



RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

2025

ORIENTATION / REORIENTATION

HANDBOOK

Los Angeles County - Department of Health Services





Konita Wilks, DDS
Chief Executive Officer

Welcome to Rancho Los Amigos

National Rehabilitation Center!

Welcome to Rancho Los Amigos National Rehabilitation Center!

You're joining a team that has been at the forefront of rehabilitation medicine for over 100 years. That legacy is built on our deep commitment to delivering world-class medical, neurological, and rehabilitation care to our patients and their families.

At Rancho, our core purpose is clear:

To restore health, rebuild life, and revitalize hope for those facing life-changing illness, injury, or disability—and to promote the well-being of our communities.

To bring this purpose to life, we lean on our Core Values:

Welcoming
Inclusive
Compassionate
Excellent
Innovative
Accountable

During orientation, you'll learn about Rancho's proud history as one of California's first rehabilitation hospitals, our current role as an international research leader and community partner, and our exciting future. Most importantly, you'll discover how you play a vital part in shaping that future and making a lasting impact on the patients and families we serve.

Thank you for bringing your passion, talent, and heart to Rancho. We're so glad you're here.

Equity, Diversity, Inclusion, and Anti-Racism

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



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

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



STRATEGIC GOAL NO. 1:

Increase the Attainment of Postsecondary Credentials with Significant Labor Market Value



STRATEGIC GOAL NO. 2:

Reduce Adult First-Time Felony Convictions



STRATEGIC GOAL NO. 3:

Increase Stable Full-Time Employment Among Individual Adults with Incomes at or Above 250% Federal Poverty Level (FPL)



STRATEGIC GOAL NO. 4:

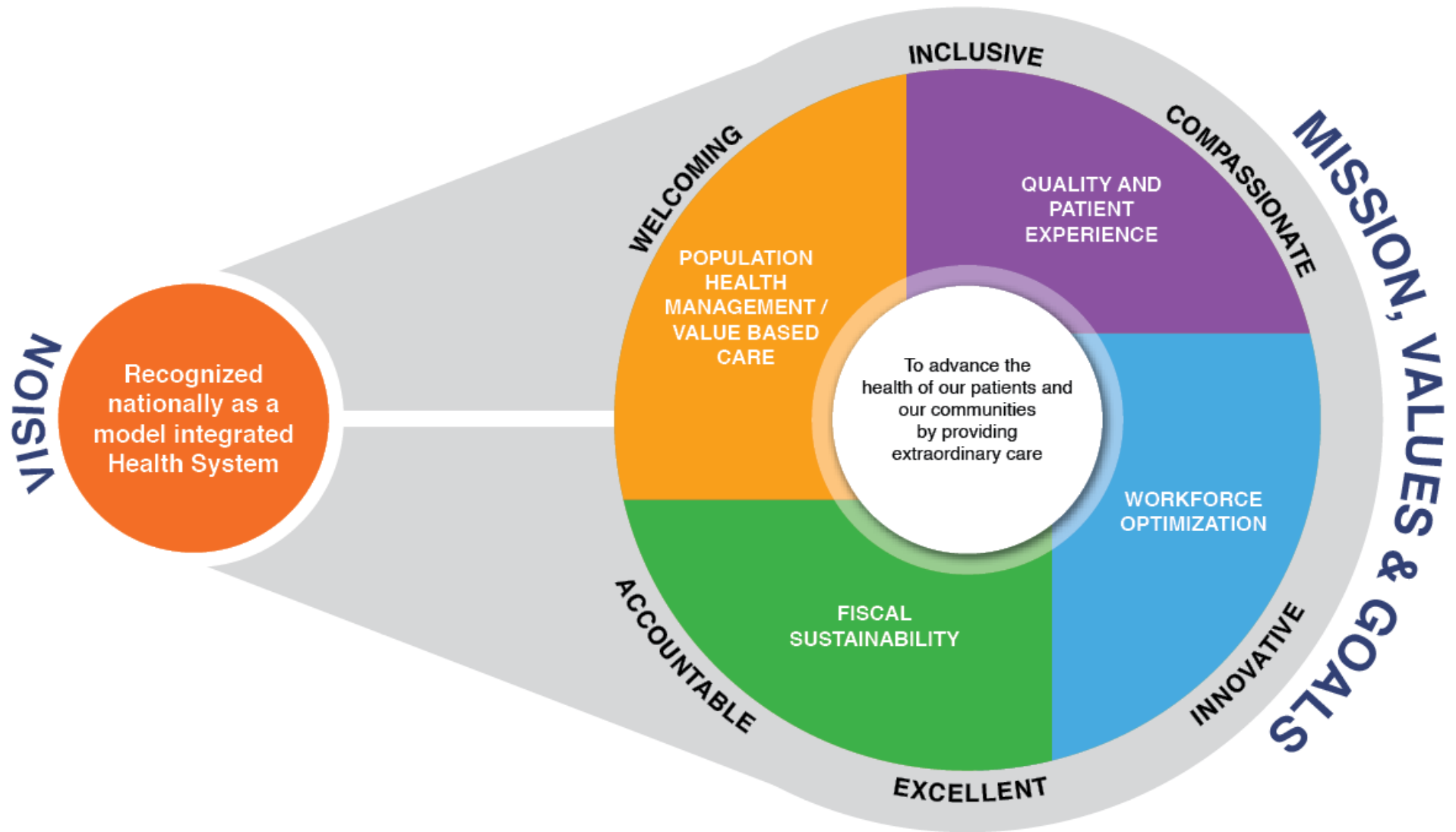
Increase the Percentage of Families with Incomes Above 250% Federal Poverty Level (FPL) for a Family of Four



STRATEGIC GOAL NO. 5:

Reduce Infant Mortality

DHS Strategic Plan



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

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

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

GOALS: Transform our system and services to provide cost-effective care of the whole patient across the continuum, optimize clinical quality and patient experience, to have a high performing workforce and ensure financial viability in support of our vision.



County of Los Angeles Board of Supervisors

Kenneth Hahn Hall of Administration
500 West Temple Street, Los Angeles CA



Hilda L. Solis

Supervisor, First District
Population: 1,982,511*
Square Miles: 268.57
Room 856
213-974-4111
Fax #: 213-613-1739
solis.lacounty.gov
E-mail: FirstDistrict@bos.lacounty.gov



Janice Hahn

Supervisor, Fourth District
Population: 2,083,832*
Square Miles: 411
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: 2,023,783*
Square Miles: 177
Room 866
213-974-2222
Fax #: 213-680-3283
mitchell.lacounty.gov
E-mail: HollyJMitchell@bos.lacounty.gov



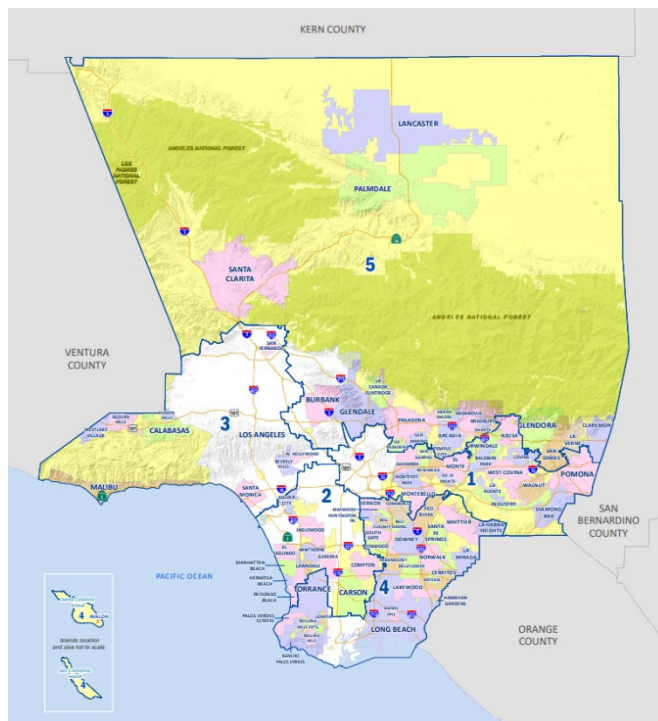
Kathryn Barger

Supervisor, Fifth District
Population: 1,896,455*
Square Miles: 2,785
Room 869
213-974-5555
Fax #: 213-974-1010
kathrynbarger.lacounty.gov
E-mail: Kathryn@bos.lacounty.gov



Lindsey P. Horvath

Supervisor, Third District
Population: 2,061,345* Square Miles: 446
Room 821
213-974-3333
Fax #: 213-625-7360
lindseyhorvath.lacounty.gov
E-mail: ThirdDistrict@bos.lacounty.gov



As of July 24, 2025

Public Affairs, Chief Executive Office, Room 358, Hall of Administration, Los Angeles, CA 90012 • Phone (213) 974-1311 • lacounty.gov

*2021 County Estimate

ACCREDITATION



Rancho is accredited by The Joint Commission, California Department of Public Health (CDPH), and Commission on Accreditation of Rehabilitation Facilities (CARF).

CORE SERVICES

Brain Injury, Cardiac Rehabilitation, Epilepsy, General Rehabilitation, Orthopedics, Limb Preservation, Neurological Disabilities, Pediatric Rehabilitation, Pressure Ulcer Management, Spinal Cord Injury, Spine Surgery, and Stroke

OTHER SERVICES

Center for Applied Rehabilitation Technology (CART), Dental Services, Driver Training, Post-Polio Program, Orthotics/Prosthetics, Pathokinesiology, Seating Center and Vocational Services

LICENSED BEDS

- 8 Intensive Care Unit Beds
- 25 Telemetry/Progressive Care Unit
- 50 Acute Medical/Surgical Beds
- 75 Rehabilitation Beds (JPI)

3,174

Inpatient
Admissions

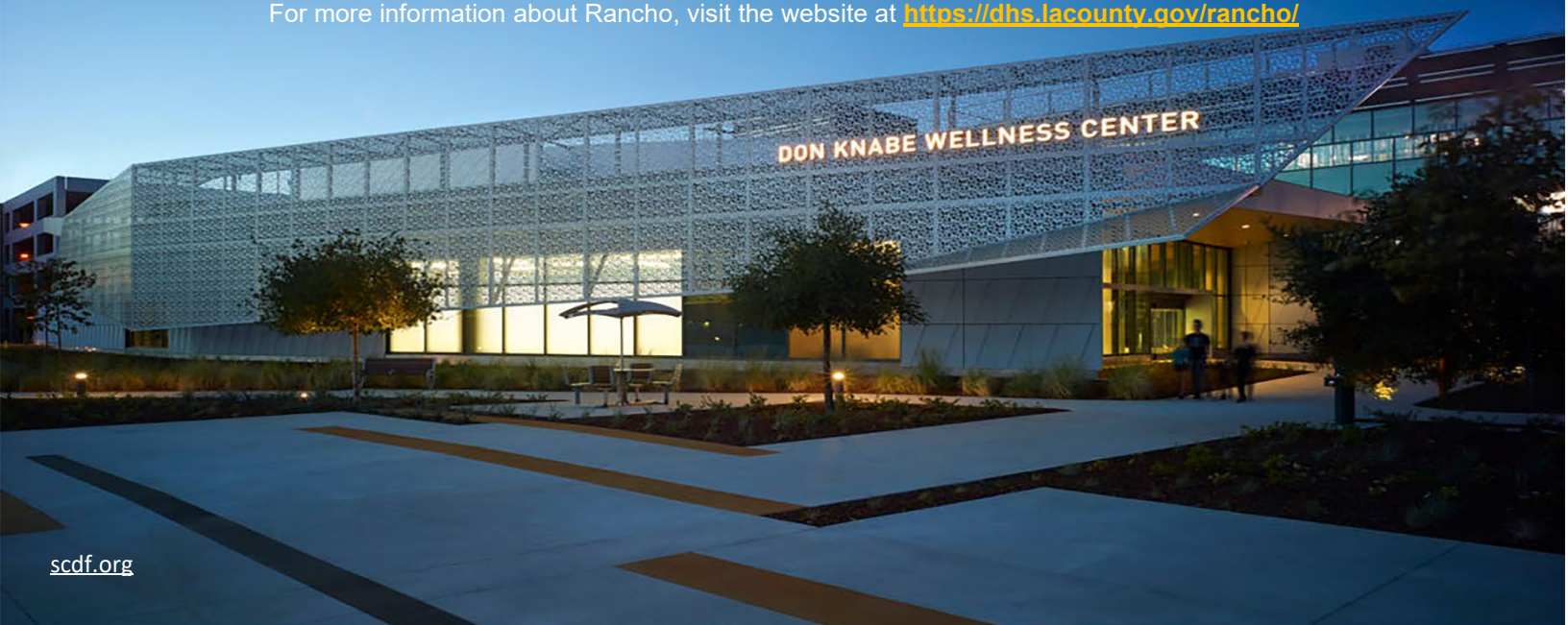
3,174

Outpatient
Visits

2,323

County & Contract Employees

For more information about Rancho, visit the website at <https://dhs.lacounty.gov/rancho/>



RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER TABLE OF CONTENTS

Table of Contents

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER	1
INTRODUCTION.....	1
RANCHO'S HISTORY	1
LOS ANGELES COUNTY STRATEGIC PLAN	3
BENEFITS AND LEAVES (COUNTY EMPLOYEES)	4
PAYCHECKS	4
BEREAVEMENT LEAVE.....	6
JURY DUTY	6
FAMILY AND MEDICAL LEAVE ACT (FMLA).....	7
TIME OFF TO VOTE.....	8
PERSONAL LEAVE FOR VICTIMS OF DOMESTIC VIOLENCE	8
RETIREMENT	9
ADDITIONAL EMPLOYMENT BENEFITS.....	9
LACTATION ACCOMMODATION.....	10
HEALTH AND WELLNESS	14
RESPECTFUL WORKPLACE	14
HEALTH SCREENING	14
SMOKING POLICY.....	15
SUBSTANCE ABUSE	15
BODY MECHANICS	15
INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)	17
EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES).....	17
VEHICLE TRIP REDUCTION – RIDESHARING	17
LEARNING AND DEVELOPMENT.....	20
TRAINING AND COMPETENCY.....	20
COMPETENCY ASSESSMENT.....	20
PERFORMANCE EVALUATION	21
MANAGEMENT APPRAISAL AND PERFORMANCE PLAN (MAPP).....	21
EMPLOYEE STANDARDS OF CONDUCT	22
PROFESSIONAL APPEARANCE	22
TIME REPORTING	22
ATTENDANCE/TARDINESS.....	22
WORKFORCE BEHAVIORAL EXPECTATIONS.....	23
ACKNOWLEDGEMENT OF EMPLOYEE RESPONSIBILITIES	23
COUNTY POLICY OF EQUITY (CPOE)/SEXUAL HARASSMENT/GENDER NON-DISCRIMINATION	24

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER TABLE OF CONTENTS

NEPOTISM.....	25
STAFF RIGHTS IN PATIENT CARE.....	26
ABUSE PREVENTION, SEXUAL ABUSE, SEXUAL COERCION (INAPPROPRIATE BEHAVIOR TOWARD A PATIENT)	26
IMPLICIT BIAS.....	27
SAFE HAVEN/SAFELY SURRENDERED BABY LAW.....	27
PRIVACY OF PATIENT INFORMATION (HIPAA).....	27
SECURITY OF CONFIDENTIAL INFORMATION	31
DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT.....	38
FALSE CLAIMS ACT	39
PROCUREMENT PROCESS.....	39
CONDITIONS OF EMPLOYMENT	40
TITLE I OF ADA - EMPLOYMENT	40
EQUAL EMPLOYMENT OPPORTUNITY	40
PROFESSIONAL CREDENTIALS (LICENSE/CERTIFICATION/REGISTRATION/PERMIT)	41
CRIMINAL BACKGROUND CHECKS.....	41
DISASTER SERVICE WORKER/DHS EMERGENCY PROTOCOL.....	42
REPORTING OF ABUSE/NEGLECT INCIDENTS	42
REPORTING SUSPICIOUS INJURIES	43
OUTSIDE EMPLOYMENT	43
CONFLICT OF INTEREST.....	44
EMPLOYEE ORGANIZATIONS (UNION REPRESENTATION)	45
CUSTOMER SERVICE	47
CUSTOMER SERVICE PHILOSOPHY	47
TEAMWORK	49
THE JOINT COMMISSION	52
THE JOINT COMMISSION'S FOCUS ON PATIENT SAFETY AND QUALITY	52
SURVEY PROCESS	52
ACCREDITATION PARTICIPATION REQUIREMENTS (APR 09.02.01)	53
PATIENT SAFETY PROGRAM	54
JUST CULTURE.....	55
LGBTQ+ INCLUSIVE CARE	56
NATIONAL PATIENT SAFETY GOALS.....	56
DETERIORATING PATIENT CONDITION.....	57
FALL PREVENTION AND RESPONSE	58
SAFE PATIENT HANDLING (SPH).....	60
SUICIDE PREVENTION.....	61
LIGATURE RISK	62
PATIENTS' RIGHTS AND SERVICES.....	63

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER TABLE OF CONTENTS

PATIENT RIGHTS AND RESPONSIBILITIES.....	63
PATIENTS' RESPONSIBILITIES	63
PATIENT ADVOCATE	64
LANGUAGE ACCESS SERVICES	64
SPIRITUAL NEEDS OF PATIENTS (CHAPLAINCY PROGRAM)	69
ADVANCED HEALTH CARE DIRECTIVE (AHCD)	69
AMERICANS WITH DISABILITIES ACT (ADA).....	69
SERVICE ANIMALS	70
ORGAN/TISSUE DONATION.....	71
EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)	71
MANAGED CARE PLAN TRAINING	72
MEDI-CAL FOR KIDS AND TEENS (ALSO REFERRED TO AS EPSDT)	72
LONG-TERM SERVICES AND SUPPORTS.....	75
CONTINUITY OF CARE (COC) OVERVIEW	77
CALAIM OVERVIEW	78
ENVIRONMENT OF CARE	81
SECURITY.....	81
SAFETY AWARENESS	82
EMERGENCY PREPAREDNESS AND MANAGEMENT	82
DHS EMERGENCY CODES	83
EMERGENCY TRANSPORT (CARRIES).....	87
FIRE/LIFE SAFETY.....	89
BOMB THREATS (CODE YELLOW)	90
WEAPONS	90
WORKPLACE VIOLENCE.....	90
CHILD/INFANT ABDUCTION (CODE PURPLE/CODE PINK)	95
HAZARDOUS MATERIALS/HAZARD COMMUNICATION	95
RADIATION EXPOSURE	96
MEDICAL EQUIPMENT AND UTILITIES.....	96
ERGONOMICS	97
QUALITY IMPROVEMENT.....	99
IMPROVING ORGANIZATIONAL PERFORMANCE WITH CONTINUOUS QUALITY IMPROVEMENT.....	99
ORYX INITIATIVE.....	101
RISK MANAGEMENT	103
EVENT REPORTING PROCESS.....	103
DOCUMENTATION - A KEY DEFENSE	106
LAWSUITS AND SUBPOENA.....	106
THE CANDOR PROGRAM.....	107

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER TABLE OF CONTENTS

INFECTION PREVENTION & CONTROL.....	110
STANDARD PRECAUTIONS	110
RESPIRATORY HYGIENE/COUGH ETIQUETTE	112
PERSONAL PROTECTIVE EQUIPMENT (PPE)	114
PREVENTING SHARPS INJURIES.....	117
SAFE INJECTION PRACTICES	117
INJECTION SAFETY TIPS FOR PROVIDERS	118
WASTE DISPOSAL.....	119
CLEANING AND DISINFECTION	120
INFECTION CONTROL FOR COMPUTERS	121
TRANSMISSION-BASED PRECAUTIONS.....	121
VACCINATIONS.....	123
AEROSOL TRANSMISSIBLE DISEASE (ATD) PLAN.....	124
TUBERCULOSIS (TB).....	124
PANDEMIC INFLUENZA PLAN	125
WORKFORCE MEMBER GUIDANCE FOR RESPIRATORY VIRAL ILLNESS.....	126
KEY POINTS TO REMEMBER (ALL STAFF).....	127
CLINICAL ORIENTATION CHECKPOINT (CLINICAL STAFF ONLY).....	132
BLOODBORNE PATHOGENS	133
BLOODBORNE PATHOGENS	133
HEPATITIS B VIRUS (HBV) AND HEPATITIS C VIRUS (HCV)	133
HUMAN IMMUNODEFICIENCY VIRUS (HIV)	133
PATIENT CARE PRACTICES	135
POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS	135
PAIN ASSESSMENT AND REASSESSMENT	136
PAIN MANAGEMENT GUIDELINES FOR DHS PROVIDERS.....	138
FOOD AND NUTRITION SERVICES.....	143
PATIENT SAFETY	144
"READ BACK", "REPEAT BACK" REQUIREMENTS	144
DETERIORATING PATIENT CONDITION.....	145
BE FAST – RECOGNIZING THE SIGNS OF A STROKE.....	145
FALL REDUCTION AND PREVENTION.....	147
SAFE PATIENT HANDLING (SPH).....	150
UNIVERSAL PROTOCOL	151
NON-OR PROCEDURAL TIME OUT SECTION	151
MEDICATION MANAGEMENT	152
"DO NOT USE" ABBREVIATIONS LIST.....	154
LOOK-ALIKE/SOUND-ALIKE LIST	154

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER TABLE OF CONTENTS

MEDICATION DISPENSING 155

MEDICATION ADMINISTRATION 155

NON-VIOLENT (NON-SELF DESTRUCTIVE) & VIOLENT (SELF-DESTRUCTIVE) RESTRAINTS 156

CODE GOLD AND CODE GRAY 156

GOLDEN HAND AWARENESS..... 157

KEY POINTS TO REMEMBER (CLINICAL STAFF) 158

KNOWLEDGE CHECK 159

QUICK REFERENCE 161

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER**INTRODUCTION**

As a vital resource for the delivery of healthcare, Rancho Los Amigos National Rehabilitation Center (Rancho) is committed to achieving the goals and objectives of the Los Angeles County Department of Health Services (DHS), our own Mission, Vision, and Values, to improving service delivery systems to our community, and to enhancing the quality of patient care provided at Rancho. In addition, we must meet quality standards established by accrediting agencies as they evaluate our programs and services by way of surveys, reviews, and other indicating tools.

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

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

RANCHO'S HISTORY

Rancho Los Amigos National Rehabilitation Center is an internationally recognized, pioneering hospital in rehabilitation medicine, consistently ranked among the top rehabilitation hospitals in the nation.

For more than 50 years, Rancho has set the standard in care for persons with physical disabilities, in many cases caused by traumatic brain or spinal injury. The hospital's interdisciplinary and highly specialized teams of caregivers provide a level of expertise unmatched in the region.

The history of Rancho dates back to 1888, when indigent patients from Los Angeles County Hospital were relocated to what was then known as the "Poor Farm." Physical and Occupational Therapies were introduced in the 1920's, and in the 1950's Rancho was designated a respiratory center for poliomyelitis (polio). The hospital gradually transitioned to a rehabilitative care center with the waning of the epidemic.

Today, Rancho is a 158-bed rehabilitation hospital owned and operated by the Los Angeles County Department of Health Services. Inpatient admissions average 4,000 annually and outpatient visits number approximately 80,000 among multiple rehabilitation and medical specialty clinics. The medical staff is composed of physicians and dentists representing the major medical, surgical and dental specialties required for the care of those with life changing disabilities.

Among Rancho's historic accomplishments was the development of the halo-vest in 1955, a device which is still in use to immobilize the cervical spine following severe neck injury or certain types of surgery. Rancho physicians also contributed to advances in pathokinesiology and breakthroughs in the rehabilitation of orthopedic and neurologic disorders.

The Rancho Los Amigos Cognitive Functioning Scale, a widely used scale to determine the cognitive functioning level in brain injured patients, was developed in the 1970s, and Rancho's spinal cord injury unit was designated as a model system by the U.S. government since 1979 and through 2006. In July 2014, Rancho was ranked among the top hospitals in the Greater Southern California metropolitan area by U.S. News & World Report and ranked 16th among all hospitals in the entire State of California.



LOS ANGELES COUNTY STRATEGIC PLAN

MISSION

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

VISION

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

VALUES

Integrity, Inclusivity, Compassion, Customer Orientation and Equity.

NORTH STARS

NORTH STAR 1: MAKE INVESTMENTS THAT TRANSFORM LIVES

LA County is a highly responsive organization investing in solutions that address our most complex societal challenges (health, jobs, housing, food insecurity, and recidivism) affecting our most vulnerable communities – one person at a time.

NORTH STAR 2: FOSTER VIBRANT AND RESILIENT COMMUNITIES

Investments in the lives of County residents are sustainable only when grounded in strong communities. LA County, with the support of a network of public/private partners, faith-based organizations, community-based organizations, philanthropic organizations, and local governments, will foster vibrant and resilient communities.

NORTH STAR 3: REALIZE TOMORROW'S GOVERNMENT

The increasingly dynamic and complex environment challenges our collective abilities to respond to public needs and expectations. LA County is an innovative, flexible, effective, and transparent partner focused on advancing the common good and being fiscally responsible.

The entire Strategic Plan is available at: <https://ceo.lacounty.gov/lacplan/>

BENEFITS AND LEAVES (COUNTY EMPLOYEES)

This section will provide performance guidelines and describe some of the benefits currently available to County Employees. This Orientation/Reorientation 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 can also see their pay statements online.

EMPLOYEE PAY STATEMENTS

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

COUNTY PAID HOLIDAYS

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

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

This does not apply to Non-County staff (contractors and volunteers).

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

VACATION AND SICK LEAVE ACCRUAL

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

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

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

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

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

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

FAMILY SCHOOL PARTNERSHIP ACT

Employees may use existing vacation, elective leave, nonelective leave, personal leave, compensatory time off (CTO), or leave without pay, for school/childcare emergencies and planned absences to participate in the school or day care program activities of their children, stepchildren, foster children, grandchildren, children 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. See DHS Policy, The Family School Partnership Act for County Employees.

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, or a stillbirth where a death certificate is issued 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 Bereavement Leave Policy provides additional information on this subject.

BEREAVEMENT LEAVE FOR TEMPORARY MONTHLY EMPLOYEES

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

Monthly Permanent 9/10 time employees (Registered Nurses on Title Sub D)

Such employees are allowed 24 hours for each qualifying occasion. If required to travel a minimum of 500 miles one way, they shall be eligible for a total of 40 hours.

JURY DUTY

County employees summoned to serve as jurors will be granted jury duty leave. An employee must notify their supervisor as soon as they receive a jury duty summons and provide a copy of the summons. All employees in a permanent position (full-time or part-time) who are ordered to serve on a jury shall be allowed the "necessary time to be absent from work" at their regular pay. "Necessary time to be absent from work" refers to the amount of time required to fulfill jury duty service, including travel time. It does not include any time in which the employee is "on call" or when their presence is not required. Due to extended workdays 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 in 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 a County criminal grand jury is covered, but service on a civil grand jury is not covered, as such service is entirely voluntary. An employee may serve on a civil grand jury if their department approves an unpaid leave of absence, but the employee will not receive their regular pay or jury duty leave.

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

County employees are not eligible for jury duty fees but do receive their regular earnings while on jury duty, as applicable. Employees may receive mileage reimbursement, beginning on the second day of service, which does not need 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 both their supervisor AND Payroll Services upon returning 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.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

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

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

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

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

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

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

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

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

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

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

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

MILITARY EXIGENCY

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

TIME OFF FOR BONE MARROW AND ORGAN DONATION

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

For more information, see PPG 701, Time Off for Bone Marrow and Organ Donation.



NOTE

See DHS Policy Family and Medical Leave Act for detailed guidelines on FMLA or contact fmlaunit@dhs.lacounty.gov for assistance.

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 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), engage in safety planning, arrange relocation for themselves or a child, and/or obtain related services. Such employees shall inform management in a reasonable amount of time in advance, if feasible, 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 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 themselves, or safe environment for their immediate family or registered domestic partner.

Any employee who feels that they have been discriminated against or retaliated against because of taking 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.

See DHS Policy Personal Leave of Absence - Domestic Violence/Crime Victims for more information.

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 made through automatic payroll deduction. Placement in a plan is determined by LACERA membership date.

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

ADDITIONAL EMPLOYMENT BENEFITS

INSURANCE BENEFITS

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

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

DEFERRED INCOME PLANS

Employees may voluntarily participate in supplemental retirement plans:

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

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

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

LACTATION ACCOMMODATION

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

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

To request an 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 be a basis 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 the employee's work performance and create an intimidating, hostile or offensive working environment. Any incident of harassment will be addressed in accordance with County policies and procedures. Non-compliance may result in a citation and a civil penalty for each violation. The procedures for citations and civil penalties are outlined in state and federal laws.

LACTATION ACCOMMODATION LOCATIONS

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
Bellflower HC	10005 E. Flower St. Bellflower, CA 90706	Suite 20, Room A3	Patricia Jimenez Pjimenez2@dhs.lacounty.gov	(562) 526-3028
CHS – Central Regional Detention Facility	11705 S. Alameda St., Lynwood, CA 90262	Room 3132	See Facility Control for room access.	(323) 568-4500
CHS – Men's Central Jail	441 Bauchet St., Los Angeles, CA 90012	Female Locker Room	See Facility Control for room access.	(213) 974-4921
CHS – Twin Towers Correctional Facility	450 Bauchet St., Los Angeles, CA 90012	Room E234	See Facility Control for room access.	(213) 893-5100
Edward Roybal CHC	245 S. Fetterly Ave. Los Angeles, CA 90022	2nd floor Room 2250	Rita Plaza rplaza@dhs.lacounty.gov	(323) 362-1401
			Lynette Gonzalez lmgonzalez@dhs.lacounty.gov	(323) 362-1406
El Monte CHC	10953 Ramona Blvd. El Monte, CA 91731	2nd Floor Room 2148	Rosalinda Villalobos rvillalobos@dhs.lacounty.gov	(626) 434-2800

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
EMS Agency	10100 Pioneer Blvd., Suite 200 Santa Fe Springs, CA 90670	2nd Floor EMS Agency in the Paramedic Training Institute Library	Jacqui Rifenberg jrifenberg@dhs.lacounty.gov	(562) 378-1640
EMS Agency Warehouse	10430 Slusher Drive, Santa Fe Springs, CA 90670	Room #7	Terry Crammer tcrammer@dhs.lacounty.gov	(562) 378-2445
Glendale HC	501 N. Glendale Ave. Glendale, CA 91206	Room 112	Sylva Aghmalian, RN saghmalian@dhs.lacounty.gov	(818) 627-3282
Harbor-UCLA Medical Center	1000 W. Carson St., Torrance, CA 90509	7th Floor West Room 20 Professional Building Lactation Room	Michele Bragger Mbragger@dhs.lacounty.gov	(424) 306-4556 Pager: (310) 501-3679
Harbor-UCLA Medical Center Family Medicine Clinic	1403 Lomita Blvd., Harbor City, CA 90710	Module C, 2nd Floor	Alexis Smith asmith4@dhs.lacounty.gov	(310) 602-2470
Health Services Office of Patient Access Central Contact Center	1000 S. Fremont Ave Alhambra, CA 91803	Building A9E 6th Floor, South/West Wall	Erica Lopez elopez32@dhs.lacounty.gov	(626) 525-5169
Health Services & DPH Administration	313 N. Figueroa St. Los Angeles, CA 90012	7th Floor Women's Lounge	Melanie Pascua MPascua@dhs.lacounty.gov HSAFMD@dhs.lacounty.gov	(213) 288-8129
High Desert Health Center Group (HDHCG)/ Lake Los Angeles Community Clinic	16921 East Avenue O, Space G Palmdale, CA 93591	Employee Break Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019
High Desert Health Center Group (HDHCG)/ South Valley Health Center	38350 40th Street East, Suite 100 Palmdale, CA 93552	Pediatric Clinic Conference Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019
High Desert Health Center Group (HDHCG)/ Antelope Valley Health Center	335 East Avenue K-6, Suite B Lancaster, CA 93535	Lactation Room (Off main lobby, across from Business Office entrance)		(661) 471-4822
High Desert Health Center Group (HDHCG)/ Littlerock Community Clinic	8201 Pearblossom Highway Littlerock, CA 93543	Employee Break Room	Susha Abraham, RN SAbraham@dhs.lacounty.gov	(661) 225-3019

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
High Desert Health Center Group (HDHCG/High Desert Regional Health Center)	335 East Avenue I Lancaster, CA 93535	Employee Health Fit Testing Room 2D29	Mary Flint-Herrera, RN mflint-herrera@dhs.lacounty.gov	(661) 471-4342
Hubert H. Humphrey Comprehensive Health Center	5850 S. Main St. Los Angeles	2nd Floor, Room 2032	Latasha Smith lssmith@dhs.lacounty.gov	(323) 897-6363
Hudson CHC	2829 S. Grand Ave. Los Angeles, CA 90007	1st Floor, Room 1296	Tyrone Clark tyclark@dhs.lacounty.gov	(213) 699-7270
Juvenile Court Health Services Administration	1925 Daly St. 1st Floor Los Angeles, CA 90031	First Floor Women's Lounge, Women's Restroom	Elena Laurich Elaurich@dhs.lacounty.gov	(323) 986-2240
La Puente Health Center	15930 Central Ave., La Puente, CA 91744	1st Floor, Room 102-A	Israel Castellanos icastellanos@dhs.lacounty.gov	(626) 434-2820
Long Beach CHC	1333 Chestnut Ave. Long Beach, CA 90813	2nd Floor Staff Lounge, Women's Restroom (212-5)	Jacqueline Valle jvalle@dhs.lacounty.gov	(562) 753-2310
Los Angeles General Medical Center	2051 Marengo St. Los Angeles, CA 90033	1st Floor – Inpatient Tower Room C1C102	E-mail LA-General-LactationRooms@dhs.lacounty.gov with first name, last name, and employee number for access requests Coordinator: Jeanie Park Assistant: Kiet Van	(323) 409-2800
Los Angeles General Medical Center Outpatient	2010 Zonal St. Los Angeles, CA 90033	Outpatient Tower 5P45	E-mail LA-General-LactationRooms@dhs.lacounty.gov with first name, last name, and employee number for access requests Coordinator: Jeanie Park Assistant: Kiet Van	(323) 409-2800
Mid-Valley Comprehensive HC	7515 Van Nuys Blvd. Van Nuys, CA 91405	5th floor, Room 560	Dolores Lopez dlopez@dhs.lacounty.gov	(818) 627-3060
MLK OPC	1670 E 120th St Los Angeles, CA 90059	1st Floor N. Support Building Room 1H04	Leonor Bango lbango@dhs.lacounty.gov	(424) 338-1001
North County Correctional Facility	29300 The Old Road Castaic, CA 91384	Room 241	Obtain the key from Hall Control	(661) 295-7810
Olive View-UCLA Medical Center	14445 Olive View Drive Sylmar, CA 91342	4B126 and 4B117	Administrative Nursing Office	(747) 210-4444
Pitchess Detention Center – North Facility	29300 The Old Road Castaic, CA 91384	Records Trailer Room TT4	Obtain facility record key from Main Control to access room	(661) 295-8840 Extension 3450

FACILITY	STREET ADDRESS	LACTATION ROOM LOCATION	FACILITY COORDINATOR (Contact Coordinator to gain access to the room)	CONTACT TELEPHONE
Pitchess Detention Center – South Facility	29300 The Old Road Castaic, CA 91384	Custody Administration Room 172	Obtain key from Watch Sergeant office	(661) 295-8805
Rancho Los Amigos NRC	7601 Imperial Hwy. Downey, CA 90242	Harriman Bldg. Room 2016 Outpatient Bldg. Room 2079 Support Services Bldg., Room 2034	Verenice Lopez-Arevalo vzepeda@dhs.lacounty.gov	(562) 401-7651
San Fernando HC	1212 Pico Street San Fernando, CA 91340	Exam Room #133	Irma Pineda, RN icpineda@dhs.lacounty.gov	(818) 627-4720 (818) 627-4721
West Valley HC	20151 Nordhoff Street Chatsworth, CA 91311	Exam Room #5		(818) 627-3078
Wilmington HC	1325 N. Broad Ave. Wilmington, CA 90744		John Ibay jibay@dhs.lacounty.gov	(310) 404-2041

HEALTH AND WELLNESS

The goal of the County’s Wellness Program is to improve the health and productivity of County employees and reduce their health-related costs, mainly by helping employees change their lifestyle habits 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 offers 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 e-mail to: workplaceprograms@hr.lacounty.gov

RESPECTFUL WORKPLACE

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

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

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

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

HEALTH SCREENING

All workforce members who work in a DHS healthcare facility, including students, volunteers, and non-DHS/non-County workforce members, must complete 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 for complying with DHS policy and ensuring that you complete your annual health screening as a condition of continued employment/assignment. You may contact your facility’s 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; doing so may subject the facility to accreditation citations.

**NOTE**

You must complete your health screening annually.

SMOKING POLICY

The campuses of DHS hospitals and health centers have been designated “smoke-free campuses.” The smoking prohibition includes tobacco products, e-cigarettes (vaping/liquid tobacco) and cannabis/marijuana. 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; or 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.

SUBSTANCE ABUSE

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

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

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

BODY MECHANICS

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

WHY YOU SHOULD PRACTICE GOOD BODY MECHANICS

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

MAINTAINING GOOD BODY MECHANICS

Think of your body as a machine that needs to be maintained in good working order 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. Wear 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

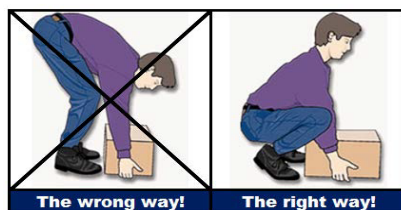
- When standing, keep your knees slightly bent to take pressure off your lower back.
- If standing for longer periods of time, rest one foot up on a low step, shelf or stool (non-wheeled).

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, 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!



**Bend your knees and hips to get close to the load.
Use the muscles of your legs to lift.
DO NOT use your back to lift!**

REPORTING WORK RELATED INJURIES/ILLNESSES

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

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

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

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

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

EMPLOYEE ASSISTANCE PROGRAM (COUNTY EMPLOYEES)

The Employee Assistance Program (EAP) is a program that provides assessment, grief counseling, and referral services to County employees and their families by 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 cause distress and interfere with 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 is responsible 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 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. workday, the schedule can be flexed to 8:15 a.m. – 4:45 p.m. to allow an employee who takes public transportation to arrive to work on time.

- **COMMUTER BENEFIT PLAN**

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

- **VEHICLE PURCHASING SERVICES PROGRAM**

- The County has arranged for employees to receive a discount on the purchase of a "green" vehicle from various car dealerships. Many sites have charging stations to accommodate electric vehicles. The Electrifyze Program is available to answer all your electric vehicle questions and can help you purchase an electric vehicle. Refer to the County's Rideshare Website for more information.

A RIDESHARE MODE INCLUDES:

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



For additional information on your site's Rideshare Program contact your site ETC.
For general information on the County Rideshare Program, visit the County Rideshare website at <https://rideshare.lacounty.gov/>

WORKFORCE WELL-BEING



<https://lacounty.sharepoint.com/sites/dhs-wellnes>

As Los Angeles County Employees, it is important that we prioritize our workplace and personal well-being.

Take a moment to explore the DHS Workforce Well-Being site for resources, guidance and information about how to care for yourself and each other.



Events & Resources • Workplace Concerns • Social Justice
Career, Training & Finances • Workforce Collaboratives • H3

LEARNING AND DEVELOPMENT

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

TRAINING AND COMPETENCY

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

The County has established mandatory trainings for all DHS workforce members. These trainings are to be completed on the County's official learning management system, TalentWorks. Workforce members are expected to comply with mandatory training deadlines.

Some countywide mandatory trainings are:

- County Policy of Equity (CPOE)
- Cybersecurity Awareness
- Privacy Awareness
- Sexual Harassment and Discrimination Prevention Training (SHDPT)
- Workplace Violence Prevention

[Click here](#) for a full list of countywide mandatory training requirements.

Some regulatory survey readiness trainings are:

- Acknowledgement of Employee Responsibilities
- Compliance Awareness Training (CAT)
- DHS Code of Conduct
- Facility Orientation/Reorientation Handbook
- Privacy & Security Survival Training (HIPAA)

[Click here](#) for a full list of regulatory survey readiness training.

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

- Fair Labor Standards Act Essentials
- Assembly Bill 1234 (Ethics)
- Drug Free Workplace: Reasonable Suspicion Training

COMPETENCY ASSESSMENT

All DHS workforce members who hold a direct or indirect patient care position and are assigned to DHS hospitals and health facilities are required to demonstrate competency in their job responsibilities by participating in the Department's ongoing competency assessment and skills validation process.

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

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

Refer to DHS Policy on Competency Assessment: Direct and Indirect Care Positions for additional information on the competency assessment process.

PERFORMANCE EVALUATION

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

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, Performance Evaluation.

Work plans (job descriptions) can be viewed and acknowledged, and most performance evaluations can be completed in TalentWorks at <https://lacounty.csod.com/> by clicking the Performance tile.

For technical assistance and performance evaluation questions, contact HREnterpriseServiceCenter@dhs.lacounty.gov. Performance evaluation training is available on TalentWorks.

MANAGEMENT APPRAISAL AND PERFORMANCE PLAN (MAPP)

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



NOTE

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

EMPLOYEE STANDARDS OF CONDUCT

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

PROFESSIONAL APPEARANCE

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 always worn above the waist while on duty and in County facilities.



NOTE

See DHS Business Office Dress Policy for detailed guidelines.

TIME REPORTING

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

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

DHS uses eHR web-based timesheets (TIMEI) for recording time worked and time off, as well as the new Acuity, Scheduling, and Time Employee Resource (ASTER) system. Those not in-scope for ASTER continue to use TIMEI to record their time.

For more information, you may also check the DHS Time Collection website <https://lacounty.sharepoint.com/sites/dhs-HR/SitePages/timecollection.aspx> and the DHS Time Reporting policy.

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.

A rest period should be taken approximately midmorning and midafternoon. Rest periods/breaks and the meal period cannot be used to cover a tardy or shorten the workday. Rest periods/breaks cannot be combined to lengthen the meal period unless as noted below and approved by management (DHS Policy Work Week/Work Hours):

1. Based on the needs of the department and current workloads, exceptions such as combining meal and breaks (noting that the breaks are paid breaks) may be an acceptable practice. A manager/supervisor who requests a waiver (to combine breaks), must demonstrate, that all reasonable efforts were taken to notify and encourage employees of their right to take breaks during an appropriate break schedule. The waiver would be for the needs of the entire department, unit, or area and not on an individual basis.
2. If a manager/supervisor determines that a request for a waiver is necessary, they must submit a memo through the appropriate chain-of-command to DHS Employee Relations Division, establishing justification for the request. The Employee Relations Division will review the request for appropriateness, and if determined to be justified, make a recommendation for approval to the Chief, Audit and Compliance.

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

WORKFORCE BEHAVIORAL EXPECTATIONS

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

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 the Workforce Behavioral Expectations policy in good faith. However, any workforce member who deliberately makes a false accusation will be subject to appropriate corrective action. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

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

ACKNOWLEDGEMENT OF EMPLOYEE RESPONSIBILITIES

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

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

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

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

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

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

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

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

PREVENTING AND REPORTING HARASSMENT OR INAPPROPRIATE BEHAVIOR

It is the responsibility of all workforce members to ensure discrimination, sexual harassment, retaliation, harassment (other than sexual), third person harassment, and inappropriate conduct toward others does not occur in the workplace. Any workforce member who believes they have been the object of, has witnessed, or has been affected by inappropriate behavior shall report the action or incident to their 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 the CPOE and/or associated procedures.

Discrimination

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

Sexual Harassment

Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other verbal, visual or physical conduct of a sexual nature which meets any one of the following criteria:

- Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment;
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
- Such conduct has the purpose or effect of unreasonably interfering with the individual's employment or creating an intimidating, hostile, offensive, or abusive working environment.

Unlawful Harassment (Other than Sexual)

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

Third-Person Harassment

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

Inappropriate Conduct Towards Others

Inappropriate conduct toward others is any physical, verbal, or visual conduct based on or because of one or more of the protected classes listed above when such conduct reasonably would be considered inappropriate for the workplace. This provision is intended to stop inappropriate conduct based on a protected status before it becomes discrimination or unlawful harassment. As such, the conduct need not meet the legally actionable state and/or federal standards of severe or pervasive to violate the CPOE. 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 the CPOE.

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 THE CPOE

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 is 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 Civil Rights Department by calling (800) 884-1684 or via their website at <https://calcivilrights.ca.gov> and/or may contact the Federal Equal Employment Opportunity Commission (EEOC) by calling (213) 785-3090 or (800) 669-4000 or via their website at www.eeoc.gov.

NEPOTISM

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

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

relationships disclosed by employees to evaluate whether potential nepotism or conflicts of interest may occur and act as necessary in accordance with the Nepotism policy.

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

A Relative is defined as any known relationship formed by blood, marriage, or adoption, such as an individual’s:

- Spouse, ex-spouse, domestic partner, ex-domestic partner.
- Child (including stepchild, adopted child, child of domestic partner, foster child).
- Parent, stepparent, adoptive parent, legal guardian, foster parent.
- Sibling (including stepsibling, adoptive sibling, half-sibling).
- Grandparent, grandchild, step or adoptive grandparent, step or adoptive grandchild.
- Father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, and similar relationships from a previous marriage or domestic partnership.
- Aunt, uncle, spouse of aunt or uncle, cousin, niece, or nephew.

Refer to DHS Policy, Nepotism and Personal Relationships.

STAFF RIGHTS IN PATIENT CARE

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

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

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

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

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

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

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

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

IMPLICIT BIAS

WHAT IS IMPLICIT BIAS?

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

HOW DOES IMPLICIT BIAS IMPACT HEALTHCARE?

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

Examples of implicit bias in healthcare include the following:

- Disparities in pain management; patients of color are less likely to be prescribed pain medication.
- Patients of color are less likely to receive cardiovascular interventions.
- There is a higher mortality rate for black women after being diagnosed with breast cancer.
- There is a 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 awareness and the effect of implicit bias on healthcare.
- Recognizing which interactions with patients are based on stereotypes and reflecting on your response; work to change similar future responses.
- Having a basic understanding of the cultures of the patients we serve.
- Practicing “evidence-based medicine”.
- Embracing diversity and inclusion.

All workforce members are required to take the [Implicit Bias and Cultural Competency](#) training on TalentWorks.

Sources:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/>
<https://www.aafp.org/fpm/2019/0700/p29.html>

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 they voluntarily surrender 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/public-safety/baby-safe-surrender-program>.

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.

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

Other laws also require the protection of **Personally Identifiable Information (PII)**, which is electronic information that can be used to trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

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

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

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

PRIVACY LAWS GIVE PATIENTS CERTAIN RIGHTS

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

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

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

USE AND DISCLOSURE OF PATIENT INFORMATION

- The patient's written permission is usually needed for us to disclose their health information to someone or an organization/agency.
- The patient's permission is not needed if the use or disclosure is for treatment (may include continuum of care), payment, healthcare operations; or as required by law, e.g., to certain agencies that protect the public.
- The ORCHID Amwell module is the only authorized platform for direct-to-patient/virtual healthcare visits.
- Microsoft (MS) Teams should only be used by DHS staff for educational rounds, clinician-to-clinician conversations, or staff meetings.
- A signed General Consent (Conditions of Admission) allows pictures or video of patients to be taken (only for clinical or medical reasons).
- The MS Teams application has replaced HIPAABridge and is the only DHS approved platform to be used for photos, videos, quick chats and file exchanges to ensure secure internal staff communications.
- Be sure to delete the quick chats and files from MS Teams as soon as the picture or video has been uploaded onto the electronic medical record or no longer needed. Pictures should not be stored indefinitely on a cellular device, OneDrive, MS 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.
- To minimize the risk of a privacy breach or adverse patient safety event, 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 when using shared printers.
- Patient information is entered into the electronic medical record and is used to make treatment decisions. Therefore, it's important to ensure the information and documents pertain to the correct patient.
- Immediately remove documents from fax machines and printers.

- PHI/Restricted Information, including photos should not be via SMS.
- Use a privacy screen or position monitors away from visibility of patients and/or the public.
- We must take reasonable safeguards or steps to make sure patient health information is kept private.

INCIDENTAL DISCLOSURES

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

DISCLOSING INFORMATION TO SPOUSES, FAMILY MEMBERS, AND FRIENDS

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

DISCLOSING INFORMATION TO THE MEDIA

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

DISCLOSING INFORMATION TO LAW ENFORCEMENT

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

DISCLOSING INFORMATION TO BUSINESS ASSOCIATES

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

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

PHOTOGRAPHING AND RECORDING

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

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

SOCIAL MEDIA

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

INAPPROPRIATE ACCESS TO OR DISCLOSURE OF PHI

If you acquire, view, or access patient information that you do not need to do your job or give patient information to someone who should not receive it (e.g., friend, family member or person of the general public), you will violate DHS policies, HIPAA, and/or State law. If your family member, friend, or coworker is admitted to the hospital, you do not have the right to view or access their information in ORCHID, even if they provide you with their written or verbal consent/authorization. You must follow DHS policy and submit their written authorization to Health Information Management (HIM) to obtain copies of the medical record.

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

MINIMUM NECESSARY

- "Minimum necessary" means you must only access the information you need to do your job.
- Just because you have access to a system, network, or patient records, does not mean you have the right to access or view confidential or patient information that you do not need to do your job.
- Only give out just enough information for someone else to do their job.
- If you are not assigned to the patient's care team or do not 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 department.

SECURITY OF CONFIDENTIAL INFORMATION

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

Examples of electronic media include:

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

Even a small incident can 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 use a network storage drive or DHS OneDrive cloud server.

Privacy and security policies are posted on the DHS SharePoint intranet, under Policies and Procedures. You should review and familiarize yourself with these policies and those of your facility/unit - so you fully understand your role in protecting patient health information as it pertains to your job responsibilities.

E-MAIL

- All e-mail communications containing PHI/Restricted Information sent outside of the County's e-mail system must be encrypted to comply with State and federal privacy laws and DHS policies. Encryption is not required for e-mail sent to recipients whose e-mail account ends in "lacounty.gov" or "lasd.org" such as @dpss.lacounty.gov, @dmh.lacounty.gov, @ph.lacounty.gov, etc. However, you may choose to encrypt the e-mail.
- To encrypt an e-mail, type [Secure] in square brackets in the subject line of the e-mail. Avoid including the patient's name in the subject line. Do not send work-related e-mails containing PHI/Restricted Information to your personal e-mail account, even if it is encrypted.
- Your e-mail account should not be used as storage device. If your e-mail account is phished or accessed inappropriately, the threat actor may have access to all of your e-mails. Save important e-mails in your shared drive and delete those you no longer need. Remember to also empty your "Deleted" items folder regularly.



REMEMBER

County equipment is for County business purposes only.

SECURITY INCIDENTS AND POTENTIAL PRIVACY BREACHES CAUSED BY SOCIAL ENGINEERING

Another threat continually 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 e-mail, including internal e-mail contacts, computers, servers, and can also be a gateway for ransomware attacks. Cybercriminals send familiar-looking e-mails pretending to be a workforce member, charitable organization, healthcare program or agency, or e-mail provider. These messages often ask you to click on a hyperlink to a fake website or document, download a malicious attachment, or reply to a fake request with your username and password, sometimes making threats if you do not comply. If in doubt, report the e-mail via the **Report Phishing** button or contact the DHS Enterprise Help Desk (EHD) at (323) 409-8000 so one of their experts can validate its legitimacy.

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

- Does the tone of the e-mail typically represent the sender? Be extra cautious if the e-mail style is not the way the sender generally communicates with you. Beware of e-mail that is unexpected or where the content does not appear to directly apply to you.
- Are there any grammar, spelling errors, or typos? E-mail from legitimate sources should be free of grammar and spelling errors.

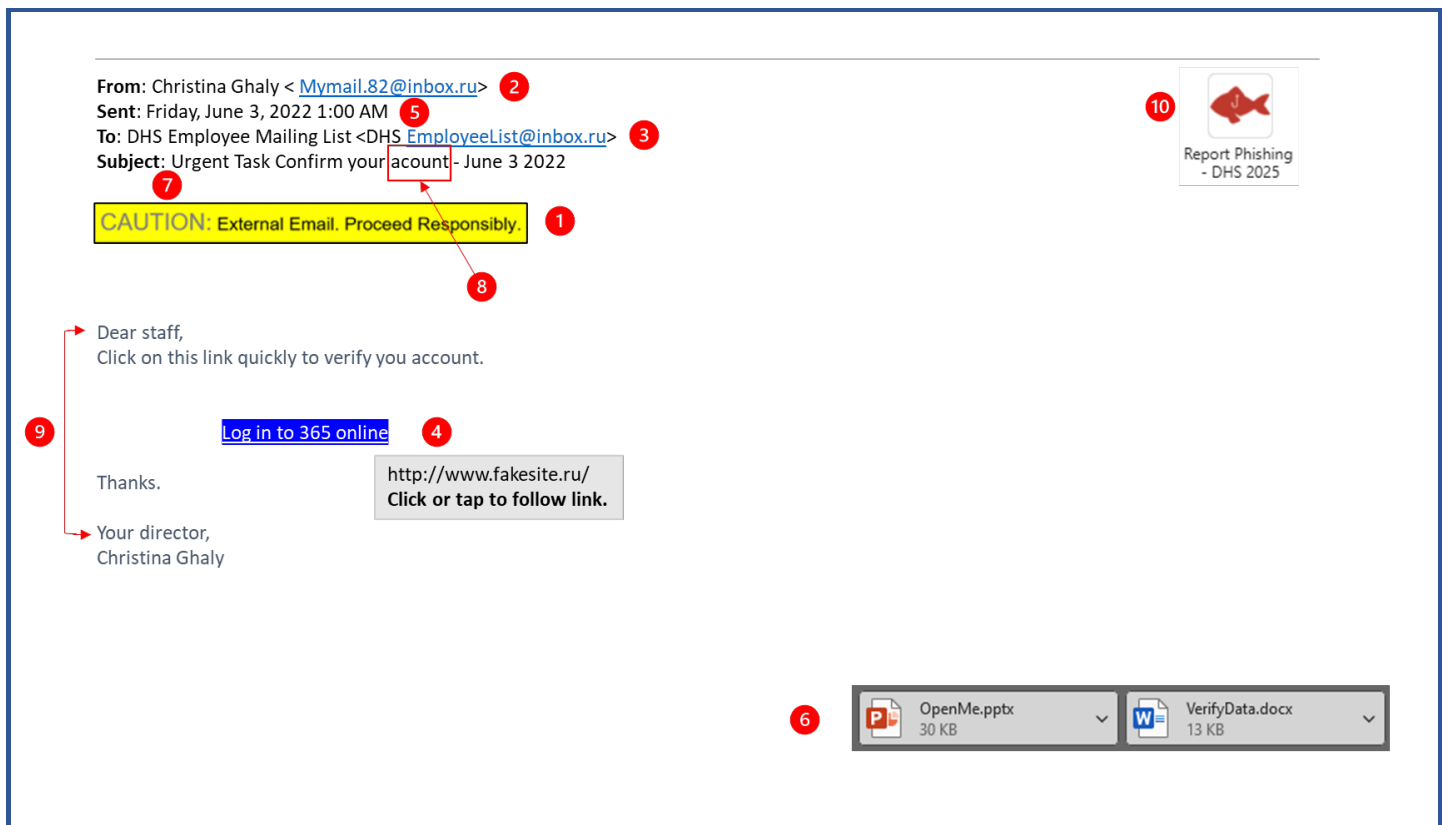
- Are there any threats or a sense of urgency to the e-mail? E-mail that threatens negative consequences or demands immediate action should be treated with suspicion.
- Does the e-mail direct you to a hyperlink or direct you to input your credentials in order to open an attachment? Beware of unexpected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

Scenario:

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

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

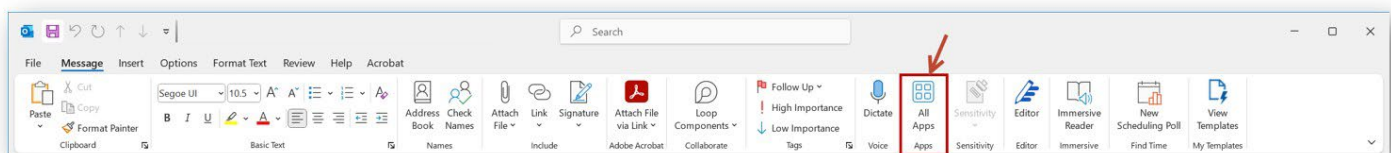
1. **External Tag:** If you receive an e-mail from someone that appears to be a colleague or a Departmental Executive, and the e-mail is tagged with the **yellow banner** indicating the e-mail was generated outside of the County, beware! This **MAY** be a phishing attempt. Look for additional suspicious signs.
2. **"From" Line:** Check the spelling of the sender's e-mail address and verify the e-mail address by hovering your mouse/pointer over it; misspelling is likely an indicator of a spoofed e-mail.
3. **"To" Line:** Check to see if you know other people in the "to" line.
4. **Hyperlink:** Avoid clicking the hyperlink if the URL does not match the text. Hover your mouse/pointer over a hyperlink to see the destination URL before you click on it.
5. **Time:** Consider the time you receive the e-mail and compare it with the normal time you receive similar e-mails. E-mails 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 action, 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 hyperlinks or downloading any files.
9. **Trust:** Check if the source appears to be a known and trusted individual.
10. If the e-mail seems suspicious, **report it** using the **Report Phishing** button.



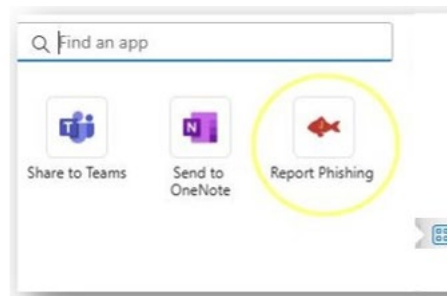
Using the Report Phishing button gives you the option to send the e-mail to your junk folder. For SPAM e-mail, you may **block** the sender's e-mail address to avoid future junk e-mail. Right-click a message from the sender you want to block, and then click Junk > Block Sender.

Where to Find the **Report Phishing** Button:

1. Click on the **Apps** icon at the top-right corner of the e-mail ribbon.



2. Locate the **Report Phishing** button within the pop-up menu. Click the button to report the phishing e-mail.



RANSOMWARE

Ransomware typically infects a system through a phishing e-mail containing a malicious attachment, an infected software download, or by visiting a malicious website or hyperlink. Once ransomware infects a system, it locks it down and either encrypts the user's files or restricts access to the computer's key features. The ransomware then sends pop-up windows demanding the user to pay a specific ransom to regain access or reactivate the computer.

If you are unsure about the e-mail's legitimacy, verify with the sender using another method of communication, such as a phone call. If in doubt, report the e-mail using the **Report Phishing** button or contact DHS Enterprise Help Desk at (323) 409-8000 so one of their experts can validate its legitimacy. Please **DO NOT** seek opinions from other colleagues by forwarding the e-mail. Doing so may help the threat actor distribute malware to a larger audience, making it much more difficult to contain.

SMISHING AND VISHING

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 on an entry form; signing up to be part of a product test group; a text indicating a credit card transaction and a hyperlink to confirm. **DO NOT CLICK** the hyperlink 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 caller may try to verify account information, claims your computer has a virus to gain access to data remotely (with your permission), or instructs you to 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 have verified that the person you are interacting with is legitimate.

WORKING REMOTELY

Working away from the office requires the same level of security awareness as working on-site and does not exempt anyone from following our policies. The way you access, store, and transfer confidential data must align with current guidelines. You are prohibited from downloading or installing any software on work devices. It is your responsibility to know if you are allowed to access our organization's network using 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. Never store PHI/Restricted Information on your personal device(s).
- Shredding or destroying sensitive documents using a cross-cut shredder.
- Not leaving documents containing PHI/Restricted Information unsecured on mobile devices or in plain view. Do not leave them in your vehicle overnight.
- Locking the door of your workspace if you have a dedicated office. This helps keep out intruders, as well as children, friends, family, and pets.
- If you do not have a dedicated office, try to work in the same area and limit others' access to that space. Always lock your screen and other devices if you step away, and lock up papers and removeable media, such as USB drives.
- Password protecting your Wi-Fi (never use default passwords).
- Using strong passwords and locking your device(s) when not in use.
- Using discretion when working in public areas, such as coffee shops with free Wi-Fi that is not secure. Avoid handling confidential information over unsecure Wi-Fi networks that are 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 compromise our security efforts.

Ensure your access is not obtained by unauthorized parties. NEVER share your login credentials, keys, or badges. ALWAYS use strong, unique passwords for every account, lock systems when not in use, and avoid granting unnecessary access to restricted workplace areas. If you suspect you've been granted unnecessary access to systems or data, do not assume it was intentional. Report the issue to management immediately.

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 violates the DHS Policy Acceptable Use of County Information Technology Resources.

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

- Accessing medical information about a family member, friend, coworker, or high-profile patient without a work-related justification.
- Failing to lock or log off a computer when stepping away. You are responsible for everything done under your credentials.
- Discussing a patient's illness in front of a family member without giving the patient a chance to agree or object.
- Losing an unencrypted flash/thumb drive, laptop, or other portable device containing patient information (i.e., leaving your laptop in your vehicle, where it could be stolen).
- Removing PHI from the facility without properly securing it. This increases the risk of inappropriate disclosure, loss or theft (e.g., taking documents containing PHI home and leaving them in your car that gets vandalized).
- Working remotely in an unsecured work location.
- Storing confidential or patient-related documents on a personally owned device.

REPORTING POSSIBLE VIOLATIONS AND INCIDENTS

- Do not hesitate to report suspicious behavior. Malicious activity may impact the entire organization and compromise patient privacy. Timely reporting helps combat threats and reduce risk.
- You must report anything a workforce member does that may violate DHS Policy or federal or state laws.
- If a workforce member accesses a patient's medical record without authorization – even if they do not share the information or no harm results – it must still be reported. It is a violation.
- You will not face retaliation for reporting a suspected or actual violation in good faith. You may stay anonymous. If you choose to report anonymously, provide as much detail as possible to enable 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.
- Potential violations may also be reported 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 malware to the DHS Enterprise Help Desk (EHD) at (323) 409-8000.
- Report potential phishing e-mail using the **Report Phishing** button. Never click on hyperlinks nor open suspicious attachments. DO NOT forward potential phishing e-mail to the EHD.

FINES AND PENALTIES

- Use good judgment when working with patient information.

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

PRIVACY AND SECURITY DO'S AND 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

1. Respect patient privacy and their information and only access, view, or use information needed to do your job.
2. Verify that all documents provided to a patient belong to that patient. Use at least two patient identifiers (or more, if necessary) before giving a patient medications or documents, such as appointment reminders, discharge summaries, or eligibility packets. When verifying, ask the patient to provide their personal information rather than you asking them if they are the correct patient.
3. Delete e-mails and attachments containing PHI/PII when no longer needed to do your job. Regularly empty your recycle or trash folder and delete unnecessary pictures, files, attachments, and e-mails from your desktop, laptop, or mobile device.
4. Delete files and pictures containing PHI/PII from Microsoft Teams and OneDrive when no longer needed for your work.
5. Immediately remove all PHI/PII from shared printers, fax machines, and photocopiers.
6. When faxing PHI/PII, be sure to verify that the recipient and phone number are correct. When possible, confirm that the recipient received the fax.
7. Discard PHI in secure shredder bins (HIPAA bins) or in cross-cut shredders.
8. Discuss patient care in a private area or speak quietly to maintain confidentiality.
9. Keep medical records and other documents that contain PHI out of public view.
10. Close patient/exam room doors or draw curtains and speak softly when discussing patient care.
11. Treat patient information as if it were your own.
12. Report suspected patient privacy violations through the Safety Intelligence™ (SI) Event Reporting System AND by phone to the facility Privacy Manager in a timely manner to comply with privacy policies and regulations.
13. Report suspected security incidents to the Enterprise Help Desk via e-mail at Helpdesk@dhs.lacounty.gov or by phone at (323) 409-8000.
14. Use the **Report Phishing** button to report potential phishing e-mail.
15. 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.
16. Only use your dhs.lacounty.gov e-mail to send or discuss patient information.
17. Obtain permission to store e-PHI on a laptop, USB thumb/flash drive or other portable device, and make sure the device is encrypted.
18. Store paper records and medical charts in locked rooms and locked cabinets.
19. Restrict access to computers or computer systems containing e-PHI to authorized users only.
20. Verify the recipient(s) e-mail address(es) before sending communications, especially if PHI, employee PII, or other confidential information is contained in the e-mail. Do not solely rely on auto-populated names in Outlook.
21. Encrypt e-mail sent outside of the DHS and/or County e-mail domain that contain PHI/PII or confidential information.
22. Always be careful when using public computers and public Wi-Fi because they are not secure.
23. Always password protect your home Wi-Fi (change from the factory password that comes with equipment).
24. Position computer workstations and monitors away from public view or use a privacy screen.
25. Log off the computer when you are away from the work area, even if you're coming right back, or when the computer is not in use.
26. If a patient requests a restriction regarding sharing information, such as diagnosis and/or treatment, with family and/or others, document the request and make sure the treatment team is aware of it.

PRIVACY AND SECURITY DON'TS

1. Don't access information about a patient unless you need it to do your job (even if you personally know the patient).
2. Don't share confidential patient information with anyone who does not need it to do their job.
3. Don't provide PHI/PII to a vendor until you have verified with your Privacy Manager that a signed Business Associate Agreement (BAA) is in place.
4. Don't use a personal laptop, notebook, or other electronic device to store PHI/PII or confidential information unless authorized by your supervisor and the device is encrypted.

5. Don't store or save patient information on the computer's hard drive. All patient information must be stored on the network drives.
6. Don't share passwords or your computer while logged in. You are responsible for all actions and information viewed while logged in under your credentials.
7. Don't store your password(s) under the monitor, keyboard, or inside your unlocked desk.
8. Don't reuse the same password for multiple accounts.
9. Don't use short and simple or personal passwords that are easy to guess (e.g. 1234567890, abcde1234, kid's names, pet's name, birthdates, etc.).
10. Don't forget to log off shared/public use computers and workstations when you are done or are briefly stepping away.
11. Don't e-mail PHI outside of the County e-mail network without proper authorization.
12. Don't send and discuss patient information or conduct County business through internet-based e-mail sites such as Yahoo Mail, Google Mail, Hotmail, etc.
13. Don't use online web-based document sharing services (e.g., Google Docs, Microsoft Office Live, Drop Box, Open-Office, etc.) to store or share patient data.
14. Don't post patient information or discuss patient care such as diagnosis, treatment, patient location, or other information that may be used to identify the patient on social networking websites (e.g., Facebook, Instagram, Twitter, YouTube, etc.).
15. Don't take photos and videos of patients for patient diagnosis and treatment using your personal cell phone unless you use the secure Microsoft Teams platform, which has replaced HIPAABridge.
16. Don't walk away from open medical records, lab results, etc. Make sure all medical records and lab results are placed in a secure location, out of public view.
17. Don't discard documents or medical supplies that contain PHI in a trashcan.
18. Don't store documents containing PHI in an area where it can be mistaken for trash.
19. Never click on hyperlinks in e-mails from unknown or suspicious senders - these may be phishing attempts.
20. Don't remove documents containing PHI/PII from the facility unless you are authorized to do so.
21. Don't forget to remove documents containing PHI from your pockets or personal belongings before leaving the workplace; secure or discard them appropriately.
22. Don't access unsecure sites or view confidential information when using public Wi-Fi.
23. Don't permanently store sensitive information in your e-mail inbox.
24. Don't burn CD's/DVD's that contain PHI without encrypting.
25. Don't leave CD's/DVD's that contain PHI unattended.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The DHS Compliance Program is a comprehensive strategy to prevent, detect, and correct instances of unethical and/or illegal conduct. DHS is committed to conducting its business in a manner that promotes 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 on providing outstanding customer service. The Compliance Program is committed to working with the entire workforce to make responsible conduct the hallmark of our patient care and the Department's overall performance.

A significant element of the DHS Compliance Program is the **DHS Code of Conduct**, which is our guide to appropriate conduct and behavior. Together with applicable laws, County and Department policies, and program-specific guidelines, the Code sets 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 they will abide by it. Non-compliance with the Code of Conduct may result in 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 outlines several resources available to help you 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 the confidentiality of the caller's identity, within limits of the law and the practical necessities of conducting an investigation.

Please note that the Los Angeles County Fraud Hotline and website, operated by the Auditor-Controller, remain available for reporting 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 otherwise 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 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 designed to prevent fraud, waste, and abuse in the healthcare industry.

Submitting false claims, statements, or records to federal health care programs can result in huge fines and penalties - including up to three times the amount of the false claim, a civil penalty of \$5,500 to \$11,000 per claim, and the cost of the civil action. The law is intended to control fraud in federal and state healthcare programs by authorizing certain governmental agencies to investigate violations and prosecute violators. A person may violate the FCA by knowingly submitting false claims or by doing so with "reckless regard" for the truth.

The FCA also provides "whistleblower protections" to individuals who report suspected fraud. In some cases, whistleblowers can file a lawsuit on behalf of the government and may be eligible to receive a portion of any recovered funds. Whistleblowers are protected from discharge, demotion, or retaliation for reporting misconduct or participating in an investigation or legal proceeding.

California has a similar false claims law that also provides protections and remedies for individuals who report fraud involving state programs.

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 nor accept goods or services without a purchase order or contract, as doing so may commit the County to a purchase obligation. Goods or services acquired without the proper authorization will be identified as unauthorized. Any workforce member who obtains goods or services from a vendor without official approval may be held personally responsible for payment 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's Supply Chain Operations Division if they have any questions regarding the procurement process or acceptance of goods or services.

CONDITIONS OF EMPLOYMENT

The purpose of this section is to provide workforce members with the conditions of employment set forth by the County and DHS. Below is 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 opportunities for persons with disabilities in compliance with the Americans with Disabilities Act (ADA) as well as applicable state law. The ADA prohibits discrimination against persons with disabilities during the application process and throughout all phases of employment. DHS is required to engage in an interactive process with qualified employees who have a disability 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. Reasonable accommodations may include, but are not limited to, removing architectural barriers, adjusting work schedules, 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 need an accommodation for a disability, inform your supervisor, departmental personnel officer, or the reasonable accommodation coordinator immediately. Requests for accommodation are evaluated on a case-by-case basis. If you request an accommodation, it is essential that you participate fully in the interactive process. This may include, but is not limited to, providing medical documentation, meeting with specialists, and identifying restrictions and possible accommodations.

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

EQUAL EMPLOYMENT OPPORTUNITY

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

In developing this policy, the Department of Health Services (DHS) is committed to:

- Recruiting, hiring, training, and promoting individuals in all job classifications without regard to any non-job-related characteristics.
- Ensuring that promotional decisions follow EEO requirements based on valid, job-related criteria.
- Ensuring that all personnel actions relating to compensation, benefits, transfers, terminations, training, and education are administered in a non-discriminatory manner.
- Prohibiting employment practices that discriminate against employees or applicants, including sexual harassment by managers, supervisors, clients, or co-workers.
- Providing a work environment free from harassment and/or other discriminatory practices.
- Complying with all federal and state disability laws and providing a thorough interactive process for individuals with disabilities that limit a major life activity.

PROFESSIONAL CREDENTIALS (LICENSE/CERTIFICATION/REGISTRATION/PERMIT)

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

Workforce members are responsible for renewing all required professional credentials and ensuring they remain in good standing with the appropriate issuing board or agency. Failure to comply with professional credential requirements may result in corrective action, including discharge or release from County service or assignment.

Primary source verification is required to confirm that workforce members 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; however, DHS requires unlimited access to review professional credentials.

If you are required to maintain a current professional credential to perform your job, it is your responsibility to provide a copy of a renewed professional credential to your supervisor before 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 if you are informed 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 report it immediately to your supervisor or the DHS 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.

CRIMINAL BACKGROUND CHECKS

All candidates selected for hire, promotion, or transfer from another department, and potential contract/volunteer/student staff, as specified in DHS Criminal Records Background Check Live Scan Policy, will participate in a criminal background check. This check includes 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 this 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 are 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 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 the charge to DHS Human Resources within 72 hours of becoming aware. If convicted, you must report the conviction to DHS Performance Management (PM) within 24 hours.

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

DISASTER SERVICE WORKER/DHS EMERGENCY PROTOCOL

The State of California Disaster Service Worker Volunteer Program (DSWVP) provides workers' compensation benefits to Disaster Service Worker (DSW) volunteers injured while performing authorized disaster service duties.

All persons employed by the state, any county, city, or public district (public employees), excluding persons legally employed but who are not a citizen or national of the United States, are Disaster Service Workers (Gov. Code, § 3101). These 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 of their regular job **AND** without pay, is eligible for state DSW program benefits (Code, § 3211.92(b)). Registration is required with an Accredited Disaster Council, authorized designee, or California Governor's Office of Emergency Services (Cal OES).

Additionally, Los Angeles County Code (2.68.060) designates all County officers and employees as members of the "County Emergency Organization" and can be activated to perform disaster services outside of their regular duties.

All DHS employees must complete the *Disaster Service Worker Awareness* training on TalentWorks. The 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. Confirm the safety of your family and property. Once verified, assist in the County's disaster response.

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

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

Employees who require evacuation assistance may complete a "Voluntary Request for Reasonable Accommodation" form and submit it to their supervisor/manager, the facility on-site HR Office, or the Department ADA Coordinator.

REPORTING OF ABUSE/NEGLECT INCIDENTS

Under California Penal Code, health care practitioners must report suspected or confirmed child abuse/neglect, and elder or dependent adult abuse/neglect. All workforce members are considered mandated reporters. Failure to report may result in criminal charges (a misdemeanor) and civil liability.

Mandated reporters are immune from criminal or civil liability when reporting in accordance with legal requirements.

CHILD ABUSE

Includes emotional, physical, or sexual abuse, or neglect of anyone under 18. It also includes cases where either a mother or newborn has a positive toxicology screen due to substance use. Reports must be made immediately or as soon as practicable to the Department of Children and Family Services (DCFS) Child Abuse Hotline. A written report must be submitted within 36 hours, either by mail or through <http://dcfs.lacounty.gov>. Sexual abuse must also be reported to law enforcement.

ELDER ABUSE

Includes physical harm, abandonment, neglect, emotional abuse, violation of rights, or financial abuse of individuals aged 60 and older. Report suspected abuse immediately or as soon as practicable by calling (877) 477-3646. A written report must be submitted within two working days via: <https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F>

DEPENDENT ADULT ABUSE

Includes the same types of abuse described above but applies to adults aged 18–59 with physical or mental disabilities. Reports must be made immediately by calling (877) 477-3646, with a written follow-up submitted within two working days via the same WellSky website listed above.

DOMESTIC/INTIMATE PARTNER ABUSE

Includes physical violence, sexual assault, emotional distress, and economic coercion involving current or former spouses, cohabitants, or dating partners. Reports must be made as soon as practicable to law enforcement when a patient seeks treatment for an injury related to domestic abuse.



NOTE

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

REPORTING SUSPICIOUS INJURIES

A SUSPICIOUS INJURY INCLUDES ANY WOUND OR OTHER PHYSICAL INJURY THAT WAS:

- Inflicted by the individual or another with a firearm; or
- Suspected to result from assault or abuse.

Under California Penal Code § 11160, any DHS health practitioner who provides care to a patient/inmate with a suspicious injury must report the injury by phone to law enforcement immediately or as soon as practicable, followed by a written report within two business days.

If the patient/inmate is in custody, the incident must be reported to the Los Angeles County Sheriff's Department Internal Affairs Bureau or the jail facility captain. Reports must also be escalated to the facility's Regulatory Affairs Unit for tracking.

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

Upon hire and annually, workforce members must disclose outside employment by completing the Outside Employment form on LA County Workplace and securing approval.

Details such as the employer, duties, and weekly hours must be included. Outside work must not exceed 24 hours per week, interfere with County duties, or occur during County time or using County property.

Refer to DHS Policy on Outside Employment, Incompatible Activity, Conflict of Interest, the State of California Conflict of Interest Disclosure Code, and Dual Compensation for more details.

CONFLICT OF INTEREST

A conflict exists if a workforce member (WFM) uses their position to influence a decision in which they have a financial interest. This includes participation in the contracting process and is prohibited by state law.

A WFM has a financial interest if the decision impacts:

- A business in which the WFM holds a \$2,000+ interest or serves in a leadership/employee role;
- Real property (worth \$2,000+) held directly or indirectly by the WFM;
- A source of income (\$500+ in the past 12 months) to the WFM or their spouse/domestic partner;
- A business where the WFM holds an executive or management position;
- A gift donor who provided \$630+ in value within the previous 12 months.

Additional financial interests are defined by law. WFMs who suspect a potential conflict must consult their supervisor immediately.

WFMs must not refer or transfer patients to private facilities in which they have a financial interest.

Complete the Conflict-of-Interest form for any potential issues. Executives or others with significant decision-making authority must complete Form 700 annually. This public document discloses financial interests to ensure transparency and prevent undue influence.

For more information, see DHS Policy Outside Employment Incompatible Activity, Conflict of Interest, State of California Conflict of Interest Disclosure Code, and Dual Compensation, or contact the DHS Human Resources Personnel Operations section or the DHS Compliance Division.

EMPLOYEE ORGANIZATIONS (UNION REPRESENTATION)

DHS is committed to fostering positive relationships with our labor partners. There are 18 unions representing LA County employees. In 2015, the Alliance for Health Integration (Department of Health Services, Department of Public Health, and Department of Mental Health) partnered with several unions to create the Labor Management Transformation Council (LMTTC). 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 the Covid-19 pandemic
- Continuous performance improvement efforts
- Involvement of front-line staff in decisions involving system transformation

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

There are several unions that represent County employees, including those that are part of the Coalition of County Unions, independent unions, and SEIU. Most DHS employees are represented by SEIU Local 721; other labor unions include, but are not limited to, AFSCME, and UAPD. County positions are divided into different categories of Bargaining Units. These Bargaining Units correlate with a specific labor union. Check the profile on your timesheet to determine your Bargaining Unit. New staff will be given information on the union representing their classification, if any, upon hire. If you have questions, please contact your supervisor/manager or the local HR office.

Labor Union	Address & Phone	Website
Service Employees International Union (SEIU) Local 721 Bargaining Units: 105, 111, 112, 121, 122, 201, 211, 221, 222, 311, 312, 341, 342, 431, 432, 711, 722, 729	1545 Wilshire Boulevard, Suite 100 Los Angeles, CA 90017 (877) 721-4968	https://www.seiu721.org/
American Federation of State, County, and Municipal Employees (AFSCME) Council 36 Local 119 Bargaining Unit: 421 Local 1271 Bargaining Unit: 321 Local 2712 Bargaining Unit: 721 Local 3511 Bargaining Unit: 724	3375 E Slauson Ave Vernon, CA 90058 (213) 487-9887	https://www.afscme36.org/
Coalition of County Unions (CCU) California Association of Professional Employees, MEBA, AFL-CIO (CAPE) Bargaining Units: 501, 502, 511, 512	3018 East Colorado Blvd, Ste. 200 Pasadena, CA 91107 (626) 243-0340	https://capeunion.org/
Coalition of County Unions, Los Angeles County Building & Construction Trades Council, AFL-CIO (BCTC) Bargaining Units: 411, 412	1626 Beverly Boulevard Los Angeles, CA 90026 (213) 483-4222	http://laocbuildingtrades.org/

Labor Union	Address & Phone	Website
Coalition of County Unions, International Union of Operating Engineers, Local 501, AFL-CIO, (IUOE) Bargaining Units: 401, 412	2405 West Third Street Los Angeles, CA 90057 (213) 385-1561, Ext. 113	https://local501.org/ca/
Coalition of County Unions (CCU) Committee of Interns & Residents (CIR)-SEIU Bargaining Unit: 323	(212) 356-8100	https://www.cirseiu.org/
Coalition of County Unions (CCU) Union of American Physicians and Dentists (UAPD), AFSCME, AFL-CIO Bargaining Units: 301, 324, 325	250 East 1 st Street, Suite 1103 Los Angeles, CA 90012 (800) 504-8273 (310) 398-4038	https://www.uapd.com/
Teamsters Local 911 Public, Prof., & Medical Employees Union	9900 Flower Street Bellflower, CA 90706 (562) 595-4518	http://www.teamsters911.com/

CUSTOMER SERVICE

CUSTOMER SERVICE PHILOSOPHY

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

- Personal Service Delivery
- Service Access
- Service Environment

PERSONAL SERVICE DELIVERY

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

Always:

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

SERVICE ACCESS

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

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

SERVICE ENVIRONMENT

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

- Report unsafe conditions to your supervisor or the Rancho Safety Officer at Ext. 56672.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers.

AIDET

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

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

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

TEAMWORK

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

EFFECTIVE WORKPLACE COMMUNICATION

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

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

Written:	Charting notes, reports, e-mail, documents, logs
Verbal:	Talking, teleconferences, telephone
Visual:	Demonstrations, videos
Electronic:	Computer, e-mail, text messages
Nonverbal:	Facial expressions, hand gestures, body movement, stance, tone of voice

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

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

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

PRINCIPLES OF INTERDISCIPLINARY COLLABORATION

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

- In communicating and collaborating, each discipline must accept the concept that each team member has a different priority related to the issue(s), care planning, or task at hand.

- It is important to identify time commitment, personal expectations, dependencies, and final expected outcomes.
- An agreement must be obtained on the plan, action(s) to be taken, and responsibility for implementation of each action step.

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

Example 2: The environmental service worker collaborates with the nurse or their supervisor through multiple methods (signs, verbal, training) about the isolation precautions that need to be taken for a safe environment for the patient, staff, and visitors.



KEY POINT

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

COORDINATION OF CARE

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

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

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



KEY POINT

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

CONFLICT RESOLUTION THROUGH TEAM BUILDING

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

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

- Minimize competition. Each party should feel a sense of contribution to the care plan and the resolution of patient care issues.
- Ask and respond to questions in a respectful manner, based on the premise that additional exploration of issues is an important method to enhance knowledge and foster collaboration between team members to provide the best possible patient care.
- Evaluate the facts of the situation and determine 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 the suggestion.
- When discussing problems remember, the problem is not the person. Separate the person from the equation so that the problem is the focus.

THE JOINT COMMISSION

THE JOINT COMMISSION'S FOCUS ON PATIENT SAFETY AND QUALITY

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

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

DHS hospitals follow a triennial survey track; however, the process for quality improvement and patient safety does not end with the survey. They must continually improve and maintain compliance with standards. Activities that support survey readiness include responding to deficiencies identified during the survey (Requirements for Improvement (RFIs)), conducting self-reviews (Focused Standards Assessment (FSA)) at 12 and 24 months after the survey to ensure RFIs are addressed, ensuring National Patient Safety Goals are met, and reviewing revised standards and elements of performance. Most importantly, these activities ensure we meet the safety and quality standards in patient care.

The Joint Commission surveys are unannounced. In addition to the triennial track, surveys may occur at various times in the interim due to patient complaints or concerns, to review compliance with new standards, or to follow up on previously identified issues.

SURVEY PROCESS

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

INDIVIDUAL TRACER ACTIVITY

Individual tracers are designed to "trace" the care experience of a patient while receiving services from DHS. This method analyzes DHS' system of providing care, treatment, or services using actual patients. Patients selected for these tracers are often in high-risk areas or have diagnoses, ages, or types of services that best support evaluating DHS' processes and practices.

SYSTEM TRACER ACTIVITY

System tracers evaluate how systems and processes work together, and how communication is coordinated among disciplines and departments. These tracers focus on areas such as data management, infection control, and medication management.

ACCREDITATION PROGRAM-SPECIFIC TRACERS

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

Reference(s):

<https://www.jointcommission.org/en-us/knowledge-library/support-center/survey-or-review-preparation/tracer-methodology>

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

1. Greet and welcome surveyor(s) to your facility.
2. Ensure your work badge is visible.
3. If a surveyor asks you a question, answer only that specific question. If you do not know the answer, do not guess. Let them know you will obtain the appropriate information and get back to them.
4. Display the awesome work you do each day!



KEY POINT

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

ACCREDITATION PARTICIPATION REQUIREMENTS (APR 09.02.01)

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

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

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

Online:	https://www.jointcommission.org/report_a_complaint.aspx
Phone:	(800) 994-6610
Mailing Address:	Office of Quality and Patient Safety The Joint Commission 1 Renaissance Boulevard Oakbrook Terrace, IL 60181



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

PATIENT SAFETY PROGRAM

Rancho 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 Steering Committee is an inter-disciplinary group, co-chaired by the Patient Safety Officer and the Chief Clinical Officer, to provide 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 Rancho’s policies and procedures regarding the National Patient Safety Goals (see The Joint Commission – National Patient Safety Goals section of this handbook).

WAYS TO REPORT SAFETY VIOLATIONS

- Safety Intelligence™ (SI) Event Reporting System

Or you may call:

- Hospital Risk Manager’s Office
- Pharmacy Hotline (Ext. 56050) to report Adverse Drug Events
- Medical Administration
- Employee Health Services
- Hospital Administration

WAYS TO STAY UP-TO-DATE 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, executive patient safety walk-arounds, and attending hospital-sponsored educational presentations. Information related to the safety program and goals will also be posted on the Rancho Intranet and on the computer start-up screen.

You should also read, review, and maintain a copy of the DHS Patient Safety and Risk Management Handbook which is provided to all workforce members.

WAYS TO MAKE PATIENT SAFETY SUGGESTIONS

You can inform or tell your supervisor about your safety suggestions. You can also e-mail your suggestions to the Risk Manager, Safety Officer, Patient Safety Officer, or mail them to Risk Management Office-SSA Building.

WAYS TO INVOLVE PATIENTS AND THEIR FAMILIES IN SAFETY

Rancho provides patients with a Patient Information Handbook, and a Patient Safety Brochure, “Tips for Safety,” 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/brochure and what you need to know:

- Rancho 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. Wear your badge on the outermost garment, at chest level or above, with your photo, name, and position/title visible.
 - Rancho 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 Rancho Number for minors) to confirm the patient’s identity, even if you are already familiar with the patient.
 - Rancho 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, Rancho 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!
 - Rancho instructs patients to ask about their test results.
 - Always refer their questions to the appropriate caregiver.
 - Rancho 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 Time-Out Process in the Universal Protocol section of this handbook.)
 - Please thank your patient, their family, or visitors if they remind you of these safety practices or when they ask questions. We want them to be participants in activities to better ensure their safety.
 - The Patient Handbook also lists the following locations and phone numbers that patient/families can call if they do not feel their safety concerns are being adequately addressed.
- | | |
|---|--|
| <ul style="list-style-type: none"> • Safety Officer – (562) 385-6672 • Patient Advocate – (562) 385-7036 • Director of Quality Resource Management – • (562) 385-7022 or (562) 385-7904 | <ul style="list-style-type: none"> • Department of Health Services Patient Safety Hotline – (213) 288-SAFE • Patient Safety Officer – (562) 385-7611 • The Joint Commission – www.jointcommission.org |
|---|--|

JUST CULTURE

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

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

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

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

Create and Maintain a Just Culture by:

- Encouraging staff to recognize and report patient safety issues and suggest ideas 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 to identify system failures.
- Focusing on designing/re-designing systems that will ultimately prevent mistakes.
- Partnering with patients and their families and letting them know how much we appreciate their active participation in making their care as safe as possible.

LGBTQ+ INCLUSIVE CARE

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. Rancho Los Amigos National Rehabilitation Center is committed to providing equitable and inclusive care regardless of 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 Rancho Los Amigos National Rehabilitation Center LGBTQ Committee actively encourages and promotes the enhancement of awareness and clinical skills through contemporary education and events.

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



KEY POINT

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

NATIONAL PATIENT SAFETY GOALS

The Joint Commission accredited healthcare organizations are surveyed for the implementation of the National Patient Safety Goals (NPSGs). The Joint Commission approved the first set of NPSGs in July 2002 with specific requirements for improving the safety of patient care in healthcare organizations. The expectation is that the NPSGs or acceptable alternatives are implemented. Patient Safety initiatives are based on meeting the NPSGs and focusing on system-wide solutions. All 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.

 = Hospital  = Ambulatory Health Care  = Laboratory

Healthcare Organization		
Identify Patients Correctly		
  	NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name <i>and</i> 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.
Improve Health Care Equity		
 	NPSG.16.01.01	Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.
Prevent Mistakes in Surgery		
 	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.



KEY POINT

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

DETERIORATING PATIENT CONDITION

As caregivers, you need to know the signs and symptoms of a decline in a patient's condition, within your scope of practice. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going assessments, handoff communication reports, medical record documentation, and other communication modalities are good methods to use in recognizing deterioration in the patient's condition. Every member of the health care

team is responsible to provide the highest level of care, and to immediately react to emergencies, potential emergencies, and/or incidents.

SIGNS AND SYMPTOMS:

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

- Acute change in mental status
- Acute change in heart rate
- Acute change in respiratory rate or effort
- Acute decrease in oxygen saturation
- Acute decrease in systolic blood pressure
- Acute decrease in urinary output
- Uncontrolled bleeding
- Any staff member's significant concern about a patient's status
- In patients under 5 years of age hypo-perfusion may often present with altered mental status, the patient feels clammy, he/she has poor capillary refill >3 seconds, may be unable to obtain blood pressure

If you are concerned that a patient is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. That patient's nurse will assess the situation and call for additional assistance if needed. Rancho has an Emergency Response Team set up to evaluate and stabilize patients or visitors who are deteriorating or who need emergent intervention. This team can be activated by dialing Ext. 544.

FALL PREVENTION AND RESPONSE

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

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

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

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

PREVENTION

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

- **Identifying and Eliminating Hazards:** If you see a hazard and you can fix the hazard (e.g. a water/liquid spill), do so. If you can't fix the hazard, promptly notify the proper department, maintenance worker, clinician, and/or area supervisor, according to your facility protocols. Try to secure the area to avoid a potential fall victim.
- **Environmental risks and hazards Include:** Wet or slippery floors, spills, debris, clutter, obstructions, stairs, change in surfaces, rugs/floor mats, extension cords, power cords of equipment in use or not in use, ladders, etc.
- **Physical/Cognitive Risks:** The elderly and the very young make up the highest percentage of fall victims. Some factors that contribute to fall risk for the 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.

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.

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 to help them back to their feet and to resume normal gait. If the fall victim is injured, unsure of injury, or disoriented, immediately call for help and remain with the victim.

Process for Obtaining Medical Assistance

- Notify your supervisor/manager.
- Activate Code Assist Team by calling Ext. 544.
- Document the incident via the Safety Intelligence™ (SI) Event Reporting System and follow other reporting procedures.

Report environmental hazards to Facilities Management at Ext. 57291 (after hours/weekends Ext. 74100) or the Safety Office at Ext. 56672. 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 or 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 Rancho'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, 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 they need assistance (e.g. co-worker carrying an unstable load, or following unsafe practices), offer them 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.

SAFE PATIENT HANDLING (SPH)

Effective October 1, 2014, every general acute care hospital was required to adopt Cal/OSHA Safe Patient Handling Regulation AB 1136. This regulation requires hospitals to have a program and policy that enables nurses and other caregivers to move patients utilizing equipment in a way that does not cause strain or injury while preserving the patient's dignity.

Department of Health Services and Rancho Los Amigos National Rehabilitation Center policies on Safe Patient Handling, addresses Safe Patient Handling. These policies require workforce members, except in an emergency, to perform patient transfers with mechanical assistive devices as appropriate for the specific patient and consistent with the professional judgment and clinical assessment of the registered nurse, who is the coordinator of care. Rancho has developed a Musculoskeletal Injury Prevention Plan which describes the elements of the Safe Patient Handling Program.

Patient handling activities that place staff at risk for injury include but are not limited to:

1. Repositioning in bed
2. Bed to chair/wheelchair
3. Bed to gurney and return
4. Gurney to treatment table and return
5. Bed to toilet
6. Floor to bed
7. Any other lift where total body movement of the non-ambulatory patient is required.

During an emergency in a nursing unit, contact a registered nurse to get help for the patient.

SUICIDE PREVENTION

The suicidal thoughts, also known as suicidal 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 suicidal ideation and take steps to help prevent suicide.

DETECTING SUICIDAL 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 suicidal 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

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 suicidal ideation, notify your supervisor.

SAFE-T

SAFE-T stands for **Suicide Assessment Five-step Evaluation and Triage**. These are the five steps:

Risk Factors: Know the risk factors (see above for a list of risk factors).

1. **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.
2. **Suicide Inquiry:** Conduct a suicide inquiry and ask specific questions about suicidal ideation, any plans they may have, including timing, locations, past or aborted attempts, rehearsals, and self-injury.
3. **Risk Level/Intervention:** After completing steps 1-3 assess the risk level, and reassess as the patient or the environment changes.
4. **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.



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

LIGATURE RISK

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

DEFINITION

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

WHAT ARE THE RISKS?

The goal for our patients at risk of suicide or self-harm is to have an environment free of ligatures and ligature points. 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**
- Means Matter from the Harvard T.H. Chan School of Public Health <https://www.hsph.harvard.edu/means-matter/>
- Mental Health Environment of Care Checklist from the U.S. Department of Veterans Affairs <https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp>



KEY POINT

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

PATIENTS' RIGHTS AND SERVICES

This section explains Rancho's patient rights and services such as patient advocacy, interpreter services, the Chaplaincy Program, advanced directives, ADA, organ/tissue donations, and EMTALA.

PATIENT RIGHTS AND RESPONSIBILITIES

To ensure that our patients' rights are protected, Rancho has a Bioethics Committee. This committee is multi-disciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises Rancho staff concerning such issues related to patient care decisions, and offers consults to Rancho departments. Rancho staff, patients, and families or significant others are encouraged to contact a committee member to review or discuss bioethical issues of concern to them.

Patients of Rancho have both rights and responsibilities. Each patient is given a Patient Information Handbook upon 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, Rancho has posted these rights and responsibilities throughout the hospital to inform patients and our staff.

- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Patient Advocate at (562) 385-7036.
- It is our responsibility to provide interpreter services free of charge for our Limited English Proficient and non-English speaking patients.
- It is prohibited to use a minor as an interpreter in any situation.
- 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 patients to determine 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.
- Rancho admissions staff and social workers inform patients of their options concerning AHCD's.
- Patients can fill out an AHCD document or give oral direction to a physician who will document it in the patient's medical record and a physician order set (Advance Directive/Resuscitation Status) will be initiated. Appropriate documentation(s) will be completed.
- Service animals must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.

PATIENTS' RESPONSIBILITIES

- Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- Patients have the responsibility to report unexpected changes in their condition to the responsible practitioner.
- Patients are responsible for making known whether they understand contemplated courses of action and what is expected of them.
- Patients are responsible for their actions if they refuse treatment or do not follow their practitioner's instructions.
- Patients are responsible for following the treatment plan recommended by their practitioner who is primarily responsible for their care. This includes following instructions of allied health staff as they carry out the plan of care and implement the appointments. If the patient is unable to keep an appointment for any reason, the patient must notify the responsible practitioner or Rancho staff member.
- Patients are responsible for being considerate of the rights of other patients and Rancho personnel, and for assisting in the control of noise, smoking, and the number of their visitors. Patients are responsible for being respectful of the property of other persons and of Rancho.
- Patients are responsible for following Rancho rules and regulations affecting patient care and conduct.
- Patients are responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.

**KEY POINT**

For more information, refer to [Rancho Administrative Policy and Procedure, Patient Rights and Responsibilities](#).

PATIENT ADVOCATE

The Patient Advocate 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 their hospital visit, make every attempt to resolve the issue or immediately refer them to your supervisor or designee. If the problem cannot be resolved in your department or if the problem is not related to your department, refer them to the Patient Advocate at (562) 385-7036.

Patients, family members, and visitors can make verbal and written complaints. If you or the patient/family believe the patient's rights are being violated, the Patient Advocate will also help resolve the problem. Regular business hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday. During after-hours, weekends, and holidays, please ask for the Charge Nurse or supervisor to resolve any patient complaints.

LANGUAGE ACCESS SERVICES

WHAT YOU NEED TO KNOW

- Most of our patient encounters are with patients who have a preferred language, other than English ([OLAI 2024 by the Numbers](#)).
- Patients and families have a right to receive care in their preferred language.
- DHS is committed to ensuring that patients are provided care in their preferred language for better patient care.
- Here are the resources available to support Language Access:
 - Qualified Interpreters, including Qualified Sign Language Interpreters
 - Qualified Translation for vital patient information written in other languages
 - Aids and Alternative Formats (auxiliary aids and different formats, such as large print, audio, and accessible electronic formats)

Department of Health Services
Office of Language Access and Inclusion (OLAI)
CY 2024 – By The Numbers



1.5M Patient Visits
Non-English Preferred Language

119K
Face-to-Face
Interpretation Sessions



1M
Phone Interpretation
Sessions

132K
LanguageLine Solutions Insight
(Interpreter)
App Sessions

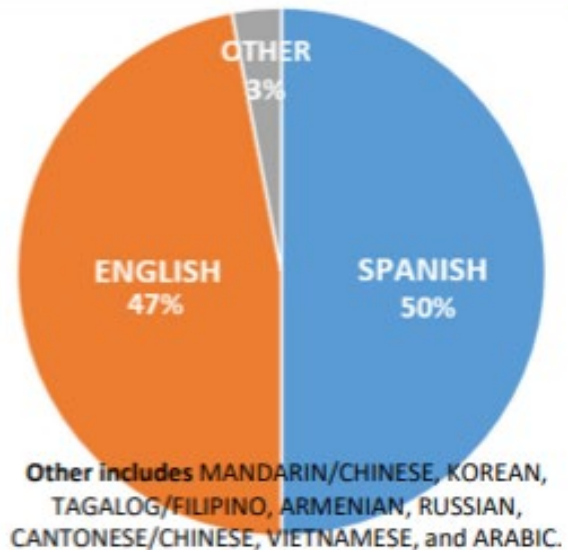


52K
Video Interpretation
Sessions

1K
LanguageLine Solutions Virtual Desktop
Infrastructure (VDI) Sessions

89
DHS Healthcare Interpreters

Top Ten Languages
(CY 2024)



1.2M*
Interpretation Services Sessions

296K*
Interpretation Service Hours

4.6/5
Average Satisfaction Rating

270
Enterprise-wide Document Translations

113
Enterprise Help Desk Tickets Closed

4K
Bilingual Bonus Recipients

email: Olaifedback@dhs.lacounty.gov

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

LANGUAGE SERVICES REQUIREMENTS

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

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

Review DHS Policies on Language Access below:

- DHS Policy Language Access – Interpretation Services
- DHS Policy Translation of Written Materials
- DHS Policy Effective Communication for Persons with Disabilities

LANGUAGE ACCESS LAWS AND REFERENCES

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

LANGUAGE ACCESS LAWS

- 1 TITLE VI OF THE CIVIL RIGHTS ACT**
 Protects against discrimination of any individual based on national origin, which includes language
 
- 2 EXECUTIVE ORDER 13166**
 Requires public entities to create and maintain a language access plan that ensures meaningful access to programs
 
- 3 THE AFFORDABLE CARE ACT**
 Requires healthcare organizations to ensure equal access for individuals with LEP through interpretation and translation
 
- 4 THE AMERICANS WITH DISABILITIES ACT**
 Requires meaningful accommodations for the Deaf and Hard of Hearing through auxiliary services like ASL interpretation
 



<https://jeenie.com/resources/blog/language-access-laws-comprehensive-guide>

ACCESSING QUALIFIED LANGUAGE SERVICES

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

In general:

1. HCIs are available to assist staff with interpretation for clinical conversations, and
2. Certified Bilingual Staff are available to provide direct communication with patients within the scope of their assigned job duties.

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

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

Note, if your role requires you to have clinical conversations with your patients, you must be Certified Bilingual to speak to them about their clinical care. Staff must pass a language proficiency assessment conducted by DHS Human Resources, qualifying them as Certified Bilingual Staff in their current assigned job duties (clinical or non-clinical role).

IMPORTANT INFORMATION ABOUT FRIENDS AND FAMILY SERVING AS INTERPRETERS

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

1. You should not have family or friends interpret for clinical conversations.
2. Minor children cannot interpret for their families.

IDENTIFYING AND CAPTURING PREFERRED LANGUAGE

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

DOCUMENTING LANGUAGE SERVICES

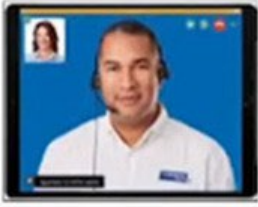
The method used to provide language services, including if services were refused, must be documented in the EHR when a healthcare member speaks to the patient about their clinical care.

For additional information, please visit [Office of Language Access and Inclusion](#) or contact your site's [Language Access Services \(LAS\) Administrator](#).

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER: (562) 385-7428

Business Hours, Monday to Friday, from 7:00 A.M. to 4:00 P.M.

How to Request Language Services

Face-to-Face Interpreting Services	To schedule a face-to-face interpreter for any language (including sign language), call the Language & Culture Resource Center at (562) 385-7428 during business hours, Monday to Friday, from 7:00 A.M. to 4:00 P.M. or e-mail to rlainterpreter@dhs.lacounty.gov any time.	
Video Remote Interpretation (VRI) Services, including American Sign Language (ASL) Interpreting Services Top Languages available on-demand 24 hours/7 days a week	Refer to the laminated cards on the Video Remote Interpretation (VRI) equipment for details regarding VRI Services. If not available, call the Language Center at (562) 385-7428, or e-mail to rlainterpreter@dhs.lacounty.gov .	
Telephonic/Audio Interpreting Services Over 240 languages available on-demand 24 hours/7 days a week	Dial ext. 58154 or (562) 385-8154 and request an interpreter from any in-house phone. For personal phone access, dial (562) 385-8154.	
LanguageLine Insight (Interpreter) App Over 240 languages available on-demand 24 hours/7 days a week	To access the app on personal smartphones, click here for instructions. To access the app Virtual Desktop Infrastructure click here to review the user guide.	
TTY or CRS	Call the Language & Culture Resource Center to obtain information about the following: • TTY (teletypewriter) Devices or the California Relay Service (CRS) [available for the deaf, hard of hearing, or speech disabled patients] • Location of Public TTY/TDD machines • Speech to Speech (STS) Relay Service for patients with speech disabilities	
Written Translation	Contact the Language & Culture Resource Center for assistance with Written Translation.	

SPIRITUAL NEEDS OF PATIENTS (CHAPLAINCY PROGRAM)

The Chaplaincy Program at Rancho supports the spiritual health and well-being of all patients, their families, friends, and hospital staff through active listening, counseling, prayer, and administration of the Sacraments. We seek to promote wellness by giving comfort to those desiring the services of our volunteer chaplains who are from various denominations. Our chaplains are available to minister to all patients, their family members, friends, and hospital staff, regardless of their religious preference.

Referrals to the Chaplaincy Program may be made by contacting the Social Work Department at (562) 385-7867 and/or Nursing by calling (562) 385-7911, Volunteer Services (562) 385-7651 or directly to the Pastoral Care Department at (562) 385-7256. Rancho chaplains are normally available Monday through Friday from 10:30 a.m. to 2:30 p.m. and can be contacted for emergencies by calling the Rancho operator at (562) 385-7111. For specific Sacramental requests such as Communion, Confession, Anointing, etc., the patient or family should contact their priest or religious leader from the spiritual community. Hospital staff should assist patients who need help in contacting their religious leader. Catholic and Protestant worship services are conducted on Sundays in English and Spanish.

ADVANCED HEALTH CARE DIRECTIVE (AHCD)

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. Rancho 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.

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 Social Work Department at (562) 385-7867, or the patient's physician. Remember patients who are of sound mind can change their mind at any time regarding AHCDs.

AMERICANS WITH DISABILITIES ACT (ADA)

DHS does not discriminate based on 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 Advocate Office, or the Departmental ADA Coordinator. Although complaints may be addressed at this level, the patient or the public retain the right to file a complaint directly with the appropriate state or federal agency.

SERVICE ANIMALS

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

Service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals. The work or tasks performed by a service animal must be directly related to the handler's disability. 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. **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 their service animal.
- A person with a disability cannot be asked to remove their service animal from the premises unless:
 1. The animal is out of control and the animal's owner does not take effective action to control it; or
 2. The animal poses a direct threat to the health and safety of others.

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

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

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

"Facility animals" are used for the purpose of therapy programming only and are not to be considered as Service Animals under the ADA. The primary animal that Rancho uses to conduct an Animal Assisted Therapy (AAT) program are healthy dogs of various breeds that are under the care of a licensed veterinarian or certified handler.

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 on-site HR Manager and your facility's ADA Coordinator, DHS Risk Management at

(323) 914-6365, or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

ORGAN/TISSUE DONATION

Rancho 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 deaths must be communicated to the *OneLegacy* 24-hour referral line at 1-800-338-6112 by the nursing staff. *OneLegacy* is a nonprofit, federally designated transplant donor network serving 18 million people in seven Southern California counties. It is extremely important to call within one hour following the identification of a clinical trigger that would identify the patient as a potential donor.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA), establishes specific responsibilities for physicians attending to the Emergency Department patient. EMTALA serves to provide structure to the proper examination, treatment, and transfer of Emergency Department patients. A hospital that operates an emergency department must provide a medical screening examination to anyone on whose behalf a request is made for examination or treatment. The purpose of the examination is to determine whether the individual is in an **emergency medical condition**. This is defined as a medical condition that could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, this includes the health of the woman and her unborn child.

MANAGED CARE PLAN TRAINING

MEDI-CAL FOR KIDS AND TEENS (ALSO REFERRED TO AS EPSDT)

This section aims to strengthen staff understanding and awareness about covered health care services under the California Medi-Cal for kids and teens program to help increase access to children’s health services.

MEDI-CAL FOR KIDS AND TEENS

Early Periodic Screening Diagnosis and Testing (EPSDT)

Federal law enacted in 1967 established EPSDT, which guarantees all medically necessary services to children and youth under the age of 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as **Medi-Cal for Kids & Teens**.

What is Medi-Cal for Kids & Teens?

- Requires comprehensive age-appropriate health care services be provided to all Medi-Cal enrolled children and youth under age 21.
- Requires preventive screening, diagnostic services, and treatment services.
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than that for adults’ care.

Medi-Cal for Kids & Teens Periodic Screenings

Comprehensive health and developmental history	Comprehensive, unclothed physical exam, including nutritional, height/weight, and Body Mass Index assessment	Behavioral health screening, including depression screening and tobacco, alcohol, or drug use
Developmental screening for physical and mental health using standardized screening tools	Age-appropriate immunizations (based on the Bright Futures / American Academy of Pediatrics (BF/AAP) Periodicity Schedule and Advisory Committee on Immunization Practices (ACIP) Recommendations)	Age-appropriate laboratory tests, including blood lead screening test
Oral health screenings and referrals to a dentist (beginning by age 1 or eruption of first tooth)	Age-appropriate vision and hearing screenings	Health education and anticipatory guidance for child and caregiver



Families do not need to request these screenings, and prior authorizations are not permitted.



REMEMBER

Medi-Cal for Kids & Teens screening services are designed to identify health and developmental issues as early as possible.

Medi-Cal for Kids & Teens Periodicity Schedule

Medi-Cal for Kids & Teens follows the Bright Futures/American Academy of Pediatrics (BF/AAP) Periodicity Schedule, which is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

Medi-Cal for Kids & Teens Screenings & Services

Subset of Required Medi-Cal for Kids & Teens Screenings and Services	
Blood Lead Screening Services	Vision Screening Services
Developmental Screening Services	Hearing Screening Services
Autism Spectrum Disorder (ASD) Screening Services	Oral Health Screening Services
Depression Screening Services (for adolescents and postpartum individuals)	Adverse Childhood Experiences (ACEs)/Trauma Screening Services
Dyadic Services/Preventative Behavioral Health Services	Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

As-Needed Screenings

- As-needed screenings may not be limited in number nor require prior authorization.
- Medical necessity of as-needed screenings may be determined by the child's physician; dentist; or health, developmental, or educational professional who comes into contact with the child.
- A parent or caregiver can request a child receive an as-needed screening outside of the BF/AAP Periodicity Schedule.
- As-needed screenings should be billed using the appropriate preventative medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination). The reason for the as-needed screening must be documented in the medical record.



NOTE

While regular (periodic) screenings are required, additional screenings must be done any time when medically necessary to assess diagnoses between regularly scheduled screenings. These as-needed screenings are called "interperiodic screenings".

Examples of As Needed Screenings (not limited to):

 A child receiving foster care receives a medical history and physical examination	 A child joining a sports team or camp receives a pre-participation medical history and physical examination
 A child enrolling in school receives a pre-participation medical history and physical examination	 A child with a history of developmental disability receives additional screenings
 A child entering California as a refugee receives a medical history and physical examination	

Medi-Cal for Kids & Teens Diagnostic Services

When diagnostic and/or treatment services are indicated as a result of a screening, providers must take all reasonable steps, including follow-up, to ensure enrollees receive necessary diagnostics and treatment **no later than 60 days after screening**.

Medical Necessity

- **Medi-Cal for Kids & Teens defines medical necessity** as broader for children and youth enrolled in Medi-Cal compared to adults. If a service is medically necessary and is included within any of the mandatory or optional categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act, then it must be provided to the child, even if the service is not included in the Medi-Cal State Plan.
- Under Medi-Cal for Kids & Teens, medical necessity is defined under federal and state requirements **as services correcting or ameliorating conditions, defects, and physical and mental illnesses**.
- A service need not cure a condition to be covered under Medi-Cal for Kids & Teens. **Services that maintain (by preventing a condition from worsening or preventing additional health problems) or improve a child's condition** are covered because they "ameliorate" a condition.

Medical Necessity Review Criteria

What is a medically necessary service per Medi-Cal for Kids and Teens?

Medically Necessary	Not Medically Necessary
✓ Service is reasonable, appropriate, and effective method to correct, maintain, or ameliorate the child's medical needs ✓ Service is in accordance with current medical standards or practices ✓ Service's scope (e.g., number of hours of skilled nursing care) is sufficient to address the child's needs ✓ Service is necessary to ensure for a safe environment for the child to ameliorate a given condition	✓ Service is experimental or investigational (considered on a case-by-case basis) ✓ Service is primarily for caregiver convenience (e.g., DME duplicated to be provided at divorced parents' homes) ✓ Service is more expensive than an equally effective and less expensive, available service; however, cost is not a basis for determining a service should not be provided
 If the service is determined to be medically necessary, the service must be covered if it can be covered under Medicaid, even if it is not in the Medi-Cal State Plan or not provided to adults, or if the child does not have a diagnosis	

California Children's Services (CCS) Requirements for Primary Care Providers

- The CCS Program, which is administered as a partnership between county health departments and DHCS, provides diagnostic and treatment services, medical case management, and physical and occupational therapy services.
- Care for children enrolled in CCS is provided by CCS-paneled providers, CCS-approved special care centers (SCCs), and approved pediatric acute care hospitals.
- The CCS Medical Therapy Program (MTP) provides direct physical and occupational therapy services for a subset of CCS-eligible children with physical disabilities.
- A child can be eligible for CCS services regardless of whether they are eligible for Medi-Cal or enrolled in a Medi-Cal managed care plan.



Examples of CCS-eligible conditions include, but are not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, lead poisoning, and traumatic injuries.



NOTE

CCS is an important component of the Medi-Cal system of care available to qualified children and youth under the age of 21 with certain diseases or health problems.

Anyone can make a referral to the CCS Program, if they suspect that a child is eligible for CCS. Primary care providers or specialists must provide a baseline health assessment and diagnostic evaluation with sufficient clinical documentation to establish - or raise a reasonable suspicion - that a child has a CCS-eligible medical condition.

- Children with CCS-eligible conditions must be referred to the local CCS Program on the same day the condition is identified.
- Referrals can be made via phone, secure e-mail, mail, or fax and include supporting medical documentation sufficient to allow for a medical eligibility determination.

Providers must continue to provide all covered services until the CCS Program eligibility is determined, and the managed care plan must reimburse the provider for those services.

Medi-Cal for Kids & Teens Skilled Nursing Services

Children and youth under the age of 21 may be eligible for Medi-Cal for Kids & Teens Skilled Nursing Services, including:

- **Private Duty Nursing (PDN)** is skilled nursing services provided by a licensed nurse (RN or LVN) on a shift basis at a child's home for children who require more individualized and continuous care than what would be provided by a visiting nurse; otherwise known as 'shift' nursing.
- **Pediatric Day Health Care (PDHC)** is skilled nursing services provided as day programs at PDHC facilities of less than 24 hours, including (but not limited to) comprehensive case management; nutrition and nursing services; developmental and educational services; and physical, occupational, and speech therapy.



NOTE

Limits based on a monetary cap or budgetary constraint may NOT be imposed; for example, if a provider determines it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week.

LONG-TERM SERVICES AND SUPPORTS

This section provides information regarding the Long-Term Services and Supports for Medi-Cal beneficiaries. These programs provide services to help individuals remain living independently in the community or the more appropriate setting of their choice.

WHAT ARE LONG-TERM SERVICES AND SUPPORTS (LTSS)?

Long-Term Services and Supports are an array of federally funded programs that provide services designed to support people to live independently in a home environment. There are four programs under Managed Long-Term Services and Supports (MLTSS):

Community Based Adult Services (CBAS)

- CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.
- It is daytime health care at centers that provide nursing, therapy, activities, and meals for people with certain chronic health conditions.

In Home Supportive Services (IHSS)

- A California state funded program that provides homecare services to low-income seniors and persons with disabilities, who need assistance with activities of daily living, allowing them to remain safely in their home.

Multi-Purpose Senior Services Program (MSSP)

- An intensive case management program for seniors who are certified for nursing home placement but wish to remain at home.
- The program provides both social and health care management services.

Long Term Care (LTC)

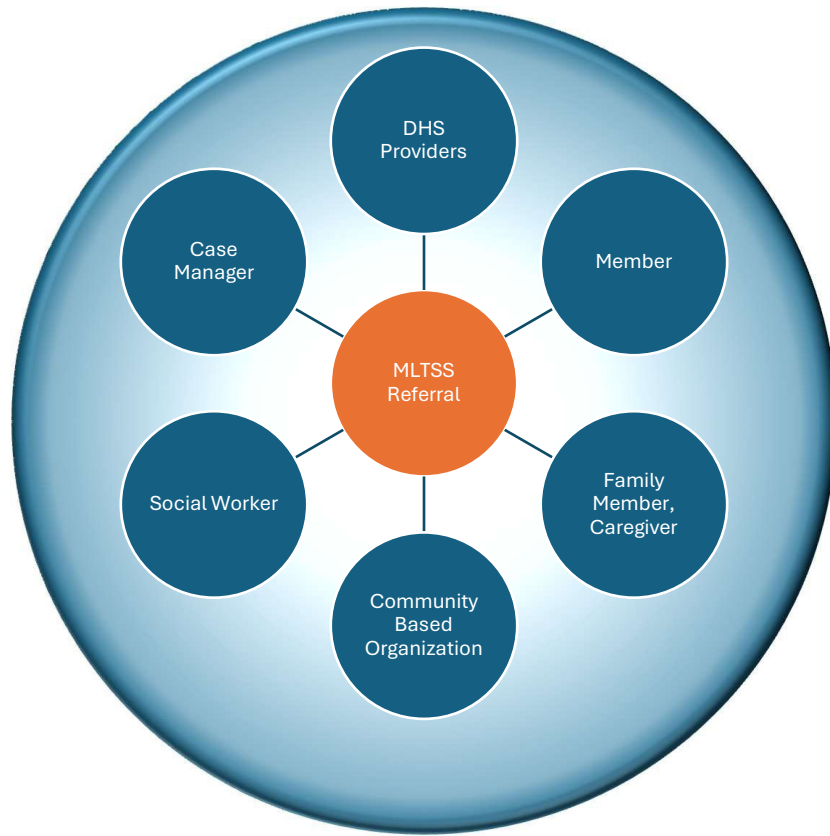
- LTC Nursing Facility services are available. If you get care in a nursing home, your health plan will work with your doctor and nursing home to better coordinate your care.

Program / Services

CBAS	IHSS	MSSP
• Professional Nursing • Social Services • Personal Care Services • Therapeutic Services • One meal per day • Transportation to and from CBAS Center	• Housecleaning • Meal Preparation • Laundry • Grocery shopping • Personal Care Services (such as bowel and bladder care, bathing, grooming, and paramedical services) • Accompaniment to medical appointments • Protective supervision for mentally impaired	• Adult day care • Housing assistance • Chore and personal care assistance • Protective supervision • Care management • Respite for Caregivers • Transportation • Meal services • Delivered meals • Social services • Communication services

RECOGNIZING THE NEED FOR MLTSS

Referrals to each Health Plan’s MLTSS department can come from various sources. Providers can find important MLTSS referral forms on each of the health plan’s website.



CONTINUITY OF CARE (COC) OVERVIEW

This section pertains to the California laws that protect a Medi-Cal managed care member’s right to continue to see their existing provider when the member’s existing provider is no longer available through the member’s health plan provider network (and is considered “out-of-network”).

CONTINUITY OF CARE (COC)

DHS Responsibility for COC

To ensure members’ continued health and safety, DHS must inform members of their right to request COC and must process their request in a timely manner.

Members with pre-existing provider relationships have the right to request continuity of care (COC) with an out-of-network provider when:

- They have a qualifying condition, and their treating provider is no longer in-network due to a change in the health plan’s provider network for which the member had no control.
- New members who are transitioning into a different health plan and are in the middle of care, and the member’s existing/treating provider is not part of the new health plan’s provider network.

Requesting COC

- Members or their authorized representatives may request for COC directly from their health plan.
- Providers can request COC on behalf of the member.

Health Plan Approval Criteria

The Health Plan approves COC requests when all the following criteria are met:

- Member demonstrates an existing relationship with the provider.
 - An existing relationship means that the member has seen the provider at least once in the previous 12 months for non-emergency condition prior to the date of their initial enrollment with the Health Plan.
- Provider is willing to provide ongoing services.
- Provider is willing to accept the payment offered from the health plan.
- Provider meets applicable professional standards and has no disqualifying quality of care issues.

COC Eligible Conditions

Problem or Condition	Member's COC Condition
Acute Condition (e.g., pneumonia)	As long as the condition lasts.
Serious Chronic Condition (e.g., severe diabetes or heart disease)	No more than 12 months. Usually, until the member completes a period of treatment and servicing provider can safely transfer the member's care to another provider.
Pregnancy	During pregnancy and immediately after the delivery (the post-partum period).
Terminal Illness	For the duration of the terminal illness.
Care of a child under three (3) years of age	For up to 12 months.
An already scheduled surgery or other procedure (e.g., knee surgery or colonoscopy)	The surgery or procedure must be scheduled to occur within 180 days of the provider or hospital leaving L.A. Care.

COC Services Not Covered for Medi-Cal Members

- Durable medical equipment (DME) providers or other ancillary services, such as transportation or carved-out services
- Out-of-network providers who do not agree to abide by the health plan's Utilization Management (UM) policies

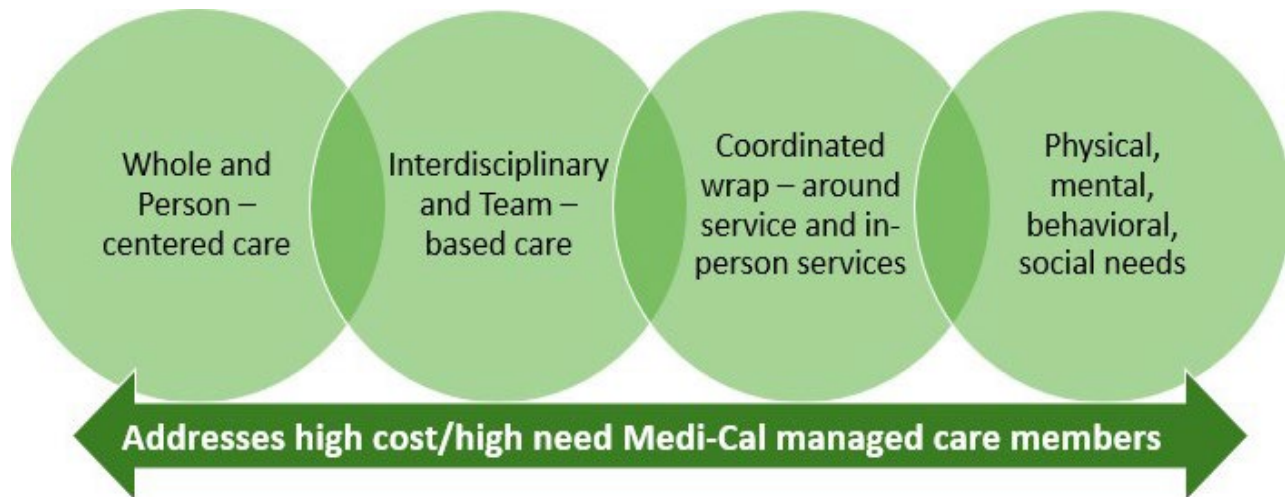
CALAIM OVERVIEW

Department of Health Care Services (DHCS) has developed a multi-year framework that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal program to:

- Address many of the complex challenges facing California's most vulnerable residents.
- Provide for non-clinical interventions focused on a whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities.

ENHANCED CARE MANAGEMENT (ECM)

ECM is a statewide enhanced care management benefit that provides a whole-person care (WPC) approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. The ECM benefit builds on the current Health Homes (HH) program and WPC Pilots and is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to populations of focus.



ECM'S SEVEN CORE SERVICES

Effective January 1st, 2022, the Medi-Cal ECM benefit designed by DHCS and authorized by the Centers for Medicare and Medicaid Services (CMS). The following seven core services are provided at the point of care:

Outreach & Engagement	• In person, culturally & linguistically appropriate
Comprehensive Assessment & Care Plan	• Assess member strengths, risks, needs, goals, gaps in care and their preferences. Develop a comprehensive, individualized, person-centered Care Plan that coordinates and integrated all Member's clinical and non-clinical health care related needs.
Health Promotion	• Promote self- management, collaborate to identify & build on successes and resiliencies
Comprehensive Transitional Care	• Develop strategies to reduce avoidable Member admissions and readmissions
Enhanced Coordination of Care	• Ensure care continuous and integrated among all service providers
Individual and Family/Social Supports	• Identify supports needed to manage the member's condition and assist them in accessing needed support services
Coordination of & Referral to Community & Social Services	• Coordinate and refer to available community resources and follow up to ensure services were rendered- "closed loop referrals"

ECM POPULATIONS OF FOCUS

- Homeless individuals or those at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
- Individuals at risk for institutionalization
 - who are eligible for long-term care services.
 - with serious mental illness (SMI), children with serious emotional disturbance (SED), or substance use disorder (SUD) with co-occurring chronic health conditions.
- Nursing facility residents who want to transition to the community.
- Individuals transitioning from incarceration with complex physical or behavioral health needs.
- Children or youth with complex physical, behavioral, developmental, and oral health needs.

ECM Eligibility and Exclusions:

1) 1915(c) Waivers	2) Services Carved Out of Managed Care	3) Services Carved into Managed Care	4) Dual-Eligible Members	5) Other Programs	6) Programs Serving Pregnant & Postpartum Individuals
Multipurpose Senior Services Program (MSSP)	California Children’s Services (CCS)	CCS Whole Child Model (WCM)	Dual Eligible Special Needs Plans (D-SNPs)	California Community Transitions (CCT) Money Follows the Person (MFTP)	Comprehensive Perinatal Services Program (CPSP)
Assisted Living Waiver (ALW)	County-Based Targeted Case Management (TCM)	Complex Care Management (CCM)	D-SNP Look-Alike Plans	Family Mosaic Project	Black Infant Health (BIH) Program
Home and Community-Based Alternatives (HCBA) Waiver	Specialty Mental Health Services (SMHS) TCM	Community-Based Adult Services (CBAS)	Other Medicare Advantage Plans	Hospice	California Perinatal Equity Initiative (PEI)
HIV/AIDS Waiver	SMHS Intensive Care Coordination for Children (ICC)		Medicare Fee For Service (FFS)	California Wraparound	American Indian Maternal Support Services (AIMSS)
HCBS Waiver for Individuals with Developmental Disabilities (I/DD)	Drug Medi-Cal Organized Delivery System (DMC-ODS) & Drug Medi-Cal (DMC) Program Care Coordination & Management Programs		Cal MediConnect		CDPH California Home Visiting Program (CHVP)
Self-Determination Program for Individuals with I/DD	Full Service Partnership (FSP)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)		CDSS CalWORKs Home Visiting Program (HVP)
	Health Care Program for Children in Foster Care (HCPCFC)		Program for All-Inclusive Care for the Elderly (PACE)		
	In Home Supportive Services (IHSS)				
	Genetically Handicapped Person’s Program (GHPP)				
			1.ECM and the other program	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.	
			2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.	
			3. Not Eligible to Enroll in ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.	

ENVIRONMENT OF CARE

This section describes the requirements for a safe patient care environment. Included are descriptions of Environmental Safety; hospital emergency codes; security procedures; safety awareness; and policies and procedures concerning 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 Rancho to provide a safe environment for our customers and workforce members. Our Environmental Safety Program looks for and identifies hazards through surveillance rounds and data collection. The Environment of Care Committee investigates all identified hazards. This Committee works under Rancho's Safety Officer. Address any concerns you have regarding safety to your supervisor or the Safety Officer at (562) 385-6672.

WHILE AT WORK, KNOW:

1. How to eliminate or minimize safety risks.

Examples include:

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

2. How to report safety concerns:

- Notify your supervisor.
- Complete an "Employee/Safety and Security Concern Program" form.
- Use the Safety Suggestion Boxes available throughout the campus.
- Notify the Safety Officer at Ext. 56672 or the Patient Safety Officer at Ext. 56085 for clinical patient safety issues.
- Use the Safety Intelligence™ (SI) Event Reporting System.

SECURITY

The Sheriff's Department provides Rancho with professional police and security services. While Sheriff's Department Deputy Supervisors and Security Officers provide a wide range of law enforcement services, contract security staff is responsible for basic security needs under the supervision of the Sheriff's Department. The entire law enforcement team strives to provide a crime free and secure environment for patients, visitors, patrons, and workforce members.

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

The LASD enforces the California penal codes, federal and state laws, County ordinances, and assists in attaining compliance with hospital policies. The LASD conducts foot and vehicle patrols of Rancho.

The Role of Contract Security Guards

- Observe and report any suspicious activities to the Sheriff's Department.
- Monitor the entrances to Rancho, check workforce member badges, visitor check in, and exterior foot patrol.

SAFETY AWARENESS

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

- Do not prop doors open or keep doors from latching.
- Walking in groups when leaving the workplace after dark.
- Reporting any suspicious activities to the Sheriff's Department at Ext. 551.
- Locking your vehicle.

EMERGENCY PREPAREDNESS AND MANAGEMENT

EMERGENCY OPERATIONS PLAN

ACTIVATION AND DEACTIVATION OF THE EMERGENCY OPERATIONS PLAN

During an emergency, like a sudden influx of infectious patients, Rancho will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Operations Manual; all departments have copies of the Emergency Operations Plan.

The Chief Executive Officer, or their designee, is responsible for determining the scope of a disaster and activating the Medical Center Disaster Plan. In their absence, and after normal working hours (i.e., 5:00 p.m. to 8:00 a.m.), weekends, and holidays, the Rancho Administrative Nursing Supervisor will have full authority to activate and direct the Medical Center Disaster Plan until such time that the Chief Executive Officer, or their designee, is able to assume command of the situation.

Once it has been determined to activate the EOP, the individual who takes the role of Incident Commander will notify the hospital staff, and executives as soon as possible. After hours this is accomplished using the fanout list through the hospital operator.

The Emergency Operations Plan provides instructions on what to do in the event of various disasters. Each nurse's station, clinic, and Department Chair and Service Director's office has a copy of the manual. When Rancho announces a **"Code Triage"** to activate the Emergency Operations Plan, you should:

- Remain calm.
- Provide reassurance to patients, visitors, and fellow workforce members.
- Return to your regular assigned workstation, check in with your supervisor or designee, and wait for instructions.

During a **"Code Triage Alert"**, **"Code Triage Internal"** or **"Code Triage External"** incident, you may be asked to:

- Assess your area for injuries and give first aid.
- Check your area for people who are trapped.
- Check your area for fires, loss of critical systems (i.e., electricity, water, wall oxygen, computer systems, phones), critical equipment (ventilators and laboratory equipment), or critical supplies.
- Provide a status report about your area to the Hospital Command Center. Listen to the overhead page announcement for the Hospital Command Center location.
- Report to the Building Emergency Coordinator (also known as BEC) in your area in order to receive your assignment to a specific disaster-response duty.

To return to normal operations from an emergency, the hospital will undertake the following:

1. When deemed appropriate, the Incident Commander will initiate the recovery phase by announcing an “All Clear” to the situation.
2. The Incident Commander will notify the Rancho Operator to alert the staff of the end of the emergency by announcing an “All Clear” by normal code announcement methods.
3. The staff are also notified through alternate announcements including Intranet messages, personal communication devices (pagers, walkie-talkies, or cellular telephones), and an overhead paging system.
4. Call List notification procedures are initiated for off-duty staff concerning the need to report to the department or to remain at their current locations.
5. The Incident Commander notifies EMS via the Reddi-Net of the “All Clear” action.

COMMUNICATIONS PLAN

Internal and Staff Notification Levels

During an emergency:

1. The Incident Commander will notify the Rancho Operator to alert the Staff of the emergency by announcing a Code Triage, usually by overhead page.
2. The staff are also notified through alternate announcements including intranet messages and personal communication devices (e. g., pagers, walkie-talkies, and cellular telephones, Everbridge) as well as Call Lists and overhead paging conducted by the Operator.
3. Alternate communication to staff may include notification through the Public Information Officer by radio or television, dependent on the procedures.
4. Communications systems may include the following:
 - a. Internal telephone system: Internal communications will be limited to disaster-related issues once an emergency has been initiated. THE OPERATOR SHOULD NOT BE CALLED FOR INFORMATION.
 - b. Radios: Communications Unit Leader will determine location and availability of radios and report to the Logistics Chief so distribution of radios can be determined.
 - c. Alpha-numeric pagers, e-mail, public address system, walkie talkies, satellite phone, inter-hospital radio network (Reddi-Net), fax, cellular phones, runners, and Ham radio.

DHS EMERGENCY CODES

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

See Emergency Codes on Next Page

DHS STANDARDIZED EMERGENCY CODES

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

LOCKDOWN - ACCESS & EGRESS CONTROL

Due to the limited amount of security in the facility at any given time, there may be a time when the facility may be locked down. Secure Operations or a “lock down” refers to the locking of all entrance and exit doors to buildings and the posting of personnel at these doors to assure that only authorized persons enter or exit. Security Staff will be responsible for locking and controlling all exits and entrances to the hospital. Employees of the hospital are required to wear badges with picture I.D. identifying them as employees. Only persons with proper identification shall be admitted to the hospital during an emergency/disaster. Incident Command staff shall wear identifying vests.

SURGE CAPACITY RESPONSE PLAN

The Surge Capacity Response Plan is designed to respond to a large influx, or the risk of an influx, of disaster victims in coordination with local, state and federal public health disaster-management, and public-safety agencies.

The Surge Capacity Response Plan is an integral part of the overall Emergency Preparedness Management and refers to disasters that require implementation of the hospitals surge capacity. These surge-capacity incidents may occur as a result of natural disaster (i.e., earthquakes, epidemics), or of human-induced disasters (i.e., mass-casualty hazardous materials exposures, mass-casualty transportation incidents, terrorist incidents).

ACTIVATION OF HOSPITAL WIDE EMERGENCY RESPONSE

Upon notification that a suspected/confirmed surge-capacity incident has impacted or is likely to impact 10 or more patients, and/or may overwhelm the medical center's ability to respond using standard operating procedures, the Hospital Administrator, or designee shall:

- Activate the Emergency Operations Plan
- Activate the Hospital Incident Command System (HICS)
- Activate the Command Post
- Activate the "Surge Capacity Response Plan"
- Announce "Code Triage Internal" via the paging system to notify employees that Rancho is in the disaster management mode.

RESOURCES

Rancho has identified and documented the assets and resources that are available on-site and/or elsewhere prior to an incident. These assets include:

- *Personal protective equipment (PPE)*
- *Water*
- *Fuel*
- *Staffing*
- *Medical, surgical, & pharmaceutical supplies available*

Memorandum of Agreements (MOA) and plans with agencies listed in the Hospital Regional Response Plan provide back-up essential services if needed. Each facility will activate plans to request delivery of additional supplies as needed. Red Cross will provide shelters and staffing for employees and/or families of affected facilities as needed.

See the Hospital Regional Response Plan for a complete list of Regional Resources which includes:

- Pharmaceuticals
- Isolation Rooms
- Blood
- Drinking water
- Food
- Fuel
- Portable generators

FACILITY EVACUATION AND SHELTER IN PLACE

DEFINITIONS:

1. Total facility evacuation - the relocation of all in-patients, out-patients, visitors, and staff from all Rancho Los Amigos buildings resulting from a national disaster or other emergency.
2. Partial evacuation - The relocation of patients, staff, and visitors from a hospital building or part of the building, resulting from a national or other emergency.
3. Horizontal Evacuation – The movement of patients, visitors, and staff from an endangered area beyond the smoke (or fire or both) doors on the same floor of the building. Horizontal evacuation is the first choice in moving people away from danger.
4. Vertical Evacuation – The movement of patients, visitors, and staff from an endangered location to a safer location on a lower floor. Vertical evacuation is used if horizontal evacuation no longer provides a safe area. The first choice in vertical evacuation is to move down the nearest stairwell. Upward movement is rarely recommended, and when used, is usually a last alternative, depending upon life and safety conditions. Elevators are not to be used during evacuation procedures. During a disaster, elevators automatically go to the first floor and are inoperative until reset by the Downey Fire Department. Any use of elevators during evacuation is directed by the Downey Fire Department.

AUTHORITY TO EVACUATE

- Normal Hours (8 a.m. - 5 p.m. M-F):
Chief Executive Officer, Chief Operation Officer, Chief Medical officer, Chief Nursing Officer, Director of Facilities Management, and/or Safety Officer.
- After Hours (5 p.m. - 8 a.m./Weekends, Holidays):
Hospital Charge Nurse, Administrator of the Day (AOD), or Triage Physician (Physician B).
- Exception - Imminent Danger:
Patient Care
Imminent danger, threatening life safety- the Charge Nurse or next in charge may initiate evacuation.
- Non-Patient Buildings:
The Building Emergency Coordinator (BEC) or alternate may initiate evacuation.
All occupants of non-patient buildings are to evacuate and assemble in a pre-designated area at least 50 feet from **the building**.

EVACUATION ROUTES

Evacuation routes, instructions, and floor layout plans shall be posted at all building entrances, elevators, and stair landings.

When advised by the Incident Commander, Chief Executive Officer (or designee), Fire Department, or appropriate designees, evacuate patients to the Emergency Assembly Point.

After arriving at your Emergency Assembly Point account for all patients and staff. Send reports to the Command Post indicating status of patients, staff, and visitors. Do not reenter the disaster area or building until cleared to do so by Safety Officer, Fire Department, or Incident Commander.

Patients shall be evacuated with their medical charts in the following priority:

1. The closest to the fire or emergency
2. Ambulatory patients
3. Patients with impaired mobility that need to be moved by gurney, wheelchair, assist/carry.
4. Patients that need to be evacuated with their entire bed.

The nurse in-charge of each floor will make sure that all patients have been cared for. The nurse in-charge will further instruct those in their charge to keep track of the movements of patients in order to account for the patients and nursing personnel.

SHELTER IN PLACE

There may be situations, depending on your circumstances and the nature of the disaster, when it's simply best to stay where you are and avoid any uncertainty outside by “sheltering in place”.

To effectively shelter, you must first consider the hazard, and then choose a place in your building or area that is safe for that hazard. For example, for an active shooter, a room should be selected that is away and secluded from the occurring event. The safest locations to seek shelter vary by hazard. Be informed about the sheltering suggestions for each hazard.

The length of time you are required to shelter may be short, such as during an incident involving a combative person, or long, such as during a winter storm or a pandemic. It is important that you stay in shelter until safety personnel or local authorities say it is safe to leave. During extended periods of sheltering, you will need to manage water, food, and supplies to ensure you and your patients have the required supplies and quantities. There may be circumstances when staying put and creating a barrier between yourself and potentially contaminated air outside or other area, a process known as "sealing the room," is a matter of survival. Use common sense and available information to assess the situation and determine if there is immediate danger (e.g., if you see large amounts of debris in the air, or if safety personnel / local authorities say the air is badly contaminated).

The process used to seal the room is considered a temporary protective measure to create a barrier between you and potentially contaminated air outside. It is a type of sheltering in place that requires preplanning.

- Lock doors, close windows, air vents.
- Turn off fans, air conditioning, and forced air heating systems.
- Go into an interior room with few windows, if possible.
- Seal all windows, doors, and air vents with 2-4 mil. thick plastic sheeting and duct tape. Consider measuring and cutting the sheeting in advance to save time.
- Cut the plastic sheeting several inches wider than the openings and label each sheet.
- Duct tape plastic at corners first and then tape down all edges.
- Be prepared to improvise and use what you have on hand to seal gaps so that you create a barrier between yourself and any contamination.

Safety personnel or local authorities may not immediately be able to provide information on what is happening and what you should do. If possible, watch TV, listen to the radio, or check the Internet often for official news and instructions as they become available.

EMERGENCY TRANSPORT (CARRIES)

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

EMERGENCY TRANSPORT SAFELY

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

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

ONE-PERSON CARRIES			TWO-PERSON CARRIES
HIP CARRY 1. Put patient's arm over your back and slide your arm under patient's back. 2. Lean backward into patient's abdomen and grip patient behind their knees. 3. Hold patient snugly against your back, then lean forward to carry. 4. Lean patient against wall and slide to floor as you drop to one knee.     DOWN	PACK STRAP 1. Cross patient's arm 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 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.     DOWN	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. 4. Pull patient out on blanket, head first.     REMOVE	SWING 1. Each nurse grasps the other's shoulder with one hand as patient places their arms around both their shoulders. 2. Reaching under patient, each nurse grasps the other's wrists.  EXTREMITY 1. Patient must be sitting on the edge of 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 waistband and grasp their other arm. 3. "Hug from behind" and walk in step, grasping your wrist. 

FIRE/LIFE SAFETY

FIRE RESPONSE

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

R	Remove patients and others from immediate danger.
A	Alarm - Activate nearest safe fire alarm pull station - call Ext. 522, Code Red , to report smoke or fire to the Downey Fire Department.
C	Contain - Close doors in fire area to prevent the spread of fire and smoke.
E	Extinguish - Use proper extinguisher to fight fire, only if safe to do so.

STEPS IN THE USE OF THE FIRE EXTINGUISHER

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

P	Pull the pin - twist and pull the pin to break the plastic seal. Some extinguishers require release of a lock hatch, pressing a puncture lever, or other motion.
A	Aim the extinguisher nozzle (horn or hose) at the base of the fire.
S	Squeeze or press the handle.
S	Sweep from side to side at the base of the fire until it goes out.

CLASSIFICATION OF FIRES

CLASS A	Fires involving 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.

5 LB. FIRE EXTINGUISHERS WILL EMPTY IN LESS THAN ONE MINUTE.

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



REMEMBER

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.

BOMB THREATS (CODE YELLOW)

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

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

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

Also, pay attention to details, such as:

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

Contact the Sheriff's Department immediately at Ext. 551, and notify your supervisor.

WEAPONS

Workforce members shall not carry a prohibited weapon of any kind while in the course and scope of performing their job, even if they are personally licensed to carry a concealed weapon. Workforce members are prohibited from carrying a weapon anywhere on County property or at any County-sponsored function.

Prohibited weapons include any form of weapon or explosive restricted under local, state, or federal regulation. This includes all firearms, illegal knives, or other weapons prohibited by law. Violations may result in any or all of the following:

- Arrest and prosecution for violations of pertinent laws.
- Immediate removal of the threatening individual from the premises pending investigation.
- Disciplinary action up to and including discharge from County service or assignment.

The Sheriff's Department will strictly enforce all weapons related laws here at Rancho.

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.

Type 5 violence - means workplace violence that occurs when a workplace or organization represents an ideology that opposes that of an extremist or value-driven individual or group and becomes a target for violence.

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 their 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 TalentWorks 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.

AWARENESS, VIGILANCE, AVOIDANCE, DEFENSE, AND ESCAPE PRINCIPLES (AVADE)

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

- **Level I:** Is a web-based training that is completed via TalentWorks. This 60-minute course covers the fundamentals of AVADE and is for all DHS workforce members.
- **Level II:** Is an in-person interactive training for workforce members with direct patient contact. This training provides knowledge on basic self-defense techniques for intervening in violent incidents that cannot be otherwise deescalated. This 4-hour training requires completion of the Level I online training as a pre-requisite and is not applicable to everyone.

- **Level III:** Is the most advanced level of training and is for workforce members who meet selective criteria for requiring advanced training. This 8-hour in-person training combines Level II and III curriculum and only requires completion of Level I training as a pre-requisite. Advanced Level III techniques may include responses to attempted lethal force, attacks against employees, defensive take-down responses, and healthcare specific restraint techniques designed to mitigate patient harm.

For more information, visit [Workforce Violence Prevention - Home \(sharepoint.com\)](#)

Immediate Danger or Imminent Threat of Violence

Any workforce member who witnesses or experiences an act of violence, or an imminent threat in the workplace, or who is informed of an imminent threat directed at or expressed by another workforce member and reasonably believes it poses 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. 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 Security Operations Unit (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 e-mailed 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 Employee Assistance Program (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 - Defensive 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

- C**ontrol – Make sure the individual is calm.
- O**rient – Orient individual to what just happened.
- P**atterns – What things triggered the crisis again.
- I**nvigate – What needs to change to prevent a crisis.
- N**egotiate – Contract to make changes or change behavior.
- G**ive – 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 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.

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.

CHILD/INFANT ABDUCTION (CODE PURPLE/CODE PINK)

When a “Code Pink” or “Code Purple” is called, all available staff members are required to immediately cover exits in their areas and report suspicious persons to the campus 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” or “Code Purple” is initiated.

HAZARDOUS MATERIALS/HAZARD COMMUNICATION

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

1. The Safety Officer or the Hazardous Materials Specialist shall be the Hazardous Materials Spill Response Team Leader and shall coordinate all emergency response measures.
2. The first person at the scene shall immediately block off the area and notify the supervisor and all staff in the immediate area that a spill has occurred.
3. The supervisor who is 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) tells you what hazards a chemical present and how to handle spills/exposures. You should know the location of the SDS in your work area. If you do not know where it is kept, ask your supervisor. The master SDS manual is located in the Nursing Resource Office, JPI, Room T1107.



REMEMBER

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

RADIATION EXPOSURE

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.

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



REMEMBER

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

MEDICAL EQUIPMENT AND UTILITIES

MEDICAL EQUIPMENT

In order to ensure the safe operation of medical equipment, the Biomedical Department is responsible for testing all medical equipment according to the hospital's preventative maintenance schedule. This may be annual, semi-annual, or quarterly based on the manufacturer recommendations and/or risk associated with its use. You can find the dated green inspection label affixed to the device. The medical equipment should not be used if the due date on the green sticker has expired. If the due date has expired immediately contact the Biomedical Department (Ext. 56328). Report all medical equipment and utilities malfunctions to your supervisor and the Facilities Management Department.

When there is an equipment malfunction, do not leave a patient unattended. In life-threatening emergencies involving medical equipment, send a co-worker to get a replacement from the nearest location. When a device failure or operator error results in a serious negative consequence to a patient, you must inform the Patient Safety Officer (Ext. 56085) and Risk Management (Ext. 57900), and report it in the Safety Intelligence™ (SI) Event Reporting System as soon as possible (within 24 hours). Immediately impound the device.

ELECTRICAL SAFETY

Before using any piece of electrical equipment, check:

- The on-off switch for proper function (it must work 100% of the time).
- The body of equipment for cracks, holes, protruding wires.
- The condition of the cord (intact insulation, presence of ground prong, intact plug, snug fit of cord to outlet).
- Inspection sticker with proper date.

Other points to remember:

- Keep long cords coiled and out of the way of traffic.
- Unplug all electrical equipment that is not in use.
- Keep chargeable batteries plugged in.
- Do not try to make electrical repairs yourself.

- Avoid using any electrical equipment, if:
- The cord or plug is warm to the touch.
- Any suspicious odors are coming from the equipment.
- The 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 emergency generator system. These emergency outlets can be used at all times; **however**, their use is restricted to life support equipment (e.g., ventilators and monitors) only.

Verify LIFE

Before connecting any electrical device to a patient:

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

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.



REMEMBER

To report a mechanical emergency, mechanical failure, or the need for mechanical repair:
Call Safety Office at Ext. 56672 or Facilities Management at Ext. 57291.

ERGONOMICS

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

COMMON CAUSES AND TYPES OF ERGONOMIC INJURIES

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

3. Eyestrain, headaches, and fatigue (due to noise, poor lighting, posture, or positioning).

RISKS FACTORS TO REMEMBER

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

TAKE CONTROL OF THE RISK FACTORS AND BE PROACTIVE

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

ADJUST YOUR EQUIPMENT AND/OR WORKSTATION

Suggestions to follow:

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

QUALITY IMPROVEMENT**IMPROVING ORGANIZATIONAL PERFORMANCE WITH CONTINUOUS QUALITY IMPROVEMENT****I. INTRODUCTION:**

Rancho Los Amigos National Rehabilitation Center (RLANRC) is committed to its mission to restore health, rebuild life, and revitalize hope for persons with a life changing illness, injury, or disability. It is the intent of leadership to support improvement that enables all departments and systems of care to work through interdisciplinary collaboration to improve systems, processes, and outcomes to minimize risks, and create a safe clinical environment.

II. PURPOSE:

The purpose of RLANRC's plan for improvement is to:

- Provide a framework for RLANRC's systematic approach to the design, measurement, and analysis for continuous improvement to ensure safe, effective, and continuously improving medical and rehabilitation services in an environment of minimal risk.
- Develop and implement projects that support organizational goals, policies, procedures, and workflows to ensure continuous improvement in patient care.
- Increase the likelihood of desired health outcomes consistent with professional knowledge.
- Deliver a report to Executive Council (EC) that details departmental improvement projects and the outcomes.

III. CONTINUOUS IMPROVEMENT PLAN

RLANRC is committed to operating efficiently and effectively in order to meet the needs of patients, families, and staff. Continuous improvement in all activities is vital for RLANRC's establishment and maintenance of successful patient and staff related outcomes. The implementation of this continuous improvement plan provides a framework for RLANRC's quality improvement program.

Improvement Department

RLANRC utilizes a departmental operation system based on the National Association of Healthcare Quality framework focusing on 8 essential areas:

- Regulatory and Accreditation
 - Direct the evaluating, monitoring, and improving compliance with internal and external requirements.
 - Lead the process to prepare for, participate in, and follow up on regulatory, accreditation, and certification surveys.
- Quality Review and Accountability
 - Direct activities that support compliance with voluntary, mandatory, and contractual reporting requirements for data acquisition, analysis, reporting, and improvement.
- Professional Engagement
 - Engage in the healthcare improvement profession with a commitment to practicing ethically, enhancing one's competence, and advancing the field.
- Improvement Leadership and Integration
 - Advance the organization through collaboration, learning, and communication.
 - Lead the integration of improvement in the fabric of the organization to achieve objectives.
- Performance and Process Improvement
 - Use improvement processes, project management, and change management methods to support operational and clinical improvement.

- Population Health and Care Transitions
 - Evaluate and improve healthcare processes and care transitions to advance the efficient, effective, and safe care of defined populations.
- Health Data Analytics
 - Leverage the organization's analytic environment to help guide data driven decision making and inform improvement initiatives.
- Patient Safety
 - Cultivate a safe healthcare environment by promoting safe practices, nurturing a Just Culture, and improving processes that detect, mitigate, or prevent harm.

RLANRC's Improvement Department clinical staff will assist departments or programs in the development and coordination of project goals, objectives, and measures (performance indicators). The Improvement Department clinical staff will assist in the education of hospital staff in quality improvement methods and tools as needed.

RLANRC's Improvement Department will assist in the development and coordination of organizational, department-wide, and/or specific program goals, objectives, and measures (performance indicators) and includes education of staff in improvement methods and tools by individual department representatives on the Improvement Committee.

Model for Improvement

The Plan-Do-Study-Act (PDSA) model is the structure through which RLANRC identifies, plans, measures, and evaluates improvement projects.

RLANRC uses the PDSA process as the model for improvement based on recommendations by organizations such as the Institute for Healthcare Improvement (IHI), Association of Healthcare Research and Quality (AHRQ), Commission on the Accreditation of Rehabilitation Facilities (CARF), National Quality Forum, National Academy of Medicine, National Association of Healthcare Quality, and others.

The PDSA process provides a framework for carrying out improvement initiatives. The following six key elements are the foundation of the program:

- Setting Aims
- Establishing Measures
- Selecting Changes
- Testing Changes
- Implementing Changes
- Spreading Changes





All improvement projects should address one of the six domains of health care quality as set forth by the National Academy of Medicine:

Safe: Avoiding harm to patients from the care that is intended to help them.

Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Timely: Reducing waits and harmful delays for both those who receive and those who give care.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

ORYX INITIATIVE

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

The Joint Commission led the ORYX Core Measures or Indicators based on standardized, evidence-based measures or factors that medical literature show positive difference in patient health outcomes. Currently, Rancho is collecting data on the following ORYX Core Measure sets:

- Measure Functional Independence Measure (FIM) score (patient's ability to perform the activities of daily living independently)

- Measure acute care discharges (limit discharges to acute care settings)
- Community discharges

We base our data collection processes on your chart documentation. The Joint Commission surveyors will have access to all our reports of performance at the time of our survey. We also make these reports available to the state surveyors through the Center for Medicare and Medicaid Services (CMS) and to the general public.

HOW ARE WE DOING COMPARED TO OTHER REHABILITATION HOSPITALS?

Overall, Rancho is doing well in most areas. We do well in maximizing patient's ability to function at a high level upon return to the community, and limit acute care discharges. Our areas of concern include:

- Length of stay.
- Time from onset of injury to rehabilitation admission.

WHAT COULD A SURVEYOR ASK YOU ABOUT ORYX?

When performing tracers, if the patient has a spinal cord injury or brain injury, the surveyor may ask you about the related ORYX core measure. Be prepared to speak on how you assure that Rancho provides evidence-based care to your patients. Some examples of evidence-based care include:

- Attaining and improving bowel and bladder function, and
- Retaining and improving mobility.

RISK MANAGEMENT

Rancho's Risk Management Department is an integrated, comprehensive, and proactive system designed to identify, evaluate, and reduce the risk of human injury and financial loss to the facility. The Risk Management Department collaborates with all departments who are ultimately responsible for the health, safety, and well-being of the patients and personnel. The Risk Manager, in collaboration with County Counsel, is available to provide consultation and advice on medico-legal issues.

The effectiveness of Rancho's Risk Management Program is dependent on the information reported by all workforce members. This section provides a guideline on reporting events, the indemnification process, the importance of documentation, and the handling of a subpoena or summons.

RISK MANAGEMENT GOALS

- Ensure timely identification, investigation, and reporting of unusual occurrences, adverse events, and sentinel events.
- Educate staff on the causation of risk management events to prevent them from recurring and to enhance a culture of safety.
- Maintain the repository of Risk Management data including Event Notification Reports for tracking/trending and quality improvement purposes and patient safety.

INDEMNIFICATION

As a County employee or covered contractor, indemnification or legal protection is provided while you are performing duties within the course and scope of your employment and while on duty at your assigned work station. However, **you are not legally protected from:**

- Liability resulting from willful misconduct, malice, or lack of good faith.
- Fraudulent activity and or intentional infliction of an injury.
- Any acts performed outside the course and scope of employment with Los Angeles County.
- When you rotate to facilities that are not owned or operated by Los Angeles County.
- When you are at your outside employment (non-County facilities).

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

EVENT REPORTING PROCESS

Rancho requires all workforce members to report near misses, unusual occurrences, sentinel events, adverse events, reportable unusual events ("Never 28"), and Provider-Preventable Conditions (PPC) in any healthcare setting or Health Care-Acquired Conditions (HCAC) in acute inpatient settings and Workplace Violence through the Safety Intelligence™ (SI) Event Reporting System. The expectation is for the workforce member to enter the event report before the shift ends.

The Safety Intelligence™ (SI) online event reporting system can be accessed by logging onto the Rancho Intranet Home Page, and clicking on the **Safety Intelligence** icon. All completed electronic event reports are reviewed, investigated, and corrective actions are implemented as applicable.

- Event notifications are confidential and used for patient safety and quality improvement initiatives. The event reports are not discoverable as long as certain protections are in place to maintain confidentiality. These include: do not print or produce copies of Event Notification Reports; do not reference the existence of Event Notification Reports in the patient's medical record; and do not write Risk Management was notified/contacted in the patient's medical record.

**REMEMBER**

See Rancho Administrative Policy & Procedure, Event Notification Reporting.

DEFINITIONS OF EVENTS

Near Miss or “Close Call” Event is an incident or unsafe condition that could have resulted in an adverse event but did not, either by chance or through timely intervention.

Unusual Occurrence Event includes epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes, or other catastrophes and unusual occurrences which threaten the welfare, safety, or health of patients, personnel, or visitors.

Adverse Event is any event which is not consistent with routine patient care or the routine operation of the facility, or caused by the patient’s underlying disease, that adversely affects or has the potential to affect the health, life, or comfort of the patient.

Sentinel event is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of a 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). Sentinel events also include events that occur during the care and treatment of individuals.

Provider Preventable Conditions and Health Care-Acquired Conditions are specific conditions for beneficiaries enrolled in the Medi-Cal program that require reporting to Department of Health Care Services Audits and Investigations Division.

MANAGING THE EVENT

When an unusual event occurs, it is important to provide any immediate care needed by the patient. In addition, the following actions should be taken to prevent complications:

- Designate a trained spokesperson from the treating team to keep the patient/family member informed. If needed, the Risk Manager or Assistant Risk Manager is available for consultation in disclosing the event with the patient/family.
- Save or sequester any “evidence” such as medical device packaging, equipment, etc. and provide these items to the immediate supervisor. Supervisor shall notify Risk Management within 24 hours of the event.
- Document facts about the event as clearly and objectively in the medical record, including conversations with the patient and family. DO NOT document blame or fault by other providers. DO NOT document or reference the Mortality and Morbidity Conference or Peer Review Process in the medical records.

“NEVER 28” OR REPORTABLE UNUSUAL EVENTS

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. Wrong surgical procedure on a patient.
4. Retention of a foreign object in a patient after surgery or other procedure.
5. Intraoperative or immediately post-operative death in a normal healthy patient.
6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
9. Infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours.
11. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.

12. Patient death or serious disability associated with a medication error.
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products (transfusion of the wrong blood type).
14. Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility.
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
16. Death or serious disability (kernicterus) associated with failure to identify and treat jaundice in newborns.
17. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
18. Patient death or serious disability due to spinal manipulative therapy.
19. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.
22. Patient death associated with a fall while being cared for in a healthcare facility.
23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
25. Abduction of a patient of any age.
26. Sexual assault on a patient within or on the grounds of a healthcare facility.
27. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.
28. Neurological Deficit not present at time of admission including coma, paralysis, nerve damage, blindness, related or unrelated to medical or surgical procedures; medication error/ADR; healthcare acquired infection; birth trauma; unanticipated medical/surgical complication; birth/brain injury unrelated to congenital condition, or attempted suicide resulting in serious disability.

PROVIDER PREVENTABLE CONDITIONS IN ANY HEALTHCARE SETTING

1. Wrong Surgery/Invasive Procedure
2. Surgery/invasive procedure on the wrong body part
3. Surgery/invasive procedure on the wrong patient

HEALTH CARE-ACQUIRED CONDITIONS IN ACUTE PATIENT SETTING

1. Air embolism
2. Catheter associated urinary tract infection (Reported by Infection Prevention and Control Department – No need to enter into Safety Intelligence™ (SI) Event Reporting System).
3. Falls/trauma
4. Iatrogenic pneumothorax with venous catheterization
5. Manifestations of poor glycemic control
6. Surgical site infection (Reported by Infection Prevention and Control Department – No need to enter into Safety Intelligence™ (SI) Event Reporting System)
7. Blood incompatibility
8. Deep vein thrombosis/pulmonary embolism
9. Foreign object retained after surgery
10. Stage III, IV, unstageable pressure ulcers
11. Vascular Catheter-Associated Infection (Reported by Infection Prevention and Control Department – No need to enter into Safety Intelligence™ (SI) Event Reporting System).

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 and prevents the assumption of liability in malpractice cases on the basis that the record is missing key documentation. In addition, a complete and accurate medical record ensures that the facility complies with the accreditation and licensure standards.

Because the medical record is a legal document, it is important to ensure completeness and integrity. **Inaccurate, inconsistent, and incomplete medical records reflect negatively on the writer's credibility.** Documentation in the medical record should be done timely and should reflect factual assessments pertinent to the patient. DO NOT document coverage discussions, disputes among services, clinical/staff behavior, or speculate someone else's involvement in a particular event. As applicable, such issues can be reported to Medical, Nursing, or Hospital Administration and reported through the Safety Intelligence™ (SI) Event Reporting System or Event Notification Report form as appropriate. **Do not make reference to an Online Event Report or Risk Management in the patient's medical record.**

MEDICAL RECORD DOCUMENTATION

- Documentation must be objective, clear, legible, relevant, accurate, complete, and sequential.
- Avoid copying and pasting of other clinician's documentation.
- Notes written by residents, interns, PA, NP, students, must reflect attending supervision. In some cases, notes must be co-signed by the attending.
- Pertinent patient care-related conversations over the phone must also be documented in the medical record.
- Making entries that are untruthful, pre-charting, or documenting care before it is provided is unacceptable and is subject to disciplinary action.

MEDICAL RECORD ACCESS

- Patients or their legal surrogate must provide signed release of information to Health Information Management (HIM) in order to obtain a copy of their medical record.

LAWSUITS AND SUBPOENA

LAWSUITS

Rancho is not authorized to accept claims or lawsuits against the facility. Lawsuit or intent to sue documents against Rancho Los Amigos National Rehabilitation Center must be served at:

Executive Officer, Board of Supervisors
500 West Temple Street, Room 383
Kenneth Hahn Hall of Administration,
Los Angeles, CA 90012
Phone (213) 974-1440

SUBPOENA

Subpoena is an order directed to an individual commanding him/her to appear in court on a certain day to testify or to produce documents in a pending lawsuit.

Service of Subpoena:

- **Health Information Management** – Ext. 57131

"Custodian of Patient Records" Patient Records and Billing Records

- **Human Resources**—Ext. 57551
"Custodian of Employee Records"
- **QRM/Risk Management**—Ext. 57900
Workforce member subpoenas related to County or Rancho patient or any subpoena related questions
- **CBO Office**—(626)525-6474
"Custodian of Billing Records"

Actions Needed When You Receive a Subpoena Or Lawsuit

- Keep the original envelope that the notice came in and 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 Risk Management Office is Available for Consultation

- During normal business hours at (562) 385-7842 or (562) 385-7475.
- During after hours, weekends, and holidays, contact the telephone operator at (562) 385-7111 or Ext. "0" to connect to the Risk Manager.

THE CANDOR PROGRAM

CANDOR stands for "Communication and Optimal Resolution." This process is a patient-centered approach that emphasizes timely disclosure of unexpected harmful events, providing an explanation of what happened, implementing actions to prevent recurrence, and when appropriate, proactively reaching a fair resolution for the patient and clinicians.

All of us in health care strive to provide excellent, high-quality medical care. However, despite our efforts to improve patient safety, patient harm is still too common. The Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, found that 98,000 people die a year because of medical errors in hospitals!

Recent research also shows a significant correlation between the frequency of adverse events and malpractice claims. Further, data from patient satisfaction and patient experience surveys have been shown to predict malpractice risk. Eliminating or reducing the risks and hazards in the delivery of patient care yields safer practices, improves patient satisfaction, and potentially reduces medical liability claims.

The CANDOR program is intended to improve patient safety and transparency by promoting open and ongoing communication between patient and/or their family and the healthcare team and to quickly respond to and resolve adverse events.

The response to health care related injury involves more than just what to do and what we say to the patient. The Communication AND Optimal Resolution (CANDOR) process is an approach that DHS uses to respond to unexpected patient harm events in a timely, thorough, and just way.

The CANDOR process improves patient safety through:

- an empathetic, fair, and just approach to medical errors
- promotion of a culture of safety that focuses on caring for the patient, family, and caregiver
- in-depth event review and analysis that identifies opportunities for improvement, and
- reconciliation and resolution with the patient or patient's family

There are five components of the CANDOR process:



- Component 1: Identification of CANDOR Event.** A CANDOR event is defined as an event that involves significant unexpected harm (physical, emotional, or financial) to a patient. These events trigger the CANDOR process even when a cause for the event is not yet known. Identification of the event can come through various methods; direct reporting in the Safety Intelligence event reporting system; from patient or family complaints/grievances; through the patient safety hotline; or from a peer support referral.
- Component 2: CANDOR System Activation.** After the event is identified as a possible CANDOR event, CANDOR Team Activation occurs and triggers the start of the next two components of the CANDOR process which occur simultaneously: Response and Disclosure (the third component) and Investigation and Analysis (the fourth component).
- Component 3: Response and Disclosure.** Response and Disclosure involves communication about the event with the patient/family and Care for the Caregiver (H3) activities.
 - Disclosure Communication* involves the engagement of trained Disclosure Leads and/or Disclosure Communicators who participate in disclosure communication with the patient and family after a harm event. It is important to understand that disclosure is a **process** and will likely be ongoing. While an initial disclosure conversation will occur within minutes after the CANDOR event occurs, a full disclosure about what happened and why will typically not occur until after the Event Investigation and Analysis has been completed, which may take place days to weeks after the event occurred.
 - Care for the Caregiver (H3)* activities are designed to support clinicians and support staff who may have been impacted by the adverse event. (Please refer to the H3 Program for more details).
- Component 4: Event Investigation and Analysis.** This component begins by thoroughly reviewing the CANDOR event and continues until all information is gathered and analyzed, and a plan is developed to prevent the harmful event from reoccurring. Patients and their families may be involved in this process to provide their perspective of what happened and to provide feedback as to how the event can be prevented from happening again.
- Component 5: Resolution/Reconciliation.** After effectively implementing the first four components of the CANDOR process, the facility will begin implementing the Resolution or Reconciliation process. During this component, the facility and DHS apply what has been learned throughout the process to improve patient safety and prevent similar adverse events from happening in the future. The CANDOR team will also determine how best to address resolving the harm event, which might include providing compensation to the patient and/or family when warranted. Resolution is a flexible process that addresses patients' expectations and needs. Resolution should lead to a settlement of the issues related to the adverse event but doesn't always lead to a financial settlement.

Openness and transparency shouldn't be limited to events that lead to significant patient harm or rise to the level of CANDOR Team activation. Patients deserve to be told about what is happening to them and what to expect even when there is an outcome that was unanticipated. For more information on communication of unanticipated outcomes and the CANDOR program, please see the DHS Policy "[Communication of Unanticipated Outcomes](#)".

Should you believe that a patient may have experienced harm as the result of the medical care and treatment that we provided, please enter a report in the [Safety Intelligence](#)™ Event Reporting System and let your supervisor know. The sooner we know about a harmful event, the sooner we can provide support to the patient or their family and implement actions to prevent future harm.

INFECTION PREVENTION & CONTROL

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 (including rashes), secretions, excretions (except sweat), and mucous membranes may contain infectious agents.

Standard Precautions include:

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

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


NOTE:

CDC recommends using ABHS with greater than 60% ethanol or 70% isopropanol in healthcare settings.

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 doorknobs, equipment, bed, etc.).
- After handling high-touch surfaces (i.e., telephones, doorknobs, 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), Norovirus, or any item/substance that may be contaminated with these pathogens.

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

PROPER STEPS ON PERFORMING HAND HYGIENE

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

TalentWorks Video: Hand Hygiene - [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 appliques other than those made of nail polish, nail-piercing jewelry of any kind, etc.).

ENVIRONMENTAL PRACTICES

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



REMEMBER

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

RESPIRATORY HYGIENE/COUGH ETIQUETTE

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

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

Individuals with signs and symptoms of a respiratory infection should:

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

Masking and separation of persons with respiratory symptoms

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

Workforce Members: Precautions to minimize exposure to respiratory droplets

- Workforce members should wear a medical-grade face mask for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection, particularly if fever is present.
- Effective September 1, 2010, personnel performing procedures on a person who is a case or suspected case of an aerosol transmissible disease, or on a specimen suspected of containing an Aerosol Transmissible Pathogen, must wear a **NIOSH-certified respirator with rating of at least N95, or a Powered Air Purifying Respirator (PAPR) or Controlled Air Purifying Respirator (CAPR)**, if potential for exposure is increased due to the anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical, and laboratory procedures that may aerosolize pathogens.



COVER YOUR COUGH

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



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



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



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



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

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, non-intact skin, excretions, contaminated items, and/or working with certain cleaning solutions or chemicals.
- **GOWNS:** Used during procedures and patient care activities when contact of clothing/exposed skin with blood/body fluids or secretions is anticipated.
- **MASK/RESPIRATOR:** Used when there is potential for exposure to airborne contaminants. Used during patient care activities likely to generate splashes or sprays of blood, body fluids secretions, or excretions. Types of face masks:
 - Surgical and medical/procedural masks
 - N95 Respirator
 - CAPR/PAPR
 - Controlled Air Purifying Respirator (CAPR): is a proprietary version of a PAPR, which fulfills all of the same functions; reusable device and battery operated; requires training.
 - Powered Air Purifying Respirator (PAPR): A low breathing resistance reusable device with high level of protection against aerosols or particles; requires training.



First Image: CAPR
Second Image: PAPR

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

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

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's room. Remove the N95 or CAPR/PAPR/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.

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. Roll the gown down without the hands touching the outside of the gown. Dispose in trash receptacle.

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



1. **Perform hand hygiene.**
2. **You may now exit patient's room.**
3. **Perform hand hygiene.**
4. **Carefully remove face shield or goggles.** Grab the strap and pull upwards and away from head. Do not touch the front of face shield or goggles.
5. **Remove and discard respirator (or mask if used instead of respirator).** Do not touch the front of the respirator or mask.
 - **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head and then pull the respirator away from the face without touching the front of it.
 - **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's room, then exit patient's room. Remove remaining PPE outside of patient's room.

**TRAINING VIDEO AVAILABLE FOR ALL WORKFORCE MEMBERS
ON TALENTWORKS**

[Donning and Doffing Personal Protective Equipment N95 Seal Check](#)

PREVENTING SHARPS INJURIES

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

Simple measures to reduce the risk of sharps injuries

DO NOT	DO
• Hurry or take shortcuts. • Reach into disposal or waste container. • Touch broken glass. • Overfill sharps container. • Carry loose sharps in your pockets. • Use hands or feet to push down waste in container. • Never bend, recap, or break needles or sharps.	• Let falling objects fall. • Activate sharps safety devices before disposal into sharps containers. • Immediately after use, dispose of sharps into covered, labeled, and rigid puncture-resistant sharps container. • Use tongs or brush & dustpan to pick up broken glass. • If tongs are not available, pick up the needle/syringe with the needle pointed away from fingers and body; carefully put it into sharps container. • Practice safe handling techniques. • Hold trash bags away from your body. • Replace sharps disposal container when $\frac{3}{4}$ full. Never overfill. • Ensure all sharps drop into the sharps disposal container and do not remain on the tilt lid. • Prepare to use the device immediately. before exposing the sharp. • Organize equipment at the point of use. • Have adequately lit workspace.

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

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

- Medications packaged as single-use vials never be used for more than one patient.
- Medications packaged as multi-use vials 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/sharpsafety & <https://www.cdc.gov/injection-safety/about/index.html>

WASTE DISPOSAL

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

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

WASTE	CONTAINER	CONTENTS
PLACENTA WASTE CONTAINER		For placenta transport only
RADIOACTIVE WASTE		- Radioactive waste must be properly labeled - The Radiation Safety Office must be called to remove this waste to the designated area, where it must be monitored by qualified staff, until its safe and appropriate terminal disposal

Images by [MedOnTheGo](#); [Grainger](#); [Uline](#).

For additional information contact:

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

CLEANING AND DISINFECTION

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

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

REMINDER

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



Super Sani-Cloth
2 MINUTES



Sani-Cloth Bleach
4 MINUTES



Sani-Cloth AF3
3 MINUTES

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

Cleaning: Removal of visible soil and impurities (e.g. cleaning solutions).

Low-Level Disinfection: Elimination of most pathogenic microorganisms, except bacterial spores (e.g. disinfectant wipes).

High-Level Disinfection: Complete elimination of all microorganisms except bacterial spores (e.g. Trophon machine, Metricide, OPA, Automated Endoscope Reprocessing machine).

Sterilization: Destroys or eliminates all forms of microbial life (e.g. autoclaving).

CATEGORIZATION OF INSTRUMENTS/ITEMS ACCORDING TO THE DEGREE OF RISK FOR INFECTION 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.

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

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

TRANSMISSION-BASED PRECAUTIONS

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

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

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

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

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

Multi-Drug Resistant Organisms (MDROs) such as VRE, MRSA, *C. difficile*, CRE, and other Multi-Drug Resistant Organisms (e.g. Candida auris, Carbapenem-Resistant Organisms (CROs), etc) are common causes of health care-associated infections. Nearly all MDROs can be spread in the hospital or ambulatory health care setting via cross-transmission from colonized or

infected patients or workforce members. The standard of care is to place all hospitalized patients with MDROs in Contact Precautions for the duration of the hospitalization.

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

EXPOSURE TO BLOOD AND BODY FLUIDS

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

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

- Wash the exposed area and/or flush eye mucous membranes with water or normal saline.
- Rinse nose or mouth with clean water.
- Instruct the patient to remain for further instruction.
- 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.

Bloodborne Pathogen Training is a mandatory annual requirement.

VACCINATIONS

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

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

RESPIRATORY VIRUS SEASON, SEASONAL INFLUENZA, AND COVID-19

To comply with DHS Policy, Influenza and COVID-19 Vaccinations for Workforce Members during the Respiratory Virus Season, as a condition of employment/assignment, annual respiratory virus season vaccines (e.g. influenza, etc.) per seasonal recommendations are mandatory for every workforce member who works in a DHS facility. A sticker will be affixed to the DHS photo identification badge of workforce members who have received the required vaccination(s). Compliance with annual mandatory vaccinations shall be required by November 1st of each year. The workforce member who declines must complete and sign an informed declination form. All workforce members who have not been vaccinated by November 1st must wear a mask during the duration of the Respiratory Virus Season, regardless of submitting a signed declination. At any time should a workforce member decide to be vaccinated, they will be given appropriate stickers denoting compliance.

Influenza is available to all workforce members at no charge. Other required seasonal vaccinations may be available depending on seasonal availability, storage requirements, and cost.

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 they are in the facility.

WORKFORCE MEMBER PRECAUTIONS

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

TRANSPORTING PATIENTS

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

EXPOSURES

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

TUBERCULOSIS (TB)

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

TB precautions include the following:

- Annual TB risk assessment for all workforce members who work inside a healthcare facility.
- Early triage and identification of TB suspects.
- Isolation of suspected and confirmed TB patients.
- Proper engineering and maintenance of negative pressure TB isolation rooms (door is to be kept closed at all times).
- TB patient wears a barrier (surgical) mask when outside of isolation room and in enclosed area.
- Any workforce member providing direct patient care to respiratory isolation patients is to be fit tested and use an N95 respirator mask:
 - In a TB patient’s isolation room.
 - During procedures that generate airborne secretions on suspect or confirmed ATD cases
 - 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 they are 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
- Weight loss
- Loss of appetite
- Night sweats
- Coughing up blood or have chest pain when coughing

LATENT TB INFECTION (LTBI)

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

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

PANDEMIC INFLUENZA PLAN

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

Seasonal influenza vaccine is available to you at Employee Health.

CLINICAL INFORMATION

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

TRANSMISSION

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

INFECTION PREVENTION AND CONTROL

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

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

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

WORKFORCE MEMBER GUIDANCE FOR RESPIRATORY VIRAL ILLNESS

KEY POINTS ABOUT RESPIRATORY VIRAL ILLNESS

Prevention Tips:

- Avoid close contact with people who are:
 - Sick or exposed to someone who is sick
- Practice physical separation (social distancing) >6 feet apart from each other when ill
- Wear your medical-grade face mask to prevent the spread respiratory illness when ill.
- 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.

IF ANY SIGNS/SYMPTOMS OF RESPIRATORY VIRAL ILLNESS DEVELOP, DO NOT COME TO WORK!

Note: COVID -19 testing is available by Employee Health Services if requested.

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.

KEY POINTS TO REMEMBER (ALL STAFF)

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.
- All licensed medical professionals are expected to adhere to the highest ethical and professional standards of behavior and performance.
- If you observe behavior in a licensed professional that may compromise patient or environmental safety, you must report it to the appropriate office.
- It is important that you understand – whether you are a healthcare practitioner, technician, clerical, or housekeeping member of our staff – that your job supports our organization’s mission to provide each patient with superior medical and rehabilitation services in a culturally sensitive and safe environment.

THE JOINT COMMISSION

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

PATIENT SAFETY

- We have a proactive, multifaceted, and integrated Patient Safety Program. 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.

Report events in one of the following ways:

- Safety Intelligence™ (SI) Event Reporting System
- Communication of Concern Form (available on the intranet) – for near miss events and other concerns not related to SI: complete page 1 and submit the hard copy or electronically to Administration (QRM).

Or call:

- Hospital Risk Manager’s Office (Ext. 57842) or (Ext. 57900)
- Pharmacy Hotline (Ext. 56129) to report Adverse Drug Events
- Medical Administration (Ext. 57161)
- Employee Health Services (Ext. 56016)
- Hospital Administration (Ext. 57022)
- Patient Safety Officer (Ext. 56085)
- **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.
- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
- Before you administer medication to patients, identify the patient using two identifiers per hospital policy.
 - **Inpatient: Patient Name and Rancho Number**
 - **Outpatient: Patient Name and Rancho Number OR Patient Name and Date of Birth**
- The Joint Commission annually establishes National Patient Safety Goals (NPSG) which Rancho workforce members must follow. You are responsible for reviewing and complying with the NPSG that are applicable to your duties.

STAFF RIGHTS AND RESPONSIBILITIES

Human Resources

- All Rancho staff must complete all mandatory training and competency validation requirements for their respective positions (e.g., orientation, compliance awareness, infection prevention and control, fire/life safety, emergency management, CPR, and other core competencies)
- All Rancho staff is required to complete initial and annual health screening/evaluation on time as required by departmental policy and regulatory agencies. You are responsible to obtain a health screening annually.
- All Rancho staff is required to ensure their professional credential, as applicable, is kept current and in good standing with the appropriate licensing board/agency. Professional staff that must maintain a current professional credential to perform their duties will not be allowed to work with an expired professional credential.

PATIENT RIGHTS, RESPONSIBILITIES, AND SERVICES

Patient Rights

- Rancho Patient Rights and Responsibilities are posted throughout the facility for reference.
- Each patient is given a Patient Information Handbook upon admission. Patients who are not admitted through the Admitting Office are provided a Patient Information Handbook by the nursing staff in the unit (such as admission by ambulance).
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the Patient Advocate at (562) 385-7036.
- It is our responsibility to provide interpreter services free of charge for our Limited English Proficient and non-English speaking patients.
- It is prohibited to use minors as interpreters in any situation.
- An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their healthcare decisions.
- The AHCD allows patients to determine 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.
- Rancho admissions staff and social workers inform patients of their options concerning AHCD's.
- Patients can fill out an AHCD document or give oral direction to a physician who will document it in the patient's medical record and a physician order set (Advance Directive/Resuscitation Status) will be initiated. Appropriate documentation will be completed.
- Service animals must be permitted to accompany the individual with a disability to all areas of the facility where customers/patients are normally allowed to go.

ENVIRONMENT OF CARE

- The Environmental Safety Program and Environment of Care Committee identify and investigate all recognized hazards to patient safety.
- Safety concerns must be reported to your supervisor and the Safety Officer at Ext. 56672 or Patient Safety Officer at Ext. 56085 for clinical patient safety concerns.
- Completion of the "Employee/Safety and Security Concern Program" form is also required.
- You can report safety concerns anonymously.

- Know what all emergency codes mean and how you should respond to each:
 - **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” (inpatient).
 - **Code Gray** means behavioral issues with outpatients, visitors, and staff.
 - **Code Silver** means person with a weapon and/or active shooter and/or hostage situation.
 - **Code Green** means Patient Elopement.
 - **Code Pink** means Infant Abduction (birth to 11 months old).
 - **Code Orange** means Hazardous Material Spill/Release.
 - **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 Emergency/Disaster Plan.
 - **Code Triage Internal** means internal disaster situation.
 - **Code Triage External** means external disaster situation.
 - **Code Police Emergency** means Emergency Police Response.
- The Safety Data Sheet (SDS) tells what hazards a chemical present 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 it is kept, ask your supervisor. The master SDS manual for Nursing Units is located in the Nursing Resource Office, JPI. Room T1107.
- In the event of a fire, follow the **RACE** 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.

PERFORMANCE IMPROVEMENT

- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.
- Ask yourself “How have you been involved in the improvements made in your department in the past 12 months?”
- How can you work with other departments to improve care/services? If you don’t know, speak to your supervisor.
- Rancho’s performance improvement (PI) model is FOCUS-PDSA, based on the four key elements of Design, Data Collection, Aggregation/Analysis, and Improve.
- We measure our performance using our PI model to assess how well we are doing, seek opportunities to improve, and look for evidence that we are making a difference.

RISK MANAGEMENT

- The success and effectiveness of Rancho’s Risk Management Program is dependent on the participation and information reported by all workforce members.
- All workforce members are expected to complete a Safety Intelligence™ (SI) Event Reporting System report by clicking on the event reporting icon on the Rancho intranet. The expectation is to complete an event report within 24-hours of a near miss, adverse, or sentinel event. Incidents that resulted in unexpected serious injury, permanent disability, or death should also be reported verbally to the Risk Manager in addition to completing the Safety Intelligence™ (SI) Event Reporting System report.
 - A near miss is an incident or unsafe condition with the potential for injury or damage.
 - An adverse event is an incident in which a person receiving care is harmed. The event may also meet the criteria for reporting to an outside agency as a “Never 28” event, “Provider Preventable Condition”, or a Joint Commission Sentinel Event.
- If you are in doubt if an event qualifies as a “near miss” or an adverse event, complete a Safety Intelligence™ (SI) Event Reporting System report. You may also enter an event anonymously.

INFECTION PREVENTION AND CONTROL

- Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection.
- You must wash your hands before and after direct patient contact, after removing gloves, before and after eating, drinking, smoking, after using the toilet, whenever there is any doubt about contamination, and when hands are visibly soiled.
- Use gloves before contact with mucous membranes, open skin, blood/body fluids, or the handling of contaminated substances or surfaces. Always change your gloves between patients. Glove use does not substitute for hand washing.
- In the event of a sudden influx of a large number of infectious patients, Rancho will implement the Hospital Incident Command System (HICS). A full description of HICS can be found in the Emergency Preparedness Manual; all departments have copies of the Emergency Preparedness Manual.

MANAGEMENT OF INFORMATION

- Protecting Patients' Rights to personal privacy.
- Only use your dhs.lacounty.gov e-mail to send patient information and obtain permission to encrypt e-mail 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.
- Position computer workstations and monitors away from 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 patient information as if it were your own.
- Cover carts when transporting medical records, so that the patient names are not visible.
- Report suspected patient privacy violations through the Safety Intelligence™ (SI) Event Reporting System AND by phone to the facility Information Security Office at (562) 385-7884.
- Obtain permission to store e-PHI on a laptop or other portable device, or USB thumb/flash drive and make sure the device is encrypted.
- Store paper records and medical charts in locked rooms and locked cabinets.
- Wear your identification badge at all times while on duty.
- Access to computers or computer systems containing e-PHI must be restricted to authorized users.
- Log off the computer when you are away from the work area or when the computer is not in use.
- Encrypt and password-protect PHI and other confidential information stored on laptops, portable devices, and removable media (e.g., USB thumb/flash drives and handheld digital equipment such as cameras, PDA, tablets, and cellular phones).
- Protect the privacy of Personally Identifiable Information as well as Protected Health Information. It is the responsibility of every workforce member of our service delivery team to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and confidentiality of our patients' PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form.
- Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment, and healthcare operations.
- Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing, and ancillary staff.
- Rancho provides "knowledge-based data and information" through the Medical Library, located in the 500 Building. Leaders and care providers can access journals, textbooks, audio visual materials, etc. The library is accessible online.

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

IF YOU ARE **NON-CLINICAL STAFF**,
[CLICK TO CONTINUE](#) TO THE
KNOWLEDGE CHECK SECTION

CLINICAL ORIENTATION CHECKPOINT (CLINICAL STAFF ONLY)

This section of the Orientation should be completed by all clinical workforce members who provide care, treatment, or services to patients. This includes direct and indirect caregivers. Examples* of direct and indirect caregivers include:

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

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

BLOODBORNE PATHOGENS

The purpose of the Bloodborne Pathogens Plan is to minimize, if not prevent, occupational exposure to blood or other potentially infectious materials (OPIM). All workforce members, who have the potential of occupational exposure to blood or body fluids, must practice Standard Precautions.

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

BLOODBORNE PATHOGENS

The three most commonly exposed viruses in a health care setting are Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Human Immunodeficiency Virus (HIV). These are the primary bloodborne pathogens that are of concern to healthcare workers. Bloodborne pathogens may be found in blood or other potentially infectious material (OPIM) and body fluids such as:

- Blood products
- Semen
- Vaginal secretions
- Fluid in the uterus of a pregnant woman
- Fluids surrounding the brain, spine, heart, and joints
- Fluids in the chest and abdomen
- Saliva in dental procedures
- Any other body fluid that is visibly contaminated with blood (e.g., urine)

HEPATITIS B VIRUS (HBV) AND HEPATITIS C VIRUS (HCV)

HBV and HCV cause serious liver disease. Some people are infected and have no symptoms. Infection may range from no symptoms at all to flu like symptoms (nausea, vomiting, and fever). Transmission of HBV and HCV occurs primarily after exposure to blood or body fluids from a person who has acute or chronic HBV/HCV infections.

HBV and HCV are transmitted in four primary ways:

1. Sexual contact (e.g., unprotected intercourse).
2. Parenteral exposure (e.g., needle sharing, blood exposure, or tattooing).
3. Perinatal exposure (may be transmitted from mother to fetus).
4. Recipient of blood/blood products (there are blood screening programs).

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. HCV poses a greater risk to healthcare workers than HBV and HIV, since it is more easily transmitted.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV attacks the immune system and causes it to break down. A person infected with HIV may carry the virus for years without developing symptoms.

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 are blood screening programs).

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

HANDLING AND TRANSPORTING SPECIMENS OF BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS

1. Specimens of blood or body fluids are placed in a leak-proof container, placed in a plastic bag, and transported to the laboratory.
2. Specimens to be transported out of the hospital are placed in a leak proof container clearly marked with a “Biohazard” label.

HANDLING BLOOD AND BODY FLUID SPILLS

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

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 lining (eyes, nose, or mouth).

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

- Wash the exposed area and/or flush eye mucous membranes with water or normal saline.
- Rinse nose or mouth with clean water.
- Instruct the patient to remain for further instruction.
- 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.

Bloodborne Pathogen Training is a mandatory annual requirement.



REMEMBER

The most effective treatment is treatment that is started immediately after the exposure.

PATIENT CARE PRACTICES

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

Workforce members with direct patient care responsibilities are trained to work with the appropriate population 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 communications, care, and interventions in order to assure that each patient's care meets their 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)

- 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.

PEDIATRICS (1 YEAR TO 12 YEARS)

- Includes the toddler (ages 1-3), pre-school (ages 3-5), and school-age child (ages 5-12).
- 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.
- Allow for peer visits.

ADULTS (18 YEARS THROUGH 64 YEARS)

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

- Offer information about support groups

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. Decline in physical strength.
 - d. Loss of ability to discriminate sounds
 - e. Decreased visual acuity
 - f. Slowed cognitive function (understanding)
 - g. Decreased heat regulation of the body
 - h. Decreased 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.
- Inspect Environment For Safety After Discharge

PAIN ASSESSMENT AND REASSESSMENT

Our approach to pain management includes the use of pharmacologic as well as non-pharmacologic interventions. We educate our patients and families about their right to have their pain managed appropriately and the purpose for frequent reassessment using the pain tools.

VISUAL ANALOG SCALE (VAS)/NUMERIC RATING SCALE (NRS)

Adults and children able to understand the scale respond verbally or by pointing at a number.

0	1	2	3	4	5	6	7	8	9	10
Instruction: "Choose a number between 0 – 10 that matches how much pain you are feeling right now. ZERO means you have NO pain and TEN is the WORST pain possible."										

OUCHER SCALE

Used For Patient Population Over the Age Of 5 When visual analog scale (Vas) Is Not Appropriate, Including Adults With Cognitive Problems Who Can Understand the Scale.

- a. Children Old Enough to Understand The Scale.
- b. Adults With Cognitive Problems Who Can Understand the Scale.

					
0	2	4	6	8	10
Instruction: Choose the face that matches how much pain you are feeling right now.					

CPOT CRITICAL CARE PAIN OBSERVATION TOOL

The Critical Care Pain Observation Tool (CPOT) is used for adult patients who are unable to communicate verbally secondary to mechanical ventilation, sedation, and changes in Level of Consciousness (LOC).

Critical Care Pain Observation Tool (CPOT)		
Use for adult patients who are unable to communicate verbally due to mechanical ventilation, sedation and changes in LOC.		
Indicator	Score	Description
Facial Expression	Relaxed, Neutral 0	No muscle tension observed
	Tense 1	Frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)
	Grimacing 2	All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the ET tube)
Body Movements	Absence of movements or normal position 0	Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection 1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness/ Agitation 2	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Compliance with the Ventilator (Intubated Patient) OR Vocalization (Extubated patients)	Tolerating ventilator or movement 0	Alarm not activated, easy ventilation
	Coughing but tolerating 1	Coughing, alarms might be activated but stop spontaneously
	Fighting ventilator 2	Asynchrony: blocking ventilation, alarms frequently activated
	Talking in normal tone or no sound 0	Talking in normal tone or no sound
	Sighing or moaning 1	Sighing or moaning
	Crying out, sobbing 2	Crying out, sobbing
Muscle Tension	Relaxed 0	No resistance to passive movements
	Tense, rigid 1	Resistance to passive movements
	Very tense or rigid 2	Strong resistance to passive movements or incapacity to complete them
Instructions: Observe the patient for 1 minute at rest for baseline score, then during nociceptive procedures. Rate the patient in each of the 4 categories, add together and document total pain score. Highest possible pain level = 8 **Provide pain relief measures for score 2 or higher		

FLACC SCALE

CATEGORIES	SCORING		
	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
CRY	No cry (awake or asleep)	Moans or whimpers; occasional complain	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to; distractible	Difficult to console or comfort
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten. The FLACC Pain Scale can be used with infant and pediatric patients age 0-5 years, cognitively impaired patients, and those patients unable to use other scales. Assess the patients in each area – total the score – evaluate the total using the 0-10 pain scale.			
Malviya, S., Merkel, S., Shayevitz, J. & Voepel-Lewis, T. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3) p. 293-297			

ASSUMED PAIN PRESENT (APP)

APP is a culmination of a pain assessment of a non-verbal patient, usually when there is no appropriate behavior assessment instrument to quantify behaviors systematically (Quinn, 2006). It is used for patients in vegetative state who are unable to elicit a behavioral response due to traumatic brain injury, pharmacologically induced coma, or those receiving neuromuscular blockers for disease management. Pain is assumed to be present in these patients. Analgesics will be administered when clinically indicated. (This concept is to be used only in ICU)

PAIN MANAGEMENT GUIDELINES FOR DHS PROVIDERS

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 and 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 and complex chronic pain to overlap with depression, insomnia, PTSD, anxiety, and substance use disorders. Address these co-occurring issues comprehensively, along with aggressive pain management, for optimal improvement in patients' health.

TREATMENT PLANNING

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

Treatment includes the following five broad categories:

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

RESTORATIVE THERAPIES

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

INTERVENTIONAL PROCEDURES

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

BEHAVIORAL HEALTH APPROACHES

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

COMPLEMENTARY AND INTEGRATIVE HEALTH

- E-Consult: The Wellness Center
 - Acupuncture, massage, and 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 three times a day if also taking oral NSAIDs, or four times a day if no oral NSAIDs. – anti-inflammatory, helpful primarily for nociceptive pain.

Oral non-opioid analgesics:

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

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

- **Cyclobenzaprine (Flexeril)** 5-10mg every night at bedtime to start may help with sleep initiation. If tolerated (watch for drowsiness, dizziness), can increase to 5-10mg three times a day as needed. This is serotonergic, so caution if patient is on more than two serotonergic agents for risk of serotonin syndrome.
- **Methocarbamol (Robaxin)** 500-1000mg three times a day as needed is usually well tolerated, tends to cause less drowsiness, and can be up-titrated to maximum 8000mg/day.
- **Tizanidine (Zanaflex)** 2-4mg three times a day as needed (watch for orthostatic hypotension, can be helpful if patient has

HTN).

- **Baclofen** 5-10mg three times a day as needed – usually first line for spasticity associated with central nervous system injury and can also be helpful for neuropathic pain.

Neuropathic analgesics:

- For neuropathic pain, and even nociceptive pain as a strategy to minimize opioid requirements, the first-line neuropathic analgesic is gabapentin. Note: Gabapentin is not available in Correctional Health Services formulary.

Gabapentin is usually started at 300mg every night at bedtime x 3-7 days to assess for side effects (can cause drowsiness/dizziness), then increased to 300mg twice a day x 3-7 days, then increased to first goal dose of 300mg three times a day. If this causes a lot of drowsiness but is helpful, increase the nighttime dose to goal dose of 900mg every night at bedtime only. As tolerated, can increase in a similar fashion to 600mg three times a day, which maximizes gabapentin's bioavailability. If creatinine clearance is 30-59 mL/min, recommend twice a day dosing up to goal dose 600mg twice a day. Maximum safe dose is 3600mg/24 hours (1200mg three times a day), but usually past 800mg three times a day there is limited benefit to dose increases.

The second-line neuropathics of choice are **duloxetine (Cymbalta)** and **nortriptyline (Pamelor)**, and they can also be helpful for mood.

- **Duloxetine (Cymbalta)** can be started at 20-30mg daily x 3 days then uptitrate as tolerated to 20-30mg twice a day (max dose for neuropathic pain). This medication does not tend to cause drowsiness, but can cause GI upset or dizziness. This is serotonergic, so caution if patient is already on multiple serotonergic medications.
- Alternatively, **nortriptyline (Pamelor)** is usually started at 10mg every night at bedtime, then after 7 days to assess for effectiveness or side effects, can uptitrate to 20mg every night at bedtime as first goal dose. Caution for drowsiness, dry mouth, dizziness, confusion, and 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 medication.
- Nortriptyline tends to have fewer side effects than **amitriptyline (Elavil)**, though amitriptyline has more evidence for efficacy in neuropathic pain associated with spinal cord injury. These medications should be avoided in the elderly > 65 years old.

If a patient has had no effectiveness with maximum dose gabapentin, a second-line neuropathic, AND a muscle relaxant (or can't try some of these because of allergies or other contraindication), then insurance companies will consider covering **pregabalin (Lyrica)**, which requires prior authorization.

- **Pregabalin (Lyrica)** typically works best in patients with complex neuropathic pain like after spinal cord injury or phantom limb pain after amputation. If starting pregabalin, wean gabapentin to at least half their previous dose, then start Lyrica at about 50-100mg twice a day. Caution for drowsiness and/or leg swelling. After 3 days, as tolerated, patient can stop gabapentin and increase pregabalin to max dose 600mg/day (so 200mg three times a day or 300mg twice a day).

An "out of the box" third-line analgesic that has most benefit in complex neuropathic or centralized pain and/or depression is ketamine.

- **Ketamine** is an N-methyl-D-aspartate (NMDA) receptor antagonist that can be helpful in depression and complex chronic pain, but it is primarily used in the peri-operative setting as an adjunct to anesthesia. It can be used in the outpatient setting, but compounded capsules are not covered by insurance and there are very few ketamine infusion programs that accept insurance.

SLEEP AIDS

- **Melatonin** 3-6mg every night at bedtime is a natural sleep aid that can help facilitate sleep quality/duration with minimal side effects.
- **Trazodone** 50-100mg every night at bedtime is a sleep aid. It can cause orthostasis, particularly in the elderly. It can also cause priapism in men.
- If melatonin and trazodone are contraindicated or ineffective, **diphenhydramine (Benadryl 25-50mg)** is also a common sleep aid, though can cause anticholinergic symptoms including cognitive problems especially in the elderly. Can also use other anti-histamines like **hydroxyzine or even cyproheptadine**. **Cyproheptadine** is also a serotonin blocker used for the treatment of serotonin syndrome.
- **Nortriptyline (Pamelor) and amitriptyline (Elavil)** are commonly dosed at night and can be helpful for neuropathic pain, mood, and sleep.
- If someone has a lot of drowsiness on **gabapentin or pregabalin**, it's recommended to keep the daytime doses low twice a day and then just increase the nighttime dose, which can help with sleep (example: Gabapentin 100mg every morning, 100mg every evening, 300mg every night at bedtime).

Hypnotics (such as zolpidem, eszopiclone, and zaleplon) have been used as short-term sleep aids and benzodiazepines have been used for brief episodic anxiety, insomnia, and muscle spasticity management. They generate physical dependence and are dangerous in combination with other sedating medications. They are not recommended for long term use for any condition and increase risk of death when combined with opioids and other central nervous system depressants.

OPIOIDS and OPIOID SAFETY

Opioids can be appropriate for acute trauma or pain (e.g. motor-vehicle accident, sickle cell crisis), acute post-operative pain, and pain from terminal illness such as malignancies. Aside from terminal pain, all patients should be counseled that they should not need opioids after the expected healing period (usually 3-10 days and generally not more than 14 days). After that, the risks of opioids almost always outweigh the benefits. Opioids are not indicated for chronic (longer than 3 months), non-terminal pain. Opioids shut down the pain-signaling pathway, and after their effects wear off, the pain returns because opioids do not address cause of pain. Opioids can also trigger the pain system to become more sensitive – a condition known as opioid induced hyperalgesia.

- DHS expected practices are to not offer treatments when harm outweighs benefit. Explain to patients the opioid-associated risks including increased risk of death, overdose, dependence, 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 and validated opioid risk tools exist, such as the ORT:
<https://nida.nih.gov/sites/default/files/opioidrisktool.pdf>

For high-risk situations (active concurrent substance use disorders, history of overdose on prescribed opioids, diversion behavior, and respiratory insufficiency), there is no benefit that would outweigh the harm of continuing opioids. Transition these patients to buprenorphine-naloxone (Suboxone) as their opioid analgesic strategy of choice. Buprenorphine is a schedule III opioid partial agonist that is categorically safer than all other opioids. It has analgesic properties and thus a wide therapeutic index for pain management. Usual dosing for analgesia is buprenorphine-naloxone 2-0.5mg to 8mg-2mg tablet thrice a day.

Risk factors for problems related to opioid use include:

- Chronic disease: risk of opioid use disorder is 30%
- History of mental health issues: depression, anxiety, bipolar disorder, schizophrenia, suicidal behaviors
- Social instability and trauma such as history of sexual abuse
- Personal history of substance use (including alcohol, tobacco use, illicit drugs, and prescriptions), any history of overdose
- Risk factors for oversedation such as concomitant sedatives, benzodiazepine use, taking > 50 MME/day
- Family history of substance abuse (including alcohol, illicit drugs, and prescriptions)

- Risk factors associated with decreased respiratory function such as obesity, COPD, asthma, OSA
- Risk factors associated with poor metabolic clearance such as advanced age, liver or kidney disease
- Structured & validated opioid risk tools exist such as the ORT:
<https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf>

Safer opioid strategies in chronic pain management:

- Avoid starting opioids for chronic non-terminal pain.
- Practice naloxone (Narcan) co-prescribing and education (indications for use, calling 911, administer second dose if effects wane).
- For patients already on opioids, we recommend evaluation for tapering the opioid dose down or discontinuous opioids at each visit. Evaluate all patients on chronic opioids for opioid misuse and/or diversion.
- Set a brief time-limited goal for use of opioids, with specific evaluation of functional improvements. If there is no improvement of functional goals on opioids, stop the opioids. Use the 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 patient compliance with taking prescribed opioid and not taking illicit medications. Note that 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.

Tapering Opioids

It is easier to taper down long acting opioids (such as methadone or morphine OR) on a patient's regimen first and subsequently transition to short acting opioids as an initial milestone. Long acting opioids such as methadone, oxycodone extended release, and morphine sulfate extended release are generally only appropriate for patients with terminal pain.

- Reduce the daily dose by 10-20% each week to month to minimize physical withdrawal and psychological anxiety about changes in opioids. Individualize the pace of tapering.
- Encourage splitting tabs in half and replacing breakthrough opioid doses with breakthrough non-opioid strategies.
- For further guidance on tapering, please see "[Addiction Medicine and Pain Medicine – Opioid Taper](#)".
- Send an eConsult to Pain Management (non-malignant) if there are specific questions about tapering opioids.

PATIENTS WITH SUBSTANCE USE DISORDERS

Opioid use disorder commonly co-occurs with chronic pain. If a patient has an opioid use disorder, the first line treatment is to initiate sublingual buprenorphine-naloxone, which can be dosed three times a day to four times a day to address pain.

Instructions for initiating buprenorphine/naloxone are discussed in the [Addiction Medicine – Medication Management of Opioid Use Disorder in Ambulatory Care Settings](#).

An X-waiver is not required to prescribe buprenorphine-naloxone for the indication of pain. Ensure that the indication of pain is documented in the ORCHID order in the instructions for the pharmacist field to clarify the indication for this buprenorphine-naloxone.

An X-waiver is required to prescribe buprenorphine-naloxone in ambulatory settings for the indication of opioid use disorder. E-mail buprenorphine@dhs.lacounty.gov to obtain an X-waiver. In the ORCHID order's field for instructions for the pharmacist, providers who prescribe buprenorphine-naloxone for the indication of opioid use disorder must include their X-waiver number and the diagnosis of opioid use disorder (F11.20).

For patients with alcohol, tobacco, and other co-occurring substance use disorders, see the DHS Clinical Care Library section on Addiction Medicine to review and implement DHS expected practices related to the treatment of these conditions:

<http://lacounty.sharepoint.com/sites/dhs-ccl/Addiction%20Medicine/Forms/AllItems.aspx>

If there are non-urgent questions about appropriate use of medications for alcohol, tobacco, and/or opioid use disorder, use the eConsult: Addiction Medicine – Medications for Addiction Treatment.

- For urgent questions about appropriate use of medications for treatment of alcohol, tobacco, and/or opioid use disorder, including during a clinical visit: DHS Addiction Medicine Consult line, 8am to Midnight everyday including weekends, (213) 288-9090.

FOOD AND NUTRITION SERVICES

The Food and Nutrition Services Department at Rancho is a county contracted service (Prop A). The contractor since 1995 has been Sodexo. The Food and Nutrition Services Department provides the following services:

- Prepare and serve all patient meals and snacks.
- Provide clinical nutrition programs for inpatients and outpatients.
- Prepare all food served in the Café Amigos, the employee and visitor cafeteria in the Support Services Building (SSB).
- Provide catering services for special functions and meetings.
- Provide meals for ordinance employees and volunteers.

The Clinical Nutrition Department consists of registered dietitians and dietetic technicians. They provide nutrition therapy services to all patients. The manager of food services is located in the SSB 1131(Ext. 57151).

Hours of operations are Monday through Friday at the following times and location:

Location	Open	Closed
Café Amigos	6:30 a.m.	3:00 p.m.
JPI Hallway food cart	7:00 a.m.	6:00 p.m.

PATIENT SAFETY

This section addresses general patient care principles related to patient safety including “Read-Back” requirements, fall reduction, deteriorating patient condition, Speak Up program, medication management, unapproved abbreviations, behavioral restraints, medical record requirements for physicians/Licensed Independent Practitioners (LIP), and medical review checklist.

"READ BACK", "REPEAT BACK" REQUIREMENTS

In an effort to improve communication among care providers, Rancho has several processes in place to confirm the accuracy of orders issued over the telephone in the case of an extreme emergency, during a surgical or technical procedure, or when the physician is immediately unavailable to enter the order and a delay in obtaining or executing the order would prove detrimental or harmful to the patient’s health and well-being.

- **Verbal/Telephone Orders** – Orders communicated verbally or by telephone from a physician to an authorized health care provider (i.e. Registered Nurse or Respiratory Care Therapist). Prior to executing the order, the health care provider receiving the order must repeat it back to the physician exactly as written and request verbal confirmation of its accuracy. Once the order is confirmed, the individual receiving the order must enter the order in the electronic health record and request co-signature of the physician who delivered the initial verbal/telephone order. The co-signature will be considered delinquent if not completed within 48 hours.
- **Critical Test Results** – Rancho uses the CSM queue within Cerner for reporting of critical laboratory values, and significant medical imaging diagnostic findings.
 - **For Critical Diagnostic Laboratory Values**
 - The laboratory personnel enters the value, the ordering practitioner or designee, and the location at which the specimen was collected into the *Cerner CSM queue* system. *Cerner CSM queue* will page or call the ordering practitioner, and at the same time, will call and fax to the ordering location (unit or clinic) to notify. After 5:00 p.m. or on weekends and holidays, the B-physician will be paged, except for Units 101 and 102 for which the Intensivist will be paged.
 - For a clinic patient: If the critical value is identified after 5:00 p.m., before 8:00 a.m., or on a weekend or holiday, *Cerner CSM queue* will call and fax a notification to the Telephone Operator Office, which then notifies and provides the Administrative Nursing Supervisor (ANS) with the fax notification. The ANS, then, contacts the on-call B physician or Intensivist.
 - Once called/paged by *Cerner CSM queue*, the ordering practitioner/designee or the on-call physician or intensivist, and the RN on the ordering unit will call the Cerner CSM queue telephone number within 30 minutes, and using the six (6) digit message number, will retrieve the critical value and close the report.
 - All critical values will be verified through a read back process.
- **For Medical Imaging significant findings**

The Medical Imaging Department reports all critical findings to the Cerner CSM queue system. The system notifies the physician or designee via telephone, page, or fax, and maintains record of when these communications occur.

DETERIORATING PATIENT CONDITION

As caregivers, you need to know the signs and symptoms of the decline of a patient's condition within your scope of practice. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going assessments, handoff communication reports, medical record documentation, and other communication modalities are good methods to use in recognizing deterioration in the patient's condition. **Every** member of the health care team is responsible to provide the highest level of care, and to immediately react to emergencies, potential emergencies, and/or incidents.

Signs and Symptoms:

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

- Acute change in mental status
- Acute change in heart rate
- Acute change in respiratory rate or effort.
- Acute decrease in oxygen saturation.
- Acute decrease in systolic blood pressure.
- Acute decrease in urinary output.
- Uncontrolled bleeding.
- Any staff member's significant concern about a patient's status.
- Pediatric patients under 5 years of age hypo-perfusion may often present with altered mental status, the patient feels clammy, he/she has poor capillary refill > 3 seconds, may be unable to obtain blood pressure.

If you are concerned that a patient is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. That patient's nurse will assess the situation and call for additional assistance, if needed. Rancho has an Emergency Response Team set up to evaluate and stabilize patients or visitors who are deteriorating or who need emergent intervention. This team can be activated by dialing Ext. 544.

BE FAST – RECOGNIZING THE SIGNS OF A STROKE

Recognizing the signs of a stroke and acting quickly can mean the difference between life and death, or between full recovery and permanent disability. Stroke is a medical emergency that occurs when blood flow to a part of the brain is interrupted or significantly reduced, depriving brain tissue of essential oxygen and nutrients. Prompt treatment is critical.

BE FAST is a simple yet powerful acronym created to help people quickly identify the warning signs of a stroke and take immediate action. It stands for **B**alance, **E**yes, **F**ace, **A**rms, **S**peech, and **T**ime, and is a life-saving tool in recognizing early stroke symptoms and empowers people to act quickly and confidently in the face of a medical emergency.

Understanding BE FAST

- **B – Balance:** Watch for a sudden loss of balance or coordination. The person may experience dizziness, feel unsteady, or have difficulty walking.
- **E – Eyes:** Be alert to sudden changes in vision, such as blurred or double vision, or sudden blindness in one or both eyes.
- **F – Face:** Check for facial drooping, especially on one side. Ask the person to smile and observe whether the smile is uneven or if one side appears numb.
- **A – Arms:** Ask the individual to raise both arms. Look for weakness or numbness on one side, where one arm may drift downward or be immobile.
- **S – Speech:** Listen for slurred or incoherent speech. Ask the person to repeat a simple sentence and check for clarity and understanding.
- **T – Time:** Time is of the essence. If any of these signs are present, even if they are temporary, activate emergency services immediately in accordance with hospital policies and procedures. Every second counts.

Why BE FAST Matters

Strokes can happen suddenly and without warning. The faster a stroke is recognized and treated, the better the chances for survival and reduced long-term disability. BE FAST helps people respond within the critical window where treatments like clot-busting medications or surgical intervention are most effective.

BE FAST education is essential not only for healthcare providers, but also for families, caregivers, and the general public. Raising awareness empowers more people to take immediate and informed action, which can ultimately lead to better patient outcomes and saved lives. In summary, **BE FAST** is more than just a medical acronym—it's a call to action. Learning it, sharing it, and acting on it could help protect someone's future, or even save their life.

When it comes to Stroke **Call**
BE FAST. **Code Assist**

Any one of these sudden symptoms could mean a stroke.

HOW TO SPOT A STROKE

B	E	F	A	S	T
					
Balance	Eyes	Face	Arm	Speech	Time
Sudden loss of balance, dizziness	Sudden loss of vision or blurred vision	Uneven smile, one side of face is drooping or numb	One arm is weak or numb	Slurred speech or difficulty speaking	Time to call code assist Immediately

KEYS TO PREVENTION

Know and manage your risks.

				
Manage high blood pressure, the leading cause of stroke.	Avoid tobacco use and vaping.	Get regular physical activity.	Manage cholesterol.	Eat healthy foods including vegetables, fruits, and lean protein.

FALL REDUCTION AND PREVENTION

The Department of Health Services has a DHS Policy DHS System-Wide Fall Prevention Program outlining our fall management program. The purpose of having a system-wide program is to ensure continuity throughout our inpatient and outpatient facilities.

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

- Fall screening
- Fall risk
- Fall prevention measures implemented
- Patient education provided

Hospitalized inpatients (1 year of age and older) will be assessed on admission and reassessed daily upon transfer to another unit, with condition change, and post-fall. The staff will document the following in the electronic medical record:

- Initial and ongoing reassessments using appropriate fall risk assessment tool
- Patient/family education
- Ongoing safety precautions
- Any fall incident, related reassessment, and physician/family notification

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 electronic 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’, and to include patient/family education.

Organization/Facility Assessment of Fall Risk:

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

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

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

Selection of System Wide Fall Assessment Tools

All DHS inpatient facilities assess patients for their fall risk using the same tools. The Morse Fall Risk Assessment Tool is used for the assessment of our adult inpatients. The Humpty Dumpty Fall Risk Assessment Tool is used for the assessment of our pediatric patients. In the outpatient settings, patients are screened for their fall risk utilizing either an adult or pediatric screening tool.

DEFINITION OF A FALL

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

Rehabilitation Fall: A fall that occurs while a patient is engaging in purposeful actions as a result of a rehabilitation therapy session (i.e., high challenge balance activities, fall recovery, etc. with therapist) that has the intent of challenging a patient's balance or attempting a functional activity the patient is unable to perform without assistance.

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

Interventions

Standardized fall prevention measures are established for each level of risk using both the Morse and Humpty Dumpty Tools. The interventions were designed as a build-upon system. Patients at a moderate or high risk for falls will have the interventions for each lower risk level implemented. For example, patients at a moderate risk will have both the low and moderate interventions implemented. The option of selecting interventions from a higher risk level is provided.

Assessment Times

Standardized assessment and re-assessment times are on admission, daily, upon inter-unit transfer, change of status, and immediately after a fall.

System-Wide Initiatives

- Yellow is the DHS fall program color. All fall management items are to be yellow as much as possible.
- The program logo is displayed.
- Yellow armbands were selected for both the outpatient and inpatient areas.
- Doorway signs and stickers were designed.
- A standardized post-fall procedure was created defining the duties of the first responder, RN, and licensed provider.
- A fall management program introduction is included in Interdisciplinary Orientation. Affiliating students assigned to clinical settings attend the fall management program orientation class.

RANCHO'S FALL MANAGEMENT PROGRAM

- Rancho's unique patient population is at a high fall risk.
- The Humpty Dumpty Fall Risk Assessment Tool is used to assess all Pediatric Service patients regardless of age.
- Rancho posts Morse Fall Signs at the bedside of each adult patient to communicate their fall risk level and interventions.
- Hand-off communication between caregivers is a low risk intervention.
- RN or licensed provider will notify the next of kin.

RANCHO'S FALL MANAGEMENT INITIATIVES

Falling Leaves Program

A colored leaf, representative of the patient's fall risk level, is attached to the nameplate outside the patient's room, communicating their fall risk level to all who enter.

Yellow – low risk

Orange – moderate risk

Red – high risk

Fall Dashboard

The dashboard communicates the unit's weekly and monthly fall rate to all caregivers. Each time a patient falls, a laminated leaf representative of the patient's fall risk level is removed from the tree and attached to the Velcro on the ground. At a glance,

staff can look at the leaves on the ground and know how many patients have fallen so far that week/month and what risk level they were at the time of the fall.

Intentional Rounding

Intentional rounding is done hourly or more frequently if the patient's situation warrants. An off-going and on-coming employee round the patient at shift change. Therapies round patients at the end of each therapy session. Before leaving a patient, they are asked if there is anything else they need that may not have been addressed. Patient satisfaction is enhanced when patients are aware that their concerns are addressed and needs met on an hourly basis, at minimum.

Bed Alarms

Bed alarms are to be on at all times, as appropriate, when moderate and high risk patients are in bed. Patients who are deemed safe to be in their bed without the alarm activated, as determined by all assigned interdisciplinary team members, will have a notation written in red on their communication board indicating a bed alarm is not needed. If the patient is in a specialty bed and does not have an alarm, it is to be reported to the Nurse Manager. If the alarm is not working, a different bed is to be used. Patients shall not be left in the bed while waiting for the repair. The alarm is to be checked when returning a patient to their bed and hourly during intentional rounds. The alarm should be set on the #2 setting.

Safety at the Bedside

Cluttered bedside stands increase a patient's fall risk because the patient may reach for items that fall. Only a small number of specific items are to be on the bedside table. They are:

- Telephone – is time sensitive and placed closest.
- Water bottle or other hydration items.
- Food items.
- Aids such as glasses, contact lenses, hearing aids, dentures.
- Leisure items.
- Trash bag.
- Reacher if issued by Occupational Therapy.

The urinal is placed within easy reach of the patient. If the patient has a strong side, the table is placed on their strong side. Side rails are positioned to improve the patient's safety. For example, if the patient has experienced a right sided stroke and is not impulsive, the right lower rail is lowered. If the patient has experienced a right sided stroke and is impulsive, the left lower rail is lowered. A consent is completed when all four side rails need to be in the upright position to keep the patient safe. Having all four side rails upright is considered a restraint.

Bedside Communication Tool

A Bedside Communication Tool is located at the patient's bedside and is used by the patient's caregiver to communicate key information about the patient to other caregivers and to the patient's family. The tool is reviewed daily and updated as changes to the patient's status occur (e.g., dietary considerations, toileting requirements, scheduled tests, staffing changes, etc.).

The Loaner Reacher Program

Reachers are devices that allow patients to grab items from the floor, table, or shelf without the need to reach, step on a ladder, bend, or stoop. The devices assist with providing a safer environment for fall risk patients who are assessed by Occupational Therapy as candidates for their use. Any interdisciplinary team member can request an Occupational Therapy assessment for the patient, if they feel the patient would benefit from using such a device. The loaner reachers are painted yellow to indicate fall measures are warranted and are mainly for hospital use, but may be provided to a patient upon discharge, if warranted.

Wheelchair Seatbelt Alarms

All Rancho owned wheelchairs are equipped with a seatbelt alarm. The alarm will sound or a voice will be activated when the patient unbuckles the seatbelt. The seatbelts are used as another measure to prevent patient falls, but this is not a substitute for monitoring. Also, the seatbelt should only be used if the patient can release themselves, otherwise the device will be considered a restraint.

JPI Second Floor Safe Zone

Patients on the second floor of the JPI building are encouraged to remain in the Safe Zone in the Activity Dining Room when not in therapy, at an appointment, or in bed. After therapy or an appointment, the patient will be returned to the Safe Zone where they and their families are allowed to participate in hourly activities (e.g., interdisciplinary patient education classes, TIGR televised education videos, crafts, group meals, and exercise). Patients, families, and other visitors are welcome to attend as many activities as they choose and can attend the same class more than once. Combined therapies are provided. If a patient would like the freedom to come and go from the Safe Zone, all team members must agree the patient can safely remain in their room unsupervised while in their wheelchair. The physician will write a note indicating this in the patient's electronic medical record and a yellow happy face sign will be attached to the patient's wheelchair and room nameplate. The unit will design an alternative intervention to keep patients safe who do not wish to be in the Safe Zone and are not cleared to be in their room unsupervised while in their wheelchair.

The Safe Zone is available Monday – Friday from 9:00 A.M. - 6:00P.M. Interdisciplinary patient education classes are held at 10:00 A.M. and 4:00 P.M. The schedule of other activities is posted in the Safe Zone.

Post-fall Huddle

As soon as possible after a patient falls, staff will conduct a post-fall huddle. Staff will review the circumstances surrounding the fall, determine possible reasons for the fall, review current fall prevention interventions and strategies, and discuss additional interventions or corrective actions for implementation. The patient and family can be included in this process, if appropriate. Once additional interventions/corrective actions are implemented staff/patient/family education is provided. There are Post-fall Huddle Champions assigned to each unit.

SAFE PATIENT HANDLING (SPH)

Effective October 1, 2014, every general acute care hospital was required to adopt Cal/OSHA Safe Patient Handling Regulation AB 1136. This regulation requires hospitals to have a program and policy that enables nurses and other caregivers to move patients utilizing equipment in a way that does not cause strain or injury while preserving the patient's dignity.

Department of Health Services and Rancho Los Amigos National Rehabilitation Center policies, addresses Safe Patient Handling. These policies require workforce members, except in an emergency, to perform patient transfers **with mechanical assistive devices** as appropriate for the specific patient and consistent with the professional judgment and clinical assessment of the registered nurse, who is the coordinator of care. Rancho has developed a Musculoskeletal Injury Prevention Plan which describes the elements of the Safe Patient Handling Program.

Patient handling activities that place staff at risk for injury include but are not limited to:

1. Repositioning in bed.
2. Bed to chair/wheelchair.
3. Bed to gurney and return.
4. Gurney to treatment table and return.
5. Bed to toilet.
6. Floor to bed.
7. Any other lift where total body movement of the non-ambulatory patient is required.

During an emergency in a nursing unit, contact a registered nurse to get help for the patient.

UNIVERSAL PROTOCOL

Rancho has adopted all components of The Joint Commission's Universal Protocol intended to prevent wrong site, wrong surgery/procedure, and wrong person. The Universal Protocol establishes a process for a defined series of pre-procedure verifications designed to maximize patient safety and well-being. It applies to all surgical and non-surgical invasive procedures. Healthcare providers facility-wide share in the responsibility of conducting this verification process in cooperation with the patient. Universal Protocol must be used on all procedures, which are not only invasive, but that present more than minimal risk to the patient. Universal Protocol is required across the campus anywhere an invasive procedure occurs.

The three main components are:

1. **Pre-Procedure Verification** – Rancho uses a standardized list for verifying that all relevant documents are available and correct before sending a patient for any surgical and non-surgical invasive procedure. Verification that the patient's history and physical is present and current, that we obtain the patient's informed consent, and that the patient is included in the process and agrees to the planned surgery/procedure is completed. If any information is missing or discrepancy found, the procedure is postponed until the information is clarified, and/or corrected. This standardized list also addresses marking of the correct surgical site, verification of the correct procedure, and patient, and the time out processes required. Documentation of the use of the standardized list on a per patient basis is not required.
2. **Site marking** – The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs). However, the licensed independent practitioner who delegates responsibility is ultimately accountable for the procedure. This option takes into account the current position of The Joint Commission, National Quality Forum, World Health Organization, and American Academy of Orthopedic Surgeons and the concern raised by the field that the current requirement is impractical under some circumstances. The Joint Commission will continue to gather input and data on this issue.
3. **"Time Out"** – The "time out" process will occur prior to incision or start of the procedure. All members of the service delivery team conduct a final verbal verification to confirm the correct identity of the patient, planned procedure, operative site, side, and level. A member of the Health Care Team (the circulating nurse, as in the case of the operating room or the person assisting with the procedure, as in the case elsewhere in the hospital) will initiate the verbal "time out", and document the confirmations. The discussion should involve all team members regarding the type of anesthesia, availability of blood, any relevant health conditions or risks, presence of x-rays or other relevant testing, presence of all surgical instruments, and any intended surgical implants.

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 levels, and when there is not an obvious wound or lesion.

NON-OR PROCEDURAL TIME OUT SECTION

All those who will be participating in a Non-OR procedure that requires a written informed consent, must conduct a Non-OR Procedural Time Out activity before the start of the procedure by using the Non-OR Procedural Time Out Checklist which includes the following elements:

1. All needed staff must be present and participated in the Non-OR Procedural Time Out activity
2. Patient's ID on and verified
3. Allergy check performed and verified
4. Procedure consent signed and verified

5. Procedure site and laterality verified (marked if applicable)
6. Correct patient position
7. Specimen collection container correctly labeled
8. Supply and medication expiration date call out done
9. Antibiotic prophylactic administered
10. Essential imaging available
11. Proceduralist/Team Patient-specific Concerns
12. Proceduralist/Team's Patient-specific concerns

When checking and verifying these elements, it must be read or said out loud during the activity or process by the proceduralist or the central line insertion procedure nurse who may be acting alone or by any member of the Non-OR Time Out Team. If a consecutive (a.k.a. second) procedure must be done, a procedural pause (which includes at a minimum a verification and confirmation of the patient's identity, procedure, and surgical site) is required and must be performed prior to commencement of the second procedure. The Non-OR Procedural Time Out activity and verification of the elements must be documented in the appropriate and designated documentation areas (e.g., Powerform or iView) in ORCHID. Lastly, if a team member(s) differs for a consecutive procedure, an additional Non-OR Procedural Time Out activity must be performed, including documentation of the Non-OR Procedural Time Out Checklist.

MEDICATION MANAGEMENT

MEDICATION USE

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

MEDICATION RECONCILIATION

It is Rancho's policy to accurately and completely reconcile medications across the continuum of care. The provider is responsible for the medication reconciliation process in collaboration with nursing, pharmacy, and other members of the interdisciplinary team.

All admissions, intra-facility transfers (including postoperative), transfers to another facility, discharges, and encounters in the Ambulatory Care setting, require the provider to reconcile medications and document that the medication reconciliation process was completed. This entails obtaining a current medication history, including prescription and non-prescription medications, such as over-the-counter medications, supplements, herbals, and alternative medications from all patients admitted to the facility or seen in the Ambulatory Care setting.

Tools and resources that are available to the provider include, but are not limited to:

- Patient medication profile from the Electronic Health Record (EHR).
- Medication Administration Records (MARs) from the previous health care facility.
- Current MARs for intra-facility transfers and discharges to another healthcare facility.
- Medication Reconciliation Worksheet.
- Interviews with previous caregivers, patient, family, and significant others.
- Any records received from the patient, e.g., discharge instructions, prescriptions, patient's personal record, list of medications.
- Actual bottles or packages of medications, supplements, etc.
- Prescription profile.

MEDICATION PRESCRIBING

Providers have the responsibility of ensuring appropriate medication prescribing in an effort to decrease the potential for medication error. The correct medication indication, dose, route, frequency, contraindications, and pharmacological effect(s) of each medication prescribed must be known to avoid adverse drug events. Rancho encourages ongoing formulary review and utilization of formulary-approved medications.

Safety Tips for Safe Medication Prescribing

Medication orders shall be clear, complete, safe, and lawful and must specify medication name, dosage, route, frequency, and any instructions/parameters. Medication orders are made clear and complete by:

- Identifying patients **with TWO** identifiers:
 - Inpatient: Name and MRUN
 - Outpatient: Name and MRUN OR Name and Birthdate
- Noting date and time on all orders.
- Using generic drug names, except for combination products which can be ordered using their trade name.
- Including specific drug name, dose, route, frequency (time), and any instructions/parameters.
- Not using range orders. (Pharmacy will not accept ranges such as 1-2 tabs or q 4-6h in orders.)
- Qualifying all as needed (PRN) orders (e.g., PRN for pain) with indications.
- Provider electronic signing of all orders.
- Entering patient's diagnosis, allergies, and height/dosing weight (in kilograms) on all admitting orders.
- Entering patient's pregnancy and lactation status and any other information required for safe medication prescribing.
- Using weight-based dosing on all pediatric patients until the adult weight is reached or the pediatric dose equals the normal adult dose.
- Notifying that medications held with no parameters provided at the time the order was written will be interpreted as a discontinued order and medications held due to parameters provided at the time the order was written will not discontinue the order.
- Using patient identification labels or computer generated patient identification on ALL patient orders. Do not write out patient names, MRUN, or birthdate. Unit location must be noted on ALL patient medication orders.
- Avoiding use of "Do Not Use" abbreviations. When in doubt, do not abbreviate! To prevent confusion, spell out the entire drug name.
- Not using trailing zeros after decimal point.
- Always using a zero before a decimal when dose is less than a whole unit.

Medication Storage Safety Tips:

- ✓ Do not store food with medications
- ✓ Different medications should NOT be stored in the same bin
- ✓ Medication for discharged patients should not be stored and must always be returned to the pharmacy.

“DO NOT USE” ABBREVIATIONS LIST

“DO NOT USE” ABBREVIATIONS/DOSE EXPRESSION	APPROVED ABBREVIATION/CORRECTION
U	Use unit
i.u., I.U.	Use international unit
Q.D., QD, q.d., qd	Use daily
Q.O.D., QOD, q.o.d, qod	Use every other day
Zero after decimal point (e.g. 1. 0) (Trailing zero)	Do not use terminal zeros for doses expressed in whole numbers (e.g., 1.0 mg should be 1 mg)
Lack of a leading zero (e.g., .1 mg)	Always use a zero before a decimal point (0.1 mg).
MgS04	Use magnesium sulfate
MS or MS04	Use morphine sulfate

LOOK-ALIKE/SOUND-ALIKE LIST

epHEDrine and epINEPHrine	lamIVUDine and lamOTRIGine
HumULIN and HumALOG	LantUS and LentE
CeLebREx and CeRebYx and CeLeXA	KlonOPin and ClonIDinE
LamiSIL and LamiCTAL	foliC acid and foliNIC acid
hydOXYzine and hydRALAzine	traMAdoL and traZOdoNE
SEROquel and SERtraline	cefOXitin and cefEPIME
cefTRIAXONE and CefEPIME	



REMEMBER

Please use enhanced caution when prescribing, dispensing, and administering look-alike/sound-alike medications.

MEDICATION DISPENSING

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

MEDICATION ADMINISTRATION

When administering medications, patient identification using two identifiers must be completed. If the patient is unable to state their full name, a picture identifying the patient will be used for identification. If there are two patients with the same name, the two patient identifiers would then be the patient's MRUN and birthdate.

For the outpatient area, the two identifiers are: patient's name and birthdate OR MRUN. Review the electronic MAR to verify and document the medication administered. The nurse reviews all physician orders and reconciles the electronic MAR before administering medications. Errors on or updates needed to the electronic MAR will be completed prior to use.

PATIENT'S OWN MEDICATIONS

Medications brought into the hospital by the patient should be sent home. Rancho will not administer a patient's personal medication unless **ALL** the following conditions are met:

1. The physician writes an order in the patient's electronic medical record indicating that the patient's personal medication supply should be administered.
2. The medication is not on the Rancho drug formulary or available.
3. The pharmacist has made a positive identification of the medication by verifying the product's physical appearance and manufacturer identification information.
4. Pharmacy has ensured that the medication has not been contaminated.

Rancho will not administer oral liquids, ophthalmic drops, intravenous admixtures, topical agents, or other products that have the potential for additional additives and/or adulterants contamination and cannot be identified without chemical analysis.

ADVERSE DRUG REACTION (ADR) HOTLINE

Report all adverse drug reactions (ADR) into the Safety Intelligence™ (SI) Event Reporting System and/or to the ADR hotline (562) 385-6129. Provide the patient's name, MRUN, location, occurrence date, suspected/known medication name, dose, route, and type of reaction. Save all items associated with the medication's administration, e.g., package, tubing, syringe, and infusion bag.

MEDICATION ERRORS

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

MEDICAL RECORD REQUIREMENTS FOR PHYSICIAN AND LICENSED PROVIDERS

- Begin medical record entry with document type (e.g., History and Physical, Internal Med Inpatient Progress Note).
- All verbal and telephone orders must be validated/authenticated within 48 hours. Rancho accepts verbal orders from a prescribing physician in an emergent or urgent situation in which harm to the patient would be imminent if the order is not implemented immediately and for which the physician is not able to write the order. No verbal orders for high alert medications are allowed except for cases of code blue, rapid response, and rapid sequence intubation.
- Specify reason(s) for prescribing medication(s) on all as needed (PRN) orders (i.e., conditions/symptoms, etc.).

Corrections and Addendum to Records

If an error is made while charting in a medical record, make the corrections by opening the finalized document and typing in the corrected information. Once the entry is signed, a revised version of the document will open identifying the newly documented information as an addendum to the original entry.

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

Rancho is dedicated to preserving the dignity, safety, and rights of each individual. Our goal is to minimize the use of restraints through comprehensive on-going assessments, the use of de-escalation techniques, and incorporating least restrictive alternatives. Restraints shall be implemented in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques and used only when less restrictive measures have been found to be ineffective to protect the patient and others from harm. Restraints may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time regardless of the expiration time of the order. The use of restraint is an exceptional event, not a routine response to a certain condition or behavior. Each patient must be assessed and interventions should be tailored to meet the individual patient's needs. Refer to Rancho Administrative Policy and Procedure, Violent and Non-Violent Restraints for additional information on the use of restraints at Rancho.

CODE GOLD AND CODE GRAY

Code Gold:

Rancho provides a process for handling aggressive, combative, violent, or abusive behavior that is displayed by **INPATIENTS** through the use of Code Gold – Behavioral Response Team (BRT). The BRT (Code Gold Team) consists of specially trained licensed and non-licensed workforce members who will provide 24 hour coverage to assist the patient in regaining control when exhibiting violent or aggressive behavior toward staff, patients, or others. The BRT members should have appropriate, mandatory training and have demonstrated competency in the use of less restrictive methods of behavior management.

Refer to Rancho Administrative Policy and Procedure, Code Gold Behavior Response Team, for additional information on Code Gold BRT response. For any concerns related to behavioral issues, contact the Risk Manager at Ext. 57842.

Code Gray:

Rancho provides a process for handling aggressive, combative, violent, or abusive behavior that is displayed by **OUTPATIENTS, VISITORS, or WORKFORCE MEMBERS (not inpatients)**. In the event of aggressive, combative, violent, or abusive behavior that is displayed by outpatients, visitors, workforce members, or other individuals, staff will implement facility standardized procedure for Code Gray. Code Gray response will be managed by the facility Los Angeles Sheriff's Department (LASD) staff that will respond and assume responsibility of the situation.

GOLDEN HAND AWARENESS

In efforts to promote safety and wellbeing of patients, workforce members, and visitors, Rancho has implemented the Golden Hand Awareness Protocol. The protocol consists of early identification of patients who are at high risk for disruptive, threatening, or physically aggressive behavior. If patient meets criteria, the Golden Hand Awareness marker is placed outside the patient's room and functions as a communication tool to caution staff. Workforce members are to ensure safety precautions are implemented before entering the patient's room by further inquiring with primary nurse for any individualized interventions that need to be implemented when approaching patient. In addition, the workforce member can review the Golden Hand Awareness form in the paper light chart for further information.

KEY POINTS TO REMEMBER (CLINICAL STAFF)

PATIENT CARE PRACTICES

Provision of Care

- Know the characteristics of each population group that you serve.
- Rancho supports every patient's rights to have their pain assessed and treated promptly, effectively, and for as long as the pain persists.

Patient Safety

- You must know how to seek medical assistance when there is a decline in a patient's condition.
- Prevention of patient falls is the responsibility of EVERY workforce member. Become familiar with Rancho's Fall Prevention Program.
- Universal Protocol applies to all surgical and non-surgical invasive procedures and establishes a process for preventing wrong site, wrong surgery/procedure, and wrong person errors.
- The Universal Protocol's three main components are: conduct the pre-procedure verification process, mark the operative site, and perform a "Time Out" before starting the procedure.
- Identify the patient by two identifiers:
 - **Inpatient: Patient Name and MRUN**
 - **Outpatient: Patient Name and Date of Birth OR Patient Name and MRUN**
- The medication process must ensure that the right medication is administered to the right patient, at the right dose, at the right frequency (time), using the right route, for the right reason, with the right response, and the right documentation is completed.
- Do not use "Do Not Use" abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire drug name.
- Report all adverse drug reactions into the Safety Intelligence™ (SI) Event Reporting System and/or to the ADR hotline at (562) 385-6129.
- Report all medication events including actual medication error and near miss error through Rancho's Safety Intelligence™ (SI) Event Reporting System.
- All medication orders must contain the name of the medication, dose, route, frequency (time), and any parameters/instructions. Medication orders need to be signed by the provider.
- Rancho is committed to using non-violent interventions to prevent and control emergencies that have the potential to lead to restraint use.
- Restraint use should be limited to those emergency situations, e.g. "Code Gold", 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.
- Rancho will dispatch the Behavior Response Team (BRT) for a "Code Gold" emergency.

KNOWLEDGE CHECK

1. California law allows you up to two hours off to vote in a statewide election without losing any pay.
 - a. True
 - b. False
2. Body mechanics is the use of proper muscles to perform tasks safely, but it is not important for preventing injuries to you and others while at work.
 - a. True
 - b. False
3. Who is responsible for reporting incidents of discrimination, sexual harassment, retaliation, harassment (other than sexual), third person harassment, or inappropriate conduct towards others?
 - a. A workforce member who believes they were the object of such an incident
 - b. A workforce member who witnessed the incident
 - c. A workforce member who has been affected by inappropriate behavior
 - d. All of the above
4. Anyone chosen for hire, promotion, or transfer—except contract, volunteer, or student staff—must pass a criminal background check.
 - a. True
 - b. False
5. Time recorded as worked should only reflect time spent performing work for the County, unless all work has been completed, in which case employees may spend time working on non-County or non-DHS related activities.
 - a. True
 - b. False
6. Most of our patient encounters are with patients who have a preferred language, other than English. Resources available to support Language Access include:
 - a. Qualified interpreters, including Qualified Sign Language Interpreters
 - b. Allowing a family member to interpret critical conversations
 - c. None of the above
7. DHS complies with applicable federal civil rights laws and does not discriminate on the basis of language, culture, age, gender, sex, sexual orientation, gender identity or expression, socioeconomic status, physical or mental ability or disability.
 - a. True
 - b. False
8. When should physical intervention be used in a violent incident?
 - a. As soon as the person becomes defensive
 - b. Only when other methods have failed and danger is imminent
 - c. Whenever a patient raises their voice
 - d. As a primary strategy to regain control
9. Managed care plan members can continue with their health provider after a health plan change if they have a qualifying condition and the health provider is no longer in their health plan. A patient's chronic illness
 - a. True
 - b. False

10. The CANDOR process should only be used when a medical error is confirmed.
 - a. True
 - b. False
11. The Safety Intelligence™ event report must be included in the medical record.
 - a. True
 - b. False
12. Unapproved medical abbreviations are acceptable when time is limited or in emergencies.
 - a. True
 - b. False
13. What does the “E” stand for in AVADE?
 - a. Execute
 - b. Evacuate
 - c. Education
 - d. Escape
 - e. None of the above
14. The CANDOR Program has these five components, except:
 - a. Identification of the event
 - b. Activate the facility Incident Command Center
 - c. Response and Disclosure
 - d. Investigate and Analyze
 - e. Resolution/Reconciliation
15. Who is responsible for preventing patient falls?
 - a. Only nurses
 - b. Only doctors
 - c. Only physical therapists
 - d. Every workforce member

QUICK REFERENCE

Rancho Los Amigos National Rehabilitation Center
7601 Imperial Highway
Downey, CA 90242

(562) 385-7111
(562) 385-8450 TTY/TDD
www.rancho.org

DHS ADMINISTRATION

Director of Health Services	Christina R. Ghaly, MD	(213) 288-8101
Administrative Deputy	Elizabeth Jacobi	(323) 914-5067
Chief Deputy Director, Clinical Affairs and Population Health	Nina Park, MD	(213) 288-8693
Chief Deputy Director, Operations	Aries Limbaga, DNP, MBA, RN, CRRN, AGNP	(562) 385-7022
Chief Financial Officer	Allan Wecker	(213) 288-7882
Chief Information Officer	Kevin Lynch	(323) 409-1220
DHS Learning Development & Metrics (LDM)		DHS Learning Development Metrics@dhs.lacounty.gov
DHS Privacy Officer		(213) 288-7730
Director, Community Programs	Clemens Hong, MD	(626) 525-5705
Director, Human Resources	Marilyn Hawkins	(323) 914-5060
Director, EDIA	Danielle M. Gautt	
Risk Management	Catherine Mathers	(323) 914-6350
Claims & Litigation	General Line	(323) 914-6364
Disability Management & Compliance	Michelle Merino	(323) 914-6365
Employee Relations		(213) 288-7000
Health, Safety & Environmental	General Line	(562) 385-7514
Performance Management		(323) 914-6361 PMU@dhs.lacounty.gov

DHS Human Resources

Human Resources Enterprise Service Center		(213) 288-7000
Administration	Marilyn Hawkins	(213) 288-7000
Classification and Compensation		(213) 288-7000
Payroll Operations & Benefits		(213) 288-7000
Personnel Operations		(213) 288-7000
Recruitment and Examinations		(213) 288-7000
Regulatory Compliance	Sharon Robinson	(213) 288-7000

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER ADMINISTRATION

Chief Executive Officer	Konita Wilks, DDS	(562) 385-7022
-------------------------	-------------------	----------------

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER | 2025 ORIENTATION / REORIENTATION HANDBOOK

Chief Financial Officer	Rocio Calderon	(562) 385-8146
Chief Medical Officer	Barry Jordan, M.D.	(562) 385-7022
Chief Nursing Officer	Michelle Sterling, R.N.	(562) 385-7911
Chief Operating Officer	Ben Ovando	(562) 385-7022
On-Site HR Administrator	Anna Carpena	(562) 385-7311
Primary Care Director	Dennis Wong, M.D.	(562) 385-7952
Specialty Care Director	Ziyad Ayyoub, M.D.	(562) 385-7611
Departmental Institution Officer	Helen Tran, M.D.	(562) 385-7933

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER DEPARTMENTS

Admissions	Jennifer Morrison/ Patricia Soltero Sanchez	(562) 385-7022
Adverse Drug Reaction (ADR)		(562) 385-6050
Audiology	Arturo Villegas	(562) 385-8258
Café Amigos		(562) 385-6152
Call Center	Monique Porter	(562) 385-7357
CART		(562) 385-6800
Case Management		(562) 385-7164
Cashier's Office		(562) 385-7493
Catering		(562) 385-7154
Central Clinic I	Joseph Quinsay, RN	(562) 385-8291
Central Clinic II	Mario Ramirez, RN	(562) 385-8260
Central Clinic III	Wan Hee Cho, RN	(562) 385-6828
Central Clinic IV	Elizabeth Molina, RN	(562) 385-6218
Central Services Processing		(562) 385-7956
Communication Disorders	Wendy Burton, MS, CCC-SLP	(562) 385-7687
Compliance Officer	Benjamin Ovando, Sr., MBA, FACHE	(562) 385-7025
CT Scan		(562) 385-8985
Dentistry	Interim, Amy Nguyen, DDS	(562) 385-7254
Employee Assistance Program (EAP)		(213) 433-7202
Employee Health Services	Leilani Hermosa-Bautista	(562) 385-6843
Environmental Services	Garland Thomas	(562) 385-7291
Facilities Management	Peter J. Teodoro	(562) 385-7291
Finance	Noel Igtanloc	(562) 385-7346

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER | 2025 ORIENTATION / REORIENTATION HANDBOOK

Food and Nutrition	David Yasutake	(562) 385-7151
Foundation	Debbie Arroyo	(562) 385-7053
Health Information Management	Annette Simmons	
Help Desk		(562) 385-4357
HIPAA Privacy Manager	Derek Johnson, MBA	(562) 385-7565
Infection Prevention and Control	Ivan Amameda, RN, BSN, CIC	(562) 385-7447
Information Management Services	Francis Tang	(562) 385-7117
Inpatient Pharmacy	Dao Tang, Pharm. D	(562) 385-7286
Laboratory/Pathology	Daniel Matsuguma	(562) 385-8998
Lactation Room		562-385-7651
Language and Culture Resource Center	Lily Wong, MA, MBA	(562) 385-7428
Linen Service		(562) 385-6575
Mail Room		(562) 385-7858
Medical Administration	Barry D. Jordan, MD, MPH	(562) 385-7161
Medical Imaging	Amelia Bernabe	(562) 385-7535
Medical Library	Robert Kelley	(562) 385-7696
Medicine	Dennis Wong, MD	(562) 385-8060
Neurology	Susan Shaw, MD	(562) 385-7022
Nursing Administration	Michelle Sterling, MFN, ASNS-BC, RN	(562) 385-6886
Nursing Education	Bincy Mathew, RN	(562) 385-7817
Occupational & Recreation Therapy	Bertha Cabral, BS, OTR-L	(562) 385-7464
Outpatient Care Services	Ziyad Ayyoub, MD	(562) 385-6260
Outpatient Pharmacy	Nam Nguyen, Pharm.D.	(562) 385-7236
Pastoral Care		(562) 385-7256
Patient Advocate	Christopher Blakely	(562) 385-7036
Patient Financial Services	Sonia Lopez	(562) 385-7322
Patient Safety Officer	Nina Patel, MD	(562) 385-7611
Pharmacy	Thinh Tran, Pharm.D.	(562) 385-7286
Physical Therapy	Lilli Thompson, PT	(562) 385-7061
Privacy Manager		(562) 385-7565
Psychology	Fernando Gonzalez, Ph.D	(562) 385-8181
Quality Resource Management	Patricia Soltero Sanchez	(562) 385-7022

Rancho Research Institute	Phil Requejo	(562) 385-8111
Recreation Therapy	Christina Webster, RT	(562) 385-6323
Referral Office		(562) 385-6535
Risk Management	Cristina Martinez, RN, BSN	(562) 385-7900
Safety Officer	Justine Dam	(562) 385-6672
Sheriff Department	Sergeant Froilan Dinco	(562) 385-7042
Social Work	Venise Russ	(562) 385-6227
Supply Chain Operations	Sandra Ruiz	(562) 385-7266
Transportation		(562) 385-7858
Ultrasound		(562) 385-7472
Vascular		(562) 385-6772

ADA Information Line	(800) 514-0301
Child Abuse	(800) 540-4000
DHS Compliance	(800) 711-5366
DHS Patient Safety	(213) 288-SAFE (7233)
Elder/Dependent Abuse/Adult Abuse	(877) 477-3646
Fraud (L.A. County)	(800) 544-6861
Intimate (Domestic) Partner Violence	(800) 978-3600
Pharmacy	(562) 385-7234
Poison Control	(800) 411-8080
Safely Surrender Baby (SSB)	(877) 222-9723
Sheriff's Department	(562) 385-7042
Suicide & Crisis Lifeline	988

THIS HANDBOOK IS PROVIDED BY:



County of Los Angeles, Department of Health Services,
Human Resources, Office of Regulatory Compliance
5701 S. Eastern Ave, Suite 400, City of Commerce, CA 90040
Telephone: (213) 288-7000

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

DHS MISSION

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



Board of Supervisors, County of Los Angeles

Hilda L. Solis, First District
Holly J. Mitchell, Second District
Lindsey P. Horvath, Third District
Janice Hahn, Fourth District
Kathryn Barger, Fifth District

COUNTY MISSION

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