td>23</td>
<td>Abuse Prevention, Sexual Abuse, Sexual Coercion (Inappropriate Behavior Toward a Patient)</td>
</tr>
<tr>
<td>24</td>
<td>Implicit Bias</td>
</tr>
<tr>
<td>25</td>
<td>Safe Haven/Safely Surrendered Baby Law</td>
</tr>
<tr>
<td>25</td>
<td>Privacy of Patient Information (HIPAA)</td>
</tr>
<tr>
<td>29</td>
<td>Security of Confidential Information</td>
</tr>
<tr>
<td>34</td>
<td>DHS Compliance Program and Code of Conduct</td>
</tr>
<tr>
<td>35</td>
<td>False Claims Act</td>
</tr>
<tr>
<td>35</td>
<td>Procurement Process</td>
</tr>
<tr>
<td>36</td>
<td>Title I of ADA - Employment</td>
</tr>
<tr>
<td>36</td>
<td>Equal Employment Opportunity</td>
</tr>
<tr>
<td>37</td>
<td>Professional Credentials (License/Certification/Registration/Permit)</td>
</tr>
<tr>
<td>37</td>
<td>Criminal Background Checks</td>
</tr>
<tr>
<td>38</td>
<td>Disaster Service Worker/DHS County Emergency Protocol</td>
</tr>
<tr>
<td>39</td>
<td>Reporting of Abuse/Neglect Incidents</td>
</tr>
<tr>
<td>40</td>
<td>Reporting Suspicious Injuries</td>
</tr>
<tr>
<td>41</td>
<td>Outside Employment</td>
</tr>
<tr>
<td>41</td>
<td>Conflict of Interest</td>
</tr>
<tr>
<td>41</td>
<td>Training and Competency</td>
</tr>
</tbody>
</table>
133 “Read Back”, “Repeat Back” Requirements
133 Deteriorating Patient Condition
134 Fall Reduction and Prevention
135 Hospital Based Outpatients
136 Inpatients
143 Universal Protocol
145 Medication Management
145 Order Transmission
145 Medication Prescribing
146 Dangerous Abbreviations
146 Medication Dispensing
146 Medication Administration
147 Adverse Drug Reaction Reporting
147 Medication Errors
147 Non-Violent (Non-Self Destructive) & Violent (Self-Destructive) Restraints
153 Medical Record Requirements for Physicians and Licensed Independent Practitioners (LIPS)
154 Key Points to Remember (Clinical Staff)
156 Knowledge Check
168 Quick Reference
153 Medical Record Requirements for Physicians and Licensed Independent Practitioners (LIPS)
As a vital resource for the delivery of healthcare, Olive View-UCLA Medical Center is an integral part of the Los Angeles County Department of Health Services (DHS). Olive View serves residents of the San Fernando, Santa Clarita and Antelope Valleys regardless of their ability to pay. Compassion, communication, integrity and improvement are our guiding values.

Olive View provides a comprehensive range of outpatient and inpatient services as well as medical and psychiatric 24-hour emergency services and specialty clinics. Areas of excellence include early detection and treatment of cancer, complex abdominal surgery, tuberculosis, HIV/AIDS, and full range of women’s care.

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

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

HOSPITAL HISTORY

Olive View opened on October 27, 1920 as the tuberculosis sanatorium for Los Angeles County to relieve the overcrowding of tuberculosis patients at County General Hospital (now known as LAC+USC Medical Center). At that time, the facility was called the Olive View Sanatorium (pictured below) because it was located adjacent to the famous Sylmar Olive Ranch. Once tuberculosis could be cured, Olive View evolved into an acute care hospital. The first open-heart surgery in the San Fernando Valley, and one of the first in Southern California, was done successfully at Olive View Hospital in 1962.

In 1970, Olive View Hospital became Olive View Medical Center, a teaching hospital affiliated with the University of California, Los Angeles (UCLA) School of Medicine. A new 888-bed hospital was dedicated in December 1970, only to be destroyed on February 9, 1971 by the 6.5 magnitude Sylmar earthquake. For the next sixteen years, Olive View served its patients at an interim facility in Van Nuys. On May 8, 1987, the new 377-bed state-of-the-art replacement facility built on the Sylmar site opened.

In 1992, Olive View incorporated UCLA in its name becoming Olive View-UCLA Medical Center.

In 2011, Olive View-UCLA Medical Center completed construction and opened a new 30,000 square foot Emergency Room and 30 bed acute care inpatient unit designed to treat long-term tuberculosis and other infectious disease patients.
TRUE NORTH

True North is a key concept in Lean transformation. It is a precise and concise set of ideas that when taken together provide focus, alignment in our goals and improvement efforts to our patients and each other. It serves as our guide, like a compass, to take us from where we are to where we need to be. Our goal is to create a culture of improvement in which each person is a problem solver capable of making small, gradual improvements each day.

Our Vision is to be recognized nationally as a model integrated health system in patient care, education, research, and innovation.

Our Mission is to contribute to the health of Los Angeles County and the communities we serve by providing high quality, patient-centered care that we would want for our loved ones.

TRUE NORTH AND METRICS

True North dimensions are our organizational goals and focus of improvement. There are metrics selected for each dimension to help us achieve our True North goals and to keep ourselves accountable. These measurable metrics guide and inform our organization in its trajectory to meeting our True North objectives. The True North metrics are reviewed annually and updated to reflect our transformational journey.

Our organization strives to provide excellent service to our patients and staff. Our True North will drive and sustain long-term results and benefits for everyone who touches healthcare daily. Let our True North be our guide to lead us collectively, to be the healthcare of choice for our patients.
PRIORITY 1: INTEGRATION AND DEVELOPMENT OF PREVENTION, TREATMENT AND HEALING SERVICES

1.1 Provide comprehensive services across the care continuum to those in most need of County and County funded health services; this includes people struggling with homelessness, housing insecurity, mental illness, substance use disorders, incarceration and re-entry, Veterans, and/or other vulnerable populations.

1.2 Optimize access to prevention and health promotion/education services.

1.3 Ensure all children, adolescents, and families engaged with the Department of Children and Family Services (DCFS) have timely access to integrated mental health, substance use, and physical health services.

1.4 Optimize use of clinical resources to promote health, improve outcomes, efficiently use scarce resources, and allow all individuals to be cared for in the least-restrictive, most clinically appropriate setting.

PRIORITY 2: REDUCTION OF HEALTH INEQUITIES

2.1 Reduce racial/ethnic gaps in birth outcomes by offering appropriate home-based support, ensuring reproductive health services, integrating mental health, tobacco and substance use prevention and treatment services, aligning systems and policies, and investing in community-based organizations addressing root causes of health inequities.

2.2 Reduce STIs/HIV through policy and system change; enhanced provider trainings; improved collaborations with health plans, community-based organizations and residents; increased culturally appropriate services; and support for integrated sexual and mental health services for adults and youth.

2.3 Reduce threats to health and well-being from exposures to violence, trauma, and environmental hazards through expanded prevention and healing efforts; partner with communities to address root causes of violence and to eliminate exposures to environmental hazards.

2.4 Deliver culturally and linguistically appropriate care to all patients, clients, customers and community members.

PRIORITY 3: IMPROVEMENT OF ORGANIZATIONAL EFFECTIVENESS

3.1 Fully implement Just Culture in partnership with labor to identify and address challenges and identify solutions that strengthen our collective capacity to do our best work.

3.2 Partner with labor in efforts to improve employee engagement at all levels of each Department’s organization to ensure high quality services, employee retention and job satisfaction.

3.3. Redesign and/or streamline contracting, contract monitoring, billing, IT, data integration, and HR processes on an as-needed basis to enhance other cross-departmental integration efforts and reduce burdens on contracted agencies.

The Los Angeles County Alliance for Health Integration was formed to strengthen innovation and collaboration and make significant improvements in health outcomes for LA County residents. The priorities listed below were created to support these initiatives.
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.

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.

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

**PAYCHECKS**

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

**EMPLOYEE PAY STATEMENTS**

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

**COUNTY PAID HOLIDAYS**

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

<table>
<thead>
<tr>
<th>Holiday Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>New Year’s Day</td>
<td>January 1st</td>
</tr>
<tr>
<td>Martin Luther King, Jr Day</td>
<td>Third Monday in January</td>
</tr>
<tr>
<td>Presidents’ Day</td>
<td>Third Monday in February</td>
</tr>
<tr>
<td>Cesar Chavez Day</td>
<td>Last Monday in March</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Last Monday in May</td>
</tr>
<tr>
<td>Juneteenth Day</td>
<td>June 19</td>
</tr>
<tr>
<td>Independence Day</td>
<td>July 4th</td>
</tr>
<tr>
<td>Labor Day</td>
<td>First Monday in September</td>
</tr>
<tr>
<td>Indigenous Peoples’ Day</td>
<td>Second Monday in October</td>
</tr>
<tr>
<td>Veterans Day</td>
<td>November 11th</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Fourth Thursday in November</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>December 25th</td>
</tr>
</tbody>
</table>

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

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

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

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

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

The Sick Leave Accrual and Sick Leave Maximum Hours of employees authorized 96 hours’ sick leave per calendar year and assigned to a 40-hr workweek is as follows:

<table>
<thead>
<tr>
<th>Sick Leave Years of Service</th>
<th>Sick Leave Accrual Hours Per Pay Period</th>
<th>Sick Leave Maximum Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1</td>
<td>4:21</td>
<td>80</td>
</tr>
<tr>
<td>More than 1 to 4</td>
<td>4:21</td>
<td>88</td>
</tr>
<tr>
<td>More than 4</td>
<td>4:21</td>
<td>96</td>
</tr>
</tbody>
</table>

FAMILY SCHOOL PARTNERSHIP ACT

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

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

The intent of this Bereavement Leave provision is to allow an eligible employee to be absent from work for a prescribed number of working days, not hours, as specified in applicable Memoranda of Understanding (MOUs). Documentation on the death of the family member and travel distance must be submitted to be eligible for use of this leave.

DHS Policy 756.8 provides additional information on this subject.

JURY DUTY

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

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

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

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

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

PROOF OF JURY DUTY SERVICE

An employee summoned to jury duty must submit a copy of the jury duty certification form(s) obtained from the court to 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.
The Department of Health Services (DHS) complies with the provisions of FMLA and designates FMLA leave whenever applicable to any eligible employee (including temporary and part-time employees).

Under FMLA and California Family Rights Act (CFRA) an eligible employee is one who meets the following criteria:

- Has completed an aggregate of 12 months of County service, which need not be consecutive; and
- Has worked at least 1,250 hours during the 12-month period immediately preceding the first day of leave.

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

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

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

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

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

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

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

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

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

An employee on an approved medical leave of absence is subject to DHS outside employment policies and procedures if they have non-conflicting outside employment or activities. Employees are responsible for appropriately disclosing outside activity that may adversely impact or interfere with existing medical limitations and/or restrictions. Outside activities subject to approval include but are not limited to: outside employment; expert witness testimony; volunteer activity; and performance of charity medical relief.

**NOTE**

See DHS Policy No. 756.6 for detailed guidelines on FMLA.
**TIME OFF TO VOTE**

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

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

**PERSONAL LEAVE FOR VICTIMS OF DOMESTIC VIOLENCE**

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

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

**RETIREMENT**

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

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

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

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

DEFERRED INCOME PLANS

Employees may voluntarily participate in supplemental retirement plans

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

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

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

LACTATION ACCOMMODATION

DHS provides employees wishing to express milk a reasonable amount of break time and a private location for that purpose near the employee’s work location. The break time shall run concurrently, if possible, with break times already established. Employees requiring additional breaks or extended break times will be granted additional, unpaid time or an extended work shift equivalent to the extended or additional breaks. The location may include the employee’s normal work area, such as a private office, if it meets the requirements of the policy.

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

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

Breastfeeding and lactation are promoted under County policy and shall not constitute a source of discrimination in employment or in access to employment. It is prohibited to harass a breastfeeding and/or lactating employee. Such conduct may unreasonably interfere with an employee’s work performance and creates an intimidating, hostile or offensive working environment. Any incident of harassment of a breastfeeding and/or lactating employee will be addressed in accordance with the County’s policies and procedures. Non-compliance could result in citation and a civil penalty for each violation. The procedures for citations and civil penalties are provided for in state and federal laws.
The goal of the County’s Wellness Program is to improve the health and productivity of County employees and lessen their health-related costs, mainly by helping employees change their lifestyle patterns through wellness initiatives.

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

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

For more information on any Los Angeles County Wellness Program, send an email to: workplaceprograms@hr.lacounty.gov

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

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

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

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

All workforce members who work in a DHS healthcare facility, including students, volunteers, and non-DHS/non-County workforce members, must have an initial and annual health screening. This includes, but is not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease screening, and/or any other medical tests, as indicated. You and your supervisor are responsible to comply with DHS policy, and ensure you obtain a health screening annually as a condition of continued employment/assignment. You may contact the facility Employee Health Services to find out when your health screening is due.

You will not be allowed to work inside a County medical facility without appropriate documentation of health clearance or required health evaluation. It is a violation of Joint Commission, Title 22, and Centers for Medicare & Medicaid Services (CMS) standards for a workforce member to work without appropriate health clearance and will subject the facility to possible accreditation citations.
NOTE
You must complete your health screening annually.

SMOKING POLICY

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

SUBSTANCE ABUSE

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

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

BODY MECHANICS

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

Why You Should Practice Good Body Mechanics

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

Maintaining Good Body Mechanics

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

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

GUIDELINES FOR DECREASING MUSCULOSKELETAL INJURY

General Guidelines for Maintaining Proper Body Mechanics During Activity

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

Reaching

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

Twisting/Turning

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

Standing

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

Patient Transfers

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

Equipment/Object Transfer

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

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

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

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

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

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

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES)

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

To schedule an appointment, call during regular office hours (see Quick Reference for details). The first appointment may be on County time with the permission of the employee’s supervisor. Subsequent EAP appointments, if any, will require usage of employee’s own time. The employee will need to advise their supervisor and request time off as with any other time-off requests, if appointment(s) are during work hours.

VEHICLE TRIP REDUCTION - RIDESHARING

The purpose of the Rideshare Program is to reduce traffic congestion and pollution resulting from air emissions from vehicles used to commute between home and work. It is also required per County agreement with the South Coast Air Quality Management District (SCAQMD).

Sites required to participate in the County’s Rideshare Program have an assigned Employee Transportation Coordinator (ETC) responsible for promoting Rideshare, facility-specific benefits and incentives available to employees that participate in a Rideshare mode as well as conducting the annual Rideshare survey.
There are a number of benefit programs provided through the County to enhance Rideshare:

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

- **GUARANTEED RIDE HOME (GRH)**
  Afraid you won’t be able to get home in an emergency? Employees that Rideshare are eligible for a “guaranteed ride home” in emergency situations (unexpected overtime, personal illness/family emergency) up to 4 times a year.

- **ALTERNATIVE WORK SCHEDULES (COMPRESSED WORK WEEK)**
  Working a 4/40 or 9/80 work schedule can reduce traffic and air pollution. Discuss this management option with your immediate supervisor or manager.

- **FLEXIBLE WORK SCHEDULES**
  Rideshare doesn’t fit your schedule? Employee work schedules can be flexed 15 minutes. Instead of the normal 8 a.m – 4:30 p.m. work day, the schedule can be flexed to 8:15 a.m.– 4:45 p.m. to allow an employee who takes public transportation to arrive to work on time.

- **COMMUTER BENEFIT PLAN**
  Save money by enrolling in the County’s Commuter Benefit Program. Elect to purchase your bus, train, or vanpool fare using pre-tax dollars. This lowers your taxable income, resulting in annual tax savings.

- **VEHICLE PURCHASING SERVICES PROGRAM**
  The County has arranged for employees to receive a discount on the purchase of a “green” vehicle from various car dealerships. Many sites have charging stations to accommodate electric vehicles. Refer to the County’s Rideshare Website for more information.

A RIDESHARE MODE INCLUDES:

- Vanpool,
- Carpool,
- Public Transit,
- Metro Light Rail,
- Metrolink,
- Telework,
- and don’t forget walking and bicycling!

For additional information on your particular site’s Rideshare Program contact your site ETC.
For general information on the County Rideshare Program, visit the County Rideshare Website at [http://rideshare.lacounty.gov/](http://rideshare.lacounty.gov/)
Wellness and Resilience

HEALTHY EMPLOYEES FOR A HEALTHY WORKPLACE

As Los Angeles County Employees it is important that we prioritize our well-being. Take a moment to explore the DHS Wellness and Resilience site for resources, guidance and information about how to take care of yourself and each other during these unprecedented times.

https://lacounty.sharepoint.com/sites/dhs-wellness
The Department of Health Services values continuous learning and development. Workforce members are given the tools to grow and are continually challenged to work at the peak of their skill set. Below you will find information on training and competency, competency assessment, Performance Evaluations, and Management Appraisal and Performance Plan.

You are mandated to complete orientation within 30 days of hire and/or transfer of assignment to a facility. Documentation of initial competency assessment must be initiated immediately upon hire/assignment and completed within the first 90 days of your assignment to the actual unit/division. Ongoing competency assessment is required annually or as needed (i.e. new equipment, new procedure/policy, remedial education process, etc.), and must be documented in your area file. You must also complete all mandatory trainings and competency certification requirements for your position (e.g., orientation, infection control, fire/life safety, emergency management, CPR and other core competencies).

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

Mandatory trainings include:

- Sexual Harassment and Discrimination Prevention Training (SHDPT)
- County Policy of Equity (CPOE)
- Disaster Service Worker (County employees only)
- Privacy & Security Survival Training (HIPAA)
- CSEC 101: The Commercial Sexual Exploitation of Children
- Implicit Bias and Cultural Competency: An Introduction
- Defensive Driver (Mileage Permittees)
- Compliance Awareness Training (CAT)
- Cyber Security Awareness Training 2022
- Workplace Violence Prevention
- Safe Youth Zone Initiative

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

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

Click [here](#) for a full list of Mandatory Training Requirements.
All DHS workforce members who hold a direct or indirect patient care position and are assigned to DHS hospitals and health facilities are required to demonstrate competency in their job responsibilities by participating in the Department’s ongoing competency assessment and skills validation process.

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

All nurses who report to physicians and who are not credentialed and privileged must complete core and specialty competencies (as applicable) initially and annually through the assigned physician. Nurse clinical practice will be evaluated with the assistance of a Nurse Manager or clinical nurse expert over the specialty.

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

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

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

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

For detailed guidelines, refer to DHS Policy 780.000.

Work plans (job descriptions) can be viewed and acknowledged, and most performance evaluations can be completed on the Performance Net at http://performancenet.lacounty.gov/. For technical assistance, including password updates and Performance Net training, contact regulatorycompliance@dhs.lacounty.gov. Performance Net training is also available on Learning Link.

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

NOTE

MAPP orientation is available and can be scheduled by contacting DHS Human Resources, Regulatory Compliance.
This section discusses your rights and responsibilities as a workforce member. This includes behavioral expectations, Security of Confidential Information, the County Policy of Equity and other essential information.

PROFESSIONAL APPEARANCE

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

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

NOTE

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

TIME REPORTING

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

DHS uses eHR web-based timesheets (TIMEI) for documenting and recording time worked and time off.

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

For more information, you may also check the DHS Time Collection website from the DHS Enterprise Intranet at https://lacounty.sharepoint.com/sites/dhs-HR/SitePages/timecollection.aspx

ATTENDANCE/TARDINESS

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

Your manager/supervisor is responsible for establishing your work hours, which include a regular start time and end time, and appropriate lunch and rest breaks in accordance with the Los Angeles County Code and applicable Memorandum of Understanding (MOU).

An official work week is defined as five days of work per week for a total of 40 hours. A normal workday consists of eight (8) consecutive hours exclusive of at least a 30-minute lunch period and inclusive of two (2) fifteen (15) minute rest periods to be taken as determined by management in accordance with Los Angeles County Code provisions and applicable MOU. A rest period should be taken approximately midmorning and midafternoon, they shall not be accumulated or combined to lengthen the lunch period, shorten the workday or to make up tardiness or absences.

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

WORKFORCE BEHAVIORAL EXPECTATIONS

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

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

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

Workforce members should report disruptive, inappropriate or unprofessional behavior. Some inappropriate or unprofessional behavior will need to be reported to the appropriate professional credential issuing agency/board. There will be no retaliation against anyone who reports a violation of this policy in good faith. However, any workforce member who deliberately makes a false accusation will be subject to appropriate corrective action. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

Corrective action will be commensurate with the nature and severity of the disruptive behavior.

ACKNOWLEDGEMENT OF EMPLOYEE RESPONSIBILITIES

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

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

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

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

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

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

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

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

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

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

PROHIBITED CONDUCT

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

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

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

Unlawful Harassment (Other than Sexual)
Unlawful harassment of an individual because of one or more of the protected classes above is also discrimination and prohibited. Unlawful harassment is conduct which has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, offensive, or abusive work environment.

Third-Person Harassment
Third-person unlawful harassment is indirect harassment of a bystander, even if the person engaging in the conduct is unaware of the presence of the bystander. When an individual engages in harassing behavior, they assume the risk that someone may pass by or otherwise witness the behavior; the County considers this to be the same as directing the harassment towards that individual.

Inappropriate Conduct Towards Others
Inappropriate conduct toward others is any physical, verbal, or visual conduct based on or because of one or more of the protected classes listed above when such conduct reasonably would be considered inappropriate for the workplace. This provision is intended to stop inappropriate conduct based on a protected status before it becomes discrimination or unlawful harassment. As such, the conduct need not meet the legally actionable state and/or federal standards of severe or pervasive to violate this Policy. An isolated derogatory comment, joke, racial slur, sexual innuendo, etc., may constitute conduct that violates this policy and is grounds for discipline, up to and including discharge from County service. Similarly, the conduct need not be unwelcome to the party against whom it is directed; if the conduct reasonably would be considered inappropriate by the County for the workplace, it may violate this Policy.

GENDER IDENTITY AND GENDER EXPRESSION NONDISCRIMINATION

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

REPORTING VIOLATIONS OF THIS POLICY

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

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

County employees may also contact the California Department of Fair Employment and Housing (DFEH) by calling (800) 884-1684 or via their website at www.dfeh.ca.gov and/or may contact the Federal Equal Employment Opportunity Commission (EEOC) by calling (213) 894-1000 or (800) 669-4000 or via their website at www.eeoc.gov.
NEPOTISM

Nepotism is a practice where one workforce member uses their personal influence or power to aid or hinder another in employment, securing employment, promotion or other benefits because of a personal relationship. A workforce member may not supervise an immediate relative or individual who has a personal relationship with the supervisor, either as an immediate supervisor or as a higher-level supervisor.

Workforce members are responsible for informing the Department about any person who is an immediate relative or a person in which the workforce member has a personal relationship that is employed by the County and assigned to DHS whether the person is an employee or a contract staff.

Immediate relative includes any relationship formed by blood, genealogy, marriage, adoption, cohabitation, and domestic partnership as defined in California Family Code Section 297 et seq. and Los Angeles County Code Section 2.210, including but not limited to spouse (common law or otherwise), child, mother, father, sister, brother, aunt, uncle, grandparent, niece, nephew, step-parent, step-child, step-sibling, cousin or legal guardian.

Personal relationships include, but are not limited to, those by virtue of blood, marriage, adoption, cohabitation, or any such other relationship which would give rise to a substantial appearance of impropriety or lack of reasonable objectiveness if the person were to be supervised as set forth in this policy.

STAFF RIGHTS IN PATIENT CARE

DHS seeks to provide high-quality patient care in an environment that protects all members of our service delivery team and respects their cultural values, ethics, and religious beliefs. Leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious beliefs conflict with the rendering of patient care. Speak with your supervisor to submit a request for considerations to be excused from that aspect of patient care. Non-County workforce members should contact the facility contract administrator for terms and conditions of their contract.

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

Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, harassment, exploitation and the reporting thereof without fear of retaliation.

Sexual contact between a health care worker and a patient is strictly prohibited, is unprofessional conduct, and will constitute sexual misconduct and/or abuse. Examples of inappropriate sexual conduct include, but are not limited to, intercourse, touching the patient’s body with sexual intent, inappropriately watching the patient undress/dress, making inappropriate comments, and conducting physical exams not needed or not within the scope of the treatment or complaint. Physicians and health care providers shall avoid any situation that may be construed as sexual misconduct.

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

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

Any workforce member who witnesses or reasonably suspects a patient was or is being subjected to inappropriate sexual conduct and/or sexual abuse shall report it to his/her supervisor and to the facility Los Angeles County Sheriff’s Department.

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

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

How does Implicit Bias Impact Healthcare?

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

Examples of implicit bias in healthcare include the following:

• Disparities in pain management; patients of color are less likely to be prescribed pain medication.
• Patients of color are less likely to receive cardiovascular interventions.
• Higher mortality rate for black women after being diagnosed with breast cancer.
• Lack of empathy toward minority patients.

Some actions you can take to help prevent implicit bias are:

• Exploring and confronting your own biases.
• Acknowledging the importance of implicit bias and its effect on healthcare.
• Recognizing which interactions with patients are based on stereotypes and reflecting on your response. Work to change similar future responses.
• Having a basic understanding of the cultures of the patients we serve.
• Practicing “evidence-based medicine”.
• Embracing diversity and inclusion.

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

Sources:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436

Freepik
SAFE HAVEN/SAFELY SURRENDERED BABY LAW

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

PRIVACY OF PATIENT INFORMATION (HIPAA)

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

WHY DO WE NEED TO PROTECT PATIENT INFORMATION?

It is the right thing to do. Federal laws, the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and California laws require us to protect the privacy and security of all patient health information. These laws:

• Require DHS to make a report when a patient’s health information kept on a computer/electronic device is not coded in a way to prevent access and is misused or wrongly released.
• Give patients more rights and increase fines for violating the law.
• Protect all forms of patient health information, including paper, electronic, verbal, video, photos, etc.
• Require DHS to take additional steps to keep patient information safe, such as providing additional privacy & security training for workforce members to stay up to date with the vast amount of information and policies.

WHAT IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION?

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

<table>
<thead>
<tr>
<th>Protected Health Information (PHI)</th>
</tr>
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<tbody>
<tr>
<td>• Demographic information, e.g., name, address, phone number, email address</td>
</tr>
<tr>
<td>• Physical or health condition of a patient, e.g., diagnosis, condition, medications</td>
</tr>
<tr>
<td>• Services or treatment provided, e.g., care plan, treatment records, progress notes</td>
</tr>
<tr>
<td>• Payment information, e.g., medical record number, health insurance numbers, account number, credit card number, social security number, date of birth, date of death, dates of service</td>
</tr>
<tr>
<td>• Other information about past, current and future medical/health care, e.g., photographs</td>
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Other laws also require the protection of Personal Identity Information (PII) which is electronic information that can be used to trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.
PII and PHI share some similarities under the law but are governed by distinctively different regulatory bodies. The best practice is to protect all information associated with a patient and follow the Department’s policies related to patient privacy.

**PRIVACY LAWS GIVE PATIENTS CERTAIN RIGHTS**

Along with a patient’s right to privacy, laws give patients other rights. This includes how we can use their information and to whom we can disclose it. Under HIPAA, DHS staff are required to provide patients with a Notice of Privacy Practices, usually during their first encounter or visit with us or anytime they request a copy. Under the Notice of Privacy Practices, patients have the right to:

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

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

**USE AND DISCLOSURE OF PATIENT INFORMATION**

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

SAFEGUARDS

• Each member of our workforce is required to take steps to protect the privacy and confidentiality of our patients’ PHI.
• You must have a legal or business “need-to-know” to access PHI. Your job duties determine how much patient information you can view or access, not your relationship to the patient.
• Your supervisor will arrange for you to obtain access to systems and networks necessary for you to do your job.
• It is a violation of HIPAA and State law to access or look at a patient’s electronic medical record(s) without a business need and will be investigated.
• To protect our patients’ privacy, patient access audits are conducted to detect unauthorized access to electronic medical records.
• Take the time to verify the identity of a patient by using at least two patient identifiers, before providing them with documents and/or medications.
• Make sure all pages of documents such as discharge summaries, clinic summaries, and medications belong to the patient. Pages can get mixed up from shared printers.
• Patient information is often inputted/uploaded into the electronic medical record, therefore it’s important to ensure the information and documents pertain to the correct patient.
• We must take reasonable safeguards or steps to make sure patient health information is kept private.

INCIDENTAL DISCLOSURES

• Activities we do for business reasons, such as calling out a patient’s name in the waiting area or talking to a patient on the phone or in an area where others might hear are called incidental disclosures.
• Incidental disclosures do not violate laws if we take sufficient steps to protect the patient’s privacy, such as closing exam room doors or privacy curtains, eliminating use of patient name while talking on phone, or using lowered voices to minimize the risk of others hearing the conversation.

DISCLOSING INFORMATION TO SPOUSES, FAMILY MEMBERS, AND FRIENDS

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

DISCLOSING INFORMATION TO THE MEDIA

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

DISCLOSING INFORMATION TO LAW ENFORCEMENT

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

SOCIAL MEDIA

• Do not post photos or information about patients or work-related issues on social networking sites such as Facebook, Twitter, Snapchat, Instagram, TikTok, YouTube, Tumblr, Reddit, WhatsApp, etc.
• It does not matter if you are not using County equipment, if you are at home, or on your break.
• Due to the nature and type of work you do, just small bits of information put together can reveal identifying information about patients and cause you to violate privacy laws (e.g., a public snapchat post of the hospital, the patient’s condition and details about what happened to them can be seen by the patient’s family member).
• Please keep the workplace professional. Do not take selfies or pictures where a patient or patient document(s) can be visible in the background.
INAPPROPRIATE ACCESS TO OR DISCLOSURE OF PHI

If you acquire, view, or access patient information that you do not need to do your job or give patient information to someone who should not receive it (e.g., friend, family member or person of the general public), you will violate DHS policies, HIPAA, and/or state law.

MINIMUM NECESSARY

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

REPORTING POSSIBLE VIOLATIONS AND INCIDENTS

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

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

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

FINES AND PENALTIES

• Use good judgment when working with patient information.
• Violations may not only result in discipline but can result in fines against the DHS facility involved. If guilty of a violation, you may also be fined and sentenced to prison.
• Anyone with a professional credential may also be reported to the issuing board or agency for investigation.
The HIPAA Security Rule covers all electronic Protected Health Information (ePHI) when stored on computers and while being sent from computer to computer. ePHI is patient health information that is either accessed, stored or transmitted through computers, via an electronic media, or across remote servers. Each DHS facility must take reasonable steps to make sure ePHI is complete, protected, and available when someone needs it.

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

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

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

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

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

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

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

Some telltale signs of a potential phishing or malicious email:

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

Scenario:

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

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

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

2. **“From” Line**: Check the spelling of the sender’s email address and verify the email address by hovering your mouse/pointer over it; misspelling is likely an indicator of a spoofed email.

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

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

5. **Time**: Consider the time you receive the email and compare it with the normal time you receive similar emails. Emails sent in the middle of the night might be phishing.

6. **Attachments**: Avoid opening attachments you are not expecting.
7. **Subject:** Phishing attempts often use scare tactics to prompt immediate actions, such as “Change password immediately”. Validate the source before you take any action.

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

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

10. If the email seems suspicious, **report it** through the PAB button.

Ransomware typically infects a system through a phishing email containing 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 demanding the user to pay a specific ransom to reclaim or reactivate the computer.

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

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

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

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

**TAKING SECURITY HOME: WORKING REMOTELY**

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

• Keeping your personal and work accounts separate. Keep all personal activity on your personal devices.
• Shredding or destroying sensitive documents using a cross-cut shredder.
• Do not leave mobile devices unattended.
• Locking the door of your workspace if you have a dedicated room for your office. It will help keep out intruders as well as children, friends, family and pets who like to cause trouble.
• If you do not have an office, try to work in the same spot and if possible, limit other people’s access to that area. Always lock your screen and other devices if you step away, and lock up papers and removable media, such as USB drives.
• Password protect your Wi-Fi (never use default passwords).
• Using strong passwords and lock your device(s) when not in use.
• Using discretion when working in public areas, such as coffee shops with free Wi-Fi that are not secure. Avoid handling confidential information over an unsecure Wi-Fi that is vulnerable to hackers.

INSIDER THREATS FOR END USERS

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

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

CLOUD SERVICES

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

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

• Respect patient privacy and their information and only access, view, or use information needed to do your job.
• Verify that all documents provided to a patient belong to that patient. Use at least two patient identifiers (additional identifiers if necessary) before providing a patient with medications or documents, such as appointment reminders, discharge summaries, and eligibility packets. When verifying, ask the patient to provide their personal information rather than you asking them if they are the correct patient.
• Delete emails and attachments containing PHI/PII when no longer needed to do your job. Empty your recycle or trash folder regularly and delete no longer needed pictures, files attachments and emails from your desktop, laptop, or phone’s mailbox.
• Delete files and pictures containing PHI/PII from MS Teams and OneDrive when no longer needed to do your job.
• Immediately remove all PHI from shared printers, fax machines, and photocopiers.
• When faxing PHI, be sure to verify if the recipient and phone number are correct and when possible, verify if the recipient received the fax.
• Discard PHI in secure shredder bins (HIPAA bins) or in cross-cut shredders.
• Discuss patient care 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™ (SI) Event Reporting System AND by phone to the facility Privacy Manager in a timely manner to comply with privacy policies and regulations.
• Report suspected security incidents to the Enterprise Help Desk via email at helpdesk@dhs.lacounty.gov or by phone (323-409-8000).
• Use the “ ” (RPB or PAB) button to report potential phishing emails.
### PRIVACY AND SECURITY DO’S

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

### PRIVACY AND SECURITY DON’TS

- Don’t access information about a patient unless you need it to do your job (even if you personally know the patient).
- Don’t share confidential patient information with anyone who does not need it to do their job.
- Don’t provide PHI/PII to a vendor until you have verified with your Privacy Manager that there is a signed Business Associate Agreement.
- Do not use a personal laptop, notebooks, or other electronic devices to store PHI/PII or confidential information unless authorized by your supervisor and the device is encrypted.
- 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 share passwords or your computer while logged on. You are responsible for all actions and information viewed while logged in with your credentials.
- Don’t store your password(s) under the monitor, keyboard or inside your unlocked desk.
- Don’t reuse the same password for multiple accounts.
- Don’t use short and simple or personal passwords that are easy to guess (e.g. 1234567890, abcde1234, kid’s names, pet’s name, birthdates, etc.).
- Don’t forget to log off shared/public use computers and workstations when you are done or briefly stepping away.
- Don’t e-mail PHI outside of the County e-mail network without authorization.
- Don’t send and discuss patient information or conduct County business through internet-based e-mail sites such as Yahoo Mail, Google Mail, Hotmail, etc.
- 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, Instagram, Twitter, YouTube, etc.).
- Don’t take photos and videos of patients for patient diagnosis and treatment with your personal cellular telephone unless you use the secure Microsoft Teams platform, which has replaced HIPAABridge.
- 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 a trashcan.
- Don’t store documents containing PHI in an area where it can be mistaken for trash.
- Never click on links in emails from unknown or suspicious senders. This could be a phishing email.
- Don’t remove documents containing PHI/PII from the facility unless you have been authorized to do so.
- Don’t forget to remove documents containing PHI from your pockets or from your personal belongings before leaving the workplace; secure or discard it appropriately.
- Do not access unsecure sites or view confidential information when using public Wi-Fi.
- Do not permanently store sensitive information in your email.
DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

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

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

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

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

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

Please note that the Los Angeles County Fraud Hotline and website, operated by the Auditor-Controller, continues to be available to report fraudulent activity.

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

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

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

PROCUREMENT PROCESS

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

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

Specific delegated signatory authority has been established for the purchase and approval of procurement requests. Workforce members should contact their facility Supply Chain Operations Division if they have any questions regarding the procurement process or acceptance of goods or services.
The purpose of this section is to provide workforce members with the conditions of employment set forth by the County and DHS. Below you will find information on the Americans with Disabilities Act (ADA), professional credentials, criminal background checks, the Disaster Service Worker (DSW) program, mandatory reporting of abuse, and reporting suspicious injuries.

**TITLE I OF ADA - EMPLOYMENT**

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

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

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

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

**EQUAL EMPLOYMENT OPPORTUNITY**

The Equal Employment Opportunity policy exists to provide equal employment opportunity to all qualified persons, regardless of race, color, religious creed, sex, national origin, ancestry, medical condition, marital status, age, physical or mental disability, sexual orientation, or gender identity, and to maintain a non-discriminatory workplace.

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

- Recruiting, hiring, training, and promoting persons in all job classifications without regard to any non-job-related characteristics.
- Ensuring that promotional decisions are made in accord with equal employment opportunity requirements by imposing only valid, job related requirements for promotional opportunities.
- Ensuring that all personnel actions relating to compensation, benefits, transfers, terminations, training, and education are administered in a non-discriminatory manner.
- Ensuring that no employment practice exists which discriminates against any employee or applicant in any aspect because of sexual harassment from a manager, supervisor, client or fellow employee.
- Providing a work environment free from harassment and/or other discriminatory practices for all employees.
- Providing a work environment that complies with federal and state statutes regarding disability and providing an interactive process for those having a disability that limits a major life activity.
Any workforce member or contractor (County or non-County) whose position requires a current valid professional credential to perform the duties of his/her position shall produce evidence of license, certification, registration and/or permit to Human Resources upon entering County service or assignment.

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

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

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

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

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

REMEMBER

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

CRIMINAL BACKGROUND CHECKS

All candidates selected for hire, promotion or transfer from another department, and potential contract/volunteer/student staff, as specified in DHS Policy 703.1, will participate in a criminal background check. The criminal background check will include Live Scan fingerprinting, conducted by the California Department of Justice (CADOJ) and the FBI. State and federal licensing and administrative agencies may also be contacted. As part of the criminal background check process, all candidates are also screened during onboarding and monthly through several federal and state exclusion/suspension lists that identify individuals excluded from participating in federal and state health care programs. DHS is prohibited from hiring or maintaining relationships with individuals and entities that have been excluded/suspended or have opted out of Medicare.

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

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

Failure to report may result in disciplinary action, including discharge or termination from assignment. DHS HR PM will review the charges/conviction to determine if a job nexus exists. All information reported to DHS Human Resources will only be released on a “need-to-know” basis as required to determine a job nexus.
The State of California Disaster Service Worker Volunteer Program (DSWVP) was created as the result of legislation to provide worker’s compensation benefits in the event a Disaster Service Worker (DSW) volunteer is injured while performing authorized disaster service duties.

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

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

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

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

WHAT TO DO WHEN A DISASTER OCCURS

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

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

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

Employees who require assistance evacuating may request assistance by completing a “Voluntary Request for Reasonable Accommodation” form and submitting it to your supervisor/manager, or the facility on-site HR Office or the Department ADA Coordinator.
The State of California Penal Code mandates that health care practitioners report incidents of suspected or identified child abuse/neglect, and elder or dependent adult abuse/neglect. Any mandated reporter (all workforce members) who fails to report abuse may be found guilty of a misdemeanor punishable by imprisonment or a fine.

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

CHILD ABUSE

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

ELDER ABUSE

Physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Workforce members are mandated to report incidents of suspected elder abuse immediately or as practicably possible by calling the Elder Abuse Hotline. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

DEPENDENT ADULT ABUSE

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 Dependent Adult Abuse Hotline. A written report must be submitted within two (2) working days of the telephone report, and may be submitted through their website at https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

DOMESTIC/INTIMATE PARTNER ABUSE

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

NOTE

Contact the Clinical Social Work Department for assistance with evaluations, reporting forms and referrals.
A SUSPICIOUS INJURY INCLUDES ANY WOUND OR OTHER PHYSICAL INJURY THAT WAS:

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

In accordance with California Penal Code Section 11160, DHS requires any health practitioner working in a DHS health facility, who in his/her professional capacity or within the scope of his/her assignment, who provides medical services to a patient/inmate who he/she knows, or reasonably suspects has a suspicious injury, to report such injury by telephone to local law enforcement immediately or as soon as practicable. Section 11160 requires the reporter to make a written follow-up report within two (2) business days to the same local law enforcement agency. If the suspicious injury is to a patient/inmate, per Los Angeles County Board of Supervisor’s (BOS) mandate, it must be reported to Los Angeles County Sheriff’s Department Internal Affairs Bureau or the Captain of the jail facility where the patient/inmate is housed.

It should be noted that the health practitioner’s reporting obligation applies to any law enforcement agency delivering a patient/inmate for intake with a suspicious injury. Reports made to the local law enforcement agencies regarding suspicious injuries to patients/inmates should be escalated to the facility Regulatory Affairs Unit for tracking and enterprise reporting purposes.

Health practitioners working in a DHS health facility, who are engaged in compiling evidence during a forensic medical examination for a criminal investigation or sexual assault, may be asked to release the report to local law enforcement and other agencies. The reports must be prepared on specific forms as required by statute. Health practitioners must follow DHS HIPAA procedures documenting the release of such information.
OUTSIDE EMPLOYMENT

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

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

See DHS Policy 740 for more information such as special conditions for physicians and appeal process in the event of denial.

CONFLICT OF INTEREST

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

A WFM has a financial interest in a decision if the decision has a material financial effect on the WFM, WFM’s immediate family, or on:
• Any business entity in which the WFM has an investment of $2,000 or more in which he or she is a director, officer, partner, trustee, employee or manager.
• Real property in which the WFM has a direct or indirect interest worth $2,000 or more including leaseholds (month-to-month leases are not considered leaseholds);
• Any source of income to the WFM totaling $500 or more in value provided to, received by, or promised to the WFM within the previous 12 months (includes community property in the interest of the spouse or registered domestic partner);
• Any business entity in which the WFM holds a position, including executive and management;
• Any donor of a gift totaling $500 or more in value provided to, received by or promised to the WFM within 12 months prior to the decision being made.
• In addition to the list above, there are additional state statutes and regulations which further define a financial interest. Any WFM who believes they may have a financial interest in a decision should immediately discuss the matter with their supervisor.

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

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

See DHS Policy 740, the DHS Human Resources Operations Section, or DHS Compliance Division for more information.
DHS is committed to fostering positive relationships with our labor partners. There are 18 unions representing LA County workforce members. In 2015, The Alliance for Health Integration (Department of Health Services, Department of Public Health, and Department of Mental Health) partnered with several unions to create the Labor Management Transformation Council (LMTC). The County’s unique partnerships with our labor partner strengthens staff involvement and brings positive change to DHS.

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

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

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

There are several unions that represent County employees, including those that are part of the Coalition of County Unions, independent unions, and SEIU. Most DHS employees are represented by SEIU Local 721; other labor unions include, but are not limited to, AFSCME, and UAPD. County positions are divided into different categories of Bargaining Units. These Bargaining Units correlate with a specific labor union. Check the profile on your timesheet to determine your Bargaining Unit. New staff will be given information on the union representing their classification, if any, upon hire. If you have questions, please contact your supervisor/manager or the local HR office.
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<th>Labor Union</th>
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<tr>
<td>Service Employees International Union (SEIU) Local 721</td>
<td>1545 Wilshire Boulevard, Suite 100, Los Angeles, CA 90017 (213) 368-8660</td>
<td><a href="https://www.seiu721.org/">https://www.seiu721.org/</a></td>
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<td>American Federation of State, County, and Municipal Employees (AFSCME)</td>
<td>514 Shatto Place, Los Angeles, CA 90020 (213) 252-1350</td>
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<td>Coalition of County Unions (CCU)</td>
<td>3018 East Colorado Blvd, Ste. 200, Pasadena, CA 91107 (626) 458-6358 (626) 243-0340</td>
<td><a href="https://capeunion.org/">https://capeunion.org/</a></td>
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<tr>
<td>California Association of Professional Employees, MEBA, AFL-CIO (CAPE)</td>
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<tr>
<td>Bargaining Units: 501, 502, 511, 512</td>
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<tr>
<td>Coalition of County Unions, Los Angeles County Building &amp; Construction</td>
<td>1626 Beverly Boulevard, Los Angeles, CA 90026 (213) 483-4222</td>
<td><a href="http://laocbuildingtrades.org/">http://laocbuildingtrades.org/</a></td>
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<tr>
<td>Trades Council, AFL-CIO (BCTC)</td>
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<td>Bargaining Units: 411, 412</td>
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<tr>
<td>Coalition of County Unions, International Union of Operating Engineers,</td>
<td>2405 West Third Street, Los Angeles, CA 90057 (213) 385-1561, Ext. 113 (310) 403-8094</td>
<td><a href="https://local501.org/ca/">https://local501.org/ca/</a></td>
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<tr>
<td>Local 501, AFL-CIO, (IUOE)</td>
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<td>Bargaining Units: 401, 412</td>
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<tr>
<td>Coalition of County Unions (CCU)</td>
<td>1545 Wilshire Blvd, Suite 608, Los Angeles, CA 90017 (213) 494-6868</td>
<td><a href="https://www.cirseiu.org/">https://www.cirseiu.org/</a></td>
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<tr>
<td>Committee of Interns &amp; Residents (CIR)-SEIU</td>
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<tr>
<td>Bargaining Unit: 323</td>
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<tr>
<td>Coalition of County Unions (CCU)</td>
<td>316 W. 2nd Street Ste. 500, Los Angeles, CA 90012 (800) 504-8273 (310) 398-4038</td>
<td><a href="https://www.uapd.com/">https://www.uapd.com/</a></td>
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<tr>
<td>Union of American Physicians and Dentists (UAPD), AFSCME, AFL-CIO</td>
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<tr>
<td>Bargaining Units: 301, 324, 325</td>
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<tr>
<td>Teamsters Local 911</td>
<td>9900 Flower Street, Bellflower, CA 90706 (562) 595-4518</td>
<td><a href="http://www.teamsters911.com/">http://www.teamsters911.com/</a></td>
</tr>
<tr>
<td>Public, Prof., &amp; Medical Employees Union</td>
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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 both internal and external customers. To that end, we strive to maintain the highest standards in customer service. Our Customer Service 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.
- Build on the strengths of families and communities.

**SERVICE ACCESS**

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

- Providing service as promptly as possible.
- Providing clear directions and service information.
- Reaching out to the community to promote available services.
- Involving families in service plan development.
- Following-up to ensure appropriate delivery of services.

**SERVICE ENVIRONMENT**

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

- Report any unsafe conditions to your supervisor or the Safety Officer.
- Ensure a professional atmosphere.
- Display vision, missions, and values statements.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers.
- Post complaint and appeal procedures.

**CORE COMPETENCIES**

**WORKFORCE MEMBER ESSENTIAL FUNCTIONS (CORE COMPETENCIES)**

Customer Relations: Demonstrate respect, empathy and regard for the dignity of all patients, families, visitors, and all workforce members to ensure a professional, responsible, and courteous environment.
Performance Criteria

1. Interact with others in a professional, responsible and courteous manner.
2. Maintain professional composure and confidence during stressful situations.
3. Maintain confidentiality of all hospital and patient information according to HIPAA. Protect patients’ privacy at all times.
4. Present a neat appearance and wear proper attire and identification as required by the position and policy.
5. Display a positive, compassionate, responsive and caring attitude.
6. Respect and respond to the diversity of the customers.
7. Hold self accountable for meeting customer service standards.

MANAGEMENT ESSENTIAL FUNCTIONS (CORE COMPETENCIES)

Customer Relations: Foster a sound customer service philosophy through role modeling, education, coaching and feedback.

Performance Criteria

1. Communicate and clarify customer service goals and performance expectations in department.
2. Monitor and measure performance according to established customer service standards.
3. Coach and manage performance through role modeling, reward and recognition, and established DHS Human Resources Employee Discipline Guidelines.
4. Hold self and staff accountable for meeting patient/customer service standards.

Please refer to Olive View Policy, Customer Service Standards, and the Core Competencies for more information.

TEAMWORK

The essential element in a healthcare 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 settings, including formal (as in a meeting), informal (as in a hallway), two-way or multi-way (as in a group). Ineffective communication can lead to failed patient outcomes (patient harm, pain), medical errors, increased medical and malpractice costs, reduced patient trust, decreased staff satisfaction and retention, and poor productivity and motivation. Barriers to effective communication which include language, age, skill level, poor listening and verbal skills, negative attitudes, time constraints, cultural differences, etc. can lead to misperception, inaccurate messages, embarrassment and failed outcomes. Good communication skills can be learned, practiced, and continuously improved.

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

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

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

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

**KEY POINT**

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

**PRINCIPLES OF INTERDISCIPLINARY COLLABORATION**

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

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

**Example 1:** A Physical Therapist schedules to see the patient at 9:00 a.m. When she/he 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.

**Example 2:** 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.

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

**COORDINATION OF CARE**

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

- Increased conflicts between team members about a patient’s care treatment and services.
- Compromised patient health and safety.
- Confusion among team members about what is expected of them and what they can expect from others.
- Crises caused by false assumptions that someone else is responsible for handling the patient’s care or treatment.
- Patient care decisions being carried out in a delayed or ineffective manner.
Communication and accurate documentation of services between disciplines is the key to providing effective coordination of care. Up-to-date information about a patient’s care, treatment or services, condition, expected outcomes and anticipated changes must be maintained to ensure appropriate care of the patient. Effective coordination of care makes it possible for patients to feel secure in the knowledge that they are receiving appropriate and timely care. This is a necessary part of the process of developing patient trust.

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

CONFLICT RESOLUTION THROUGH TEAM BUILDING

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

• Learn to respect the ideas, suggestions, processes, and contributions of all members of the team, however varied and diverse. For example, physicians, pharmacists, nurses, social workers, and psychologists have been educated to view and process problems in various ways. Each one may have a unique and different perspective on the problem.
• Acknowledge and appreciate other disciplines’ processes and contributions to ensure that thorough and complete care planning is patient-focused, family-focused, and outcome oriented.
• Minimize competition. Each party should feel a sense of contribution to the care plan and the resolution of patient care issues.
• Ask and respond to questions in a respectful manner, based on the premise that additional exploration of issues is an important method to enhance knowledge and foster collaboration between team members to provide the best possible patient care.
• Evaluate the facts of the situation and make a determination of the problem.
• Promote open dialogue and allow all voices to be heard in the exploration of appropriate methods to resolve problems and issues.
• Keep an open mind and listen to the idea or suggestion being presented. Explore all options before discarding them.
• When discussing problems remember, the problem is not the person. Separate the person from the equation so that the problem is the focus.
During an accreditation survey, The Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-centered and organizational functions that support the safety and quality of care, treatment, and services. The assessment is accomplished through evaluating an organization’s compliance to applicable Joint Commission standards, based on the following activities and information:

- Tracing the care, treatment, and services delivered to the patient
- Verbal and written information provided to The Joint Commission
- On-site observations and interviews by The Joint Commission surveyors
- Review of documents provided by the organization

The Joint Commission’s accreditation process seeks to help organizations identify and correct problems and improve the safety and quality of care, treatment, and services provided.

When The Joint Commission surveyors visit our facilities, they will spend 60 – 70% of their time tracing the delivery of patient care throughout the facility in what is known as a tracer. This means the surveyors will select specific inpatients and review their medical records to determine the services each patient received during their hospitalization. By tracing the course of care and services experienced by the patient (a real time review), the surveyors will interact with direct care providers and/or other applicable workforce members to determine the relationship among departments involved in the care, the integration and coordination of important processes, opportunities for improvement and education (as appropriate) and validation of findings through review of additional records. The surveyors will observe:

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

**KEY POINT**

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

**ACCREDITATION PARTICIPATION REQUIREMENTS**

Under The Joint Commission’s Accreditation Participation Requirements, any workforce member who has concerns about the safety or quality of care provided in the organization may report those concerns to The Joint Commission. Safety or quality of care concerns/complaints may be made through the workforce member’s supervisor, the facility Risk Manager, and/or the DHS Quality Improvement and Patient Safety Division at (213) 288-7233 (SAFE). Olive View will not take disciplinary action against a workforce member for making a good faith report. However, any workforce member who deliberately makes a false accusation will be subject to discipline/release of assignment. Workforce members may also contact The Joint Commission with their concerns in the following manner:

- **Online:** [https://www.jointcommission.org/report_a_complaint.aspx](https://www.jointcommission.org/report_a_complaint.aspx)
- **Mailing Address:**
  - Office of Quality and Patient Safety
  - The Joint Commission
  - One Renaissance Boulevard
  - Oakbrook Terrace, IL  60181
Olive View is dedicated to providing the highest quality care in the safest environment. We are committed to creating a culture where:

- Members of our staff feel encouraged and supported to identify and report safety issues. This includes ideas on how we can improve.
- We acknowledge that errors in healthcare occur.
- We view mistakes as opportunities to learn and identify system failures.
- We focus on designing or re-designing systems that make it harder to make mistakes.
- We partner with our patients and families and appreciate their active participation in making their care as safe as possible.

We have a proactive, multifaceted, and integrated Patient Safety Program. The goal of the program is to be proactive and prevent adverse occurrences rather than just react to them. The Patient Safety Committee is a multidisciplinary group providing leadership and direction to the program and for all safety initiatives.

YOUR RESPONSIBILITY

You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental condition, or "near miss" that causes you concern for the safety of patients, visitors, or staff as soon as possible. You can report safety concerns anonymously.

It is also your responsibility to follow Olive View’s policies and procedures regarding the National Patient Safety Goals (see the National Patient Safety Goals section of this handbook).

WAYS YOU CAN REPORT SAFETY INCIDENTS

You may report events by completing an event notification via the Safety Intelligence™ (SI) Event Reporting System located on Olive View’s intranet site.

You may call:

- Hospital Risk Manager’s Office
- Medical Administration
- Patient Safety Officer
- Employee Health Services

WAYS YOU CAN STAY UPDATED ON PATIENT SAFETY INITIATIVES

One of the ways you can keep updated is by reading the Patient Safety Goals posted in each unit.

Other ways to stay current include reviewing the poster presentations of important safety information posted in each unit, participating in patient safety discussions in your unit staff meetings, attending the hospital-wide Daily Operational Safety and Executive (DOSE) Brief, and attending hospital-sponsored educational presentations.

WAYS YOU CAN MAKE SUGGESTIONS REGARDING PATIENT SAFETY

You can give your supervisor any safety suggestions you have or you can share them directly with the Patient Safety Officer or Patient Safety Coordinator.
WAYS YOU CAN INVOLVE PATIENTS AND THEIR FAMILIES IN SAFETY

Olive View provides patients with a Patient Information Handbook to encourage them to participate in making their care as safe as possible. The following are some of the tips shared with patients in the handbook and what you need to know:

- **Olive View encourages patients to know who is in charge of their care.**
  - Always introduce yourself to patients and their families and wear your hospital ID badge at all times while on duty. Wear your badge on the outermost garment, at chest level or above, with your photo, name and position/title visible.

- **Olive View instructs patients about their medications.**
  - Always tell patients the name of the medication(s) you administer, what it is for and the possible side effects.
  - Always check the patient’s ID band for name and date of birth (name and Olive View Number for minors) to confirm the patient’s identity even if you are already familiar with the patient.

- **Olive View instructs patients to speak up if they have questions or concerns.**
  - Your patients have the right to know about their care and question any member of the care team. For example, Olive View instructs patients on the importance of hand washing. Don’t be surprised or offended if a patient asks you if you have washed your hands. Remember, he/she may not have seen you do it!

- **Olive View instructs patients to ask about their test results.**
  - Always refer their questions to the appropriate caregiver.

- **Olive View also instructs patients that, if they need surgery, they should make sure that all the caregivers involved agree on what is to be done.**
  - Always include your patients in all pre-procedure verification checks and encourage their participation in marking the surgical site. (See the Time-Out process section of this handbook)

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 for reckless, dangerous behaviors and appropriate corrective action taken, even if no patient has been harmed. Actions will be consistent with Just Culture principles, AND with 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 of how we can improve.
- Acknowledging that errors in healthcare occur and provide a supportive environment for the staff should an error occur.
- Viewing mistakes as opportunities to learn and then identify system failures.
- Focusing on designing/re-designing systems that will ultimately prevent mistakes.
- Partnering with patients and their families and letting them know how much we appreciate their active participation in making their care as safe as possible.
Our lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patient population has historically experienced discrimination on many levels which have directly contributed to identifiable and disproportionately high health disparities. Unfortunately, this discrimination is experienced by the LGBTQ+ community while accessing and receiving healthcare as well. Olive View-UCLA Medical Center is committed to providing equitable and inclusive care without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

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

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

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

KEY POINT
Our LGBTQ Committee promotes equity through education, community engagement, enforcement of inclusion policies, and facilitates a safe and welcoming environment for all.
The Joint Commission accredited healthcare organizations are surveyed for the implementation of the National Patient Safety Goals (NPSGs). The Joint Commission approved the first set of NPSGs in July 2002 with specific requirements for improving the safety of patient care in healthcare organizations. The expectation is that the NPSGs or acceptable alternatives are implemented. Patient Safety initiatives are based on meeting the NPSGs, and focusing on system-wide solutions. County workforce members are required to comply with the NPSGs. Each workforce member should be knowledgeable of the NPSGs and how to directly apply them to their service unit.

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

- **Healthcare Organization**
- **Identify Patients Correctly**
  - NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

- ** Improve Staff Communication**
  - NPSG.02.03.01 Get important test results to the right staff person on time.

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

- **Use Alarms Safely**
  - NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

- **Prevent Infection**
  - NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

- **Identify Patient Safety Risks**
  - NPSG.15.01.01 Reduce the risk for suicide.

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

The exact language of the National Patient Safety Goals can be found at [www.jointcommission.org](http://www.jointcommission.org)

**KEY POINT**

You are responsible for reviewing and complying with the current NPSGs that are applicable to your duties.
RESPONDING TO 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 hospital/patient care area may at times notice a patient/visitor who does not seem to be doing well. What do you do if a patient/visitor appears to you to have fallen, is having trouble breathing, appears unconscious, or is behaving strangely? If you notice a patient/visitor whom you believe is in distress or a state of medical emergency, there are facility-specific actions you should take. All Workforce Members should be aware of how to seek medical assistance.

If you are in a patient care area, always 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.

- Rapid Response Team (RRT): The team that is available 24-hours per day, 7 days a week to respond to urgent clinical patient situation.
- Code Assist Team: The team that is available 24-hours per day, 7 days a week to respond to urgent clinical situations that occur in non-clinical area of the First and Second Floor Lobbies, the adjacent patient loading zones, and Parking Lot I.

Registered Nurses in the areas covered by the Rapid Response Team and Code Assist Team have been trained in how and when to activate the teams. This is why notification of the patient’s nurse is the first step in getting assistance for a person who is in possible distress. In non-patient areas, anyone can call a code blue or code assist in response to a patient, visitor or employee in distress by calling Ext. 114. At Olive View-UCLA Medical Center it is important that you know that anyone can call for emergency medical assistance:

<table>
<thead>
<tr>
<th>Code Rapid Response</th>
<th>Ext. 114</th>
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<tbody>
<tr>
<td>Code Assist (1st &amp; 2nd Floor lobbies, adjacent patient loading zones and Parking Lot I only)</td>
<td>Ext. 114</td>
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</tbody>
</table>

If a medical emergency occurs outside the main hospital building (e.g. buildings other than the main hospital, parking lots, adjacent streets or areas near the facility, etc.), call x111 from a campus phone or from a cellular phone call (747) 210-1555 and ask the Operator to call 9-1-1. If you encounter a situation that you feel requires emergency assistance then you should always act on it by calling for help!

OLIVE VIEW-UCLA MEDICAL CENTER:

<table>
<thead>
<tr>
<th>Code Blue: Adult Medical Emergency</th>
<th>Ext. 114</th>
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<tbody>
<tr>
<td>Code Rapid Response: Urgent Medical Attention to Inpatients</td>
<td>Ext. 114</td>
</tr>
<tr>
<td>Code Assist (1st &amp; 2nd Floor lobbies and adjacent patient loading zones, Parking Lot H &amp; I, MRI &amp; Mobile PET/CT)</td>
<td>Ext. 114</td>
</tr>
<tr>
<td>Medical emergencies outside the main hospital</td>
<td>Ext. 114</td>
</tr>
</tbody>
</table>
Prevention of patient falls is the responsibility of EVERY workforce member.

A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, such as a trash can or piece of other equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient’s descent to the floor or by breaking the patient’s fall. You may encounter visitors, registered or unregistered patients, and staff who may have fallen and are in need of assistance.

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

PREVENTION

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

- **Identifying and Eliminating Hazards**: If you see a hazard and you can fix the hazard (e.g. a water/liquid spill), do so. If you can’t fix the hazard, promptly notify the proper department, maintenance worker, clinician, and/or area supervisor; according to your facility protocols. Try to secure the area to avoid a potential fall victim.

- **Environmental risks and hazards** Include: Wet or slippery floors, spills, debris, clutter, obstructions, stairs, change in surfaces, rugs/floor mats, extension cords, power cords of equipment in use or not in use, ladders, etc.

- **Physical/Cognitive Risks**: The elderly and the very young make up the highest percentage of fall victims. Some factors that contribute to fall risk for elderly are: medication usage, confusion, unsteady gait, declined hearing and vision. Some factors that contribute to fall risk for children are: running, climbing, jumping, illness or injury.

- **Fall Risk Communication**: Communicating potential hazards anywhere on campus to the correct people in a timely manner can keep staff, visitors, and patients safe from falls and injuries and provide a safer, healthier environment. When a patient is identified as high risk for falls, the nursing staff will place them on “fall risk” alert. Nursing staff might place a sign on the door or wall alerting staff to the patient’s fall risk, and have the patient wear a wristband or some other modality based on the facility protocols. We must use precautions to prevent patient falls.

**TIPS FOR PREVENTING FALLS**

**Environmental**

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

**Inpatients**

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

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

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

Process for Obtaining Medical Assistance

1. Notify your supervisor/manager.
3. Document the incident via the Safety Intelligence™ (SI) Event Reporting System and follow other reporting procedures.

Report environmental hazards to Facilities Management at x74900 (after hours/weekends x74100) or the Safety Office at x73405. Safety concerns/complaints may be made through the workforce member’s supervisor, department/unit Safety Coordinator, Safety Officer, Risk Manager, and/or the DHS Quality Improvement and Patient Safety Division (213) 288-7233 (SAFE).

In order to monitor, measure, and analyze conditions associated with falls, it is critical that you report **ALL** falls. If you encounter, witness a fall, help or assist someone whom has fallen; follow the facility’s reporting process (or immediately notify your supervisor) so conditions associated with falls can be corrected and documented. **Falls are to be reported in the Safety Intelligence™ (SI) Event Reporting System located on Olive View’s intranet site.** Patterns and risks leading to falls can be identified and processes can be developed to improve the safety of the environment. Workforce members without access to the Safety Intelligence™ (SI) Event Reporting System should report falls to their supervisor, or the facility Risk Manager, Patient Advocate, or Patient Safety Officer.

ELIMINATING OCCUPATIONAL HAZARDS

Worksite hazards need to be identified and eliminated to improve occupational safety. From parking lots, to your work area/unit, we can all improve occupational safety by being **AWARE** of the surroundings. Workforce member exposure to wet floors or spills and clutter can lead to slips/trips/falls and other possible injuries. Workforce members can reduce or eliminate these hazards by following these tips for providing a safe environment.

**Tips for a Safer Workplace Environment**

- Keep exits free from obstruction. Keep floors clean and dry. Access to exits, hallways and walkways must remain clear of obstructions at all times.
- Where wet processes are used, maintain drainage, and wear appropriate footwear.
- Provide warning signs for wet floor areas if you encounter them or are cleaning them. Also, in addition to being a slip hazard, wet surfaces promote the growth of bacteria that can cause infections.
- Use the handrail on stairs, avoid undue speed, and maintain an unobstructed view of the steps ahead.
- Use adequate lighting especially during night hours. Use flashlights or low-level lighting when entering patient rooms.
- Ensure spills are reported and cleaned up immediately.
- Be extra cautious in slippery areas such as toilet and shower areas, and outside areas, especially in the rain.
- Use only properly maintained ladders to reach items. Do not use stools, chairs, or boxes as substitutes for ladders.

BE A GOOD SAMARITAN

If you encounter a co-worker who looks as though he/she needs assistance (e.g., co-worker carrying an unstable load, or following unsafe practices), offer him/her assistance to eliminate potential falls or injury. If you see a person with a disability struggling to get out of the car, to stand up, or in apparent need of assistance, you should respectfully offer to help.
The 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.

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 stands for Suicide Assessment Five-step Evaluation and Triage. 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.
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.

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

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

**Additional Resources**

- Suicide & Crisis Lifeline 988
- Mental Health Environment of Care Checklist from the U.S. Department of Veterans Affairs [https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp](https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp)

**KEY POINT**

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

References:

- SAFE-T Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals. (2009). Education Development Center, Inc. and Screening for Mental Health, Inc.
This section explains Olive View’s patient rights and services such as interpreter services, the Chaplaincy Program, Advance Health Care Directives, Americans with Disabilities Act, Service Animals, organ/tissue donation, and EMTALA.

PATIENTS’ RIGHTS

To ensure that our patients’ rights are protected, Olive View has a Patients’ Rights and Organizational Ethics Committee. This committee is multi-disciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises Olive View staff concerning such issues related to patient care decisions, and offers consults to Olive View departments. If a staff member feels there is an ethical issue related to the patient, they should request an ethics consult by calling the Hospital Operator and requesting the Bioethics Point Person.

Patients of Olive View have both rights and responsibilities. Each patient is given a Patient Information Handbook upon admission. The Patient Rights are printed on the back of the Conditions of Admission. Patients who are not admitted through the Admitting Office are provided a Patient Information Handbook by the nursing staff in the unit. In addition, Olive View has posted these rights and responsibilities throughout the hospital to inform patients and our staff.

- Olive View Patients’ Rights and Responsibilities are posted throughout the hospital for reference.
- An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their healthcare decisions.
- The AHCD allows a person to give directives regarding healthcare decisions, such as whether or not they want life-sustaining treatment should they become terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so.
- Olive View admissions staff informs patients of their options concerning AHCD’s.
- Patients can fill out an AHCD document or give oral direction to a physician who will document it in the patient’s medical record.
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Customer Services Department. Staff is available to help customers Monday through Friday between 8:00 a.m. and 4:30 p.m.

Patients may also express concerns to any of the following agencies:

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

Institute for Medical Quality  
180 Howard Street, Suite 210  
San Francisco, CA  94105  
Phone: (415) 882-5151  
E-mail: liacopi@imq.org

U.S. Department of Health and Human Services  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-12-25  
Baltimore, Maryland 21244-1850  
(800) 633-4227

California Department of Public Health  
 Licensing and Certification  
Information Hotline: (800) 228-1019
The Customer Service Department helps ensure that we are protecting our patients’ rights. If a patient, family member or visitor comes to you with a complaint about any part of his/her hospital visit, make every attempt to resolve the issue or refer them to your supervisor. If the problem cannot be resolved in your department or if the problem is not related to your department, call the Customer Service Department at (747) 210-4883 or send the person to Room 2A103 on the second floor.

Patients, family members, and visitors can make verbal and written complaints. If you or the patient/family believes the patient’s rights are being violated, the Grievance Coordinator will help resolve the problem.

After regular business hours of 8:00 a.m. to 5:00 p.m., weekends and holidays, please ask for the Nursing Shift Supervisor to resolve any patient complaints.

As the Los Angeles County Department of Health Services, it is our responsibility to offer and provide meaningful access to qualified interpreter services, including Sign Language, for our deaf, or hard-of-hearing, Limited English Proficient (LEP) and non-English speaking patients 24 hours a day, 7 days a week, so they can meaningfully participate in their own care. These required services are to be provided free of charge, accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. Section 1557 of the Affordable Care Act, provides the following specific guidance.


**SERVICES MUST BE PROVIDED BY AN INTERPRETER OR TRANSLATOR WHO:**

A. Adheres to generally accepted interpreter ethics principles, including client confidentiality;

B. Has demonstrated proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation or has demonstrated proficiency in writing and understanding at least written English and the written language in need of translation; and

C. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

**Guidelines on use of accompanying adult or minor:** Section 1557 restricts use of certain persons to interpret or facilitate communication. If an entity is required to provide language services, such entity shall not:

A. Require an individual with limited English proficiency to provide his or her own interpreter;

B. Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except
   
   i. In an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no qualified interpreter for the individual with limited English proficiency immediately available; or
   
   ii. Where the individual with limited English proficiency, or a deaf or hard-of-hearing patient, specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;*

   C. Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no qualified interpreter for the individual with limited English proficiency immediately available; or

   D. Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
“Relying on untrained individuals as interpreters is more likely to result in misinterpretation, lower quality of care, or could even contribute to an adverse event. Untrained individuals—including family members, friends, other patients, or untrained bilingual staff—should not be used to provide language access services during medical encounters.”
(Source: http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf, Pg. 58)

* Under Option (B)(ii) above, if after being offered qualified interpretation services at no cost by DHS, a patient still specifically requests to utilize an accompanying adult to interpret, and reliance on that adult for such assistance is appropriate under the circumstances, the request and permission to utilize the accompanying adult needs to be documented. The patient’s request and permission to utilize an accompanying adult can only be attained through the documented use of one of the following:

1. Professionally qualified healthcare interpreter (including Sign Language Interpreter); OR
2. Qualified bilingual staff; OR
3. With the patient’s expressed written permission which will be placed in the medical record

Without the expressed written attestation of the patient or through the use of a qualified healthcare interpreter or qualified bilingual staff, a family member or friend cannot indicate patient consent for the family member or friend to interpret. The exception to this requirement is in case of emergency where any delay in providing immediate services to the individual could have life-altering or life-ending consequences, or is necessary to alleviate severe pain. The form, entitled “HS-1001 Interpreter Attestation During Informed Consent” must be completed and signed, appropriately. If the patient requests to use a family member or another person for interpretation, document in the medical record, the request, how permission was attained, and the name of the person serving as the interpreter.

**HOW TO REQUEST AN INTERPRETER:**

First, verify that the patient’s preferred language is documented accurately in the Electronic Health Record (EHR).

There are a number of ways to access services:

- Face-to-Face Interpreting Services
- Video Medical Interpretation (VMI) Services including American Sign Language Interpreting Services (ASL)
- 24-Hour Telephonic Interpreting Services
- California Relay Service (CRS)

Arrangements can be made through your facility Language Center for an on-site face-to-face qualified Healthcare Interpreter (HCI) if needed for the patient visit. 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.

Refer to the laminated cards on the Video Medical Interpreter (VMI) equipment and other interpreter equipment for details regarding VMI and telephonic interpreter services. If not available, call the Language Center at 747-210-3411.

- Video Medical Interpretation (VMI) devices can be utilized to access interpreters (including Sign Language) any day or time. This service will automatically convert to telephone (audio only) if the requested interpreter is not available by video connection.
- If the call is urgent and requires immediate interpretation, or to access an “over-the-phone” interpreter for any language at any day or time, dial extension 73298 from any in-house phone. The operators of this service will request your Employee ID number and Department Name.
- To reach an interpreter for any language (including Sign Language), call the Language Center at 747-210-3411 during business hours from 8:00 a.m. to 4:30 p.m.
- Call the Language Center at 747-210-3411 to obtain information about the following:
  - TTY (teletypewriter) Devices or the California Relay Service available for the deaf, hard of hearing or speech disabled patients.
  - Public TTY/TDD machines/pay phones located at various locations.
  - Speech to Speech (STS) for patients with speech disabilities.
- For questions concerning interpreting or written translation, call the Language Center at 747-210-3411.
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 Section 1557 must provide information in a culturally and linguistically appropriate manner in order to comply with the relevant anti-discrimination provisions of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.**

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

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

**KNOW THE RIGHTS THAT PROTECT INDIVIDUALS WITH DISABILITIES FROM DISCRIMINATION**

**US HHS Office for Civil Rights Commemorates the Americans with Disabilities Act’s 30th Anniversary:**

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

**What is Section 504?**

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

**What is Title II of the Americans with Disabilities Act?**

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

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

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

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

DHS:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

To access language access services, contact your local DHS facility’s “Interpreter Services / Language Center”.

REMEMBER
Speak directly to the patient, not to the interpreter, and remember the policies and procedures. Be careful not to break confidentiality.
# How to Request Interpreter Services

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</tr>
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| Video Medical Interpretation (VMI) Services including American Sign Language Interpreting Services (ASL) |
| Refer to the laminated cards on the Video Medical Interpreter (VMI) equipment and other interpreter equipment for details regarding VMI and telephonic interpreter services. If not available, call the Language Center at 747-210-3411. Video Medical Interpretation (VMI) devices can be utilized to access interpreters (including Sign Language) any day or time. This service will automatically convert to telephone (audio only) if the requested interpreter is not available by video connection. |

| 24-Hour Telephonic Interpreting Services |
| If the call is urgent and requires immediate interpretation, or to access an “over-the-phone” interpreter for any language at any day or time, dial extension 73298 from any in-house phone. The operators of this service will request your Employee ID number and Department Name. |

| TTY or CRS |
| Call the Language Center at 747-210-3411 to obtain information about the following:  
- TTY (teletypewriter) Devices or the California Relay Service is available for the deaf, hard of hearing or speech disabled patients.  
- Public TTY/TDD machines/pay phones are located at various locations.  
- Speech to Speech (STS) for patients with speech disabilities. |
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 Fiscal Year 2019 - 20**

- **Total Patient Visits**: 2,536,334
- **Patients with LEP Skills**: 1,355,364
- **Unique Patients**: 447,789
- **English Speaking**: 53%
- **Non-English Speaking**: 47%
- **140 Non-English Languages**
- **Top 12 Languages**
  - Spanish
  - Korean
  - Armenian
  - Tagalog
  - Mandarin
  - Cantonese
  - Vietnamese
  - Russian
  - Arabic
  - Thai
  - Farsi
  - Khmer (Cambodian)

**Spiritual Needs of Patients**

The Chaplaincy Program at Olive View provides for the spiritual health and well-being of the patients, their families, friends and staff through active listening and prayer. We seek to promote wellness and comfort for those desiring the services of our interdenominational volunteer Chaplains. If the patients or their families so desire, the chaplains will call for a minister of their choice. A “clergy call list” is at each nursing station and offices of administration. Our Chaplains minister to all patients, their family members, friends and hospital staff, regardless of their religious preference.

Referrals to the Chaplaincy Program or specific sacramental requests may be made by contacting the Pastoral Services Department at (747) 210-3080. Olive View Chaplains are usually available Monday through Friday from 9:30 a.m. to 4:30 p.m. The Pastoral Services office is located at 1D142, across from Volunteer Services. The Hospital Chapel is located at 1D145.
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. Olive View Nursing Staff is responsible for informing patients of their options regarding an AHCD. A patient can also give an AHCD verbally to a physician who will document it in the patient's medical record. Staff MUST ensure a copy of the AHCD is in the medical record.

If you are directly involved in the care of a patient who wishes to execute an AHCD, or to discuss this option, please contact the Hospital Social Work Department at (747) 210-4236 or the patient's physician. Remember patients who are of sound mind can change their minds at any time regarding AHCDs.

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

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

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

A patient has the right to not participate in any program or service designed specifically for persons with disabilities. DHS has adopted an informal complaint procedure to investigate and resolve general complaints that allege DHS has not complied with the ADA. Patients may address concerns regarding access to services or reasonable accommodations to their care provider, the facility Patient 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 animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals. The work or tasks performed by a service animal must be directly related to the handler's disability. Examples of work or tasks include, but are 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, and thus are not confirmation of service animal designation. **Service animals are working animals, not pets.**
A sight-impaired individual who is allergic to dogs may use a miniature horse (generally range in height from 24 inches to 34 inches and generally weigh between 70 and 100 pounds). However, the miniature horse must be trained to provide assistance to the individual with a disability and must be house broken.

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

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

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

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

INTRODUCTION

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

IMPORTANCE OF EXCLUSIVE BREASTFEEDING

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

WHY BREASTFEEDING MAKES A DIFFERENCE

Breastfeeding offers an unmatched beginning for our children

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

Mothers who choose to breastfeed are healthier

Recent studies show that women who breastfeed enjoy lower risks of breast and ovarian cancer, anemia, and osteoporosis.

Families who breastfeed save money

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

Communities reap the benefits of breastfeeding

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

The environment benefits when babies are breastfed

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

OLIVE VIEW-UCLA MEDICAL CENTER RECEIVES BABY FRIENDLY DESIGNATION

In July 2011, Olive View Medical Center became one of the first facilities in the nation to receive from Baby-Friendly USA the prestigious international recognition as a Baby-Friendly® birth facility. Olive View has since received redesignation through 2021.

ORGAN/TISSUE DONATION

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

• Ventilated patients (with a devastating injury/illness)
  • With a loss of one or more brainstem reflexes, and/or
  • Initiating discussion for end of life care (withdrawal of life support and changes in “Do Not Resuscitate” DNR status)
• All cardiac deaths

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

**REMEMBER**

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

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

EMTALA Statute: 42 USC 1395 dd. Examination and treatment for emergency medical conditions and women in labor; also known as Section 1867 of the Social Security Act; also known as Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985. Common names: COBRA, EMTALA, Anti-dumping law.

**EMTALA contains two basic requirements:**

1. For any person who comes to a hospital emergency department, “the hospital must provide for an appropriate medical screening examination…to determine whether or not an emergency medical condition exists” (see 42 USC Section 1395dd(a)).
2. If the screening examination reveals an emergency medical condition, the hospital must “stabilize the medical condition” before transferring or discharging the patient.

**MEDICAL SCREENING EXAM**

Any person requesting emergency services, who presents to a facility that provides emergency services, must receive a medical screening exam (MSE). This includes a woman in labor and her unborn child, and psychiatric emergencies. The purpose of the MSE is to identify whether an emergency medical condition (EMC) exists. This request can come from the patient, someone accompanying the patient, a law enforcement officer bringing someone to the ED, or someone walking into the ED requesting a blood pressure check.

If the MSE reveals an emergency medical condition, it is the obligation of the treating hospital to stabilize the patient prior to discharge or transfer.

EMTALA compliance is regulated by the CMS, a division of the Department of Health and Human Services (HHS). There are significant financial consequences for violating EMTALA rules. A hospital and/or the responsible physician may face individual fines imposed by the government as well as civil damages claims. Additionally, the hospital can be excluded from participating in the Medicare program, which may be financially devastating. It is imperative that ED physicians and staff be fully aware of their obligations under EMTALA regulations.

**ENFORCEMENT**

EMTALA legislation is enforced by CMS. A hospital that has more than 100 beds may be fined up to $50,000 per violation, and a hospital with fewer than 100 beds may be fined up to $25,000 per violation. Individual physicians may be fined as well, including on-call physicians who fail to appear. On-call physicians who request that an unstable patient be transferred when the risk of transfer outweighs the benefit may also be fined. Ultimately, a hospital may have its Medicare provider agreement revoked in response to EMTALA violation.
HUMAN TRAFFICKING

Effective April 1, 2013, SB 1193, Chapter 515, Statutes of 2013 added Section 52.6 to the Civil Code, regarding Human Trafficking; it requires posting of public notice in prominent areas or near the entrance, in clear view of the public and employees. The postings shall be printed in English, Spanish, and one other prevalent language widely spoken in the county where the facility is located. The posted notice will provide resource information regarding where the victim can obtain help. The liability for business or establishment failing to comply with the requirements of this section, results in a penalty of $500 for the first offense and $1000 for each subsequent offense. The following resource numbers will be included on the posted public notice:

National Human Trafficking Resource Center: 1-888-373-7888 or [https://humantraffickinghotline.org/](https://humantraffickinghotline.org/)

The California Coalition to Abolish Slavery and Trafficking (CAST): 1-888-KEY-2-FREE(888-539-2373) or [https://www.castla.org/](https://www.castla.org/)

DEFINITION: The United Nations Office on Drugs and Crimes (UNODC) defines Trafficking in Persons as the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, or the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs. (Article 3, paragraph (a) of the [Protocol to Prevent, Suppress and Punish Trafficking in Persons](https://www.unodc.org/)).

IF YOU SEE SOMETHING, SAY SOMETHING

If you or someone you know is being forced to engage in any activity and cannot leave -- whether it is commercial sex, housework, farm work, construction, factory, retail, or restaurant work, or any other activity -- call the National Human Trafficking Resource Center at 1-888-272-7888 or the California Coalition to Abolish Slavery and Trafficking (CAST) at 1-888-KEY-2-FRE(EDOM) or 1-888-539-2373 to access help and services.

Victims of slavery and human trafficking are protected under United States and California law.

The hotlines are:

- Available 24 hours a day, 7 days a week.
- Toll-Free.
- Operated by nonprofit, nongovernmental organizations.
- Anonymous and confidential.
- Accessible in more than 160 languages.
- Able to provide help, referral services, training, and general information.
This section describes the requirements for a safe patient care environment. Included are descriptions of the Olive View Environmental Health and Safety Program; hospital emergency codes; security procedures; safety awareness; and policies and procedures concerning bomb threats, workplace violence, hazardous materials, emergency preparedness and management, fire/life safety, work-related injuries, injury and illness prevention, and body mechanics and ergonomics.

It is our ongoing priority here at Olive View to provide a safe environment for our patients, visitors and workforce members. Our Safety Program looks for and identifies hazards through surveillance rounds and data collection. The Safety Officer investigates all identified hazards. All findings are reported and evaluated by the Environment of Care Committee. Address any concerns you have regarding safety to your supervisor or the Safety Officer at (747) 210-3405 or email ovmc.safetyhotline@dhs.lacounty.gov.

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
- Ensuring machinery guards are in place to protect against harmful moving parts
- Using ladders/step stools only on level ground
- Checking for frayed cords and ensuring proper equipment maintenance, etc

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

- Notify your supervisor/manager.
- Notify the Safety Officer by phone at (747) 210-3405.
- Notify the Safety Officer by email at ovmc.safetyhotline@dhs.lacounty.gov.
- Complete a “Report of Safety Hazard/Suggestion form” and send it to the Safety Office via inter-office mail.
- Safety Intelligence™ (SI) Event Reporting System on the Olive View Medical Center SharePoint site.

**DHS EMERGENCY CODES**

Emergency overhead paging is used at Olive View to alert workforce members to potential emergency situations and to summon workforce members who are responsible for responding to specific emergency situations, among other things.

See Emergency Codes on Next Page
The Los Angeles County Sheriff’s Department provides Olive View with sworn law enforcement and security services. They strive to provide a safe environment for patients, visitors, patrons, and workforce members. The Sheriff’s Department consists of full-time sworn Sheriff Deputies and Sheriff Security Officers who provide law enforcement services such as making arrests, report writing, and issuing both traffic and parking citations. The Sheriff’s Department is also responsible for overseeing the contract security personnel assigned to Olive View.

<table>
<thead>
<tr>
<th>CODE</th>
<th>REASON</th>
<th>TELEPHONE EXTENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assist</td>
<td>Urgent Medical Attention to Outpatients, Visitors and Staff</td>
<td>114</td>
</tr>
<tr>
<td>Code Blue</td>
<td>Adult Medical Emergency</td>
<td>114</td>
</tr>
<tr>
<td>Code Gold</td>
<td>Mental Health/Behavioral Response</td>
<td>111</td>
</tr>
<tr>
<td>Code Gray</td>
<td>Disruptive/Combative Person Response</td>
<td>111</td>
</tr>
<tr>
<td>Code Green</td>
<td>Patient Elopement</td>
<td>111</td>
</tr>
<tr>
<td>Code Orange</td>
<td>Hazardous Material Spill/Release</td>
<td>111</td>
</tr>
<tr>
<td>Code Pink</td>
<td>Infant Abduction (Newborn to 12 months)</td>
<td>111</td>
</tr>
<tr>
<td>Code Purple</td>
<td>Child Abduction (1 year to 17 years)</td>
<td>111</td>
</tr>
<tr>
<td>Code Rapid Response</td>
<td>Urgent Medical Attention to Inpatients</td>
<td>114</td>
</tr>
<tr>
<td>Code Red</td>
<td>Fire</td>
<td>113</td>
</tr>
<tr>
<td>Code Silver</td>
<td>Person with Weapon; Active Shooter; Hostage Situation</td>
<td>111</td>
</tr>
<tr>
<td>Code Triage Alert</td>
<td>Potential Disaster</td>
<td>111</td>
</tr>
<tr>
<td>Code Triage External</td>
<td>External Disaster</td>
<td>111</td>
</tr>
<tr>
<td>Code Triage Internal</td>
<td>Internal Disaster</td>
<td>111</td>
</tr>
<tr>
<td>Code White</td>
<td>Pediatric Medical Emergency</td>
<td>114</td>
</tr>
<tr>
<td>Code Yellow</td>
<td>Bomb Threat</td>
<td>111</td>
</tr>
</tbody>
</table>
THE ROLE OF THE SHERIFF’S DEPUTIES AND SECURITY OFFICERS

The Sheriff’s Department, as full-time, State-certified peace officers, enforces California penal codes, federal and state laws, County ordinances, and assists in attaining compliance with hospital policies. Sheriff Deputies and Security Officers conduct foot and vehicle patrols of the Olive View campus.

THE ROLE OF CONTRACT SECURITY GUARDS

- Contract Security Guards observe and report any suspicious activities to the Sheriff’s Department.
- Contract Security Guards monitor the entrances to the hospital building and conduct weapons screening and workforce member badge checks.

SAFETY AWARENESS

In the interest of protecting yourself and your personal property, please leave valuables such as expensive jewelry or electronic devices at home. Do not leave wallets, purses, cell phones, laptop computers, tablets, or any electronic devices unattended in the work area. Other security safeguards that you may employ include:

- Do not prop doors open or keep doors from latching.
- Walking in groups when leaving the workplace after dark.
- Locking your vehicle, and leaving valuables in the trunk or out of sight.

Always be aware of your surroundings. If you see something, say something! Report any suspicious activity to the Sheriff’s Department at (747) 210-3409.

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 Code Yellow.

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

- When is the bomb going to explode?
- Where is the bomb?
- 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?

At Olive View, contact the Sheriff’s Department immediately at (747) 210-3409 and notify your supervisor. Ambulatory care health centers, call 9-1-1.

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 prohibited 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.
WORKPLACE VIOLENCE

All workforce members are entitled to a safe work environment. The Department of Health Services has a zero-tolerance standard regarding any workplace acts of violence or threats in any form directed toward another workforce member, the public or patients.

What is Workplace Violence?

Workplace violence is any act of violence or threat of violence that occurs at the worksite. It can include:

Type 1 violence – means workplace violence committed by a person who has no legitimate business at the work site and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

Type 2 violence – means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.

Type 3 violence – means workplace violence against an employee by a present or former employee, supervisor, or manager.

Type 4 violence – means workplace violence committed in the workplace by someone who does not work there but has or is known to have had a personal relationship with an employee.

Workforce Member Responsibilities

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.

All workforce members are required to take the Workplace Violence Prevention training on the Learning Link and 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 by calling 9-1-1.
- Warn potential victim(s).
- Seek personal safety.
- Post-event, the victim or supervisor/manager shall contact the Chief Executive Office, Security Operations Unit (SOU) by telephone at (213) 893-2031 within 24 hours of incident.
- The supervisor/manager shall ensure a Security Incident Report (SIR) form is completed and submitted to SOU.
**Code Silver**

Code Silver is the DHS-wide emergency code used when there is a person with a weapon, active shooter and/or hostage situation.

Upon encountering a person with a weapon, workforce members shall take the following steps:

1. **Notify**
   a. Notify your facility’s on-site security/law enforcement and/or operator and state that a Code Silver is occurring. Provide as much information as you can including:
      i. Location
      ii. Suspects
      iii. Any known hostages
      iv. Other relevant information, such as weapons or demands
   b. The Operator or Facilities Manager will notify staff via overhead paging system by announcing a “Code Silver” three times and call 9-1-1. Administrator approval is not required.

2. **Escape**
   a. Seek cover/protection.
   b. Warn others.
   c. Have an escape route or plan in mind.
   d. Leave your belongings behind.

3. **Hide Out**
   a. Hide in an area out of the active shooter’s view.
   b. Close all patient rooms if safe to do so.
   c. Turn off cell phones and other noise making devices. Remain calm and quiet.
   d. Turn off lights.
   e. Hide behind large items.
   f. Barricade the door of your hiding place if possible.
   g. Try to escape.

4. **Take Action (only if necessary)**
   a. Attempt to incapacitate the active shooter.
   b. Throw items and improvise weapons.
   c. Coordinate with others and take actions as a group.

When law enforcement arrives, workforce members should take the following steps:

1. Remain calm.
2. Put down items and raise hands with fingers spread. Always keep hands visible.
3. Avoid making quick movements toward officers.
4. Avoid pointing, screaming, and/or yelling.
5. Do not stop officers from entering the area by asking for help or directions.

**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, timely notifications shall be made by the reporting workforce member, supervisor, and/or manager to the following:

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

In addition to calling the SOU, supervisors/managers shall ensure a Security Incident Report (SIR) is completed by the person reporting or involved in the incident and faxed or emailed to the Chief Executive Office, SOU by the end of the business day in which the incident occurred. Management must also maintain an incident log, formulate a security plan to address the safety of the affected employee or facility, and advise staff of the availability of EAP.
The Crisis Cycle

The County of Los Angeles promotes a safe work environment for all its workforce members. Workplace violence doesn't occur without warning; it is the third of four stages in the crisis cycle. Knowing the stages allows you to better identify and address potential danger.

1st Stage of Crisis - Anxious Person

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

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

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

2nd Stage of Crisis - Defense Person

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

3rd Stage of Crisis - Person in Crisis

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

4th Stage of Crisis - Tension Reduction

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

**COPING**

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

The County of Los Angeles has a “zero tolerance” policy that addresses workplace violence and violent behavior. Violation of this policy may result in disciplinary action up to and including discharge from County service or assignment. If you observe violence or signs of violent behavior, notify your manager or supervisor and the facility security. Please refer to DHS Policy and Procedure No. 792, Threat Management “Zero Tolerance” for further information.
Incident Reporting

Report violent incidents to security or on-site Los Angeles County Sheriff. All workplace violence incidents must be documented in the Safety Intelligence™ (SI) Event Reporting System. The supervisor/manager shall ensure a Security Incident Report (SIR) form is completed and submitted to SOU.

Code Gold – Called when there is an emergent issue with a patient’s mental state and there is the potential to bring harm to themselves or others.

- Notify- Warn others of the situation.
- Escape- Evacuate if it is safe to do so.
- Hide Out- Seek cover/protection. Assist patients in seeking shelter/protection.
- Take Action/Fight- Only as a last choice.

Code Silver – Called when there is a person with a weapon, active shooter and/or hostage situation.

- Notify- Warn others of the situation.
- Escape- Evacuate if it is safe to do so.
- Hide Out- Seek cover/protection. Assist patients in seeking shelter/protection.
- Take Action/Fight- Only as a last choice.

Code Gray – called when there is a combative person or situation.

- Contact security or on-site Los Angeles County Sheriff, if available.
- Assist victims(s) and remain calm and non-combative (diffuse the situation if possible).
- Clear the area of non-involved persons.

Dress with Safety in Mind

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

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 persons to the 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 a suspected child abduction. Staff should follow the same procedures as they do when a “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 in accordance with Olive View Policy, “Selecting, Handling, and Disposal of Hazardous Materials.”

The Safety Officer or the Hazardous Materials Specialist shall be the Hazardous Materials Spill Response Team Leader and shall coordinate all emergency response measures.

1. The first person at the scene shall immediately follow the Hazardous Material Spill Procedure. He/she shall also notify the supervisor and all staff in the room that a spill has occurred. If necessary, notify the hospital operator by dialing x111.
2. The hospital operator shall notify the Hazardous Material Spill Response Team or Safety Officer of the spill location.
3. Staff who are trained and familiar with the material spilled/released, shall take the following actions until the Hazardous Materials Spill Response Team arrives at the scene:
   a. Keep unnecessary people away and deny entry.
   b. Isolate hazard area and place yellow tape around the seclusion zone.
   c. Remove injured or exposed personnel from the release site if condition permits safe removal.
   d. Control the leak and the spread of the material.
Should you encounter a hazardous waste spill or if you or anyone else is exposed to hazardous waste, perform the following First Aid procedures:

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

The Safety Data Sheet (SDS) formerly Material Safety Data Sheet (MSDS) describes what hazards a chemical presents and how to handle spills/exposures. You should know the location of the SDSs in your work area. If you do not know where they are kept, ask your supervisor or safety coordinator. SDSs can be downloaded from your department’s SDS e-binder, which is located on the Olive View intranet. If you are unable to locate a particular SDS, contact your department safety coordinator or Safety Office at x73405.

New universal hazardous materials labeling standards have been implemented. Labels must include the following pictograms that provide specific information about the hazards of a chemical. You should familiarize yourself with the new hazardous materials symbols.
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.

### EMERGENCY PREPAREDNESS AND MANAGEMENT

<table>
<thead>
<tr>
<th>What Is An Emergency (Disaster) Preparedness Plan?</th>
<th>What Is Considered A Disaster?</th>
<th>What Are Two Types Of Disasters?</th>
</tr>
</thead>
</table>
| • 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. | • 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. | • **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. |

**Olive View Hospital Emergency Operations Plan (Disaster Plan)**

The Olive View Hospital Emergency Operations Plan defines each workforce member’s role and/or responsibility during 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. The detailed plan can be found on the Olive View intranet under “Emergency Management”. Be familiar with the Emergency Operations Plan and where it is kept in your area/department.

The Hospital’s evacuation procedure can be found in the Safety Manual and the Fire Manual.

**Hospital Incident Command System (HICS)**

The Hospital Incident Command System is an incident management system based on the Incident Command System (ICS) that assists hospitals in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events.

• Hospital Incident Command  
• Operations Section  
• Planning Section  
• Logistics Section  
• Finance Section
ARE YOU PREPARED AT WORK FOR A DISASTER?

EMERGENCY PREPAREDNESS AND RESPONSE FOR HOSPITAL WORKERS

The ability of a hospital to respond to an emergency depends upon having staff that know what to do, and have the needed skills. As a hospital worker, you should be able to:

1. **LOCATE** and **USE** the section of the hospital emergency response plan that applies to your position.
2. **DESCRIBE** your emergency response role and be able to **DEMONSTRATE** it during drills or actual emergencies.
3. **DEMONSTRATE** use of any equipment (such as personal protective equipment or special communication equipment) required by your emergency response role.
4. **DESCRIBE** your responsibilities for communicating with or referring requests for information from other employees, patients and families, media, general public or your own family, and **DEMONSTRATE** these responsibilities during drills or actual emergencies.
5. **DEMONSTRATE** the ability to seek assistance through the chain of command during emergency situations or drills.
6. **DEMONSTRATE** the ability to solve problems that arise carrying out your role during emergency situations or drills.

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 Olive View workforce members, it is likely that your assistance may be required at work.

The Office of Environmental Health & Safety has handouts available outlining what you should do at home to be prepared. Call (747) 210-3405 for further information.

Other resources are also available at:

- [http://publichealth.lacounty.gov/eprp/](http://publichealth.lacounty.gov/eprp/)
- [http://ems.dhs.lacounty.gov/](http://ems.dhs.lacounty.gov/)

EMERGENCY TRANSPORT (CARRIES)
EMERGENCY TRANSPORT SAFELY

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

Although you may need assistance (where 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 their knees.
3. Hold patient snugly against your back, then lean forward to carry.
4. Lean patient against wall, and slide to floor as you drop to one knee.

**PACK STRAP CARRY**

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

**CRADLE DROP**

1. Place blanket on floor next to bed, then grip patient under shoulders and knees.
2. Slide patient to edge of bed.
3. On both knees, slide patient down your chest to blanket. Or on one knee, lower their legs then their body, to blanket.

### TWO-PERSON CARRIES

**SWING**

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

**EXTREMITY**

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

**SEMI-AMBULATORY**

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

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

<table>
<thead>
<tr>
<th>S</th>
<th>Safety of Life. Remove all people in the immediate fire area and close the door to the room.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Alarm – Activate the alarm. Pull the nearest fire alarm and report the fire by dialing Ext. 113. Give the operator your name, location of fire, and type of fire. Relay location of fire and type of fire to other employees.</td>
</tr>
<tr>
<td>F</td>
<td>Fight the Fire (optional). Close doors to all other areas, adjacent rooms and fire doors. Return to fire with proper extinguisher; if possible and practical, extinguish fire until the arrival of the Fire Department.</td>
</tr>
<tr>
<td>E</td>
<td>Evacuate as Necessary. Remove patients and visitors from the adjoining area. Make sure that all Fire Doors and doors to patient rooms remain closed until their turn to be moved or rescued.</td>
</tr>
</tbody>
</table>

STEPS IN THE USE OF THE FIRE EXTINGUISHER

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

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

CLASSIFICATION OF FIRES

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

<table>
<thead>
<tr>
<th>Extinguisher Type</th>
<th>Canister Color</th>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Silver</td>
<td>A</td>
<td>Pressurized water tank used for wood, paper, cloth (Class A) fires. Do not use on flammable liquids or electrical fires.</td>
</tr>
<tr>
<td>B-C</td>
<td>Red</td>
<td>B-C</td>
<td>Contains either carbon dioxide or dry chemical, which smothers the fire; used for flammable liquids (Class B) or electrical (Class C) fires.</td>
</tr>
</tbody>
</table>
| A-B-C             | Red            | A-B-C  | • Contains a dry chemical (monoammonium phosphate) which smothers the fire; used on ordinary combustibles (Class A), flammable liquids (Class B), and electrical (Class C) fires.  
  • Whenever an A-B-C extinguisher is used on a Class A fire, always follow with water. |

Class D fires require special extinguishing agents and procedures.

Class K fire extinguishers were developed for deep fat fryers in commercial cooking operations. It uses wet chemicals that extinguishes the fire by removing the heat of the fire triangle. It can be found in commercial kitchens.

MRI – Special Consideration

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

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

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

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

REMEMBER SAFETY FIRST! EVEN IF THE FIRE IS SMALL.

WHO SHOULD RESPOND TO A CODE RED (EXT. 113) IN THE HOSPITAL?

• Weekdays (8:00 a.m. – 4:30 p.m.) The following on-duty staff responding to the scene – Senior Administrator, Sheriff and/or Security staff, Facilities staff, and one available staff from other areas of the hospital. Staff in the affected area will also respond.

• Weekends, Holidays and After-Hours – Nursing Administrator on duty, Sheriff and/or Security staff, Facilities staff, and one workforce member (if staffed) from each department will respond with appropriate fire extinguishers.

Code Red (All other areas): Check your department/unit-specific fire plan.

If the fire is not on your unit:

Workforce members throughout the hospital are responsible for returning all patients to their rooms and closing their doors. All carts and equipment must be moved out of corridors and away from fire exits. A Code Red is a hospital-wide response.
If the fire is on your unit:

You are responsible for all of the above, plus you are expected to be ready to take direction in the event an attempt is made to extinguish the fire or in the event evacuation of patients becomes necessary.

The staff must be aware that during a “Code Red” all visitors should be escorted to a waiting room away from hospital corridors. If you observe co-workers, visitors and patients opening fire doors, please remind them that they are not to enter these areas until they hear an overhead page stating “All Clear Code Red.”

DEPARTMENT SPECIFIC FIRE PLAN

In addition to the Safety Plan, each department manager is required by Cal/OSHA to have a Department Specific Fire and Safety/Evacuation Plan for their departments. On an annual basis, each workforce member is responsible for reading and signing an acknowledgment of the Olive View and departmental safety plan and disaster plan.

In order to protect yourself and your patients, you must be familiar with the department-specific fire plan in your area. You can expect The Joint Commission surveyors to ask you about these issues during their surveys of Olive View. Remember, be careful, and think safety!

SMOKE COMPARTMENTS

Smoke Compartments are created by the closure of fire/smoke doors. The hallway doors will close automatically during a “Code Red” and form smoke compartments. These doors contain the fire/smoke to a specific area of the hospital. Once these doors close, you are asked to stop and wait until you hear the overhead announcement “All clear Code Red” before you open any closed hallway doors.

The only two acceptable reasons for breaching a fire door are to respond to the “Code Red” (preferably with a fire extinguisher) or responding to a “Code Blue” (a life threatening emergency).

SUPPLY STORAGE

• DO NOT STORE SUPPLIES ON TOP OF CABINETS. You must leave an 18” clearance from the ceiling when utilizing shelving for storage of boxes, etc.
• Supplies must not be stored on the floor. It is recommended you make more frequent, lower volume supply requests from the Warehouse. If you can’t store an entire case of Xerox paper, how about splitting one with another department, then letting them order the next case?

EMERGENCY POWER

In the event of a Power Failure, most of the electrical outlets will not work. Only the Red Color outlets will be functional. You must make sure all life support systems are plugged into the red outlets. Turn off all non-essential equipment. Be sure you have flashlights ready. Be prepared to ventilate patients (if necessary).

Please take a look around your department and identify white outlets and red outlets.

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

In order to ensure the safe operation of medical equipment, the 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 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 (747-210-3405) and Risk Management (747-210-3026) as soon as possible (within 24 hours) and immediately impound the device. You must also submit an incident report via the Safety Intelligence™ (SI) Event Reporting System located on Olive View’s intranet site.
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 rechargeable 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.

Medical Gas Valves

In the event of a fire or emergency, it may be necessary to shut off oxygen or other medical gases. Usually, only Facilities Management, a Charge Nurse, Respiratory Care Practitioners, or the Fire Department are authorized to shut off medical gas valves. Check your facility’s policy or procedures to verify who is authorized to shut off medical gases.

Should it become necessary to shut off medical gases, ensure that all oxygen-dependent patients have alternate means of life support. Oxygen should only be shut off at the zone valve when a fire is being fed by oxygen and is becoming larger, or when the oxygen cannot be shut off at the bedside without endangerment of life. To shut off the oxygen valve:

- Note the label above or inside the valve box which identifies the rooms that are controlled by that valve.
- Remove the valve box cover. Verify the correct valve to be secured.
- For flat handle valves, grasp handle and rotate ¼ turn; for round handle valves, turn handle clockwise until it stops.

Call Facilities Management to turn the valve on again. Be sure to identify which valves were turned off.

In the event there is failure to shut off the gas valve or supply medical gases, notify Facilities Management.

To report a mechanical emergency, mechanical failure, or the need for mechanical repair, call (747) 210-4900 or (747) 210-4100.

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).

RISKS FACTORS TO REMEMBER

1. Your posture. Poor body mechanics overworks your body and puts stress on your joints. Even with good posture, a position if held for too long, can tense your muscles. It is always important to change your position frequently throughout the day to relieve pressure and stress on your body.

2. Your tasks. Watch for activities that require excessive force or frequent repetition. Also be aware of contact forces, such as pressing a body part against a hard surface or a sharp edge for prolonged periods of time. An example would be leaning against the edge of the desk. Frequent repetition for long periods make the muscles tense and tired.

3. Your work area. Environments with high stress, noise, poor lighting, poor seating, uncontrollable room temperature, vibrations, etc., can add extra strain to your body. Be aware of broken equipment, chairs or stools. Do not use them and report them to your supervisor immediately.

TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

1. Recognize the force or strain placed on your body caused when you grip, push, pull or lift heavy materials. Think about ways to minimize these strains or avoid some of these movements. Be aware of pain or numbness in the neck, shoulders, arm, wrist, fingers and back. Immediately, report any work related injuries to your supervisor.

2. Alternate tasks to use different muscles and to give you time to recover. Pace yourself.

3. Use eyeglasses, if needed. Remember uncorrected vision problems can cause eyestrain. Remember to blink and look away from the monitor frequently to decrease strain on your eyes.

4. Use tools in a safe and appropriate manner. Keep your worksite safe and clean. Do not use unsafe tools, remove them and report them.

5. Report any worksite safety concerns to your supervisor. This will help your manager identify harmful patterns or environmental conditions so that necessary changes may be made.

6. Ergonomic worksite evaluations are available through the Safety Office. To request an evaluation, please notify your supervisor, then go to https://lacounty.sharepoint.com/sites/dhs-ergonomics and fill out the self-assessment form.

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

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:

1. Adjust the height of your chair to achieve proper posture.
   • Position hips, knees and elbows at approximately a ninety-degree angle. Your shoulders should be relaxed and elbows kept close to your body.
   • Feet should be flat on the floor or supported by a step if they are dangling.
   • Avoid stretching, twisting or bending beyond what is comfortable for you.
   • Know how to adjust your chair. If the chair controls are not working properly, notify your supervisor.

2. Position your monitor directly in front of you.
   • Adjust the monitor screen so it sits at or below eye level.
   • Sit at least an arm’s length away from the computer screen.

3. Check the lighting to reduce monitor screen glare.
   • Aim the light at the task, not the screen.
   • Adjust the contrast and brightness of your monitor to improve viewing comfort at your computer workstation.

4. Change your position, stretch and change your pace of work regularly throughout the day.
The goal of Quality Management and Performance Improvement is to continuously improve patient safety and health outcomes. Every department within the organization performs and reports improvement activities in an effort to provide the safest, highest quality healthcare services possible.

OLIVE VIEW’S PERFORMANCE IMPROVEMENT MODEL

To achieve sustainable improvement, Olive View-UCLA Medical Center uses quality improvement principles such as the Institute for Healthcare Improvement (IHI) Model for Improvement, Lean Six Sigma, and other methodologies. The goals of Lean Six Sigma are to eliminate waste. The Model for Improvement asks three questions: What are we trying to improve? How will we know a change is an improvement? What change can we make that will result in an improvement? These questions are combined with PDSA cycles (Plan, Do, Study, Act) to conduct small tests of change for rapid cycle improvement. Quality improvement techniques are taught as “just in time” training when a project is needed to address a quality problem. These methods incorporate robust tools such as control charts, fishbone diagrams, and process maps. Olive View-UCLA Medical Center also conducts root cause analysis and failure modes and effect analysis to accomplish its goals for performance improvement.

Examples of performance and process improvements made at Olive View:

- Improving turn-around time discharge prescriptions.
- Improving compliance with hand hygiene.
- Improving appropriate use of telemetry beds.
- Improving patient satisfaction by reducing inpatient noise at night.
- Communications with patients.
- Reducing sepsis mortality.
- Improving outpatient clinic cycle time.

While the Quality Service Division oversees hospital-wide performance and process improvement, each department and some committees have identified performance improvement indicators around four perspectives: The Customer, Internal Processes, Learning and Growth, and Financial. These four perspectives comprise a balanced scorecard approach to performance improvement.

CORE MEASURES

Just as Olive View’s Quality Services Division strives to improve the health and safety of patients locally, The Joint Commission (TJC) and The Centers for Medicare & Medicaid Services (CMS) have designed quality standards and safety initiatives aimed at improving the quality of healthcare nationwide. These standards were developed as a result of evidence-based research data, and are geared toward improving illness outcomes, decreasing lengths of stay, and avoiding patient harm and medical errors.

Olive View currently participates in the following Core Measure data sets:

- Emergency Department Throughput measures
- Venous Thromboembolism
- Flu Immunizations
- Sepsis
- Perinatal Care
- Hospital-Based Inpatient Psychiatric Services
- Alcohol and tobacco screening, treatment, and counseling
- Screening for Metabolic Disorders
- Transition Records and Timely Transmission of Transition Records
- Hospital Outpatient Measures
- Electronic Core Quality Measures (eCQMs)

This process requires that Olive View collect and electronically submit data directly to TJC and CMS. Once the data is collected, The Joint Commission publishes a report detailing the performances of all participating healthcare organizations. This information is made available to the public at [https://www.medicare.gov/care-compare/](https://www.medicare.gov/care-compare/) and [Home | Provider Data Catalog (cms.gov)](https://www.medicare.gov/care-compare/ and [Home | Provider Data Catalog (cms.gov)]) and to State surveyors through CMS.
HOW ARE WE DOING COMPARED TO OTHER HOSPITALS?

Overall, Olive View is doing well in many areas. Typically we perform well in giving the appropriate medications, and generally have low mortality rates. It is important to note, however, that data collection results are based on medical record documentation, and the organization continues to struggle with documentation of some key elements of . Areas that need improvement are:

- Assessing & documenting flu immunization status.
- Reducing admission to departure time in the ED.
- Providing tobacco cessation medication during inpatients stay in the psych unit.
- Providing exclusive breast milk feeding.
- Improving sepsis bundle compliance.
Risk Management involves the identification, evaluation, and reduction of the risk of injury and/or loss to the County and Olive View. This section provides policies and procedures on how to report adverse events, sentinel events, near miss incidents, and how to respond 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 and professional credentials (license, etc.), and while on duty at your assigned work station. However, **you are not legally protected from**:

- Liability resulting from willful misconduct or malice.
- Liability for any injury by one workforce member to another workforce member during the course of their employment/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).

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

**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.

**Sentinel event**: A patient safety event (not primarily related to the natural course of the [patient’s] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

- **Severe harm**: An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continual physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.

- **Permanent harm**: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual’s baseline.

A sentinel event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition), 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, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services.
• Sexual abuse/assault or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital or while providing care or supervision to patients.
• Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
• 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™ (SI) 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™ (SI) Event Reporting System which can be found on the Olive View intranet.

You may enter an event from any computer in the facility. Please see Olive View Policy and Procedure “Reporting Adverse/Sentinel Events, Incidents, and Near Misses" for information on close call/near miss, adverse and sentinel event notification, reporting and documentation.

You must report events as soon after the event as possible. The Risk Management Office is available for consultation:

• During normal business hours at (747) 210-3026.
• 24-hour Hotline (ANO) at (747) 210-3170.

REMEMBER
Olive View requires you to report sentinel events immediately at the time of the event to your Department 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 Department Supervisor and Olive View’s Risk Manager using the following steps:

• Complete an Event Notification Report on the Safety Intelligence™ (SI) Event Reporting System for all events without exception as soon as possible.
• Your Department Supervisor is responsible for immediate notification of the Administrator of the Day and the Risk Manager.
• The Risk Management Office can be reached by calling (747) 210-3026 or the hotline number at (747) 210-3170 (ANO) at any time, 24 hours a day, 7 days a week.
• In the case of power failure affecting the Safety Intelligence™ (SI) Event Reporting System, use the paper Event Notification Form (HS-10).

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. In addition, a complete and accurate medical record ensures that the facility complies with the accreditation and licensure standards.
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™ (SI) 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 Hospital Administration or recorded through the Safety Intelligence™ (SI) 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 HANDWRITTEN ERRORS IN THE MEDICAL RECORD BY:

• Using one line to cross out the error(s). Write the correction along with the date, time, and initials.
• Do not “white out”, erase or otherwise obliterate entries.
• Do not write the word “error”.

CORRECTING THE ELECTRONIC MEDICAL RECORD

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

REMEMBER

DO NOT MAKE COPIES of SI reports nor refer to an SI report in the patient’s medical records.

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, contact the Risk Management Office (Ext. 73026) 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 the Risk Management Office.
• DO NOT ACCEPT LEGAL DOCUMENTS OR SUBPOENA ON BEHALF OF ANOTHER PERSON OR DEPARTMENT.
• DO NOT ACCEPT ANY LEGAL DOCUMENT THAT IS NOT ADDRESSED TO YOU.

The 24-hour Risk Management Hotline is (747) 210-3170
Infection Prevention and Control program goals include:

- Preventing the transmission of infection to patients, visitors and workforce members.
- Providing a safe work environment.
- Improving patient care.
- Complying with regulatory requirements.

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

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

Processes that reduce the risk for transmission:

- Standard Precautions
- Transmission-Based Precautions

STANDARD PRECAUTIONS

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

Standard Precautions include:

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

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

NOTE:

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

**USE ALCOHOL-BASED HAND SANITIZER**

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

**HANDS MUST BE WASHED WITH SOAP AND WATER**

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

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

---

### PROPER STEPS ON PERFORMING HAND HYGIENE

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

Training video available on Learning Link: [Hand Hygiene - Soap/Water and Alcohol-Based Hand Sanitizer](#)
FINGERNAILS

Natural nails must be clean, with tips less than ¼ inch long. If fingernail polish is worn, it must be in good condition, free of chips, and preferably clear in color. Hand jewelry with stones and crevices should not be worn as germs are difficult to remove from crevices and stones may tear gloves.

Artificial fingernails are not permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or patient care equipment, supplies, food, specimens, or medications.

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

ENVIRONMENTAL PRACTICES

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

RESPIRATORY HYGIENE/COUGH ETIQUETTE

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

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

INDIVIDUALS WITH SIGNS AND SYMPTOMS OF A RESPIRATORY INFECTION SHOULD:

- Cover their nose and mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use.
- If you don’t have a tissue, then cough or sneeze into your upper sleeve or elbow, NOT your hands.
- Wash hands or use alcohol-based hand sanitizer/hand gel after having contact with respiratory secretions and contaminated objects/materials.

MASKING AND SEPARATION OF PERSONS WITH RESPIRATORY SYMPTOMS

- During periods of increased respiratory infection activity, offer masks to persons who are coughing. Masks are used to contain respiratory secretions.
- Encourage coughing patients to sit apart (at least six feet away, if possible) from others in common waiting areas.
WORKFORCE MEMBERS: PRECAUTIONS TO MINIMIZE EXPOSURE TO RESPIRATORY DROPLETS

• Workforce members should wear a medical-grade face mask for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection, particularly if fever is present.

• Effective September 1, 2010, personnel performing procedures on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an Aerosol Transmissible Pathogen must wear a **Powered Air Purifying Respirator (PAPR)** or **Controlled Air Purifying Respirator (CAPR)**, if potential for exposure is increased due to the anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

**PERSONAL PROTECTIVE EQUIPMENT (PPE)**

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

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

- **Gloves**
- **Gown**
- **Mask or respirator**
- **Face shield or goggles**
When to use the following PPE:

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

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

- **MASK/RESPIRATOR**: Used when there is potential for exposure to airborne contaminants. Used during patient care activities likely to generate splashes or sprays of blood, body fluids secretions, or excretions. Types of face masks:
  - Surgical mask
  - N95 Respirator
  - Medical mask
  - PAPR/CAPR/Elastomeric Respirators
    - Controlled Air Purifying Respirator (CAPR): is a proprietary version of a PAPR, which fulfills all of the same functions, reusable device and battery operated, requires training
    - Powered Air Purifying Respirator (PAPR): A low breathing resistance reusable device with high level of protection against aerosols or particles, requires training
    - Elastomeric Respirator: A reusable device with exchangeable cartridges or filters, requires training

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

Donning (putting on) and Doffing (removal) of PPE:

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

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

Sequence for Donning (Putting on) PPE:

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

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

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

4. **Gloves**: Extend to cover wrist of isolation gown.
INFECTION PREVENTION AND CONTROL

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

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

Sequence for Doffing (Removal) PPE:

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

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

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

1. Perform hand hygiene.
2. May now exit patient room.
3. Perform hand hygiene.
4. Carefully remove face shield or goggles. Grab the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
5. Remove and discard respirator (or mask if used instead of respirator). Do not touch the front of the respirator or mask.
   • Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
   • Mask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.
6. Perform hand hygiene after removing the respirator/face mask and before putting it on again if your workplace is practicing re-use.

Note:
Doffing with an Anteroom: Exit patient’s room and remove PPE in Anteroom. Without Anteroom: Remove gown and gloves in patient room, then exit patient room. Remove remaining PPE outside of patient room.

TRAINING VIDEO AVAILABLE FOR ALL WFM ON LEARNING LINK

Donning and Doffing Personal Protective Equipment N95 Seal Check
Injuries can occur while handling or passing a sharps device after it has been used, recapping a device, manipulating a device in a patient, colliding with coworkers, transferring potentially infectious material between containers, or during disposal, clean up, or decontamination of used equipment. Injuries can also occur from sharps left in unusual places, like laundry, mattresses, tables, trays, or other surfaces. Any workforce member handling sharps devices or equipment such as scalpels, needles for sutures, hypodermic needles, blood collection devices, or phlebotomy devices is at risk.

**SIMPLE MEASURES TO REDUCE THE RISK OF SHARPS INJURIES**

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

[Source: Centers for Disease Control and Prevention’s (CDC) HICPAC “Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007”]

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

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

INFECTION CONTROL REQUIREMENTS DURING BLOOD GLUCOSE MONITORING AND INSULIN ADMINISTRATION:

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

INJECTION SAFETY TIPS FOR PROVIDERS

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

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

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

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

For more information about sharps safety, please see: www.cdc.gov/sharpssafety & www.oneandonlycampaign.org
The facility maintains appropriate handling and storage areas for hazardous materials and waste that are designed to minimize the possibility of contamination of food, clean and sterile goods, or contact with staff, patients or visitors. Be aware of the various types of hazardous materials and waste, and their appropriate measure of disposal.

<table>
<thead>
<tr>
<th>WASTE</th>
<th>CONTAINER</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| SHARPS WASTE         |           | • Any device that is sharp at the time of disposal; such as needles, scalpels, razor blades, broken glass, glass slides, glass pipettes, trocars, staples, empty ampules  
| CONTAINER            |           | • All empty syringes and empty medication vials  
|                      |           | • Guide wires  
|                      |           | • Replace container at 3/4 full  
| PHARMACEUTICAL       |           | • Acceptable non-RCRA pharmaceutical waste: partial IVs, un-used pills, partial vials, sponges soaked in liquid medications  
| WASTE (NON-RCRA)     |           | • Sharps, needles, syringes and vials with remaining medications  
|                      |           | • No hazardous (RCRA) pharmaceuticals (see “black bucket” below)  
|                      |           | • No free flowing liquids are allowed in containers (no wasting or pouring of medications into the container); place entire syringe, entire partial IV bag into the container  
| HAZARDOUS            |           | • Warfarin, nicotine (gum, patch, lozenge), dandruff shampoo or lotion, cough syrup/elixer (containing more than 24% alcohol) iodine, hydrochloric and acetic acid, phenol, multi-dose vaccines  
| PHARMACEUTICAL       |           | • Chemotherapy IV bags & tubing that have moving liquid when moved or tilted  
| (RCRA) - BLACK       |           | (RCRA) - BLACK  
| BUCKET               |           | • Disposal of supplies used to administer chemotherapy  
|                      |           | • Empty chemotherapy sharps & glass bottles  
|                      |           | • Gowns & gloves used to administer chemotherapy  
|                      |           | • Chemotherapy IV bags & tubing that have no moving liquid when moved or tilted  
| BIOHAZARD WASTE      |           | • Infectious waste; including blood and blood products, items containing blood, infectious body fluids, any body-fluid containing blood, cultures, viruses, bacteria and live vaccines  
|                      |           | • Bag and IV tubing containing blood products  
|                      |           | • Suction canister with secretions  
|                      |           | • Hemovacs  
|                      |           | • Chest drainage units  
|                      |           | • Replace container at 3/4 full  
| REGULAR TRASH        |           | • Gloves, gowns, masks, etc. that do not have blood or blood by-products  
|                      |           | • Chux & paper towels  
|                      |           | • Empty IV bags (place HIPAA blackout label over (PHI)  
|                      |           | • Empty tubings  
|                      |           | • Non-regulated medical waste  
| UNIVERSAL WASTE      |           | • Batteries that do not have blood or blood by-products  
| CONTAINER            |           | * for OR use only; use disinfectant wipes to clean batteries before disposal  

UNIVERSAL WASTE CONTAINER
<table>
<thead>
<tr>
<th>WASTE</th>
<th>CONTAINER</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACENTA WASTE</td>
<td>[Image]</td>
<td>• For placenta transport only</td>
</tr>
<tr>
<td>CONTAINER</td>
<td>[Image]</td>
<td></td>
</tr>
<tr>
<td>RADIOACTIVE</td>
<td>[Image]</td>
<td>• Radioactive waste must be properly labeled</td>
</tr>
<tr>
<td>WASTE</td>
<td>[Image]</td>
<td>• The Radiation Safety Office must be called to remove this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>waste to the designated area, where it must be monitored by</td>
</tr>
<tr>
<td></td>
<td></td>
<td>qualified staff, until its safe and appropriate terminal disposal</td>
</tr>
</tbody>
</table>

For additional information contact:

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

**CLEANING AND DISINFECTION**

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

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

**REMEMBER**

Follow the guidelines for PDI wipe “dwell/contact kill time”

- Super Sani-Cloth: 2 MINUTES
- Sani-Cloth Bleach: 4 MINUTES
- Sani-Cloth AF3: 3 MINUTES
- OPTIM 1 Wipes: 1 minute
CLEANING, DISINFECTION, AND/OR STERILIZATION OF ENVIRONMENT AND PATIENT CARE EQUIPMENT:

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

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

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

INFECTION CONTROL FOR COMPUTERS

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

<table>
<thead>
<tr>
<th><strong>DO</strong></th>
<th><strong>DO NOT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Perform Hand Hygiene prior to using device.</td>
<td>× Lay a device on a patient bed or any furnishings in the patient room.</td>
</tr>
<tr>
<td>✓ Clean and disinfect device regularly between users or when visibly soiled or contaminated with blood.</td>
<td>× Place food or drinks on any mobile cart or in any wall unit.</td>
</tr>
<tr>
<td>✓ Clean device before moving to another patient room.</td>
<td>× Use gloves during computer use.</td>
</tr>
<tr>
<td>✓ Remove devices from patient room following use; this includes isolation rooms.</td>
<td></td>
</tr>
<tr>
<td>✓ Keep computer at least 3 feet from sink.</td>
<td></td>
</tr>
</tbody>
</table>

TRANSMISSION-BASED PRECAUTIONS

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

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

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

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

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

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

### EXPOSURE TO BLOOD AND BODY FLUIDS

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

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

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

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

**SEASONAL INFLUENZA**

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

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 mask during the duration of the influenza season, regardless of submitting a signed declination, if they work in a health care area that provides patient care. If the workforce member later decides to accept the vaccination, it will be provided to them.

**COVID-19**

All DHS staff with an e# or c# are eligible to receive the FDA-authorized vaccine for COVID-19 which is highly effective at preventing disease and hospitalizations. The vaccine is free of charge and available at one of the many employee vaccination clinics operating across the DHS network.

Visit EHS database system to sign up. You can click through to view a visual [How to Complete the COVID-19 Vaccine Request Form](#) if you have any questions about how to sign up.

**AEROSOL TRANSMISSIBLE DISEASE (ATD) PLAN**

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

**EARLY IDENTIFICATION**

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

**WORKFORCE MEMBER PRECAUTIONS**

Workforce members are to wear a NIOSH approved N95 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 by Employee Health for those employees with a significant exposure.

TUBERCULOSIS (TB)

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

TB precautions include the following:

• Annual TB screening for all workforce members who work inside a healthcare facility.
• Early triage and identification of TB suspects.
• Isolation of suspect and confirmed TB patients.
• Proper engineering and maintenance of negative pressure TB isolation rooms (door is to be kept closed at all times).
• TB patient wears a barrier (surgical) mask when outside of isolation room and in enclosed area.
• Any workforce member providing direct patient care to respiratory isolation patients is to be fit tested and use an N95 respira-
  tor 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.

ACTIVE TB DISEASE

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

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

LATENT TB INFECTION (LTBI)

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

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

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

CLINICAL INFORMATION

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

TRANSMISSION

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

INFECTION PREVENTION AND CONTROL

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

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

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

WORKFORCE MEMBER GUIDANCE FOR COVID-19

Key Points about COVID-19

Prevention Tips:

- Avoid close contact with people who are:
  - Sick
  - COVID-19 positive or Person Under Investigation (PUI) with no evidence of symptoms (asymptomatic)
- Practice physical separation (social distancing) >6 feet apart from each other
- Wear your medical-grade face mask to prevent the spread of COVID-19
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Avoid touching your eyes, nose and mouth
- Clean and disinfect frequently touched objects and surfaces
- Perform hand hygiene often with hand washing (soap/water) or ABHS (see page 92).
Definition of a Close Contact:

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

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

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

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

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

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

Note: This list does not include all possible symptoms of COVID-19. Some people with COVID-19 never get symptoms. Seek COVID-19 Testing: If negative, WFM may return to work when they have been absent of fever for minimum of 24 hours without use of fever reducing medicine.

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

- If you are sick, you are required to stay home.
- If symptoms appear at work, immediately notify your supervisor and request to leave work, leave the patient care/work area and notify Employee Health Services (EHS). Click HERE for your local EHS contact information.
- Self-isolate at home and follow your healthcare provider’s order and directions.
- If you test positive for COVID-19 outside of DHS you must report the results to Employee Health Services and your supervising manager within 24 hours or prior to coming to your next shift, whichever comes first.
- Confidentiality of Medical Information Act (CMIA) is in place for your protection. All efforts are made to protect the privacy of all workforce members.
- All workforce members should self-monitor for symptoms consistent with COVID-19, including twice-daily temperature measurements for fever.
- If you are a WFM with a confirmed known high-risk exposure to a patient(s) with confirmed COVID-19, you will be evaluated by Employee Health Services. You may be required to home quarantine for 10 days.
- If a household member tests positive for COVID-19, then a risk assessment is needed by EHS to determine if the criteria for home quarantine is indicated for the employee based on the exposure.

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

Affected department(s) are identified by IP&C. Notification to these departments is done either by IP&C or Employee Health Services (EHS) per facility. Staff are instructed to present or call EHS for exposure evaluation. Employee Health Services will perform the exposure evaluation and, based on risk, determine if work restrictions are required.
What else is DHS doing to assure a safe workplace during the COVID-19 pandemic?

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

Return to Work Guidelines

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

• If a workforce member has been off due to illness but has not been tested (we encourage the workforce member to get tested whenever possible), or tested negative for COVID-19, they can return to work when the following criteria have been met:
  • They have been fever-free for at least 24 hours without use of fever-reducing medication; and
  • Respiratory symptoms (e.g., cough, shortness of breath) have improved; and
  • Workforce member must continue to wear a medical-grade face mask while at work

• If a workforce member has tested positive for COVID-19 and was directed to care for themselves at home, they can return to work when the following criteria have been met:
  • They have been fever-free for at least 24 hours without use of fever-reducing medication; and
  • At least 10* days have passed since symptoms first appeared; and
  • Other symptoms have improved; and
  • Workforce member must continue to wear a medical-grade face mask while at work
  • See the Workforce Member Guidance for COVID-19 for more information, such as guidelines for vaccinated individuals.

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

REMINDER: The Department of Health Services encourages you to review COVID-19 Expected Practices on an ongoing basis, as they may change during this COVID-19 Pandemic period. You may access the Expected Practices on the intranet.
ALL STAFF (What a Joint Commission Surveyor Is Likely to Ask You)

The following information lists some of the key points that are important to remember as they are an integral part of providing outstanding patient care while fulfilling the accreditation standards of The Joint Commission. If a Joint Commission surveyor is on site, they are likely to ask you questions that relate to the information below.

LEADERSHIP

• Our mission, vision and values statements are included in various training programs. In addition to the definition of Olive View’s mission, vision and values contained in this handbook, the hospital makes it available in a wallet-size format so that you can insert it in your identification (ID) badge holder.

• All licensed professionals are expected to adhere to the highest ethical and professional standards of behavior and performance.

• If you observe behavior in a licensed professional that may compromise patient or environmental safety; you should report it to your supervisor or the DHS Human Resources Performance Management Unit.

• It is important that you understand, whether you are a healthcare practitioner, technician, clerical or housekeeping member of our staff, that your job supports our organization’s mission to improve the health of our patients.

THE JOINT COMMISSION ACCREDITATION

• Under The Joint Commission’s Accreditation Participation Requirements, any workforce member who has concerns about the safety or quality of care provided in the organization may report those concerns to The Joint Commission.

• All surveys are **unannounced**, so it is important to maintain continuous preparedness.

• During the survey process, the surveyors will observe: direct patient care; medication administration; care planning processes; environment of care (including security); and medical record documentation.

PATIENT SAFETY

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

• You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmentally unsafe condition, or “near miss” that causes you to have concern for the safety of patients, visitors, or staff as soon as possible.

• The Joint Commission annually establishes National Patient Safety Goals (NPSGs) which Olive View workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.

• Universal Protocol applies to **all surgical and non-surgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery.

• If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility’s response mechanism and stay with the patient/visitor until help arrives.

• Prevention of patient falls is the responsibility of every workforce member.

• Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.

STAFF RIGHTS AND RESPONSIBILITIES

• All Olive View’s staff must complete all mandatory training and competency validation requirements for their respective positions (e.g., orientation, compliance awareness, infection control, fire/life safety, emergency management, CPR, unit/area-specific orientation, and other core competencies.)

• Workforce members are responsible for reporting any activity that appears to violate the Code of Conduct. DHS will not retaliate against anyone who reports a suspected violation in good faith.
Compliance Awareness Training is mandatory and provided to workforce members at the start of service. Annual update training is provided through the facility orientation/reorientation handbook.

The County of Los Angeles has established a “zero tolerance policy” for any conduct that could possibly be interpreted as harassing, offensive or inappropriate in the workplace, including actions of a sexual nature.

It is the responsibility of the licensed professional to renew required professional credentials. Failure to comply with licensure requirements may subject the person to disciplinary action, up to and including discharge/release from County service or release from a contracted assignment. Professional staff that must maintain a current professional credential to perform their duties will not be allowed to work with an expired professional credential.

It is your responsibility to obtain an annual health screening.

PATIENTS’ RIGHTS, RESPONSIBILITIES, AND SERVICES

Olive View Patients’ Rights and Responsibilities are posted throughout the hospital for reference.

An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their healthcare decisions.

The AHCD allows a person to give directives regarding healthcare decisions, such as whether or not they want life-sustaining treatment should they become terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so.

Olive View admissions staff informs patients of their options concerning AHCD’s.

Patients can fill out an AHCD document or give oral direction to a physician who will document it in the patient’s medical record.

If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Customer Services Department. At Olive View-UCLA Medical Center, Customer Service is located on the second floor, Room 2A103, telephone number (747) 210-4813. For the health centers, Customer Service is located at the Mid-Valley Comprehensive Health Center on the fifth floor, Room 520, telephone number (818) 947-4033. Staff is available to help customers Monday through Friday between 8:00 a.m. and 4:30 p.m.

ENVIRONMENT OF CARE

The Environmental Health and Safety Program and Environment of Care Committee investigate all recognized hazards to patient safety.

Safety concerns must be reported to your supervisor and the Safety Officer. You can report safety concerns anonymously by phone at (747) 210-3405, or email at ovmc.safetyhotline@dhs.lacounty.gov.

The Safety Data Sheets (SDS) tell what hazards a chemical presents and how to handle spills/exposures.

You should know the location of the SDS sheets in your work area. If you do not know where they are kept, ask your supervisor. The master SDS manual is located in the hospital’s Safety Office.

In the event of a fire, follow the SAFE and the PASS procedures as appropriate.

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

Know what all emergency codes mean and how you should respond to each, for example:

- **Code Blue** means cardiac (or cardiopulmonary) arrest involving an adult.
- **Code White** means cardiac (or cardiopulmonary) arrest involving a child.
- **Code Red** means fire emergency.
- **Code Gold** means “Behavior Response Team”.
- **Code Gray** means “Disruptive/Combative Person”.
- **Code Silver** means person with a weapon and/or active shooter and/or hostage situation.
- **Code Green** means patient elopement.
- **Code Purple** means child abduction.
- **Code Pink** means infant abduction.
- **Code Orange** means hazardous spill/radiation incident.
- **Code Yellow** means bomb threat.
- **Code Rapid** Response means urgent medical assistance is needed for inpatients.
• Code Assist means urgent medical assistance is needed for outpatients, visitors, or staff.
• Code Triage Alert means potential disaster situation.
• Code Triage Internal means internal disaster situation.
• Code Triage External means external disaster situation.

PERFORMANCE IMPROVEMENT

• Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
• How have you been involved in the improvements made in your department in the past 12 months? How have you worked with other departments to improve care/services? If you don’t know, speak to your supervisor.
• Olive View uses Lean Six Sigma and other performance improvement methodologies, such as the Plan Do Study Act Model (PDSA).

RISK MANAGEMENT

**Sentinel event**: A patient safety event (not primarily related to the natural course of the [patient's] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

• **Severe harm**: An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continual physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.
• **Permanent harm**: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline.

You may report events in one of the following ways:

• Safety Intelligence™ (SI) Event Reporting System
• Risk Manager’s Office at (747) 210-3026
• Medical Administration at (747) 210-3025
• Patient Safety Officer at (747) 210-3026
• Employee Health Services at (747) 210-3403

MANAGEMENT OF INFORMATION

• Protect Patients’ Right to Personal Privacy.
• Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mails to be sent outside the DHS e-mail domain.
• When conducting a conversation regarding a patient, do so in a private place or speak quietly to minimize the possibility of being overheard.
• Keep medical records and other documents containing PHI out of public view.
• If a patient requests a restriction regarding sharing information about them such as diagnosis and/or treatment with family and/or others, document the request and make sure the treatment team is aware of the request.
• Make sure all documents belong to the patient and use the two identifier process before providing patients with documents such as appointment reminders, discharge summaries, and eligibility packets.
• Treat other people’s confidential information as if it were your own.
• Report suspected HIPAA violations to the facility Privacy Coordinator at (747) 210-3001.
• Protect the privacy of Personally Identifiable Information as well as Protected Health Information. It is the responsibility of every member of our service delivery team to maintain reasonable and appropriate administrative, physical and technical safeguards to protect the privacy and confidentiality of our patients' PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form. PHI may only be used and/or disclosed for purposes of treatment, payment and healthcare operations (TPO).
• Personally Identifiable Information (PII), information similar to PHI, must be protected.
• Olive View uses the following safeguards to protect patient-specific information:
  • Use shredders and locked bins to discard PHI documents.
  • Cover carts used to transport medical records.
• Lock doors and use sign-in logs to limit access to the Health Information Management Department.
• Required Compliance Awareness Training and Privacy & Security Survival Training: Protecting Patient Information for all staff.
• Implement a need to know level of security to access PHI.
  • If you access or disclose patient information that is not related to your job or that does not have the patient’s authorization, you are in violation of DHS policy, HIPAA and State law and may be subject to monetary fines, civil or criminal penalties, or corrective action including discharge from County service or assignment. Licensed professionals may be reported to their licensing board/agency for disciplinary action.
• Use automatic log-off of PC’s after non-use of systems.
• Use user-ID and Password to access PHI.
• Encrypt laptops, external storage devices and portable medical equipment that store ePHI.
• Regularly review reports from Information Technology (IT) showing outgoing, incoming and transferring staff to ensure valid users.
  • Limited remote access is provided to user by Virtual Desktop Infrastructure (VDI).
• In the event of a disaster, Olive View ensures against loss of data by activating the IT Disaster Recovery Plan. Additionally, IT performs daily data backup on all servers and stores the backed-up information at an off-site location.
• Olive View management conducts an annual IT Needs Assessment Survey to determine information needs of all staff, including physicians. The information is then included in the County-wide Business Automation Plan for budgeting.
• Olive View has instituted “read back”, “repeat back” procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.
• The report of critical test results should be documented on the Provider Notification Form with the actual time that the provider was notified. The provider should be notified within 10 minutes of receiving results.
• Olive View direct patient care staff obtains clinical information from other treatment sites by requesting the patient’s medical record from the Health Information Management (HIM) Department. Patient information may also be accessed through the electronic patient information system. Access to the system is controlled through a security clearance process.
• Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.
• Olive View provides “knowledge-based data and information” through the Olive View Health Science Library, located at Olive View Library. Leaders and care providers can access journals, textbooks, audiovisual materials etc. The library is accessible online.

INFECTION CONTROL

• Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection.
• You must wash your hands before and after direct patient contact, after removing gloves, before/after eating, drinking, smoking, after using the toilet, whenever there is any doubt about contamination, and when hands are visibly soiled.
• Follow the Respiratory Hygiene/Cough Etiquette guidelines.
• Artificial fingernails are not permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or equipment that will be used by a patient or used directly on a patient, or for those who have contact with food.
• Use gloves before contact with mucous membranes, open skin, blood/body fluids, or the handling of contaminated substances or surfaces. Always change your gloves between patients. Glove use does not substitute for hand hygiene.
• The three categories of Isolation/Transmission-Based Precautions are: Airborne, Droplet, and Contact Precautions.
• You must follow the Personal Protective Equipment guidelines to prevent exposure to blood or body fluids or to airborne infections.
• In the event of a sudden influx of a large number of infectious patients, Olive View will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the disaster manual; all departments have copies of the disaster manual.
IF YOU ARE CLINICAL STAFF, PLEASE CONTINUE TO THE NEXT SECTION (PAGE 113) OF THIS HANDBOOK

IF YOU ARE NON-CLINICAL STAFF, CLICK TO CONTINUE TO THE KNOWLEDGE CHECK SECTION (PAGE 156)
All clinical workforce members who provide care, treatment or services to patients should complete this section of the Orientation. This includes direct and indirect caregivers. Examples* of direct and indirect caregivers include:

<table>
<thead>
<tr>
<th>Registered Nurses</th>
<th>Diagnostic Ultrasound Technicians</th>
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<tbody>
<tr>
<td>Licensed Vocational Nurses</td>
<td>EEG Technicians</td>
</tr>
<tr>
<td>Nursing Attendants</td>
<td>Lab Assistants</td>
</tr>
<tr>
<td>Physicians</td>
<td>Medical Technologists</td>
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<tr>
<td>Dentists</td>
<td>Pharmacists</td>
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<td>Respiratory Care Practitioners</td>
<td>Pharmacy Technicians</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>Nuclear Medicine Technologists</td>
</tr>
<tr>
<td>Radiology Technologists</td>
<td>Phlebotomy Technicians</td>
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<td>Physical Therapists</td>
<td>Recreation Therapists</td>
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<td>Speech Pathologists</td>
<td>Clinical Social Workers</td>
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<td>Rehabilitation Therapy Technicians</td>
<td>Surgical Technicians</td>
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<tr>
<td>Licensed Physical Therapy Assistants</td>
<td>Dental Assistants</td>
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<td>Dental Hygienists</td>
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<td>CRNA'S</td>
<td>Registered Dietitians</td>
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<td>Physician Assistants</td>
<td>Occupational Therapy Assistants</td>
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<tr>
<td>Nurse Practitioners</td>
<td>Cardiac Monitor Technicians</td>
</tr>
</tbody>
</table>

* Also anyone as required by his or her classification and who provides patient care.
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).

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.

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), and proper disposal of trash.

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. Examples of such controls are autoclaving, self-sheathing needles, other sharp-safety devices, sharps disposal containers, and handwashing sinks.

Dirty and contaminated instruments must be transported in a closed, leak-proof, puncture-resistant and clearly marked biohazard container.

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

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

If you are exposed, **IMMEDIATELY:**
- Wash the cut or exposed skin area with soap and water.
- Wash the exposed area and/or flush eye mucous membranes.
- Report the exposure to your supervisor.
- Go to Employee Health/Urgent Care for follow-up.

Bloodborne Pathogen Training is a mandatory annual requirement.

**NOTE**

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

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS

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

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

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

VENTILATOR ASSOCIATED PNEUMONIA (VAP)

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

Prevention Strategies for Reducing the Incidence and Risk of VAP

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

PREVENTION OF CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

CAUTI’s are the most common hospital associated infections (HAI); 80 percent are attributable to an indwelling catheter. Limiting catheter use and duration are important to preventing infection. As of January 1, 2013 hospitals were required to implement a plan to prevent CAUTI’s based on evidence-based practice. OVMC has implemented a Nurse Driven Urinary Catheter Assessment and Removal Protocol. A physician order is not required for removal of an indwelling catheter.

CAUTI Evidence-Based Prevention Strategies

1. Insert catheters only for appropriate indications.
2. Remove unnecessary catheters.
3. Perform Hand Hygiene.
4. Insert catheters using aseptic technique and sterile equipment.
5. Properly secure indwelling catheters after insertion.
6. Maintain a closed drainage system.
7. Maintain unobstructed urine flow.
8. Daily review for catheter necessity.
9. Keep bag off the floor and maintain below level of bladder.
10. Use silver impregnated catheters.

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, bloodstream infections, and pneumonia, and they can infect wounds, the respiratory tract and surgical sites.
Prevention Strategies for Reducing the Incidence and Risk of MDROs

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

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

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

Prevention strategies for reducing the incidence and risk of MRSA infections

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

MRSA Screening Protocol

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

VANCOMYCIN-RESISTANT ENTEROCOCCI (VRE)

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

Prevention strategies for reducing the incidence and risk of VRE infections

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

CLOSTRIDIUM DIFFICILE (C. DIFFICILE)

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

Prevention strategies for reducing the incidence and risk of CDI

- 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).
This section addresses general patient care principles related to population-specific guidelines, infection control, read back requirements, pain assessment/reassessment, medication management, behavioral restraints, Universal Protocol and medical records requirements for physicians and Licensed Independent Practitioners (LIPs).

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

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

- Use a firm direct approach and give one direction at a time.
- Use a distraction, e.g., pacifier or bottle.
- Keep the parent(s) in the infant’s line of vision.
- Use equipment and supplies specific to the age and size of 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 and interfere 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 Joint Commission Patient Rights standards, all patients have the right to effective pain management. Effective pain management consists of a multidisciplinary team approach to assessing, treating and educating the patient and their family regarding pain.

PAIN ASSESSMENT

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 (non-pharmacologic or pharmacologic). 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.

Here at Olive View we have six approved pain scales:

• Numerical Rating (0-10) Scale
• FACES Scale
• FLACC
• N-PASS Scale
• Critical Care Pain Observation Tool (CPOT)
• Assumed Pain Present (APP)

The Numerical Rating (0-10) scale is taught by discussing the concept of pain and describing that zero is no pain and at the other end of the spectrum, 10 is the worst pain.

The FACES rating system, also known as Wong-Baker FACES Pain Rating Scale, is used with people age 3 and older, facilitating communication and improving assessment so pain management can be addressed (Wong-Baker FACES Foundation, 2016). The child/adult is shown a series of faces ranging from happy and smiling to sad and tearful, and instructed to select that face that best correlates with how they feel.

The FLACC Scale is used in patients under 5 years of age. Can be used in patients greater than 5 years of age who are developmentally delayed, unable to verbalize, or are non-communicative.

The 24-Hour Neonatal Pain Assessment Form, or N-PASS (Neonatal Pain, Agitation, and Sedation Scale), is used for those infants less than 28 days unless still in the NICU in which case it will be continued.

Pain assessment scales to be used include:

a. Infants <30 days of age (corrected for gestational age) use 24 Hour Neonatal Pain Assessment Form (N-PASS) in the NICU.

b. Infants to 5 years (and cognitively impaired) use FLACC Scale. NOTE: This scale can also be used for the non-verbal patient (e.g., MRCP, severe developmental delay). This scale is used in Pediatrics and Mother-Baby unit.

c. School Age (5 years – 12 years) may use Wong-Baker FACES or Numerical 0-10 pain rating scale.

d. School Age/Adolescent (7-18 years) may use either FACES or Numerical 0-10 scale according to the patient’s preference.

The Critical Care Pain Observation Tool (CPOT) is used for adult patients who are unable to self-report pain due to altered level of consciousness secondary to being mechanically ventilated and/or medically sedated. This tool has 4 sections: facial expression, body movements, muscle tension and compliance with the ventilator for intubated patients or vocalization for extubated patients. Items in each section are scored from 0 to 2, with a possible total score ranging from 0 to 8 (Gelinas C., 2006).

The Assumed Pain Present (APP) tool is used for adult patients who are unresponsive to traumatic brain injury, pharmacologically induced coma, or neuromuscular blockade.

NOTE
The same pain scale should be used throughout the child’s hospital admission to promote consistency.
PAIN INTERVENTION

The second step of the pain management processes is the intervention or treatment of pain. According to Olive View policy, a pain rating greater than the patient’s established goal or acceptable pain level indicates the need for pain 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 advocate for patient and notify the health care provider. Educate patients and their families about why pain management is so important.

FLACC PAIN RATING SCALE

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

Note: Each of the five categories Face (F), Legs (L), Activity (A), Cry (C), and Consolability (C) is scored from 0-2, which results in a total score between 0 and 10.

## CRITICAL CARE PAIN OBSERVATION TOOL

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed, neutral</td>
<td>0</td>
<td>No muscle tension observed</td>
</tr>
<tr>
<td>Tense</td>
<td>1</td>
<td>Presence of frowning, brow lowering, orbit tightening, and levator contraction or any other change (e.g., opening eyes or tearing during nociceptive procedures)</td>
</tr>
<tr>
<td>Grimacing</td>
<td>2</td>
<td>All previous facial movements plus eyelid tightly closed (the patient may have mouth open or may be biting the endotracheal tube)</td>
</tr>
<tr>
<td>Body movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movements or normal position</td>
<td>0</td>
<td>Does not move at all (does not necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)</td>
</tr>
<tr>
<td>Protection</td>
<td>1</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
</tr>
<tr>
<td>Restlessness</td>
<td>2</td>
<td>Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
</tr>
<tr>
<td>Compliance with the ventilator (intubated patients)</td>
<td>Tolerating ventilator or movement</td>
<td>0</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>1</td>
<td>Coughing, alarms may be activated but stop spontaneously</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>2</td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
</tr>
<tr>
<td>Vocalization (nonintubated patients)</td>
<td>Talking in normal tone or no sound</td>
<td>0</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>1</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>2</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Relaxed</td>
<td>0</td>
</tr>
<tr>
<td>Tense, rigid</td>
<td>1</td>
<td>Resistance to passive movements</td>
</tr>
<tr>
<td>Very tense or rigid</td>
<td>2</td>
<td>Strong resistance to passive movements, inability to complete them</td>
</tr>
</tbody>
</table>

Total ____/8

*Adapted with permission from Gélinas et al.*
# 24 Hour Neonatal Pain Assessment Form

**Document Baseline Vital Signs**

<table>
<thead>
<tr>
<th></th>
<th>HR</th>
<th>RR</th>
<th>BP</th>
<th>SpO2</th>
<th>Print Name, Title</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evenings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N-PASS: Neonatal Pain, Agitation, & Sedation Scale © Hummel & Puchalski

## 24 Hour Neonatal Pain Assessment

### Assignment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sedation</th>
<th>Normal</th>
<th>Pain/Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying/Irritability (CI)</td>
<td>No cry with painful stimuli</td>
<td>Moans or cries minimally with painful stimuli</td>
<td>Appropriate Crying Not irritable</td>
</tr>
<tr>
<td>Behavior State (BS)</td>
<td>No arousal to any stimuli</td>
<td>Aroused minimally to stimuli</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td>Facial Expression (FE)</td>
<td>Mouth is lax</td>
<td>No expression</td>
<td>Minimal expression with stimuli</td>
</tr>
<tr>
<td>Extremities Tone (ET)</td>
<td>No grasp reflex</td>
<td>Flaccid tone</td>
<td>Weak grasp reflex Decrease muscle tone</td>
</tr>
<tr>
<td>Vital Signs: HR, RR BP SaO2</td>
<td>No variability with stimuli</td>
<td>Hypoventilation or apnea</td>
<td>&lt; 10% variability from baseline with stimuli</td>
</tr>
</tbody>
</table>

Premature Pain Assessment

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

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**Reference**


Food & Nutrition Services (FNS) provides food service to patients at Olive View-UCLA Medical Center following Hazard Analysis Critical Control Point (HACCP) safe food handling guidelines.

1. Patient trays are delivered by FNS staff according to the posted schedule in the FNS department which ensures that no more than 14 hours elapses between dinner and breakfast. Meals are served at the following times:

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7:25 am – 8:30 am</td>
<td>11:25 am – 12:30 pm</td>
<td>5:25 pm – 6:30 pm</td>
</tr>
</tbody>
</table>

2. Used trays are picked up by FNS personnel, usually 1 hour after meals were served.

3. “NOW” (late) trays are ordered by calling the Diet Office at Ext. 6171. Prior to calling, all diet changes must be entered into the electronic health record (EHR) to support the new order. The NOW tray delivery guidelines are found below.

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery (hot meal)</td>
<td>8:30 am - 10:00 am</td>
<td>12:30 pm - 2:00 pm</td>
<td>6:30 pm - 7:30 pm</td>
</tr>
<tr>
<td>Pick-up (cold meal)</td>
<td>10:00 am – 10:30 am</td>
<td>2:00 pm – 4:00 pm</td>
<td>7:30 pm – 8:00 pm</td>
</tr>
<tr>
<td>No Service</td>
<td>10:30 am – 11:15 am</td>
<td>4:00 pm – 5:00 pm</td>
<td>After 8:00 pm</td>
</tr>
</tbody>
</table>

4. Physician enters patient diet orders into the EHR, referring to the Manual of Clinical Nutrition Management, as needed. This manual is located on the Food and Nutrition Department page on the hospital intranet. The Diet Manual Addendums provide hospital-specific diet information. FNS will call nursing units for diets that are not clearly defined in the medical record.

5. FNS offers select menus daily to patients on the following diets: Regular, Low Sodium, Cardiac, Mechanical soft, Dysphagia Advanced, GI Soft, Consistent Carbohydrate, Gestation Consistent Carbohydrate, Vegetarian, Renal, Dialysis, High Calorie/High Protein, Post-gastrectomy/Dumping Diet, and Diet for Age for ages 4-18 years. Non-select menus are sent to the following diets: Diet for Age 6 months to 3 years, Clear Liquid, Full Liquid, Dysphagia Mechanically Altered, Dysphagia Puree, Ground texture, Wired Jaw, and Kosher.

6. Patient trays are identified with diet, name, birth date, unit/room, and any known food allergies.

7. Unit Floor Stock is delivered daily by FNS according to established par levels. FNS is responsible for stocking supplies, recording refrigerator temperatures, acting on temperatures not meeting standard, checking for outdated product, and discarding any non-patient items in unit kitchenette refrigerators. Environmental Services maintains cleanliness of the kitchenettes, including the refrigerators.

8. Physicians may order between meal snacks to supplement patient diet orders. Snacks are prepared by FNS staff and are available up to three times a day at 10:00am, 2:00pm, and 8:00pm. The Gestational Consistent Carbohydrate Diet and the Post-Gastrectomy Diet have three snacks a day built into the diet order. Diet for Age 1-3 years also receives an automatic 2:00 pm snack. For patients requesting between meal snacks without a physician’s order, nursing may provide food items from the unit floor stock in compliance with the patient’s diet. A Nourishment Serving Guide is available in each kitchenette for reference.

9. Patients on Radioactive Isolation receive meals on disposable-ware and Nursing staff pass their trays. “Disposable dishes” should be ordered as a diet modifier in the patient chart.

10. Patients in the psychiatric unit and medical patients with a psychiatric disorder receive plastic utensils on their tray.

11. FNS sends enteral products for tube feeding when ordered via the EHR.

12. Extended stay patients may be offered items from the Café menu if applicable to their diet.
13. Guest trays may be ordered for a member of a patient’s immediate family during an emergency situation. The decision for ordering a guest tray should be made based on the patient’s medical condition and not on the family’s financial status. Physician or Nurse will decide when a visitor should receive a guest tray and obtain verbal approval from Nursing Administration for the guest tray. If approved, the tray should be ordered via the EHR as a “One Time Meal” or “Guest tray”. Other applicable guest trays are for parents of children admitted to the NICU or 4C unit.

14. Patients are not excluded from the public Cafeteria unless they do not meet the dress codes requirements. Patients are encouraged to ask for any additional food requests from FNS.

15. See hospital policy No. 306, Food Brought into Patients from Outside. Bringing food from the outside is highly discouraged as FNS cannot guarantee its safety or oversee the proper holding of the food.

16. FNS follows HACCP safe food handling guidelines in its receiving, storing, preparing, holding, and serving practices.

Principles Standards include:

<table>
<thead>
<tr>
<th>Refrigeration Temperature</th>
<th>41° F or below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freezer Temperature</td>
<td>0° F or below</td>
</tr>
<tr>
<td>Internal Cooking Temperatures</td>
<td></td>
</tr>
<tr>
<td>Poultry: 165° F</td>
<td></td>
</tr>
<tr>
<td>Pork, ground beef, eggs: 155° F</td>
<td></td>
</tr>
<tr>
<td>Roast beef, fish: 145° F</td>
<td></td>
</tr>
<tr>
<td>Reheating (one time only): 165° F</td>
<td></td>
</tr>
<tr>
<td>Food Holding Standards</td>
<td></td>
</tr>
<tr>
<td>Hot foods: 140° F or above</td>
<td></td>
</tr>
<tr>
<td>Cold foods: 41° F or below</td>
<td></td>
</tr>
<tr>
<td>Dish Machine Temperatures</td>
<td></td>
</tr>
<tr>
<td>Wash: 150° F</td>
<td></td>
</tr>
<tr>
<td>Final rinse: 180° F</td>
<td></td>
</tr>
</tbody>
</table>

Café Services

The Food & Nutrition Services Department shall provide food services for staff, patients and visitors through cafeteria operations.

1. **Regular Hours**: 6:15 a.m. – 7:30 p.m. seven days a week. Full service hot food shall be available from 6:15 a.m. to 10:30 a.m.; 11:00 a.m. to 2:00 p.m.; and 4:00 p.m. to 7:30 p.m.

2. **Payment**: Patrons may pay cash, debit/credit card, utilize the Meal card system, or present a meal ticket through Volunteer or Nursing Administration offices. No authorized employee discounts.

3. **Cash Control**: Cash banks and revenue are justified daily. Cashiers may not leave cash drawers unattended.

4. **Smoking**: Olive View is a smoke-free campus.

5. **Take-Out Food**: Due to operational parameters and sanitation regulations, no food may leave the cafeteria unless it is on disposable service ware/covered.

6. **Refund Requests**: Should be directed to Food & Nutrition Services supervisor or manager.

7. **Children**: Under age of 11 should be supervised by an adult.

8. **Conference Dining Room**: Must be reserved through Administration by calling (747) 210-3001.

9. **Dress Code**: No person may be permitted to the cafeteria service or dining area unless properly attired. Proper attire includes: shoes or slippers and street attire or robe. To reduce trip hazards in the confined space of the Café, no IV poles are permitted in the Café.
NUTRITION SCREENING/MEDICAL NUTRITION THERAPY/CONSULTS

NURSING (INITIAL NUTRITION SCREEN)

1. Gathers information from patients within 24 hours of admission based on pre-determined nutrition criteria and documents the information gathered in the medical record. Based on results of the admission assessment, consults a dietician from this criteria including, but is not limited to:
   - Malnutrition Screening Tool (MST) score of 2 or higher indicates patient with nutrition risk
   - Pressure ulcers
   - Impaired Intake

DIETITIAN (OR SUPERVISED DIETETIC INTERN)

1. Acts on information/consults resulting from Nursing Admission Assessment within the timeframes specified in Reassessment and Follow-up Guidelines.
   - Pediatric Nursing Admission Assessment will be reviewed for nutrition problems within 48 hours of hospital admission.
2. Evaluates information from the following sources as it becomes available:
   - Registered Dietician (RD) Census Report: diet/TF orders; # days patient has been NPO/CLD
   - Pharmacy: New orders for TPN/PPN
   - EHR Census Task List: Consults from physicians, nurses, and other healthcare professionals; RD-entered initial and follow-up instructions
   - Multidisciplinary team meetings
   - FNS: meal rounds; Patient Alert Notes
3. Patients are continuously assessed and prioritized and will receive nutrition intervention when applicable per policy.

NUTRITION DIAGNOSIS & INTERVENTION

1. Based on the Nutrition Assessment findings, the RD identifies a Nutrition Diagnosis and gains patient agreement on the appropriate Nutrition Intervention that will follow.
2. When recommendations are made which require a physician order, the dietitian will follow-up within 48 hours to verify a response to the recommendation. If the physician does not respond to the recommendation by ordering the requested intervention or by another entry in the medical record, the RD will do one or all of the following:
   - Contact the physician to discuss the recommendation(s) made and document the results of the discussion.
   - Resubmit the intervention in the Electronic Health Record (EHR), requesting a response. If still no response, the RD will contact the physician to discuss the recommendation, and documents the results of the discussion.

NUTRITION MONITORING & EVALUATION

1. The RD monitors and evaluates the patient’s response to care according to Reassessment and Follow-Up Guidelines (D006A). Nutrition monitoring and evaluation may include any or all of the following: nutrition reassessment, meal rounds, medical rounds and/or care plan rounds/meetings. Monitoring and evaluation may or may not result in new nutrition recommendations. The results of monitoring and evaluation are documented in the patient’s medical record by the Dietitian/designee.
2. When nutrition goals are met or are no longer applicable a dietitian may “sign off” on a patient. The dietitian will document in the medical record that future involvement will be provided by consult or when additional information regarding the patient’s medical condition warrants it.
3. Hand-off Communication: When the care of a patient transfers from one dietitian to another, there is a “hand-off” of information about the patient. While the information may be written or verbal, there must always be the opportunity to ask and respond to questions, in a timely fashion. Information communicated during the “hand-off” includes the patient’s current condition, nutrition interventions implemented and the patient’s response to the interventions.

ASSESSING PAIN

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

PAIN HISTORY AND PHYSICAL EXAM

Assess:

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

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

Examine:

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

Physical exam both informs the assessment of pain and demonstrates to patients that we are committed to a comprehensive evaluation of their pain.

GOALS FOR PAIN MANAGEMENT

Elicit from the patient what their functional goals are.

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

THREE MAJOR TYPES OF PAIN

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

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

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

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

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

Treatment includes the following five broad treatment categories:

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

RESTORATIVE THERAPIES

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

INTERVENTIONAL PROCEDURES

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

BEHAVIORAL HEALTH APPROACHES

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

COMPLEMENTARY AND INTEGRATIVE HEALTH

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

MEDICATION MANAGEMENT:

Topicals: Always offer wherever feasible.

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

Oral non-opioid analgesics:

- If no hepatic failure, Acetaminophen (Tylenol) is safe and effective. Typically most patients tolerate 1000mg TID standing or PRN. Limit to maximum 2,000mg daily for hepatic insufficiency.
- If no renal insufficiency or other contraindication, **Ibuprofen (Advil/Motrin)** 600-800mg TID with food PRN is helpful for nociceptive pain. If there is history of GERD/stomach irritation, consider instead **Meloxicam** 7.5mg BID with food PRN or even **Celecoxib (Celebrex)** 100mg BID with food PRN.
If there is significant objective muscle tightness or myofascial pain, muscle relaxants can be considered. Muscle relaxants do cause drowsiness, increase fall risk, and potentiate other sedatives including alcohol. Caution in starting these medications and monitor closely. These medications should be avoided in the elderly or patients with polypharmacy. Recommend starting with low dose just at bedtime at first to assess for side effects.

- **Cyclobenzaprine (Flexeril)** 5-10mg QHS to start may help with sleep initiation. If tolerated (watch for drowsiness, dizziness), can increase to 5-10mg TID PRN. This is serotonergic, so caution if patient is on more than two serotonergic agents for risk of serotonin syndrome.
- **Methocarbamol (Robaxin)** 500-1000mg TID PRN is usually well tolerated, tends to cause less drowsiness, can be up-titrated to maximum 8000mg/day.
- **Tizanidine (Zanaflex)** 2-4mg TID PRN (watch for orthostatic hypotension, can be helpful if patient has HTN).
- **Baclofen** 5-10mg TID PRN – usually first line for spasticity associated with central nervous system injury, can also be helpful for neuropathic pain.

**Neuropathic analgesics:**

- For neuropathic pain, and even nociceptive pain as a strategy to minimize opioid requirements, the first-line neuropathic analgesic is gabapentin. Note: Gabapentin is not available in Correctional Health Services formulary.

Gabapentin is usually started at 300mg QHS x 3-7 days to assess for side effects (can cause drowsiness/dizziness), then increased to 300mg BID x 3-7 days, then increased to first goal dose of 300mg TID. If this causes a lot of drowsiness but is helpful, increase the nighttime dose to goal dose of 900mg QHS only. As tolerated, can increase in a similar fashion to 600mg TID, which maximizes gabapentin’s bioavailability. If creatinine clearance is 30-59 mL/min, recommend BID dosing up to goal dose 600mg BID. Maximum safe dose is 3600mg/24 hours (1200mg TID) but usually past 800mg TID there is limited benefit to dose increases.

The second-line neuropathics of choice are **duloxetine (Cymbalta)** and **nortriptyline (Pamelor)**, and they can be helpful for mood too.

- **Duloxetine (Cymbalta)** can be started at 20-30mg daily x 3 days then uptitrate as tolerated to 20-30mg BID (max dose for neuropathic pain). This medication does not tend to cause drowsiness but can cause GI upset or dizziness. This is serotonergic, so caution if patient is already on multiple serotonergic medications.
- **Alternatively, nortriptyline (Pamelor)** is usually started at 10mg QHS, then after 7 days to assess for effectiveness or side effects, can uptitrate to 20mg QHS as first goal dose. Caution for drowsiness, dry mouth, dizziness, confusion, bladder retention. Can continue to uptitrate to lowest effective dose, max safe dose is 150mg/24 hours. This is serotonergic, so caution if patient is already on multiple serotonergic meds.
- Nortriptyline tends to have fewer side effects than **amitriptyline (Elavil)**, though amitriptyline has more evidence for efficacy in neuropathic pain associated with spinal cord injury. These medications should be avoided in the elderly > 65 years old.

If a patient has had no effectiveness with maximum dose gabapentin, a second-line neuropathic, AND a muscle relaxant, (or can’t try some of these because of allergies or other contraindication) then insurance companies will consider covering **pregabalin (Lyrica)**, which requires prior authorization.

- **Pregabalin (Lyrica)** typically works best in patients with complex neuropathic pain like after spinal cord injury or phantom limb pain after amputation. If starting pregabalin, wean gabapentin to at least half their previous dose, then start Lyrica at about 50-100mg BID. Caution for drowsiness, leg swelling. After 3 days, as tolerated, can stop gabapentin and increase pregabalin to max dose 600mg/day (so 200mg TID or 300mg BID).

An “out of the box” third-line analgesic that has most benefit in complex neuropathic or centralized pain and/or depression is ketamine.

- **Ketamine** is an NMDA receptor antagonist that can be helpful in depression and complex chronic pain, but it is primarily used in the peri-operative setting as an adjunct to anesthesia. It can be used in the outpatient setting, but compounded capsules are not covered by insurance and there are very few ketamine infusion programs that accept insurance.
SLEEP AIDS

- Melatonin 3-6mg qhs is a natural sleep aid that can help facilitate sleep quality/duration with minimal side effects.
- Trazodone 50-100mg qhs is a sleep aid. It can cause orthostasis, particularly in the elderly. It can also cause priapism in men.
- If melatonin and trazodone are contraindicated or ineffective, diphenhydramine (Benadryl 25-50mg) is also a common sleep aid, though can cause anticholinergic symptoms including cognitive problems especially in the elderly. Can also use other anti-histamines like hydroxyzine or even cyproheptadine. Cyproheptadine is also a serotonin blocker used for the treatment of serotonin syndrome.
- Nortriptyline (Pamelor) and amitriptyline (Elavil) are commonly dosed at night and can be helpful for neuropathic pain, mood, and sleep.
- If someone has a lot of drowsiness on gabapentin or pregabalin, it’s recommended to keep the daytime doses low BID and then just increase the night time dose, which can help with sleep (example: Gabapentin 100mg qAM, 100mg qPM, 300mg qHS).

Hypnotics (such as zolpidem, eszopiclone, and zaleplon) have been used as short term sleep aids and benzodiazepines have been used for brief episodic anxiety, insomnia, and muscle spasticity management. They generate physical dependence, and are dangerous in combination with other sedating medications. They are not recommended for long term use for any condition and increase risk of death when combined with opioids and other central nervous system depressants.

OPIOIDS and OPIOID SAFETY

Opioids can be appropriate for acute trauma or pain (e.g. motor-vehicle accident, sickle cell crisis), acute post-operative pain, and pain from terminal illness such as malignancies. Aside from terminal pain, all patients should be counseled that they should not need opioids after the expected healing period (usually 3-10 days and generally not more than 14 days). After that, the risks of opioids almost always outweigh the benefits. Opioids are not indicated for chronic (longer than 3 months), non-terminal pain. Opioids shut down the pain-signaling pathway, and after their effects wear off, the pain returns because opioids do not address cause of pain. Opioids can also trigger the pain system to become more sensitive – a condition known as opioid induced hyperalgesia.

- DHS expected practices are to not offer treatments when harm outweighs benefit. Explain to patients opioid-associated risks including increased risk of death, overdose, dependence and hyperalgesia, and interference with other pain management treatments. Non-opioid treatments are safer and better address the inflammation and nerve irritation that are physiologic causes of pain. Structured & validated opioid risk tools exist such as the ORT: https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf

For high-risk situations (active concurrent substance use disorders, history of overdose on prescribed opioids, diversion behavior, and respiratory insufficiency), there is no benefit that would outweigh the harm of continuing opioids. Transition these patients to buprenorphine-naloxone (Suboxone) as their opioid analgesic strategy of choice. Buprenorphine is a schedule III opioid partial agonist that is categorically safer than all other opioids. It has analgesic properties and thus a wide therapeutic index for pain management.Usual dosing for analgesia is buprenorphine-naloxone 2-0.5mg to 8mg-2mg tablet SL TID.

Risk factors for problems related to opioid use include:

- Chronic disease: risk of opioid use disorder is 30%
- History of mental health issues: depression, anxiety, bipolar disorder, schizophrenia, suicidal behaviors
- Social instability and trauma such as history of sexual abuse
- Personal history of substance use (including alcohol, tobacco use, illicit drugs, and prescriptions), any history of overdose
- Risk factors for over sedation such as concomitant sedatives, benzodiazepine use, taking > 50 MME/day
- Family history of substance abuse (including alcohol, illicit drugs, and prescriptions)
- Risk factors associated with decreased respiratory function such as obesity, COPD, asthma, OSA
- Risk factors associated with poor metabolic clearance such as advanced age, liver or kidney disease
- Structured & validated opioid risk tools exist such as the ORT: https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf
Safer opioid strategies in chronic pain management:

- Avoid starting opioids for chronic non-terminal pain.
- Practice naloxone (Narcan) co-prescribing and education (indications for use, calling 911, administer second dose if effects wane).
- For patients already on opioids, we recommend evaluation for tapering the opioid dose down or discontinuous opioids at each visit. Evaluate all patients on chronic opioids for opioid misuse and/or diversion.
- Set a brief time-limited goal for use of opioids, with specific evaluation of functional improvements. If there is no improvement of functional goals on opioids, stop the opioids. Use lowest effective dose. The maximum recommended daily opioid dose is 50 MME (e.g. Oxycodone 40mg/day).
- If choosing to prescribe opioids for chronic pain, consider abbreviated prescriptions e.g. 3-7 days for new acute pain.
- Implement safeguards such as random urine drug screens (UDS) to ensure compliance both that patient is taking prescribed opioid and not taking illicit medications. Note urine fentanyl test is a unique order. Practice naloxone (Narcan) co-prescribing and education (indications for use, calling 911, administer second dose if effects wane).
- Minimize risky combinations, avoid co-prescription of benzodiazepines and other potentially sedating medications.
- CURES report checks: use first 1-3 letters of first and last names plus date of birth to capture all versions of patients’ names.
- For high-risk situations (active concurrent substance use disorders, history of overdose on prescribed opioids, diversion behavior, and respiratory insufficiency), there is no benefit that would outweigh the harm of continuing opioids. Transition these patients to buprenorphine-naloxone (Suboxone) as their opioid analgesic strategy of choice. Buprenorphine is a schedule III opioid partial agonist that is categorically safer than all other opioids. It has analgesic properties and thus a wide therapeutic index for pain management.
- Some providers find that Pain Treatment Agreements can facilitate difficult conversations and preserve a therapeutic relationship between patient and care team. There is no evidence to support the outcome based clinical benefit of Pain Treatment Agreements (Controlled Substance Prescription/Opioid Contracts).
- Consult Pain Management for advice, education, and support: eConsult to Pain Management (non-malignant) for patients in ambulatory settings.

**Tapering Opioids**

It is easier to taper down long acting opioids (such as methadone or morphine OR) on a patient’s regimen first and subsequently transition to short acting opioids as an initial milestone. Long acting opioids such as methadone, oxycodone extended release, and morphine sulfate extended release are generally only appropriate for patients with terminal pain.

- Reduce the daily dose by 10-20% each week to month to minimize physical withdrawal and psychological anxiety about changes in opioids. Individualize the pace of tapering.
- Encourage splitting tabs in half and replacing breakthrough opioid doses with breakthrough non-opioid strategies.
- For further guidance on tapering, please see “Opioid Tapering Expected Practice Guidelines”.
- Send an eConsult to Pain Management (non-malignant) if there are specific questions about tapering opioids.
PATIENTS WITH SUBSTANCE USE DISORDERS

Opioid use disorder commonly co-occurs with chronic pain. If a patient has an opioid use disorder, the first line treatment is to initiate sublingual buprenorphine-naloxone, which can be dosed TID to QID to address pain. Instructions for initiating buprenorphine/naloxone are discussed in the Expected Practice: Outpatient Medication Management of Opioid Use Disorder.

An X-waiver is not required to prescribe buprenorphine-naloxone for the indication of pain. Ensure that the indication of pain is documented in the ORCHID order in the instructions for the pharmacist field to clarify the indication for this buprenorphine-naloxone.

An X-waiver is required to prescribe buprenorphine-/naloxone in ambulatory settings for the indication of opioid use disorder. Email buprenorphine@dhs.lacounty.gov to obtain an X-waiver. Providers who prescribe buprenorphine-naloxone for the indication of opioid use disorder must include their X-waiver number, the diagnosis of opioid use disorder (F11.20) in the ORCHID order in the instructions for the pharmacist field.

For patients with alcohol, tobacco, and other co-occurring substance use disorders, see the DHS Clinical Care Library section on Addiction Medicine to review and implement DHS expected practices related to the treatment of these conditions: http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx

If there are non-urgent questions about appropriate use of medications for alcohol, tobacco, and/or opioid use disorder, use the eConsult: Addiction Medicine – Medications for Addiction Treatment.

- For urgent questions about appropriate use of medications for treatment of alcohol, tobacco, and/or opioid use disorder, including during a clinical visit: DHS Addiction Medicine Consult line 8am to Midnight everyday including weekends: (213) 288-9090
“READ BACK”, “REPEAT BACK” REQUIREMENTS

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

- **Telephone Orders** – While the licensed independent provider (NP, PA, MD) issues the order, the registered nurse (RN) enters the telephone order into the electronic health record. Before ending the telephone call, the RN “reads back” the order to the provider to confirm that he/she understood and transcribed it correctly. The RN will document the phrase “Telephone Order issued by” or the abbreviation “T.O. by” followed by the provider’s printed full name and provider identification number. The electronic telephone order will be automatically routed to the issuing provider, to be signed as soon as possible, and no more than 48 hours later.

- **Verbal Orders** – It is not always feasible to do a formal “read back” for a verbal order (e.g., during a code blue or in surgery). In such circumstances, a “repeat back” is an acceptable means of confirming the accuracy of the order. When able, the RN will enter the verbal order into the electronic medical record. The order must include the date, time, specific order, ordering provider’s name and the communication type selected as "Verbal with Read Back". The electronic verbal order will be automatically routed to the issuing provider, to be signed as soon as possible, and no more than 48 hours later.

- **Critical 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, Olive View requires you to “read back” the test result or value to the caller. Then, telephone the physician caring for the patient. Olive View also requires the physician to do a verification “read-back”.

- 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 “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. 

(Applicable to laboratory only)

DETERIORATING PATIENT CONDITION

RESPONDING TO THE DECLINE IN PATIENT CONDITION

As patient caregivers, you need to know the signs and symptoms of the decline in a patient’s condition, within your scope of practice. The assessment and recognition of the deteriorating patient is an ongoing challenge throughout the patient’s stay or visit to your facility. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going health assessments, handoff communication reports, chart documentation and other communication modalities are good methods to use in recognizing declination in the patient’s condition. **Every** member of the healthcare team is responsible to ensure that he/she give the highest level of care, and to immediately react upon emergencies, potential emergencies and/or incidents. Olive View-UCLA Medical Center has two response teams that can assist:

- **Rapid Response Team (RRT):** The team that is available 24-hours per day, 7 days a week to respond to urgent clinical patient situation.
- **Patient Assist Team:** The team that is available 24-hours per day, 7 days a week to respond to urgent clinical situation in First and Second Floor Lobbies, including the first and second floor patient loading areas and Parking Lot I.

RAPID RESPONSE TEAM

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

The RRT is set up to evaluate and stabilize patients who are deteriorating. If you are concerned that a patient is deteriorating, activate the RRT right away, and explain what concerns you. Any staff member can call to activate an RRT by calling the ICU at (747) 210-4415. In addition, the patient’s RN must notify the patient’s Primary Team or Cross-Cover Team.

**Patient Assist Team**

If you see a patient/visitor needing medical assistance in the First or Second Floor Lobbies, including the adjacent patient loading zones and Parking Lot I, activate the Patient Assist Team by calling the Hospital Operator at Ext. 111. The Hospital Operator will announce Patient Assist Team (PAT) by overhead page. The PAT will respond to any urgent clinical outpatient situations whereby the patient’s condition warrants medical assessment and clinical intervention.

PAT does not replace the Code Blue Team. Anyone can call a Code Blue for cardiac arrest by dialing Ext. 114 from a hospital phone. In areas outside the main hospital building, call 9-1-1 for a medical emergency.

**FALL REDUCTION AND PREVENTION**

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

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

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

**Hospitalized inpatients** (1 year of age and older) will be assessed on admission, and reassessed daily, on transfer to another unit, with condition change, and post fall. The staff will document the following in the medical record:

- Using the appropriate Fall Risk Assessment Tool, the initial assessment and ongoing reassessments
- Patient/family education related to falls
- Ongoing safety precautions
- Any fall incident, related assessment, and notification of physician/family

**Emergency Department** patients will be screened for fall risk using specific assessment screening elements. The staff will document all fall reduction interventions and patient/family education in the medical record. Appropriate fall prevention measures will be implemented for all patients identified as ‘at risk for falls’. If any screening criteria element is positive, a licensed healthcare professional will implement and document interventions to reduce the ‘risk of falls’ including patient/family education.

**Organization/Facility Assessment of Fall Risk:**

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

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

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

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

Rehabilitation Fall: A fall 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™ (SI) Event Reporting System.

HOSPITAL BASED OUTPATIENTS

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

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

   2. Screen each adult and/or pediatric patient (over 1 year of age) for fall risk using the age appropriate screening tool.
   • Adult Ambulatory Care Fall Screening Criteria
   • Pediatric Ambulatory Care Fall Screening Criteria (patient >1 year of age)

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

C. Outpatient Fall Prevention Measures
   1. Maintain a safe, hazard free environment (remove any obstacles from patient pathway).
   2. Place ‘at-risk’ patients who are identified as needing assistance on exam table only at the time of examination, with staff present.
   3. Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so).
   4. Ensure adequate lighting.
   5. Use wheelchair locks when indicated.
   6. Keep beds, stretchers, and/or gurneys in lowest, locked position with side rails up, as appropriate.
   7. Keep call light, as applicable, within reach.
   8. Identify and manage areas of concern during Environmental/Safety Rounds.
   9. Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
   10. Notify the appropriate professional for focused fall reduction interventions and patient/family education, including, but not limited to:
       • Diagnosis and treatment underlying etiology of fall risk
       • Ensure ‘fall risk’ alert armband is in place based on patient condition and determination of fall risk.
   11. Provide patient/family education regarding:
       • Fall risk determination.
       • Safety measures for prevention of falls during their outpatient visit.
       • Rising slowly from a sitting or lying position.
       • If possible, consider having patient relocate to an area that allows closer nursing observation.
12. Offer wheelchair, if appropriate.
13. Ensure assistive devices (e.g., cane, crutches, walker, wheelchair) are within reach of the patient.
14. Assist patients walking with medical equipment, as appropriate (e.g., wound vacuum devices, IV poles, oxygen tubing, tanks, etc.).
15. Alert subsequent providers that patient is a fall risk (e.g., during transfers or hand-off to another clinical area/service).

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

INPATIENTS

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

Assessment/Reassessment

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

<table>
<thead>
<tr>
<th>Morse Fall Risk Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Factor</strong></td>
<td><strong>Scale</strong></td>
</tr>
<tr>
<td>History of Falls</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory Aid</td>
<td>Furniture</td>
</tr>
<tr>
<td></td>
<td>Crutches / Cane / Walker</td>
</tr>
<tr>
<td></td>
<td>None / Bed Rest / Wheel Chair / Nurse</td>
</tr>
<tr>
<td>IV / Heparin Lock</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Gait / Transferring</td>
<td>Impaired</td>
</tr>
<tr>
<td></td>
<td>Weak</td>
</tr>
<tr>
<td></td>
<td>Normal / Bed Rest / Immobile</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Forgets Limitations</td>
</tr>
<tr>
<td></td>
<td>Oriented to Own Ability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Morse Fall Score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>51 and higher</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>25 - 50</td>
</tr>
<tr>
<td>Low Risk</td>
<td>0 - 24</td>
</tr>
</tbody>
</table>
## Humpty Dumpty Scale and Prevention – Inpatient Program

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Criteria</th>
<th>Score (Circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Less than 3 years old</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3 to less than 7 years old</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>7 to less than 13 years old</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>13 years and above</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Neurological Diagnosis</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Alteration in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Psych/Behavioral Disorders</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td><strong>Cognitive Impairments</strong></td>
<td>Not Aware of Limitations</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Forgets Limitations</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Oriented to Own Ability</td>
<td>1</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td>History of Falls or Infant-Toddler Placed in Bed</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Patient Uses Assistive Devices or Infant-Toddler in Crib or Furniture/Lighting</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Patient Placed in Bed</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Outpatient Area</td>
<td>1</td>
</tr>
<tr>
<td><strong>Response to Surgery/Sedation/Anesthesia</strong></td>
<td>Within 24 Hours</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Within 48 Hours</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>More Than 48 Hours/ None</td>
<td>1</td>
</tr>
<tr>
<td><strong>Medication Usage</strong></td>
<td>Multiple Usage of: Sedatives (Excluding ICU Patients Sedated andParalyzed), Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/ Diuretics, Narcotic</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>One of the Meds Listed Above</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other Medications/None</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total**
2. Patients not initially identified as moderate or high risk for falls on admission will be reassessed daily, upon inter-unit transfer, upon change of status, or upon fall to determine the need for Fall Prevention Measures (FPM) implementation.

Risk Determination

### Adults

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Any adult patient who receives a score of 0-24 on the Morse Fall Scale is considered as low risk. Level 1 interventions will be implemented for these patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Risk</td>
<td>Any adult patient who receives a score of 25-50 on the Morse Fall Scale is considered as moderate risk. Level 2 interventions will be implemented for these patients in addition to Level 1 interventions.</td>
</tr>
<tr>
<td>High Risk</td>
<td>Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients in addition to Level 1 and 2 interventions.</td>
</tr>
</tbody>
</table>

- When a patient is identified as moderate or high risk for falls, the nursing staff will initiate a plan of care related to the patient’s identified risk factors and place a colored “fall risk” alert arm band on the patient.
- Place a sign at the entrance to the patient’s room and/or head of the patient’s bed.

### Pediatrics

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and “General Fall Prevention Interventions for All Children” will be implemented for these patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for High Risk for the duration of his/her hospitalization.</td>
</tr>
</tbody>
</table>

- If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a falls risk reassessment may be performed and documented to justify the discontinuation of the high risk for falls identification and implementation of Falls Prevention Measures.
- If, in the nurse’s judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures.

Initiation of Plan of Care

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

Fall Prevention Measures

When a patient is identified as moderate or high risk for falls either on admission or during his/her hospitalization, the RN will implement the following fall prevention measures:
**Level 1 Low Risk**  
**Score: 0 – 24**

- The patient’s risk for falls will be discussed with interdisciplinary team members.
- Provide patient/family education related to fall prevention.
  - Purpose and importance of fall/injury prevention measures.
  - Use of call light.
  - Maintain bedrails in appropriate position.
  - Safe ambulation/transfer techniques.
  - Importance of wearing non-skid footwear.
  - Reporting environmental hazards to nursing staff (e.g., spills, cluttered passages).
- Family/ significant others may assist with fall reduction strategies once fall management training is completed. (Note: staff remains responsible for overall safety of patients even with family in attendance.).
- Perform intentional rounds.
- Orient patient to surroundings and hospital routines.
- During exchange of patients between staff, hand off communication should include fall risk level, supervision provided, and observation of unsafe behaviors.
- Set the bed in the lowest position with brakes locked.
- Place personal belongings within reach on the bedside stand/table.
- Reduce room clutter. Remove unnecessary equipment and furniture.
- Provide non-skid (non-slip) footwear.

**Level 2 Moderate Risk**  
**Score: 25 – 50**

- Attach fall prevention stickers to the front of the medical record.
- Place a sign at the entrance to the patient’s room and/or head of the patient’s bed.
- Offer toileting, minimally, every 2 hours.
- Activate the bed alarm and wheelchair seat belt alarm, if appropriate.

**Level 3 High Risk**  
**Score: 51 and higher**

- Increase intentional rounds based on patient need.
- Collaborate with interdisciplinary team for therapy schedule/ activities.
- Cohort patients, when possible.
- Restraints are discouraged, however, if needed, apply per Hospital Specific Restraint Policy.
- Provide continuous in-person observation with a trained staff member as needed for safety reasons.
- Place the patient in a room or area where they can be easily observed.
- Offer toileting, minimally, every 2 hours.
- Stay with patient at all times while toileting out of bed.
  - Refusal by patient for direct observation during toileting must be documented in the patient’s medical record, as applicable. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.)
  - Notify the appropriate licensed professional of patient’s refusal.
### General Fall Prevention Measures

Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all children:

- Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
- Leave crib side rails up at all times unless an adult is at the bedside.
- Bed type and size shall be determined based on child’s developmental and clinical needs.
- Instruct patient/parent on how to prevent falls in the hospital setting:
  - Maintain side rails in appropriate position.
  - Maintain crib rails up.
  - Do not allow the child to jump on the bed.
  - Do not allow the child to run in the room or hallway.
  - Do not allow the child to climb on hospital furniture or equipment.
  - Importance of wearing non-skid footwear.
  - Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.
  - Notify nursing staff of environmental hazards (e.g., spills, cluttered passages).

Supervise the child’s activities, e.g., walk next to the child and provide support as strength and balance are regained.

### Fall Prevention Measures for High Risk

- Consider locating the child closer to nursing station for closer observation.
- Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion and pain.
- Offer assistance with toileting, minimally, every 2 hours while awake.
  - Stay with child at all times while toileting out of bed.
  - Refusal by the child’s parent/guardian for direct observation during toileting must be documented in the patient’s medical record.
  - Notify the appropriate licensed professional of child’s parent/guardian’s refusal.
- Provide calming interventions and pain relief.
- Accompany patient with ambulation.
- Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications).
- Set bed alarms, as appropriate, to alert when child is exiting the bed.
- Evaluate need for and encourage family to remain at the child’s bedside.
Post-Fall Procedure

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

Post-Fall Evaluation and Management Algorithm

First Responder
- Stay with patient. Call for help.
- Check patient for pain or injury, check LOC
- Report fall to licensed personnel.
- Provide comfort measures until licensed staff member arrives and assesses patient for injury

Licensed Provider
- Assesses patient asap after fall
- Provides follow-up orders, medical, and diagnostic work-up, and care as indicated
- Reviews patient’s medications. If patient is on anticoagulation therapy and has struck head, consider indication for radiographic exams, including head CT or MRI
- If patient shows change in neurological status, considers transfer to a higher level of care
- Notifies emergency contact and documents notification in medical record
- Recommends additional steps for fall prevention

RN Staff
- If patient has struck head/face and/or is on anticoagulation therapy, immediately notify physician, and initiate neuro checks. If physician does not respond at bedside within the hour, follow medical chain of command
- Documents clinical status and description of fall in medical record
- Completes Fall Risk Reassessment and updates care plan
- Implements additional intervention as needed or as ordered. (e.g., increased level of supervision)

NOTE

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

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

DOCUMENTATION

Outpatient
For patients at risk for falls, staff will document the following on appropriate outpatient record:
- Falls screening
- Fall risk
- Fall prevention measures and patient education provided

Inpatient
The RN will document the following on the appropriate forms:
- Using the appropriate Fall Risk Assessment Tool, document the initial assessment and ongoing reassessments
- Patient/family education related to falls
- Ongoing safety precautions
- Any fall incident, related assessments, and notification of physician/family

EMERGENCY DEPARTMENT (ED)

A. Screening (adult, pediatric, psychiatric, and all other ED areas) will take place at the time of triage assessment using age appropriate fall risk screening criteria:
Adult
1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure or syncope
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit-sight/hearing/speech impairment
7. Unsteady gait/weakness

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

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

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

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

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

UNIVERSAL PROTOCOL

Olive View has adopted all components of The 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 preprocedure 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:

- **Pre-Operative/Pre-Procedure Verification** – Olive View uses 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.

- **Marking the Operative Site** – Olive View 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.

- Team conducts 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.

Attestation of performance of a Time Out, including the date and time, is documented in the electronic medical record.

- Use of the Universal Protocol is required for procedures for non-OR settings, including bedside procedures. Pre-procedure verification of relevant documents and informed consent is necessary. Site marking must be done for any procedure that involves laterality, multiple structures or level, when there is not an obvious wound or lesion. All those who will be participating in the procedure conduct a DHS Standardized Non-OR Procedural Time Out before the start of the procedure. The ASK NICE mnemonic captures the core components of the Time Out: A – announce time out/allergy check, consent. S – specimen, K – “K”orrect patient, procedure, site/laterality, N – needed equipment, I – informed consent, C – coagulation status, E – expiration date “call out” when supplies and medications are opened. Attestation of performance of a Time Out, including the date and time, is documented in the electronic medical record. In non-specialty areas (e.g., bedside procedures), the provider documents the occurrence of the “TIME OUT” in his/her procedure note.
“LOOK-ALIKE/SOUND-ALIKE” MEDICATIONS

To further enhance medication safety, please refer to the ISMP list of look alike, sound alike medications. These medications are stored apart in the Pharmacy and in patient care areas. Special attention should be given when administering one of these drugs to ensure that it is the correct drug.

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

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

- Tall man lettering is used to describe LASA drugs on medication labels, Medication Administration Record (MAR).
- LASA drugs are separated where drugs are stored and labeled with a cautionary sticker.

Prescribers are encouraged to include the indication for use when prescribing LASA medications.

### LOOK-ALIKE/SOUND-ALIKE MEDICATION LIST

<table>
<thead>
<tr>
<th>Look-Alike/Sound-Alike</th>
<th>CARBOplatin</th>
<th>CISplatin</th>
</tr>
</thead>
<tbody>
<tr>
<td>(antineoplastic)</td>
<td></td>
<td>(antineoplastic)</td>
</tr>
<tr>
<td>clonAZEPAM</td>
<td>ClonIDINE</td>
<td></td>
</tr>
<tr>
<td>(anticonvulsant)</td>
<td>(alpha-adrenergic agent)</td>
<td></td>
</tr>
<tr>
<td>DAUNOrubicin</td>
<td>DOXOrubicin</td>
<td></td>
</tr>
<tr>
<td>(antineoplastic)</td>
<td>(antineoplastic)</td>
<td></td>
</tr>
<tr>
<td>DOPAmine</td>
<td>DOBUTamine</td>
<td></td>
</tr>
<tr>
<td>(adrenergic agonist)</td>
<td>(adrenergic agonist)</td>
<td></td>
</tr>
<tr>
<td>ePHEDrine</td>
<td>EPINEPHrine</td>
<td></td>
</tr>
<tr>
<td>(bronchodilator)</td>
<td>(alpha-beta agonist)</td>
<td></td>
</tr>
<tr>
<td>foLIC acid</td>
<td>foLINIC acid</td>
<td></td>
</tr>
<tr>
<td>(vitamin)</td>
<td>(antidote)</td>
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</tr>
<tr>
<td>hydromorPHONE</td>
<td>MORPHine</td>
<td></td>
</tr>
<tr>
<td>(narcotic analgesic)</td>
<td>(narcotic analgesic)</td>
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</tr>
<tr>
<td>hydR oxyzine</td>
<td>hydRAZINE</td>
<td></td>
</tr>
<tr>
<td>(anti-histamine)</td>
<td>(anti-hypertensive)</td>
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</tr>
<tr>
<td>LAMIVudine</td>
<td>LAMOtrigine</td>
<td></td>
</tr>
<tr>
<td>(anti-retroviral)</td>
<td>(antiepileptic)</td>
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</tr>
<tr>
<td>LORazepam</td>
<td>ALPRAzolam</td>
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<tr>
<td>(benzodiazepine)</td>
<td>(benzodiazepine)</td>
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</tr>
<tr>
<td>SufSALazine</td>
<td>SulfaDIAZINE</td>
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</tr>
<tr>
<td>(anti-inflammatory agent)</td>
<td>(antibiotic)</td>
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</tr>
<tr>
<td>VinBLASTine</td>
<td>VinCRIStine</td>
<td></td>
</tr>
<tr>
<td>(antineoplastic)</td>
<td>(antineoplastic)</td>
<td></td>
</tr>
</tbody>
</table>
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.

• There is a documented diagnosis, condition, or indication for use for each medication ordered.
• As applicable, weight-based dosing for pediatric patients is required.
• Medication orders are entered appropriately.
• Enforcement/feedback policy and procedures are in effect.

ORDER TRANSMISSION

Medication orders placed in the Electronic Health Record (EHR) are seen at the Medication Manager for pharmacist review. To ensure rapid dispensing of STAT orders, the providers must select STAT under the “First Dose Priority” field in order details. Written medication orders i.e., oncology and adult TPN must be promptly “scanned” to the pharmacy through the Pyxis scanners in areas equipped with this hardware or “faxed” to the pharmacy. This facilitates the timely dispensing of medications.

MEDICATION PRESCRIBING

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

Safety Tips for Safe Medication Prescribing

Make your medication orders clear and complete by:

• Identifying your patient with TWO identifiers (Patient Name and a second identifier, such as Date of Birth, Financial Identification Number or Medical Record Number).
• Using generic drug names on all medication orders.
• Including specific dose, route, and frequency.
• Not using range orders (Pharmacy will not accept ranges such as 1-2 tabs; q 4-6h in orders.).
• Qualifying all as needed (PRN) orders (e.g., PRN moderate pain).
• Placing date, time and signatures on all orders. Electronic signatures do not require a separate date and time if the information is automatically recorded in the system.
• All written documentation shall be clear and legible.
• Entering the patient’s diagnosis, allergies, and height/weight on all admitting orders to avoid delay in dispensing.
• Using weight-based dosing on all pediatric patients less than 40 kg of weight.
• Discontinuing and reordering medications instead of “Hold” orders.

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

Medication Storage Safety Tips:

- ✓ Do not store food with medications
- ✓ Different medications should NOT be stored in the same bin
- ✓ Medication for discharged patients should not be stored and must always be returned to the
DO THE “WRITE” THING!
The following dangerous abbreviations are banned:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>New Description</th>
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<tbody>
<tr>
<td>U</td>
<td>Write instead “Units”</td>
</tr>
<tr>
<td>IU</td>
<td>Write instead “International Units”</td>
</tr>
<tr>
<td>QD</td>
<td>Write instead “once daily” or “q day”</td>
</tr>
<tr>
<td>qd</td>
<td>Write instead “once daily” or “q day”</td>
</tr>
<tr>
<td>QOD</td>
<td>Write instead “every other day”</td>
</tr>
<tr>
<td>MS</td>
<td>Write instead “morphine sulfate”</td>
</tr>
<tr>
<td>MSO₄</td>
<td>Write instead “morphine sulfate”</td>
</tr>
<tr>
<td>MgSO₄</td>
<td>Write instead “magnesium sulfate”</td>
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</tbody>
</table>

Trailing zeros are not allowed: Write 20, not 20.0
Leading zeros are required: Write 0.75, not .75

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 age, height, weight, diagnosis provided to determine appropriateness, and reviews the patient medication profile to avoid therapeutic duplication and drug interactions. If orders are incorrect or require clarification, the pharmacist will contact the prescriber to clarify before dispensing the medication.

MEDICATION ADMINISTRATION

If you administer medication to patients, you are responsible for properly performing patient identification using two identifiers (Patient Name and a second identifier, such as Date of Birth, Financial Identification Number or Medical Record Number, per hospital policy). Document the dose administered on the electronic Medication Administration Record (eMAR). Scanning should be utilized to chart on the eMAR in areas where the scanners are available.
PATIENT’S OWN MEDICATIONS

Medications brought from home should not remain with the patient during hospitalization. Medications not returned home shall be delivered to the inpatient pharmacy for safe storage until the patient is discharged from the hospital. Patient’s own medication shall not be administered to a patient unless ALL the following conditions are met:

1. The physician enters a medication order in the Electronic Health Record (EHR), indicating the use of patient supply in order details.
2. The medication is not on the Olive View drug formulary or available in the pharmacy and a reasonable therapeutic substitution cannot be made.
3. The pharmacist is able to make a positive identification of the medication and it is to be contained in its original prescription container with an expiration date. IV admixtures and TPN solutions shall not be used.

ADVERSE DRUG REACTION REPORTING

Please report all adverse drug reactions (ADR) through the Olive View Safety Intelligence™ (SI) Event Reporting System. Provide the patient’s name, Olive View number, location, date of occurrence, name of the suspected medication, type of reaction, and your name. Signs and symptoms of an ADR are (but 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 to 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 Olive View Safety Intelligence™ (SI) Event Reporting System.

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

Olive View is dedicated to preventing, reducing, and ultimately eliminating, the use of restraints throughout our facility. We are committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints. When restraint is used for the management of violent self-destructive behavior, restraint shall be implemented in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques and used only when less restrictive measures have been found ineffective to protect the immediate physical safety of the patient and others. During such an emergency where a patient’s violent or self-destructive behavior jeopardizes the immediate physical safety of a patient, a staff member or others, a Code Gold is activated and the response team is dispatched to assist in the management of the violent or self-destructive behavior.

The Code Gold Response Team works collaboratively with other staff present in an attempt to de-escalate the emergency. If efforts to de-escalate fail, and physical intervention is necessary, the Response Team may initiate restraints. The Response Team provides coverage 24 hours, 7 days/week throughout the hospital to assist in these emergencies. All members of the Response Team are specially trained in Crisis Prevention Institute (CPI) non-violent crisis intervention, least restrictive alternatives and restraint application.

PRINCIPLES FOR HANDLING AGGRESSIVE BEHAVIOR

1. Implement your self-control plan (e.g., take slow, deep breaths) to enable critical thinking. Focus on the problem, not your emotions.
2. Assess the situation before you act. Identify the possible triggers for violence and offer alternative responses that reduce the risk of harm. Accurately identify the visual and auditory signals that come before an assault (e.g., pacing, rapid speech, whining, threatening, demanding, standing very close, tapping, head banging or shouting).
3. Keep communication open, simple, direct, and brief. In crisis intervention, use no more than 5 words (e.g., “Jim, put down the chair.”).

4. Be PATIENT if interventions are not immediately successful. Avoid under or over-reacting. The crisis will pass even if crisis intervention is not successful.

5. Switch your response if the cause of an assault changes as the incident progresses (e.g., manipulation to frustration or frustration to fear).

POSSIBLE ALTERNATIVE INTERVENTIONS PRIOR TO CALLING A “CODE GOLD”

**Verbal:**
- Engage patient in dialogue to identify reasons for anger and hostility.
- Set limits (e.g., communicate expectations, offer choices and relevant consequences).
- Contract for safety (e.g., have patient verbally agree not to harm self or others).
- Explain consequences for not changing behavior.
- Provide teaching (e.g., teach patient the importance of compliance toward rules and/or treatment plan).

**Physical:**
- Environmental manipulation – reduces stimuli or remove patient from the stimuli causing agitation or undesirable behavior (e.g., decrease noise level, dim lights, take to a private room).
- Companionship – 1:1 observation.
- Diversion activities (e.g., television, reading, exercise, games, arts & crafts).
- Offer time-out or seclusion (inpatient psych units only).

**Medical:**
- Pharmacologic intervention – offer PRN or STAT medications, if ordered, to reduce agitation.

**Other:**
- Family involvement – encourage family members to sit or talk to the patient.

If the above Standards of Performance and Alternative Interventions are ineffective, and the patient poses an immediate danger to self or others, call a “Code Gold” (dial Ext. 111 to call the Hospital Operator).
### RERAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR

**Definition:** The use of any physical device to assist with treatment or a diagnostic procedure. For example, soft restraints to protect G.I. tube, I.V. line, and so on. Excluded from this definition is a medical immobilization restraint; the use of a physical or mechanical device to temporarily immobilize the patient in order to facilitate medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes. For example, surgical positioning, IV arm board, radiotherapy procedures, etc. are based on standard practice for the procedure.

**NOTE:** Devices and mechanisms, such as helmets, orthopedic appliances, braces and wheelchairs, when used for postural support, facilitation of mobility, protection, or to obtain/maintain normative bodily functions are not considered restraint interventions. Full side rails per se are not considered a restraint unless they are intended to restrict the patient’s movement.

- Use only when alternative measures have been found to be ineffective.

**No standing orders on an as needed (PRN) basis.**

**Maximum order duration:** 24 hours

**MD RESPONSIBILITIES:**
- Place an MD order in electronic health record.
- Face to face evaluation within 24 hours (of the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and behavioral condition and the need to continue or terminate the restraint).
- Renew order every 24 hours if restraint use continues to be clinically justified.

### RERAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

**Definition:** The use of a physical or mechanical device to involuntarily restrain physical activity of the patient with violent or self-destructive behavior in order to protect the patient or others from injury. For example, a patient who is a danger to others as evidenced by his/her physically threatening behavior.

- Restraints are used to manage violent or self-destructive behavior when unanticipated, severely aggressive or destructive behavior (i.e. physical outburst, punching, banging of head) places the patient or others in imminent danger and nonphysical interventions would not be effective.
- Seclusion is defined as the involuntary confinement of a patient alone in a room in which the patient is physically prevented from leaving for a period of time. Seclusion is utilized in the inpatient psychiatric unit(s) only.

**MD (OR CLINICAL PSYCHOLOGIST) RESPONSIBILITIES:**
- Place an MD order for restraint or seclusion in electronic health record.
- Complete a face-to-face evaluation within one hour after the initiation of restraint or seclusion (of the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and behavioral condition and the need to continue or terminate the restraint).
- Conduct an ‘in person’ patient assessment at least every eight hours for adult patients (18 years of age and over) and every four hours for adolescent patients (17 years and younger).
- Identify ways to help the patient regain control and revise the treatment plan, as needed.
- Participate in the daily reviews of restraint use related to his/her patients.

**No standing orders on an as needed (PRN) basis.**

**Maximum order duration:**
- Four hours for adults (18 years of age and over).
- Two hours for children and adolescents (9-17 years of age).
- One hour for children under 9 years of age.
<table>
<thead>
<tr>
<th>RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR</th>
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<tr>
<td><strong>IN ADDITION, FOR PSYCHIATRIC INPATIENT UNIT(S) ONLY:</strong></td>
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<tr>
<td>• Clinical leadership is notified of any instance in which an individual remains in restraints and/or seclusion for more than 12 hours, or experiences 2 or more separate episodes of restraints and/or seclusion of any duration within 12 hours.</td>
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<tr>
<td>• Staff will inform the patient’s family of the restraint and/or seclusion episode, as appropriate, and in conjunction with the patient’s rights to confidentiality.</td>
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<tr>
<td>• A post-restraint/seclusion debriefing will occur as soon as possible following each episode but no longer than 24 hours after the episode.</td>
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<tr>
<td><strong>NURSING RESPONSIBILITIES:</strong></td>
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<td>• Initiate use of restraints, only in an emergency situation, without a physician order.</td>
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<tr>
<td>• Notify the physician during or <strong>immediately</strong> after the application of emergency restraints and obtain an order <strong>within one hour</strong> of emergency initiation.</td>
<td>• Notify the physician <strong>immediately</strong> as the physician must complete a face-to-face evaluation and provide written order within one hour of restraint incident.</td>
</tr>
<tr>
<td>• Provide education, i.e. purpose of restraint to the patient (and as appropriate, family and/or significant other) regardless of his/her physical and mental condition.</td>
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<td>• Inform the patient under what circumstances the restraint will be discontinued.</td>
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<tr>
<td>• Complete an initial assessment and reassessments to determine need for continuation or early removal.</td>
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</tr>
<tr>
<td>• <strong>Reassessment frequency</strong> – a <strong>minimum</strong> of every shift.</td>
<td>• <strong>Reassessment frequency</strong> – Not to exceed 4 hours for adults; 2 hours for children and adolescents (9-17 years of age); and 1 hour for children under 9 years of age.</td>
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Document all assessments/reassessments on the electronic health record restraint management portion.

<table>
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<tr>
<th><strong>NURSING STAFF WILL:</strong></th>
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<tr>
<td>• Perform/deliver patient care services and document on the electronic health record restraint management portion.</td>
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</tr>
<tr>
<td><strong>Every 15 Minutes</strong></td>
<td>• Observe patient face-to-face continuously for safety.</td>
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<tr>
<td>• Monitor for safety including nerve and circulatory impairment.</td>
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</table>
### RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR

**Every 2 Hours**
- Re-position restrained limbs and check circulation.
- Release restraints on restrained extremity.
- Offer fluids.
- Offer use of toilet facilities.
- Document care every 2 hours or more often as needed.

**Scheduled Meal/Snack Times**
- Offer nourishment and assist the patient, as needed, to ensure safety and adequate nutritional intake.

Document nourishment at scheduled meal/snack times or more often as needed.

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### RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

**Every 15 Minutes**
- Monitor for:
  1. Safety, physical, psychological status and comfort.
  2. Nerve and circulatory impairment.
  3. Readiness for discontinuation.
  4. Hygiene and elimination.
  5. Vital signs when indicated by physical and/or psychological assessment.
- Document every 15 minutes.

**Every 2 Hours**
- Reposition restrained limbs and check circulation.
- Release restraints on restrained extremity.
- Offer fluids.
- Offer use of toilet facilities.
- Document care every 2 hours or more often as needed.

**Scheduled Meal/Snack Times**
- Offer nourishment and assist the patient, as needed, to ensure safety and adequate nutritional intake.
- Document nourishment at scheduled meal/snack times or more often as needed.

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### Scenario #1
Mrs. P.E., a 79-year-old female, is admitted with a diagnosis of pneumonia. She continually removes her oxygen mask and desaturates to 80%. Mrs. P.E. is confused and states, “I need to catch the bus…I’ll be late for my appointment”.

**Q** Are restraints indicated? Why or why not?  
**A** Yes. The patient’s behavior (continually removing her oxygen mask) is impeding treatment and her recovery from the medical condition (pneumonia).

**Q** Is a physician’s order required?  
**A** Yes.

**Q** Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why?  
**A** Restraints for Non-violent Behavior. The patient’s behavior (continually removing her oxygen mask) is impeding treatment and her recovery from the medical condition (pneumonia).

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### Scenario #1
Mr. P.S., a 55-year-old male, admitted to 5A with a primary diagnosis diabetic acidosis. The patient has a history of paranoid schizophrenia. He was found wandering the street naked and incoherent; talking about his involvement with the CIA. The patient’s behavior becomes out-of-control on admission. He suddenly runs wildly down the hallway screaming obscenities; rams his fist into the door and strikes out at the CNA attempting to intervene.

**Q** Are restraints indicated? Why or why not?  
**A** Yes. This is an emergent situation (i.e. sudden aggressive outburst) in which there is an imminent risk that the individual will physically harm self or others.

**Q** Is the physician’s order required?  
**A** Yes.
RESTRAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR

Q) What type of restraint would be most effective?  
A) The choice of a safe, effective and least restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used.

Q) How often does nursing assess/observe the patient for safety, comfort, and circulation?  
A) A minimum of every 15 minutes (the 15 minute observations must be documented once a shift by signing the appropriate space on the Restraint Management Flow Sheet – Medical Management).

Q) How often is nursing required to document on the Restraint Management Flow Sheet?  
A) Initial assessment - Once  
   Reassessment – Every shift; include clinical justification for continuation.

   Every two hours – Circulation check; Fluids, elimination, ROM or exercise.

   Meal times – Offer of nutrition

Scenario #2
I.D., a 20-year-old female, is brought to the hospital by paramedics following an overdose. She states, “I only want to be left alone.” She pulls out her IV and NGT.

Q) Are restraints indicated? Why or why not?  
A) Yes. The patient is pulling her IV and NGT which is impeding her treatment and medical recovery. The restraint is used as an adjunct to medical surgical care to support medical healing.

RESTRAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

Q) Would this be restraints for Violent/Self-Destructive or Non-violent Behavior and why?  
A) Restraints for Violent/Self-Destructive Behavior. The patient’s behavior (out of control, running around wildly, ramming his fist into the door and striking out at staff) is physically harmful to himself and others.

Q) What type of restraint would be most effective?  
A) The choice of a safe, effective and least restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used.

Q) How often does nursing assess/observe/document the patient for safety, comfort, and circulation?  
A) The patient will be observed continuously face-to-face. Document every 15 minutes.

Q) How often is nursing required to document on the Restraint Management Flow Sheet?  
A) Initial assessment – Once  
   Reassessment – Not to exceed 4 hours for adults; 2 hours for children/adolescents (9-17 years) and 1 hour for children under 9 years old. Reassessment must include clinical justification for continuation.

   Every two hours – Fluids, elimination, ROM  
   Meal times – Offer of nutrition

Scenario #2
I.D., a 20-year-old female, is brought to the hospital by paramedics following an overdose. She screams at the staff “leave me alone!... don’t come near me again!” She slaps the physician in the face and kicks the nurse attempting to insert the IV line.

Q) Are restraints indicated? Why or why not?  
A) Yes. This is an emergent situation (i.e. sudden physical outburst) in which there is an imminent risk the individual will physically harm himself or others.
### RERAINTS FOR MANAGEMENT OF NON-VIOLENT BEHAVIOR

<table>
<thead>
<tr>
<th>Q) Is a physician’s order required?</th>
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<td>A) Restrains for Non-violent Behavior. The patient’s behavior (pulling out her IV and NGT) is impeding treatment and her recovery from the overdose.</td>
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<td>A) The choice of a safe, effective and least restrictive method is always based on the assessed needs of the patient and the effective or ineffective methods previously used. Always use the lowest level restraint needed to allow staff to work safely to meet the patient’s needs.</td>
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### RERAINTS FOR MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

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<td>A) Restrains for Violent/Self-Destructive Behavior. The patient’s behavior (slapping and kicking) is physically harmful to herself or others.</td>
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<tr>
<th>Q) What type of restraint would be most effective?</th>
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<tr>
<td>A) The use of a soft or hard restraint will be determined based on the assessed needs of the patient and the situation.</td>
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CLINICAL STAFF (What a Joint Commission Surveyor Is Likely to Ask You)

The following information lists some of the key points that are important to remember as they are an integral part of providing outstanding patient care while fulfilling the accreditation standards of The Joint Commission. If a Joint Commission surveyor is on site, they are likely to ask you questions that relate to the information below.

PATIENT CARE PRACTICES

- 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.
- Patients have the right to effective pain management.
- All patients are assessed for pain upon admission, with vital signs, and with pain assessment/reassessment procedures.
- Olive View’s approved pain assessment tools are:
  - Critical Care Pain Observation Tool (CPOT)
  - Numerical Rating Scale
  - FACES Scale
  - Face, Legs, Activity, Cry and Consolability (FLACC) Scale
  - Assumed Pain Present (APP)
  - N-PASS (Neonatal Pain, Agitation, and Sedation Scale)
- Effective pain management consists of a multidisciplinary team approach to assessing, treating, and educating the patient and their family regarding pain.
- Nursing performs initial nutrition screening on all patients admitted to Olive View-UCLA Medical Center within 24 hours of admission.
- Know that Code Blue means cardiac (or cardiopulmonary) arrest.

PATIENT SAFETY

- Use “Read-Back” procedures to ensure important information is accurately communicated and recorded.
- Olive View has instituted “Read-Back” procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.
- As caregivers, you need to know the signs and symptoms of the decline in patient’s condition, within your scope of practice.
- If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility’s response mechanism and stay with the patient/visitor until help arrives.
- Prevention of patient falls is the responsibility of EVERY workforce member. Become familiar with the Olive View Fall Prevention Program.
- Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.
- You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental unsafe condition, or “near miss” that causes you concern for the safety of patients, visitors, or staff as soon as possible.
- The Joint Commission annually establishes National Patient Safety Goals (NPSGs) which Olive View workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.
- Universal Protocol applies to all surgical and non-surgical invasive procedures and establishes a process for preventing wrong site, wrong procedure and wrong person surgery or procedure.
- The Universal Protocol’s three main components are: conduct the pre-procedure verification process, mark the operative site, and perform a “Time Out” before the procedure.
- The medication process must ensure that the right medication is administered to the right patient, at the right dose, at the right time, using the right route.
- Identify your patient with TWO identifiers (Patient Name and a second identifier, such as Date of Birth, Financial Identification Number, or Medical Record Number).
- Avoid the use of unapproved abbreviations. When in doubt, do not abbreviate! To prevent any confusion, spell out the entire name of the drug.
• Report all medication events, whether an actual medication error or an identified potential medication error, through the Olive View Safety Intelligence™ (SI) Event Reporting System.
• Olive View is committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints.
• Use of restraints should be limited to those emergency situations in which the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or visitors, and when maintaining safety requires an immediate physical response.
• Olive View will dispatch a Code Gold Response Team for a behavioral emergency.
• All medical records must contain an identifier, legible signature and identification number, counter signature for verbal orders, and a rationale for medicine prescribed.
1. You must report any work-related injury, accident, or illness to your supervisor:
   a. Immediately
   b. Within 24 hours
   c. Within 48 hours
   d. Reporting is not necessary if you decline medical treatment

2. Orientation must be completed within the first ___ days of hire and/or transfer of assignment to a facility.
   a. 30
   b. 60
   c. 90

3. Violations of the County Policy of Equity must be reported to:
   a. Your manager or supervisor
   b. County Intake Specialist Unit
   c. A trusted coworker
   d. A or B

4. Examples of implicit bias in healthcare include the following EXCEPT:
   a. Disparities in pain management
   b. Improved patient outcomes
   c. Higher mortality rates for black women diagnosed with breast cancer
   d. Lack of empathy toward minority patients

5. Incidental disclosures, which include calling a patient’s name in the waiting area or talking to a patient on the phone are HIPAA violations:
   a. True
   b. False

6. You are allowed to access the following information:
   a. Your own PHI
   b. The PHI of any DHS patient
   c. The PHI of a patient at your facility
   d. The information you need to do your job

7. When receiving a suspicious email, you should:
   a. Report the email using the “Report Phishing” button
   b. Delete the email
   c. Click on links and attachments to investigate further
8. All workforce members are mandated reporters and must report incidents of suspected or identified abuse and neglect.
   a. True
   b. False

9. Outside employment activities for all employees excluding physicians may not exceed ____ hours per week.
   a. 16
   b. 24
   c. 32

10. The DHS Emergency Code for a bomb threat is:
    a. Code red
    b. Code blue
    c. Code yellow
    d. Code green

11. You can re-hang a fire extinguisher once it has been discharged.
    a. True
    b. False

12. You should position your monitor directly in front of you
    a. At or above eye level
    b. At or below eye level
    c. At least an arm’s length away
    d. B and C

13. When reporting patient safety events, you should always make reference to Risk Management or a Safety Intelligence™ (SI) report in the patient’s medical record.
    a. True
    b. False

14. Simple measures to reduce the risk of sharps injuries include all the following EXCEPT:
    a. Letting falling objects fall
    b. Reaching into disposal or waste containers
    c. Having an adequately lit workspace
    d. Using tongs or brush and dustpan to pick up broken glass

15. Infection control for computers includes all the following EXCEPT:
    a. Using gloves during computer use
    b. Performing hand hygiene prior to use
    c. Cleaning and disinfecting device regularly
    d. Keeping computer at least 3 feet from sink
<table>
<thead>
<tr>
<th>Department</th>
<th>Contact Person</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>Konita Wilks, DDS</td>
<td>(747) 210-3300</td>
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<tr>
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<td>Soma Wali, MD</td>
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<td>Holli Mason, MD</td>
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<td>Bahareh Gordon, MD</td>
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<td>(877) 477-3646</td>
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This handbook was prepared as a collaborative effort of many individuals. We greatly appreciate their contributions.

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Administration/True North
Administration/True North
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Chief Quality Officer/Performance Improvement
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DHS Audit & Compliance
DHS Audit & Compliance
DHS Competency
DHS Competency
DHS Pain Management
DHS Human Resources
DHS Human Resources
DHS Risk Management
Employee Health Services
Environment of Care
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Food and Nutrition Services
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REVISED 2022

The purpose of this handbook is to provide the Los Angeles County Department of Health Services (DHS) workforce members with the resources and regulatory/procedural information that applies to them. All DHS workforce members are governed by these standards, which you should read and be familiar with.

The information presented in this handbook is the most current. Nothing contained in this handbook constitutes an employment contract or an offer to contract with any employee, and nothing contained in this handbook changes the employment-at-will status of any employee, creates any additional rights, remedies at law, or expectations of continued employment.
DHS MISSION

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

Board of Supervisors, County of Los Angeles

Hilda L. Solis, First District
Holly J. Mitchell, Second District
Sheila Kuehl, Third District
Janice Hahn, Fourth District
Kathryn Barger, Fifth District

COUNTY MISSION

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