Health Services
LOS ANGELES COUNTY

Employee Clinical Risk Management and Patient Safety Handbook

2024

Clinical Risk Management and Patient Safety Program

PREFACE

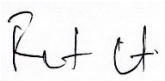
The LA County Department of Health Services Clinical Risk Management and Patient Safety Program is proud to present this year's revised Employee Clinical Risk Management and Patient Safety Handbook. Input for the handbook was received from patient safety officers, clinical risk managers, and other key stakeholders from DHS facilities around the County. The goal of this handbook is to help guide you in your daily practice and serve as a resource for patient safety and clinical risk management issues.

Patient Safety and Clinical Risk Management issues are important to all workforce members (WFMs), whether WFM directly interact with patients, or provide a vital service to support the provision of patients' high quality and safe care. While we are all encouraged to try our best and provide the highest quality service we can, simply trying hard is not enough to prevent accidental harm to patients. Learning the simple techniques described in this handbook can go a long way toward preventing medical errors, patient harm and preventing lawsuits.

Please take a moment to review the content of the handbook each year. If you have questions about how the materials that follow whether it apply to your specific work environment, please feel free to discuss them with your supervisor or patient safety officer. Remember that any identified risks, patient safety suggestions or concerns for unsafe conditions can also be reported using the online Safety Intelligence™ tool.

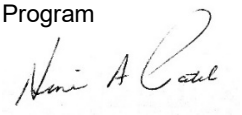
Arun Patel, MD, JD, MBe
Director of Clinical Risk Management, Patient Safety, Grievance and Appeals, and Quality Measures
Department of Health Services

Marife Mendoza, RN, MBA-HCM
Patient Safety Coordinator
DHS Clinical Risk Management and Patient Safety Program



Roberto Avitia, RN, MS, MJ
Clinical Risk Manager
DHS Clinical Risk Management and Patient Safety Program

Allison Luu, MD
Patient Safety Officer
LAC+USC Medical Center



Nina Patel, MD
Patient Safety Officer
Rancho Los Amigos Rehabilitation Center

Maryanne Chumpia, MD
Patient Safety Officer
Harbor-UCLA Medical Center

Bahareh Gordon, MD
Patient Safety Officer
Olive View-UCLA Medical Center

Nickolay Teophilov, MD
DHS Ambulatory Care Network
(includes MLK Jr. Outpatient Center, JCHS, and High Desert Regional Center)

Liz Augusta, RN, MSN
Clinical Risk Manager
DHS Clinical Risk Management and Patient Safety Program

Special thanks to the Department of Health Services Clinical Risk Management and Patient Safety Executive Team Members

DHS Patient Safety Executive Team Members:

Nickolay Teophilov, MD……..……..DHS Ambulatory Care Network

Nina Patel, MD……..…….. Rancho Los Amigos Rehabilitation Center

Maryanne Chumpia, MD……..Harbor UCLA Medical Center

Marife Mendoza, RN, MBA-HCM…….. Clinical Risk Management and Patient Safety Program

Arun Patel, MD, JD, MBe……. Clinical Risk Management and Patient Safety Program

Allison Luu, MD…….. LAC+USC Medical Center

Bahareh Gordon, MD …..……..…...Olive View UCLA Medical Center

DHS Risk Management Members

Liz Augusta, RN, MSN…… Clinical Risk Management and Patient Safety Program

Arun Patel, MD, JD, MBe……. Clinical Risk Management and Patient Safety Program

Roberto Avitia, RN, MS, MJ …….. Clinical Risk Management and Patient Safety Program

Table of Contents

2024 EMPLOYEE CLINICAL RISK MANAGEMENT AND PATIENT SAFETY HANDBOOK LEARNING OBJECTIVES:

Upon completion of this educational material, the reader will be able to:

1) Discuss the concepts and principles surrounding patient safety on the following specific areas: 2024 NPSGs, Communication, Event and/or Risk Reporting, Medication Safety, Transfusion Safety, Infection Prevention and Control, Surgical and Procedural Safety, Restraints, Patient Falls, Transportation Safety, Equipment Safety, Environment Safety, and Other Safety Issues.
2) Enumerate at least two examples of patient safety best practices or recommendations mentioned in the handbook, specific to each of the patient safety areas listed above (#1).
3) Describe the common reasons for litigation in health care.
4) Give at least two actions DHS workforce members can take to prevent complaints, claims, and lawsuits.

INTRODUCTION

Your facility's Clinical Risk Management and Patient Safety Programs work with the Los Angeles County Department of Health Services (DHS) Clinical Risk Management and Patient Safety Program (CRMPS) to provide a coordinated approach to keep our patients free from unjustified risk and preventable injury.

Utilizing the input from multiple information sources, we work to prevent the occurrence of patient harm resulting from lapses in optimal care.

The Clinical Risk Management and Patient Safety Program provides:

- An organizational climate of safety with communication and teamwork as the core operating principles at all levels
- Analysis of service delivery systems to identify system's weaknesses that may lead to a compromise in patient safety
- Recommendations to prevent injury through design and redesign of processes based on established safety principles and the limitations imposed by human factors
- Visibility of errors and risks through a system of reporting of patient safety events which include adverse events, no-harm events, near misses, and hazardous (unsafe) conditions, which are supported by our DHS Just Culture Program
- A process for a coordinated response to hazardous (unsafe) conditions
- Assistance complying with regulatory requirements regarding patient safety (e.g. The Joint Commission (TJC), California Department of Public Health, and other regulatory bodies)
- Assistance with disclosure of adverse events and medical errors to patients and/or families (e.g., CANDOR program)
- Patient safety education for patients, families, and health care providers through various modes of communication

The CRMPS is under the direction and supervision of the Director Clinical Risk Management and Patient Safety. The Director works collaboratively with the Clinical Risk Management and Patient Safety Committees as well as representatives from your facility in the areas of Patient Safety, Administration, Infection Control, Pharmacy, Environmental Health & Safety, Medicine, Nursing, Ancillary Services, and other groups as needed, to coordinate safe patient care and minimize risk. However, every workforce member is encouraged to implement clinical risk management and patient safety principles as well as high reliability strategies in their daily work to keep patients and their families safe and free from harm.

GOALS AND STANDARDS FOR PATIENT SAFETY

Joint Commission Safety Goals and Standards

TJC is an independent accrediting organization whose mission is to continuously improve the safety and quality of care provided to patients. To earn and maintain accreditation, organizations must undergo an extensive on-site review at least once every three years. During these unannounced reviews, organizations are expected to show compliance with TJC National Patient Safety Goals and Standards.

In July 2002, TJC approved its first set of six National Patient Safety Goals, each with their own set of recommendations for compliance. The purpose of the goals is to reduce the risk of adverse events and improve patient safety. TJC has since modified the goals on a periodic basis. The following is a list of the current National Patient Safety Goals for hospitals and ambulatory care

settings. Several previous Safety Goals have been reclassified as Joint Commission Standards, and compliance with them is still required.

Visit TJC's website at https://www.jointcommission.org/standards/national-patient-safety-goals/

2024 National Patient Safety Goals (NPSG) and Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

2024 NPSGs

Goal I

Improve the accuracy off patient identification.

A. Use at least two patient identifiers when providing care, treatment, or services (NPSG.01.01.01)

Goal II – Hospital setting only

Improve the effectiveness of communication among caregivers.

A. Report critical results of test and diagnostic procedures on a timely basis (NPSG.02.03.01)

Goal III

Improve the safety of using medications

A. Label all medications medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings (NPSG.03.04.01)

Note: Medication containers include syringes, medicine cups, and basins

B. Reduce the likelihood of patient harm associated with the use of anticoagulant therapy (NPSG.03.05.01)

Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (e.g., elated to procedures of hospitalization)

C. Maintain and communicate accurate patient medication information (NPSG.03.06.01)

Goal VI - Hospital setting only

Reduce harm associated with clinical alarm systems.

A. Improve the safety of clinical alarm systems (NPSG.06.01.01)

Goal VII

Reduce the risk of health care-associated infections.

A. Comply with either the current Centers for Disease Control Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines (NPSG.07.01.01)

Goal XV

The organization identifies safety risks inherent in its patient populations.

A. Reduce the risk for suicide (NPSG.15.01.01)

Note: Elements of Performance (EPs) 2-7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3-7 apply to all patients who express suicidal ideation during the course of care.

Goal XVI

Improve Health Equity

A. Improving health care equity for the hospital's patients is a quality and safety priority (NPSG 16.01.01)

Universal Protocol (UP)

UP applies to all surgical and nonsurgical invasive procedures. High risk patients are the ones who will be placed under general anesthesia and deep sedation. UP is successfully implemented when there is teamwork and when all team members are empowered to protect patient safety. There are three major components in UP, namely:

A. Conduction of a pre-verification process (UP 01.01.01)
B. Marking the procedure site (UP 01.02.01)
C. Performance of a time-out before the procedure (UP 01.03.01)

DHS developed a standardized Time Out checklist. The DHS Standardized Surgical Final Time Out checklist must be used for each procedure performed in the surgical suite of operating room. In addition to the DHS Surgical Time Out, a pre-sterilization pause may also be required and conducted in the operating room before performing a planned subsequent procedure that involves sterilization regardless of the patient's sex.

The DHS Standardized Non-OR Time Out checklist must be used for any procedures that require an informed consent and is performed at the patient's bedside, any procedural area, and at any outpatient clinical area. All staff and/or surgical/procedural team members must verify all the items that are listed in the checklist before starting a procedure.

To learn more, read policies 321.005 and 321.006. You can also watch the Surgical Final Time Out and Non-OR Time Out videos.

HUMAN FACTORS AND HUMAN PERFORMANCE

The science of "human factors" is the study of "the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work" (WHO Patient Safety Curriculum Guide for Medical Schools, 2008-99).

Human factors play a role in health care everyday—for example, when patients receive incorrect medication or treatment because of look-alike medication names and packaging or when health care staff incorrectly identify a patient because she or he has the same or similar sounding or looking name as someone else. Since we cannot eliminate human fallibility, it is important to act promptly and effectively to limit the risks. To do this, there may be a need to redesign current processes and organize the system/workflow in order to eliminate, if not minimize, the likelihood of errors and impact of errors when they occur. "Human factors" is about understanding the human limitations, workplace design, and equipment that staff use at work which should allow for variability in human performance.

A failure to apply human factors principles is a key aspect of most adverse events in health care. It is important for all health care providers to be mindful of situations that increase the likelihood of errors for human beings in any situation. Studies show that fatigue and stress are the two major factors that impact human performance the most and predispose a person to error. In addition, fatigue, stress, and performance deterioration are known risk factors to patient safety. High stress and fatigue are both something that everyone can relate to in health care at the time. Low levels of stress are also counterproductive, as this can lead to boredom and failure to attend to a task with appropriate vigilance. Other factors that are known to cause errors are sleep loss,

illness, anxiety, interpersonal relations, interruptions, noise, visual stimuli, distractions, lighting, device design, training shortfalls, improper maintenance, support system failure, equipment misuse, tampering & sabotage (abuse errors), and differing situational awareness (the degree of accuracy by which one's perception mirrors reality). To limit the potential of committing errors in the workplace, the following suggestions and strategies are highly recommended for all workforce members and the organization:

1) Avoid reliance on your memory (e.g., use checklists, protocols, color-matching, pre-packaging, automated reminders)
2) Manage fatigue
3) Make things visible (e.g., use of pictorial reminders to staff & patients about handwashing)
4) Standardize common processes and procedures (e.g., have a standardized way of doing surgical and non-OR time out, end of shift handoff report)
5) Simplify tasks and processes (e.g., make handoff simpler by implementing communications strategies that are fewer in number but clearer in purpose)
6) Reduce handoffs
7) Reduce the need for calculation (e.g., calculators, double blind checks, automation and artificial intelligence)
8) Decrease reliance on vigilance (e.g., bar-coding, constraints, forced functions-automatic shutoff of warming devices)
9) Provide for reversibility or automatic correction
10) Plan for recovery when prevention fails
11) Provide/utilize adequate training
12) Provide adequate informational resources

DHS JUST CULTURE

DHS strives to build, maintain, and support a Just Culture work environment, one in which accountability is fairly balanced between systems of organization and the workforce members (WFM). It is a work environment that encourages and empowers workforce members to improve the quality of care and service delivery across DHS facilities.

To successfully achieve in building and sustaining a Just Culture work environment, it is important for every workforce member to bring awareness, knowledge, and practical application of Just Culture concepts and principles, for example, one must:

1) Acknowledge that human error is an inevitable product of human activity
2) Work to prevent undesired and unintended outcomes by evaluating every event in an objective, thorough, and impartial manner to identify and define system and human contributors, and responding to them in a way that balances system and individual accountability and avoids inappropriate blame & punishment
3) Incorporate fairness and balanced accountability in the daily activities
4) Empower and promote workforce members to recognize and communicate system characteristics and human behaviors predictably which may be associated with unintended outcomes

Further, a work environment with Just Culture is one where a culture of safety is highly recognized and is an individual and organizational priority. It promotes open and honest reporting of risks, errors, near misses, adverse events, and safety or quality concerns. These reports are viewed as an opportunity to learn as a health care provider and as a health system. It is also one way to improve our healthcare system's delivery of care.

The workforce member will not carry the burden for system flaws over which they have no control. The DHS Just Culture System and Behaviors Response Guide, Just Culture User Guide, Just Culture Worksheet, and Just Culture Contributor Map, are just culture tools developed to assist leadership and management in determining the system and organizational contributors as well as underlying human error or behavior associated with the unintended outcome. It also offers guidance on the appropriate response/s applicable to the situation.

Please see DHS Just Culture Policy and DHS Just Culture Sharepoint site for more information and details. There are also Just Culture training materials available via Cornerstone. For any questions regarding the DHS Just Culture Program, please contact your facility Just Culture lead or email us at justculture@dhs.lacounty.gov

SECOND VICTIM

Defining Second Victim

The term "second victim" was first described by Dr. Albert Wu who wrote an article about the phenomenon that he observed his residency classmate going through following a medical error. The idea is that the patient and their family are the "first victims" of unanticipated clinical events but the staff who take care of the patient are also profoundly affected both professionally and personally and are thus the "second victims." Dr. Sue Scott is another pioneer in "second victim" and she defines it as:

Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimize in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.

History of Second Victim Programs

After Dr. Wu brought attention to the suffering of his residency classmate, multiple other anecdotes were published in the literature surrounding staff feelings of guilt, incompetence or inadequacy. Dr. Scott noticed the psychological and emotional suffering in providers during patient safety event investigations at University of Missouri Health Care System (UMHC). She put together a research team to investigate second victim prevalence at UMHC. Through her work, Dr. Scott found that 1 in 7 staff members reported symptoms of second victimization within past year and 68% of them did not receive institutional support. They followed up with a qualitative study to better describe the experience and identified six stages of predictable recovery trajectory. Dr. Scott and her team built a robust for YOU Team and UMHC that provides staff support to those suffering from second victimization. Multiple other second victim programs have sprung up throughout the United States but the broad acceptance of second victim phenomenon and investment in staff support programs has been slow.

Stage of Recovery from Second Victimization

There are six stages of second victim recovery process as described by Dr. Scott and her team:

Stage 1: Chaos and accident response

Stage 2: Intrusive reflections

Stage 3: Restoring personal integrity

Stage 4: Enduring the inquisition

Stage 5: Obtaining emotional first aid

Stage 6: Moving on: dropping out, surviving or thriving

Second Victim Programs
The general goals of a second victim program are to increase awareness of second victim phenomenon and the support program, normalize the human response to events, and talking about the emotional and psychological response, destigmatize seeking help, provide resiliency training, peer support, and referral to available psychology/psychiatry/social-work/spiritual resources.

Sorry Works!
Sorry Works! is a phrase coined by Doug Wojcieszac to describe early disclosure and apology by providers when a medical error occurs. This has been found to decrease malpractice claims and lead to improved learning cultures. DHS strives for early disclosure and resolution in order to allow for second victims to heal and the organization to learn and grown from adverse events.

Resources Available to DHS Staff
Since 2017, DHS has created a second victim program called Helping Healers Heal or H3. The H3 initiative began at LAC+USC Medical Center and has now spread to Olive View UCLA Medical Center Harbor UCLA Medical Center. Rancho Los Amigos Medical Center Correctional Health Services, and the Ambulatory Care Network are just starting their H3 program now. If you feel that you or a colleague are suffering from second victimization, the existing resources available to you are:

All DHS Employees
- Employee Assistance Program (EAP): 213-738-4200
- Department of Mental Health (DMH) Access Hotline: 800-854-7771
- 24-Hour Suicide Prevention Center (877) 727-4747
- National Suicide Prevention Lifeline: 800-273-8255
- National Suicide Prevention Lifeline: 800-273-8255 or 988

LAC+USC Specific Resources:
- Helping Healers Heal (H3team@dhs.lacounty.gov)

LAC+USC Employees:

- USC Center for Work & Family Life: 213-821-0800 (Faculty and Staff)
- Eric Cohen Student Health Center: (USC Students) 213-740-WELL (9355)

Harbor UCLA Specific Resources:
- Helping Healers Heal (HarborH3Team@dhs.lacounty.gov)

Olive-View UCLA Specific Resources:
- Helping Healers Heal (H3TeamOVMC@dhs.lacounty.gov)

Tier 3 Escalation Contacts:
Referrals will be determined on an individual basis after meeting with a peer supporter with the assistance of Social Work

- **For UCLA Faculty:**

  UCLA Staff and Faculty Counseling Center (SFCC)

The SFCC is an employee assistance program for UCLA staff and faculty members and families. It offers short-term professional counseling as well information and referrals to practitioners, agencies and programs. The SFCC's services are strictly confidential. (310) 794-0245

UCLA's SFCC fosters a productive and supportive work environment for all employees. Discover the wide range of services available, such as confidential counseling for employees and their family members, management consultation, coaching, training, retreat facilitation, work-life programs, support groups and community resource referrals.

https://www.chr.ucla.edu/employee-counseling

Employee Counseling - UCLA Human Resources

www.chr.ucla.edu

- **For Olive View and UCLA Residents and Students:**

  UCLA Counseling and Psychological Services
  John Wooden Center West
  221 Westwood Plaza Box 951556
  Los Angeles, CA 90095-1556
  (310) 825-0768 (24/7 hours)
  http://www.counseling.ucla.edu/

Rancho Los Amigos Specific Resources:

- Helping Healers Heal (RanchoH3@dhs.lacounty.gov)
- Psychology: (562) 385-8181
- Social Work: (562) 385-7867

Correctional Health Services:

- Helping Healers Heal: MSBCHSC3PeerSupporters@lasd.org

Other National Resources:

- Crisis Text Line (24 hours): Text 741-741 from anywhere in the USA, anytime, about any type of crisis.
- National Suicide Prevention Lifeline Confidential Line (800) 273-TALK (8255) Text: START to 741-741
  www.crisistextline.org
- Compassion Fatigue Awareness Project
  Website for caregivers suffering from compassion fatigue
  http://www.compassionfatigue.org/
  http://www.healthycaregiving.com/
- Center for Patient Safety
  http://www.centerforpatientsafety.org/second-victims/
- University of Missouri for YOU Team
  https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou
- Black Bile

Website for physicians suffering from depression
http://www.black-bile.com/index.html

It is imperative that you immediately seek psychiatric emergency services for yourself or a peer who is having suicidal ideation. Either go directly to the nearest Emergency Department or call 9-1-1.

REPORTING OF EVENTS AND NEAR MISSES

Reporting adverse events, errors, and near misses is the responsibility of all DHS WFMs. The purpose of reporting is to allow designated staff to begin investigating and mitigating harm from an event, to alert others to potentially adverse events so that future injuries are avoided, and to identify opportunities for improvement. Your facility depends on information reported by all members of your worksite team to make your facility safer.

Patient Safety Risks and Events

To become a highly reliable organization, it is critical that facilities identify and understand safety risks, manage the human behaviors that may contribute to event occurrence, and sustain any implemented safety initiatives. Safety risks that may lead to a patient safety event are related to one, or a combination of these contributor types:

- System (i.e., a mechanical or software breakdown or malfunction, a false alarm, an ineffective process or procedure, etc.)
- Human (i.e., individual's lack of knowledge, skills, or abilities, human behavior, an act of commission or omission)
- Organization (composed of system and people – i.e., culture influences, competing priorities, leadership decisions affecting resources, etc.)

Patient Safety events include adverse events, no-harm events, near misses, and hazardous (unsafe) conditions.

- An adverse event is a patient safety event that resulted in harm to a patient
- A no-harm event is a patient safety event that reaches the patient but does not cause harm
- A near miss (or "close call" or "good catch") is a patient safety event that did not reach the patient.
- A hazardous (or "unsafe") condition is a circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event

Patient safety events may or may not be related to an error. An error is inadvertently doing something other than what should have been done; for example: a slip, lapse, or mistake.

Every WFM is expected to proactively report safety risks and patient safety events (of any type) via the Safety Intelligence (SI) event reporting tool, directly to a supervisor/manager, facility patient safety officer, and/or, to any member of the leadership or management team. The Clinical Risk Manager or Medical Director may then decide if the event meets criteria for a CDPH reportable event, Joint Commission Sentinel Event or other significant event that requires reporting or further investigation.

Sentinel Events

A Joint Commission Sentinel Event is 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, permanent harm, or severe temporary harm and intervention required to sustain life. The events are considered "sentinel" because they signal a need for immediate investigation and response.

Joint Commission Sentinel Events include:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department Unanticipated death of a full-term infant
- Homicide of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Any intrapartum maternal death
- Severe maternal morbidity (leading to permanent harm or severe harm)
- Sexual abuse/assault of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Sexual abuse/assault of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Physical assault (leading to death, permanent harm, or severe harm) of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or magnitude of the outcome
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm, or severe harm to the patient
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in death, permanent harm, or server harm
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin > 30mg/dl)

For more information about sentinel events, read TJC's Sentinel Event Policy and Procedures.

California Department of Public Health (CDPH) Reportable Events

In 1999, the Institute of Medicine's report, *To Err is Human*, raised the public's awareness regarding safety problems within healthcare organizations. Their report recommended the

establishment of mandatory reporting systems for state governments to collect information about adverse events that result in death and serious harm.

The list of adverse events that must be reported to the CDPH include:

Surgical Events

- Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
- Surgery performed on the wrong patient.
- The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
- Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
- Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

- Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
- 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. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

- An infant discharge to the wrong person.
- Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
- A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

Care Management Events

- A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
- Patient death or serious disability associated with a hemolytic transfusion reaction due to administration of ABO-incompatible blood or blood products.
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
- Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
- Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
- A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
- Patient death or serious disability due to spinal manipulative therapy performed at the health facility.

Environmental Events

- A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
- A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
- A patient death associated with a fall while being cared for in a health facility.
- A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

Criminal Events

- Any instance of care ordered or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
- The abduction of a patient of any age.
- The sexual assault on a patient within or on the grounds of a health facility.
- The death or significant injury of a patient of staff member from a physical assault that occurs within or on the grounds of a health facility.

Other Events

- An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel or visitor.

CDPH must be notified of an adverse event within five days after it has been detected or within 24 hours after it has been detected if it involves the sexual assault of a patient, including allegations of sexual assault of a patient, or is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors. Your facility Clinical Risk Manager or Administrator will make these reports to CDPH on behalf of your hospital or ambulatory surgery center. CDPH may conduct an on-site inspection and investigation of these reported events.

Other Reporting Situations

In addition to the adverse events noted above, CDPH also requires facilities to report unusual occurrences including: Any discontinuation or disruption of services; the threat of a walkout of a substantial number of employees; an earthquake, fire, power outage, or other calamity that cause damage to the facility or threatens the safety or welfare of patients or clients; or an epidemic outbreak, poisoning, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel, or visitors.

In addition to reporting in the SI event reporting tool, LACDHS WFMs who are considered healthcare providers are required by the California Welfare and Institutions Code to report any known or suspected instances of abuse to protective agencies immediately. Abuse must be reported for all cases involving children, domestic partners, and dependent adults to Social Services and when appropriate, to County Police. Penalties for not complying with these regulations may include possible jail time and/or monetary fines.

Workplace Violence

All workforce members, whether full-time, part-time, or contracted, are entitled to a safe work environment. To help protect workers from violence, LACDHS has developed both a “zero tolerance” policy (LACDHS Policy #792) and (LACDHS Policy #902.000). Threats, threatening behavior, or acts of violence against workforce members, patients, visitors or other individual by anyone on County property or anywhere a workforce member is engaged in County-related business, are prohibited. Any workforce member receiving a threat or involved in a violent episode – with-or-without injury – must report the occurrence immediately to the supervisor/ manager, facility’s law enforcement officer, and file an event notification in SI.

Completing an Event and/or Safety Risk Report

When reporting a patient safety risk or event in the SI event reporting tool, all mandatory fields noted in red must be completed. However, WFMs are strongly encouraged to add any additional specific details about the event that may not be included in the patient’s chart. The reports should be objective, factual, and thorough. The SI report will be routed to the appropriate people for follow-up once the report is submitted.
Event notifications cannot be used in litigation against the County as long as certain steps are taken to maintain protection and confidentiality. These include not printing, copying, or sharing

electronic copies of the report unless authorized to do so; not documenting that a report was completed in the medical record; and not telling the patient or their representative that an event report was filed.

Click here to report safety risks, a near miss, or an event in SI.

Other Venues for Reporting Safety of Quality of Care Concerns

Any WFM who has concerns about the safety or quality of care provided in the health care setting may report these concerns by email at patientsafety@dhs.lacounty.gov. WFMs may also report concerns directly to TJC via the internet at www.jointcommission.org or by phone at (800) 994-6610. Workforce members will not be punished or retaliated against for reporting safety risks, adverse events, errors, close calls, or safety or quality concerns.

Managing the Event

When a patient safety event occurs, it is important to manage the event properly. The following actions should be taken:

- Provide any immediate care needed by the patient.
- Save any 'evidence' such as medications, equipment, device packaging, photographs, diagnostic imaging, monitoring strips (fetal, EKG, etc.), staffing assignment sheets, patient logs, etc.
- Report the event via the SI event reporting tool. Reminder: do not document any references to the SI event report in the medical record.
- Consult with your supervisor or facility Clinical Risk Manager for advice and coordination in disclosing the event with the patient or family (see Communications of Unanticipated Outcomes below).
- Document facts about the event clearly, factually, and objectively in the medial record. Do not document opinions about what might have happened, or discussions with the Clinical Risk Managers in the medical record.

Analysis of the Event

- A Root Cause Analysis (RCA) is a process that many health care systems, including DHS, use to determine how and why errors, adverse events, close calls, and/or unintended outcomes occur. The RCA process is usually conducted by a multidisciplinary team which may include: the individuals who were affected by the event; frontline staff who were involved in or witnessed the event; experts in the subject area being reviewed and analyzed; and, facility leadership. The team is tasked with finding out what happened, why it happened, and how to prevent it from happening again. The RCA process is based on the culture of safety which focuses on prevention rather than punishment. The RCA team investigates how well patient care systems function – essentially determining and focusing on the "how" and the "why" not on the "who". The team analyzes the sequence of events leading to the adverse event, unintended outcome, or unsafe condition. The RCA may include a review of the medical record, participant interviews, and analysis of workflows, policies, and best practices. Once the underlying and contributing causes are identified, the RCA team determines if there are any opportunities for improvement in processes and/or systems that would prevent future reoccurrence. DHS facilities will

often share the results of their RCAs at a central level to identify and implement sustainable system-level solutions.

COMMUNICATION

Communication breakdown is a significant root cause of medical errors and near misses that threaten a patient's safety. TJC has cited communication failures as the leading cause for medication errors, delays in treatment, and wrong-site surgeries. It is also the second most frequently cited root cause for operative and postoperative events and fatal falls. The prevention of errors requires effective communication between you, your patients, and the staff that you work with.

Communication of Unanticipated Outcomes

An unanticipated outcome is one that differs significantly from that which was anticipated; it can be negative or positive. These outcomes do not necessarily occur as the result of substandard care, error, or negligence. They may occur even when the standard of care has been met.

DHS recognizes that effective communication with patients and their families is the first step to involving patients as active members of their healthcare team. Effective communication and providing accurate information about any unanticipated outcome assist all in making important healthcare decisions. In addition, TJC requires that patients and, when appropriate, their families, are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes. When you become aware of any unanticipated outcomes, you are advised to:

- Talk with your supervisor and develop a communication plan before speaking about the unanticipated outcome with the patient/family members
- Be prepared to participate in the analysis of the event, which may include a root cause(s) analysis (RCA) to help identify the cause(s) of the unanticipated outcome and develop corrective actions to prevent the event from happening again
- Be aware that unanticipated outcomes may also adversely affect the employees involved, also known as Second Victimization (see Second Victim section). Employees' well-being directly affects the safety of their patients. The County of Los Angeles Employee Assistance Program (EAP) is available to confidentially help employees dealing with difficult job situations. EAP is accessible at: (213) 738-4200 or online at http://employee.hr.lacounty.gov/employee-assistance-program/

For additional information on the process and policy for communication of unanticipated outcomes, see DHS Policy 311.201.

Medical Record

The primary function of the medical record is to communicate to members of the healthcare team the needs and plans for the patient as well as the patient's response to treatments. A complete and accurate medical record also:

- Ensures that the health care facility complies with accreditation and licensure standards;
- Prevents payers from refusing to pay claims based on poor record keeping; and

- Prevents the assumption of liability in malpractice cases on the basis that the record is missing key documentation.

AHRQ – Approach to improving patient safety: Communication - Approach to Improving Patient Safety: Communication | PSNet (ahrq.gov)

Patients have the legal right to view the information contained within their medical record. With the appropriate authorization, patients may also obtain a copy of the medical record. The only persons authorized to examine a patient's medical record are, with few exceptions, the patient and the health care team responsible for the care of the patient. Friends, family members, and others are prohibited access to a patient's medical record unless specifically authorized by the patient. Because the medical record is a legal document owned by the County of Los Angeles, it is important to ensure completeness and integrity in any documentation. The medical record reflects a recording of factual, assessment pertinent to the patient. The medical record is not an appropriate place to document frustration with other health care team members or to speculate as to someone else's involvement in a particular event.

Additionally, in order to engage patients in their care and support transparent communication, patients have access to their medical record through the patient portal. This includes labs, imaging studies, almost all physician notes and reports, and microbiology reports. Clinicians should be aware that these results are immediately available to patients at the same time they are available to clinicians. Although clinical staff should make every effort to review and address results in a timely fashion, the possibility exists that patients may encounter a result before a clinician has had the opportunity to review and communicate the results to the patient.

Mistakes made during documentation are inevitable, however; inaccurate, incomplete, illegible or altered medical records may reflect negatively on the writer's credibility. In addition, making entries that are untruthful, intended to conceal facts, or documented before care has been provided, is considered to be falsification of the medical record. As a general rule, medical record documentation should follow the guidelines below:

- Dates, times, and signatures (electronic or printed), are required at the time each entry is made
- Late entries (notes that are recorded out of time sequence with existing notes) must be designated as a "late entry"
- Documentation of conversations with patients over the phone should include who initiated the call, the nature of the call, and any instructions of advice provided
- Entries should be factual and avoid placing blame on other providers. Notes written by residents and interns must reflect attending supervision. Residents and interns should document "discussed with attending or chief resident" to demonstrate supervision. In some cases, notes must be co-signed by the attending or chief resident. See DHS Policy 310.2, for more information about documenting the supervision of residents

Communicating with Staff/Team

The receipt, documentation, and timely communication of critical results of tests and diagnostic procedure reports to the responsible licensed provider of care is an important component of patient safety. Communicating these abnormal results within an established timeframe may help to prevent life-threatening situations. DHS recommends that any test results or orders that are received, verbally/telephone, are written down, read back, and verified. Two patient identifiers should be used to correctly identify the patient prior to receiving this information. In certain situations, such as during a Code or in the operating room, it may not be possible to do a formal "read-back". In such cases, "repeat-back" is acceptable. Check with your facility for the proper process and timeframe required for documenting critical results and verbal/telephone orders.

TJC has recommended specific measures to improve communication between staff including reducing the use of verbal orders, requiring a "read-back" of verbal orders and critical test results, using a standardized approach to communicate with other staff, and performing face-to-face handoff communication with changing shifts.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, dictates that confidential patient information should only be shared with healthcare providers who need the sensitive information for their job functions. Staff must take extra caution not to discuss a patient's care with someone other than a healthcare provider or insurance company without a patient's consent. Many lawsuits have come from casual conversations between providers about a particular patient that has been overheard by a friend or relative of the patient. There are exemptions for law enforcement with mandatory reportable crimes and when public safety is at risk. These exemptions can be found on the US Department of Human Health Services website.

Unauthorized access, use, and/or disclosure of PHI, or the failure to maintain and safeguard PHI may lead to disciplinary action and fines. Workforce members are expected to comply with these regulations by performing simple actions such as logging off computers when finished and discussing a patient's care plan in a private location. See the LACDHS Policies #361.1 – 361.9 for additional information about ensuring confidentiality with PHI.

TeamSTEPPS

What is TeamSTEPPS?

TeamSTEPPS, an evidence-based patient safety curriculum grounded in teamwork and communication, designed by the Department of Defense, for health care professionals. Communication and teamwork are essential for providing quality and safe health care.

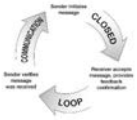
What are the four pillars in TeamSTEPPS?

1. Communication
2. Leadership
3. Situation Monitoring
4. Mutual Support

What are the communication tools used in TeamSTEPPS?

1. **SBAR**: provides a standardized framework for members of the health care team to communicate about a patient's condition
    a. Situation – What is happening with the patient?
    b. Background – What is the clinical background?
    c. Assessment – What do I think the program is?
    d. Recommendation – What would I recommend?
2. **Call-out**: communicates critical information during an emergent event, where information is vocalized by one team member, for the benefit of other team members. Also referred to as "thinking out loud".
3. **Check-Back**: Closed-loop communication used to verify a request is received. Sender initiates request or message, receiver confirms they have received the request

Handoff: Enhances information exchange at critical times such as transitions in care. (i.e., shift change, patient transfer).

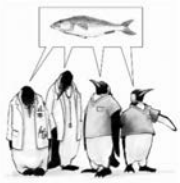


What is effective team leadership?

Team leaders are well-informed team members who make decisions and take actions. Team leaders establish the goals of the team and help maintain its focus. Three strategies that team leaders can use to facilitate these activities and promote teamwork are:

1. Briefs: A strategy for sharing the plan when leading a team. Defining clear goals and a plan to achieve those goals is an important part of the brief as well as establishing clear roles and expectations for each team member.
2. Huddles: Ad hoc, "touch-base" meetings to regain situational awareness.
3. Debriefs: A brief (< 3 minutes) team event, typically initiated and facilitated by the team leader after a clinical event.

What is Situation monitoring?



Ensures new or changing information is identified for communication and decision-making. Situational awareness leads to a "Shared Mental Model".

Shared Mental Model is the perception of, understanding of, or knowledge about a situation or process that is shared among team members through communication.

What is Mutual Support?

Mutual support or "backup behavior," is derived from situation monitoring through the ability to anticipate patient and/or staff needs and subsequently provide support.

One method of providing mutual support is through **task assistance**. This includes both asking for assistance when needed and helping team members when the opportunity arises.

Another strategy used to facilitate mutual support is **advocacy and assertion**. Advocacy and assertion interventions are invoked when a team member's viewpoint does not coincide with that of a decision maker. In advocating for the patient and asserting a corrective action, the team member has an opportunity to correct errors and intervene when patient safety is vulnerable Failure to use advocacy and assertion has been frequently identified as a primary contributor to the clinical errors found in malpractice cases and sentinel events.

Two Challenge Rule:

One strategy to facilitate team members' speaking up is the Two-Challenge Rule. It is important to voice your concern by advocating and asserting your statement at least twice if the initial assertion is ignored (thus the name, "Two-Challenge Rule"). These two attempts may come from the same person or two different team members.

- The first challenge should be in the form of a question
- The second challenges should provide some support for your concern

CUS:

The CUS technique is another tool for conflict resolution, advocacy, and mutual support. *I am **C**oncerned. I am **U**ncomfortable. This is a **S**afety issue.*

Source: TeamSTEPPS 2.0. Content last reviewed November 2023. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/teamstepps/instructor/fundamentals/index.html

EXECUTIVE SAFETY BRIEFING AND UNIT BRIEFING/HUDDLE

Background

Safety briefings have been used as a critical tool in aviation and other industries where safety is incorporated into the daily routine. Going back to the seminal publication, The Institute of Medicine's "To Err is Human", they discuss how the military uses briefings before missions and debriefings after. This concept of having the critical team members gather together to plan during a brief and once again after the event or shift to debrief how things went, learn, and discuss how to improve next time is not groundbreaking or new in the military and other industries. Healthcare has been slow to adopt these simple communications and learning tools. TeamSTEPPS dedicates an entire module (Leadership) to briefs, huddles, and debriefs. They define the brief as a planned meeting before an event or shift that is dedicated to planning. Huddles are touch base or ad hoc meetings when conditions have changed, and the team needs to adjust the plan. Debriefs are meetings after an event or shift with the purpose of discussing what went well, what didn't go well, and how the team can do better next time.

The Institute for Healthcare Improvement (IHI) tested safety briefings in patient care units in hundreds of health care organizations using their Model for Improvement framework. The lessons learned included:

- Safety briefings must be non-punitive
- Safety briefings must be brief
- Identify in advance a list of safety issues for discussion
- Safety briefings must be easy to use
- Safety briefings must be applicable to all patient safety issues

Many healthcare organizations do the executive safety briefing and unit level huddles well and they include Cincinnati Children's Hospital and Downey Kaiser Permanente Medical Center.

Executive Safety and Operational Briefing

The primary purpose of an executive safety and operational briefing is to promote situational awareness, teamwork, collaboration, effective communication, and "timely" resolution of operational, risk, and patient safety issues. It is a scheduled, usually daily meeting where hospital executives and representatives from each unit and department come together to discuss a set safety agenda. It is critical that the briefing is brief, no more than 10-15 minutes. A checklist ensures that all topics are covered and keeps the team members on track. Often, Operations and Safety topics are combined into one briefing. The communication at the briefing should flow two ways, information about events and patients at risk flowing from the frontline up to leadership and goals, strategies, and unusual circumstances being communicated from leadership to managers to be disseminated to frontline staff. Additionally, bringing all units and departments together allows for immediate communication, collaboration, and resolution of issues.

The DHS Patient Safety Program standardized Daily Operations and Safety Executive Briefing (DOSE) includes but not limited to the following items:

- Green/red for each unit or department
- Last Never 28 Event

- Last staff workplace injury
- Last patient fall with harm
- Last Stage 3, 4, or unstageable HAPU
- Physical plant problems
- Shout outs (days since last harm event, other recognition)
- Infection Prevention
- Days since last CLABSI
- Days since last CAUTI
- Patient Safety Tip of the Week
- Good Catch Award (Employee recognition for catching a near miss (preventing patient harm)
- Open Agenda (questions, concerns, lessons shared)

Unit Briefing/Huddle

The unit briefing or huddle is a critical tool to ensure that important patient safety information is communicated to the frontline staff. Ideally, after a unit or department representative attends the DOSE briefing, the information and decisions made during the brief need to be communicated to the rest of the unit or department by that representative. The unit representative is often the charge nurse, lead nurse, director, service chief, or attending of the day. Unit briefings/huddles should be regularly scheduled, at a convenient location for staff members to attend, structured with a standing agenda as well as provide time for open questions/concerns, and most importantly – should be brief. Holding unit briefs/huddles around a white board allows for visual reinforcement and brainstorming. Aside from sharing the information discussed from the executive safety and operational brief, a unit brief/huddle agenda items should also include but not limited to:

- Unit census
- Staffing levels
- Specific patients on fall risk precautions
- Central line (necessity, maintenance)
- Foley catheters (necessity, maintenance)
- Patients on ventilators
- Patients in restraints patients in isolation
- Patients with or at risk of developing healthcare associated pressure injuries

The unit briefs/huddles can be led by any workforce member. It is encouraged that the person leading them rotate so that frontline staff are actively engaged, building skills, and gaining confidence in being patient safety advocates. Any issues, lessons learned, or questions that arise from a unit brief/huddle should be communicated back up to leadership through the next executive safety and operational briefing or immediately if it is a serious patient safety risk and/or issue.

Behavior that Undermines the Culture of Safety

A safety culture operates effectively when the organization fosters a cycle of trust, event reporting, and improvement efforts. A safe and highly reliable patient care delivery system requires all workforce members at all levels to work together as a team, collaborate, and communicate effectively. Behaviors that undermine the culture of safety disrupt collaboration, communication, and teamwork. These behaviors are manifested in many forms like the use of inappropriate words

(i.e., profane, insulting, intimidating, demeaning, humiliating, or abusive language) when talking to a coworker, shaming others for negative outcomes, unjustified negative comments or complaints about another provider's care, refusal to comply with known and generally accepted practice standards, refusal to collaborate or cooperate with other team members, creating rigid or inflexible barriers to request for assistance or cooperation, and not returning pages or calls promptly. DHS does not tolerate any of these behaviors and has published a Code of Conduct and DHS Policy 747.300 to provide clear guidelines and expectations for workforce member's conduct in the workplace. For more information, read TJC's Sentinels Event Alert Issue #40.

Further, DHS is focused on continually achieving and improving a work environment with a culture of safety across DHS facilities. In an effort to monitor and trend results on DHS safety culture, a patient safety culture survey is conducted every two years across DHS facilities. The survey results are reviewed, analyzed, and presented to the DHS executives and facilities' leadership. Opportunities for safety culture improvement are identified and various strategies are implemented specific to work areas that needed attention.

Communicating with Patients

Studies have shown that most of the lay public does not understand the details of providing medical care. They do, however, have some ideas about how that care should be given. Most would like information about their particular condition and treatment in a manner that they can understand. Communicating this information to your patients is one of your most important roles. Patients judge a health care practitioner's competency by their ability to be compassionate and caring. Studies have shown that many health care providers are sued by their patients not because of their level of technical skill, but because of their perceived attitude toward the patient. It is important, therefore, to maintain a caring and compassionate attitude, to treat patients with dignity, and to answer their questions in language they understand while empowering them to participate in their care. When communicating with patients, providers should also be aware of other people in the vicinity who may overhear conversations. Sensitive information (like HIV results) must be relayed in private.

Communication is also affected by language barriers, limited health literacy, and cultural diversity. Health literacy is defined as the "capacity of an individual to obtain, interpret, and understand basic health information, products and services, and the competence to use such information and services in ways which are health enhancing". Effective communication is critical to the successful delivery of health care services. It is estimated that there are more than 300 languages spoken in the United States and more than 90 million Americans have low health literacy, meaning these individuals with have difficulty understanding and using health information. Only 12% of U.S. adults have the health literacy skills needed to manage the demands of our complex health care system, and even with these individuals their ability to absorb and use health information can be compromised by stress and illness.

To learn more about health literacy, please see "Health Literacy Universal Precaution Toolkit, 2nd edition" by the US Agency for Healthcare Research, "Quality and National Partnership for Action to End Health Disparities Toolkit: Toolkit for Community Action" by the Department of Health and Human Services, and Title VI of the 1964 Civil Rights Act Executive Order 13166 which mandates any organization to provide Limited English Proficiency (LEP) patients with meaningful access to interpretation services and other LEP activities.

TJC advocates for patient-centered communication and health equity across the patient's continuum of care regardless of the patient's and their families' race, color, ethnicity, age, gender, sexual orientation, and religious and cultural beliefs. TJC also urges hospitals to create a welcoming health environment with improved health care quality for lesbian, gay, bisexual, and transgender (LGBT) patients and their families which continue helping the other patients and their families while continue helping the other patient groups with developmental delays, vision and hearing impairments, limited language skills, and religious issues.

For more information about communication standards, review TJC's R3 (Requirement, Rationale, Reference) on Patient-centered communication standards for hospitals and Roadmap for Hospitals and Patient- and Family Centered Care communication Standards for Hospitals.

Patient Engagement and Patient Education

According to the Agency for Healthcare Research and Quality (AHRQ), patient engagement means "the patient's involvement in their own care be individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and health care and take actions to support those decisions".

A patient with greater engagement in healthcare contributes to improved health outcomes, better satisfaction, and incur lower costs. To better engage your patient, you must educate your patient about his/her medical conditions and ensure to involve your patient more in making healthcare informed decisions.

Below are strategies where you can promote effective communication and education with your patient:

1) Teach back method-ask your patient to tell you in his/her own words what you had just discussed with him/her to ensure his/her full understanding on the verbal health teachings/instructions given
2) Show me approach – ask your patient to demonstrate the desired skill (i.e., checking a blood sugar or using an asthma inhaler) to ensure your patient has the desired technical competency
3) AskMe3program – encourage your patient to ask the following 3 questions in every medical encounter
    - What is my main problem?
    - What do I need to do?
    - Why is it important for me to do this?

In addition, remind patients to bring a family member or friend with them to their medical encounters. This strategy improves the education process as patients who are ill, under stress, and potentially overwhelmed with their healthcare encounter are unlikely to retain information well. Advise patients to bring a list of their health concerns and medications (they are currently taking; preferably in their original bottles) during their visit. Whiteboards in patient rooms have also been shown to be an effective way for workforce members and patients to communicate key information and questions to each other. Encourage patients to write down questions and concerns as they think of them on the whiteboard to ensure they are conveyed to their healthcare providers.

The DHS Patient Safety Committee has developed various patient safety education information in multiple languages. This information is accessible via DHS Patient Safety Sharepoint® website under Patient Resources.

Language Access Services

What You Need To Know

- Majority of our patient encounters are with patients who have a preferred language, other than English (OLAI 2022 by the Numbers.pdf).
- Patients and families have a right to receive care in their preferred language.
- LA Health Services, and this site, 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)

See section below to learn how to access these services at LA General

Language Services Requirements

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

Qualified Interpretation Services, as well as Written Translation, and other Effective Communication Services are provided at no cost, accurately, timely, and protect the privacy of the individuals.

Review DHS Policies on Language Access below:

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

Accessing Qualified Language Services

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

In general:

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

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

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

Important Information About Friends and Family Serving as Interpreters
A patient may not be asked to bring their own interpreter. With the exception of medical emergencies until a qualified interpreter is available:

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

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

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

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

Language Access Laws and References

Los Angeles Health Services complies with applicable federal civil rights and regulatory requirements.

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

Department of Health Services

Office of Language Access and Inclusion (OLAI)

CY 2022 by the Numbers

1.3M Patient Visits
Non-English Preferred Language

57K
Face-to-Face Interpretation Encounters

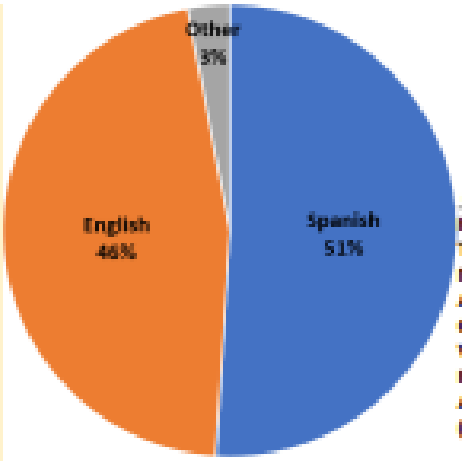
662K
Phone Interpretation Encounters

27K
LLS Insight (Interpreter) App Encounters

21K
Video Interpretation Encounters

150
LLS Virtual Desktop Infrastructure (VDI) Encounters

Top Ten Languages



Other:
Korean
Tagalog
Mandarin
Armenian
Cantonese
Vietnamese
Russian
Arabic
(<0.05% each)

767K*
Interpretation Service Encounters

221K*
Interpretation Service Hours

4.4/5
Average Satisfaction Rating

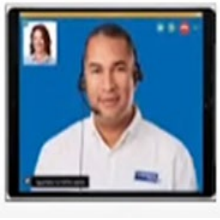
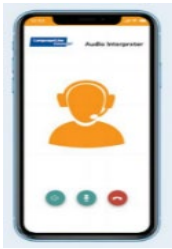
225
System-wide Document Translations

85
DHS Healthcare Interpreters

3.8K
Bilingual Bonus Recipients

email: Olaifeedback@dhs.lacounty.gov

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

LA GENERAL LANGUAGE CENTER: (323) 409-5533 [Business Hours from 8:30 a.m. to 10:00 p.m.]		
How to Request Language Services		
Face-to-Face Interpreting Services	To schedule a face-to-face interpreter for any language (including Sign Language), call the Language Center at (323) 409-5533 during business hours from 8:30 a.m. to 10:00 p.m.	
Video Remote Interpretation (VRI) Services, including American Sign Language Interpreting Services (ASL) 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 (323) 409-5533.	
Telephonic/Audio Interpreting Services Over 240 languages available on-demand 24 hours/7 days a week	Dial "0" for the operator and request an interpreter or dial ext. 93600 from any in-house phone. For personal phone access, dial (323) 409-3600.	
LanguageLine Insight (Interpreter) App Over 240 languages available on-demand 24 hours/7 days a week	To access the app on personal smartphones, click here for instructions. To access the app on Virtual Desktop Infrastructure, click here to review the user guide.	
TTY or CRS	Call the Language Center to obtain information about the following: • TTY (teletypewriter) Devices or the California Relay Service (CRS) [available for the deaf, hard of hearing, or speech disabled patients] • Locations of Public TTY/TDD machines/pay phones • Speech to Speech (STS) Relay Service for patients with speech disabilities.	

Written Translation	Contact the Language Center for assistance with Written Translation.	

Upset/Angry Individual

Treatment for a health condition can be stressful and frustrating for patients and family members. The loss of control that patients and family members sometimes experience may lead to emotional instability and erratic behavior. Should you encounter this type of situation keep these following points in mind to prevent escalation of the situation:

- Be patient, flexible, and positive
- Encourage verbal, not physical expression
- Avoid public spectacles; be attentive to signs of distress
- Be empathetic, listen, and attempt to build trust
- Do not personalize, moralize, or judge
- Do not challenge or ridicule
- Do not overreact or argue
- Do not promise something you cannot deliver
- Do not threaten or get defensive
- Keep yourself safe from potential injury
- Be prepared to call for additional help or security if situation gets out of hand

Understanding the Emotional Curve

The healthcare setting is a high pressure, high stakes, and fast-paced environment with many stakeholders. This can lead to conflict and emotional distress involving staff, patients, and family members. The emotional response after a trigger event spikes immediately while the cognitive response takes time to catch up. Recognizing your own stress symptoms such as palpitations, sweating, and flushing is critical to not acting while at the peak of the emotional response curve. Delay tactics such as removing yourself from the situation, taking deep breaths, and pausing before responding can help defuse conflicts. This applies to e-mail communication as well. Ensure that your cognitive response has caught up with your emotional response before responding to verbal or email communications.

CONSENT AND DESIGNATION OF PATIENT WISHES

When patients come to the hospital or health center, they retain their right to choose what is done to their body. Before any medical procedure or treatment is performed, the patient, or their legally authorized representative, must provide consent for that procedure or treatment. This consent may be either implied (such as holding one's arm out for a blood draw) or expressed either by written or verbal means. Failure to obtain proper consent for treatment may result in a claim of battery or professional negligence. Battery may also arise if the patient consents to a particular

procedure and the provider either exceeds the scope of the consent or performs a different procedure than what the patient consented to.

Patients also have the right to make their wishes for health care known prior to initiation of treatment. Communication about a patient's desires for treatment can be determined and documented prior to receiving care with the Advance Directive or Physician Orders for Life Sustaining Treatment (POLST).

General Basic Consent

As noted above, patients have a right to make decisions about the care that they receive. This includes basic health care services such as routine blood tests, chest x-rays, nursing services, etc. The hospital has a responsibility for obtaining a patient or their representatives' consent for these basic healthcare services through the use of the "Conditions of Admission."

Informed Consent

If the treatment proposed is complex, the consent must be "informed". This requires the treating physician to address the following elements of informed consent in a discussion with the patient or legal representative:

- The nature and indications for the proposed care, treatment, services, medications, interventions, or procedures
- Material risks and benefits for the patient, including the likelihood of each. Material risks include risks with a high degree of likelihood but a low degree of severity, risks with a very low degree of likelihood but high degree of severity, and the potential problems that might occur during recuperation.
- Reasonable alternatives to the treatment and the relative risks, benefits and side effects related to those alternatives
- The probable consequences of declining recommended or alternative therapies.
- Who will conduct the proposed care, treatment, service, medication administration (such as anesthesia), intervention, or procedure
- Whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks
- The likelihood of achieving goals
- Any potentially, conflicting interests, such as research or financial interests
- When indicated, any limitations on the confidentiality of information learned from or about the patient
- It is the treating provider's responsibility to obtain informed consent.

Who May Consent?

The determination of who may consent to medical treatment is based on the patient's legal status, capacity to make decisions, and the physician's assessment of the patient. Capacity means a person's ability to understand the nature and consequences of a decision, and includes, in the

case of proposed health care, the ability to understand its significant benefits, risks, and alternatives. Those able to give consent include, but are not limited to:

- Adults (over age 18), emancipated minors, and minors receiving care for specific health conditions such as pregnancy and sexually transmitted disease (STD) treatment
- Surrogate decision makers appointed by the patient for the duration of stay (max 60 days)
- Agents appointed in an Advance Health Care Directive or Power of Attorney for Health Care form
- Court appointed conservators
- Closest available relatives
- Multi-disciplinary committee

Obtaining consent for treatment on patients that lack the capacity to make informed decisions, including refusal of medical care, may require a court order.

Since there are many exceptions to the consent laws relating to minors and incapacitated patients, consult your facility Clinical Risk Manager if you are unsure of who may consent.

The informed consent discussion is documented in the patient's medical record. Completion of the applicable informed consent form is documented using the iMed Consent system.

The consent form itself is not informed consent; it is evidence that informed consent was obtained. The form is not a substitute for the critical role of the physician in the informed consent process.

Refusal of Treatment

Patients have a constitutional right to decide and consent to which treatments and procedures are performed on their body. This includes the right to decline treatment as well. When a patient declines drugs, blood, or other medical treatment ordered, the physician must determine if the patient has the legal authority and capacity to decline such treatment. If the patient is determined to have capacity, the physician must ensure that the patient is aware of the possible risks and complications that may occur because of declination. The physician has a duty to give the patient all the information that is relevant to a meaningful decision to decline.

The declination of treatment should be clearly documented in the patient's medical record by including a summary of the events that led to the declination, and the outcome of the discussion between the patient and the physician.

Emergency Situations

In the event of a medical emergency, treatment may be given if the situation meets the criteria for an emergency, and if there is no evidence to indicate that the patient (or their legally authorized representative) would refuse the treatment.

California law defines a medical emergency to exist when:

- Immediate services are required for the alleviation of pain; or

- Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated

The exception for obtaining consent in medical emergencies applies to minors as well as to adult patients. However, it is important to note that only the emergency condition may be treated and any treatment beyond that may not be administered without proper consent.

For more information, refer to policy DHS 314 "Informed Consent"

Do Not Resuscitate Order

Informed declination of treatment may also include the initiation of a "do not resuscitate order" or DNR. A DNR order is one which directs health care providers not to initiate resuscitative measures in the event of cardiac or respiratory arrest. A DNR order authorizes the withholding of life-sustaining procedures. It does not authorize the withdrawal of procedures that have been previously initiated. Failure to follow a DNR order may lead to a claim of battery against a health care provider.

Advance Directive

In 1991, Congress passed the Patient Self-Determination Act (PSDA). The act requires all hospitals, skilled nursing facilities, and home health agencies to maintain policies and procedures assuring that patients are provided written information about their right to make decisions regarding medical care. This includes the right to formulate advance directives.

The advance directive is a written document that contains information about a patient's desires, particularly as it relates to end-of-life care. The advanced directive may also authorize another person to make health care decisions for a patient when the patient is no longer able to make their own decisions. Patients may designate another person to make health care decisions even when they are still capable of making their own decisions.

Physician Orders for Life Sustaining Treatment (POLST)

Effective January 1, 2009, a patient and their health care provider may complete a POLST form which is generally more detailed than the advanced directive in outlining a patient's wishes regarding resuscitative and life-sustaining treatment. The POLST form is signed by both the patient and the patient's health care provider and details the patient's wishes for CPR, antibiotic use, nutrition, and other medical interventions. The form is a physician's order that applies across and within any health care setting. Since the POLST form is considered a legal document, any subsequent health care providers are obligated to accept a POLST and incorporate its content into their treatment plan.

MEDICATION SAFETY

Medication safety involves all steps of the medication process, which includes reconciling, prescribing, dispensing, administering, and monitoring. It encompasses the safety of both patients as well as the individuals involved in the handling of medication. While most medication errors do not result in harm to the patient, the potential for patient harm is ever present. Medications errors are often related to systems and processes such as complex electronic health records systems and care-team communications. Other contributors are human factors such as training, distractions and knowledge gaps.

Patient Identification

Every time a patient receives care, treatment or services (including medications), he/she must be identified using at least two DHS-approved patient identifiers. Examples of acceptable identifiers include the individual's full name, date of birth, or medical record number. The room or bed number should never be considered an identifier. The Financial Identification Number (FIN) in ORCHID may be useful in searching for a patient's unique encounter but changes between encounters and hence must not be used as one of the patient's two identifiers. Refer to your facility's policy for more information regarding appropriate patient identifiers.

Medication Error and Adverse Drug Event Reporting

An Adverse Drug Event (ADE) is defined as an injury or undesirable clinical manifestation that results from a pharmacologic medical intervention. This includes Adverse Drug Reactions (ADRs) including allergic reactions and medication errors across the continuum of pharmacotherapeutic care. Reporting ADEs and near misses is essential to medication safety. ADEs associated with medication errors are considered preventable, while those that are related to a medication side effect may or may not be preventable. Reporting all medication safety-related events in the SI system allows the patient safety leaders at your facility to identify problematic systems and redesign these systems for improved safety. By documenting and reporting adverse drug events, near misses, and unsafe conditions, you are promoting patient safety by creating opportunities for improving quality of care provided to our patients.

Abbreviations

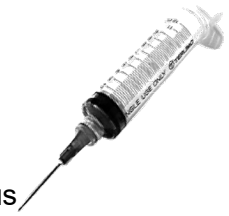
Abbreviations save time and are commonly used for convenience in medical documentation. However, some abbreviations, symbols and dose designations are dangerous and should not be used. Many of these dangerous abbreviations are frequently misread and lead to serious mistakes which compromise patient safety. TJC requires accredited organizations to develop and implement a list of prohibited abbreviations. TJC maintains their own official "Do Not Use" list of abbreviations which must be incorporated by each organization, but your facility may also have additional "Do Not Use" abbreviations. For the complete list be sure to check with your facility's list. While implementation of Electronic Health Records has reduced the risk from misinterpretation of hand-written abbreviations, it has not fully eliminated the risk. Prohibited abbreviations should never be used when documenting patient's medical records including notes, medication orders, lab orders and results. If you notice the use of an unapproved abbreviation, notify your immediate supervisor and/or the Medication Safety team in your facility. Visit

https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-do-not-use-list/ for TJC's list of restricted abbreviations.

High Alert Medications

High alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. The consequences of error with these medications can be detrimental to a patient, potentially resulting in serious injury or death. To improve patient safety, TJC requires healthcare facilities to develop a list of "High Alert Medications" which necessitate additional precautionary measures/processes during the preparation, storage, dispensing and/or administration of these medications. Refer to your facility's policy for managing high-alert medications, which should include multi-disciplinary safeguards to minimize errors associated with use.

Although each facility may have its own modified list, the DHS Standardized Core High-Alert Medication List includes:



- Anticoagulants
- Concentrated potassium
- Sodium chloride solution (concentrations > 0.9%)
- Insulins
- Narcotic/opiate analgesics patient-controlled analgesia route, continuous infusions, fentanyl transdermal patches, and methadone)
- Benzodiazepine continuous infusions
- Neuromuscular blocking agents
- Antineoplastic agents
- Magnesium sulfate (in all obstetrical areas only)
- Medication administered via intrathecal and epidural routes

Look-Alike Sound-Alike Medications

TJC requires an organization to annually review a list of Look-Alike/Sound-Alike medications and enact measures to prevent errors involving the mix-up of these medications. DHS follows TJC requirements and has implemented several other methods to prevent patient injury from Look-Alike/Sound-Alike medications. These preventative methods include: physically separating the Look-Alike/Sound-Alike medications in work areas, limiting the number of available drug concentrations, and using TALLman labeling to highlight the difference in medication names (e.g. oxyCODONE and OxyCONTIN). ORCHID uses TALLman lettering to help distinguish between Look-Alike/Sound-Alike Drugs. If you find that certain medications look-alike or sound-alike and are not presently addressed by DHS procedures, please notify your immediate supervisor and/or Medication Safety Team for investigation and/or action.

Patient Controlled Analgesia

- Patient Controlled Analgesia (PCA) is an effective method for controlling pain when used as prescribed and administered appropriately. However, PCA is also associated with a heightened risk of causing severe patient harm. Serious adverse events can occur when

family members, caregivers or clinicians who are not authorized to administer PCA doses, do so. The unauthorized administration of PCA doses by someone other than the patient is known as "PCA by proxy". Root cause analysis of harm occurring as a result of PCA by proxy often implicates family members and/or unauthorized individuals administering doses in an attempt to keep the patient comfortable. Several recommendations for preventing adverse events related to PCA administration include the following: Ensure the utilization of established criteria for PCA use in the selection of patients, medications, and dosing regimens

- Carefully monitor patients who are on PCA medications for the risk of respiratory and cardiac depression
- Teach patients and family members/caregivers about the proper use of PCA and provide them with written instructions on the PCA's use (in their preferred language)
- Instruct family/caregivers NOT to administer PCA doses
- Use warning tags on the PCA delivery patient's control that states, "Only patients should press this button"
- Diligently record and reconcile PCA use

Your facility may have other specific methods for preventing PCA adverse events. Review your facility PCA policy for more details. See Patient/Family PCA Education pamphlet located in the DHS Patient Safety Subsite.

Equianalgesic Opioid Dose Conversion

Overdosing or underdosing patients may occur if equianalgesic dosing is not considered when changing the type or route of opioid analgesics. Equianalgesic dosing tables should be referenced when converting patients between opioids to guide efficacy and safety. These table provide relative potencies of major opioid agents and differentiate between the available routes of administration. Below is a comparison of frequently used opioids.

Drug	Equinanalgesic Dose (mg)		Sample Starting Dose for Opioid Naïve Adult	Duration of Effect (hours)
	Parenteral	Oral		
Morphine	**10**	**30**	**Parenteral: 2-5mg IV Q3-4H** **Oral: 10-30 mg PO Q4H**	**3-4** **3-6**
Morphine Extended-Release	-	30	MS Contin®: 15-30mg PO Q8-12H Kadian®: 20mg PO Q24H	8-12
Meperidine	75	300*	Avoid in renal insufficiency and use caution in hepatic impairment and in the elderly (potentially neurotoxic metabolite accumulation)	
Hydromorphone	1.5	7.5	Parenteral: 0.3-1mg IV Q4H Oral: 2-4mg PO Q3-4H	3-4 3-6
Oxycodone Controlled-Release	-	20	Oxycontin®: 10mg PO Q12H	8-12
Hydromorphone	1.5	7.5	Parenteral: 0.3-1mg IV Q4H Oral: 2-4mg PO Q3-4H	3-4 3-6
Fentanyl†	0.1	-	Parenteral: 25-50mcg IV Q1-2H Transdermal: 25mcg Q72H	0.5-2 48-72

* 300mg Oral Meperidine is not recommended

† Fentanyl is for opioid-experienced patients only (>60mg morphine equivalent per day)

When switching between opioids, use **morphine as your conversion factor**

Ex: What would be the equianalgesic dose of Parenteral (IV) Fentanyl for 20mg Oral Oxycodone?

20mg Oral Oxycodone = 30mg Oral Morphine = 10mg IV Morphine = **0.1mg IV Fentanyl**

UpToDate. Selected opioid analgesics for pain and equianalgesic doses. 2013

Equianalgesic dosing table like the one above provides good guidance, but clinical judgment should be based on patient characteristics (such as age, weight, co-morbidities, hepatic function and renal function) and the unique properties of certain opioids must also be taken into account. It is important to note that when switching between different types of opioids, the dose of the new

opioid should be reduced to account for differences in tolerance. The DHS Expected Practice "Emergency Department and Urgent Care Clinic treatment of Pain" contains further information about safety considerations when prescribing controlled pain medications including controlled substance medications.

Anticoagulant Safety

Anticoagulants are used in the treatment and prevention of venous thromboembolism (VTE), prevention of valve thrombosis and arterial thromboembolism in patients with heart valves, prevention of stroke in patient with atrial fibrillation, and other medical conditions. Anticoagulants inhibit the formation and prolongation of blood clots. Management of anticoagulants is challenging as they can lead to complications (bleeding) or adverse events because of the following:

- Complex dosing due to narrow therapeutic ranges and drug-drug or drug-food interactions
- Inconsistent patient compliance and adherence to monitoring, dietary, and safety expectations
- Insufficient patient documentation, evaluation and monitoring by healthcare providers.
- Need for complex care team communication.

A critical component of anticoagulation safety includes education of staff, patients and family.

Staff education may include:

- Protocols, order sets, and published consensus guidelines

Patient/family education includes the following:

- Signs and symptoms of bleeding, and channels for communicating concerns to care team
- The potential for adverse drug reactions and interactions
- Medication and treatment compliance
- The importance of follow-up monitoring
- Drug-drug interactions
- Drug-food interactions

Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to ensure patients understand the risk involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) laboratory monitoring.

For more information on anticoagulant safety, refer to the following DHS expected practices:

Management of Therapeutic Anticoagulation in Adults

Anticoagulant reversal in adult patients

Or check out,

https://www.jointcommission.org/standards/r3-report/r3-report-issue-19-national-patient-safety-goal-for-anticoagulant-therapy/

Medication Labeling

Errors, sometimes tragic, have resulted from the mix-up of medications and solutions removed from their original containers and placed into unlabeled containers. Medications in unlabeled containers are unidentifiable. TJC requires labeling of all medications, medication containers, and other solutions, both on and off the sterile field in perioperative and other procedural areas. Medication containers include syringes, medicine cups, and basins. Some general rules in labeling medications are as follows:

- Labeling occurs when any medication or solution is transferred from the original packaging to another container and is not immediately administered
- Such labeling is to occur immediately after preparation. Labels should include: a) medication or solution name, b) strength, c) quantity, diluent, and volume if not apparent from the container and d) expiration date and specified time is less than 24 hours
- At the conclusion of a procedure, remove all labeled containers from the sterile field and discard their contents
- Immediately discard any medication or solution found unlabeled
- All medications and solutions, and their labels, are reviewed by entering and exiting staff responsible for the management of medications

Tubing Misconnections

Tubing misconnections occur with significant frequency and continue to cause severe patient injury and death, since tubes with different functions (i.e. intravenous, epidural, or feeding tube administration) can easily be connected using luer connectors, or connections can be "rigged" (constructed) using adapters, tubing or catheters. ENFit is a universal standard, reverse luer-lock connector that reduces the risk of misconnection by ensuring only enteral devices can connect to each other. When available, using designated EnFit universal standard tubes and connectors for enterals reduces patient risk.

Examples of tubing misconnections include:

- Intravenous (IV) infusions connected to epidural lines, and epidural lines connected to peripheral or central or IV catheters
- Infusions intended for IV administration connected to an indwelling bladder catheter or nasogastric tube
- Primary IV solutions administered through various other functionally dissimilar catheters, such as external dialysis catheters, ventriculostomy drains, amnio-infusion catheters, and distal ports of pulmonary artery catheters

Tubing misconnections can be prevented by following the recommendations below:

- Always trace and re-check a tube or catheter from the insertion site on the patient to the point of origin before connecting any device or infusion, at any transition (such as arrival to new setting or service), during shift change, and as part of hand-off process
- Never modify or adapt the device or its connector outside of its intended application since this may defeat the safety system
- Request training or in-service on how to use new connectors and devices
- Emphasize the risk of tubing misconnections in orientation and training curriculum

- Inform non-clinical staff, patients, and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices and infusions
- For certain high-risk catheters/tubings (e.g., epidural, intrathecal, arterial, dialysis, central lines, wound drain, etc.), label the catheter/tubing per facility's policy
- Standardize the "line reconciliation" process

For more information on reducing the risk of medical device tubing misconnections and the new regulatory mandates and standards, visit: http://stayconnected.org/ and http://www.jointcommission.org/sea_issue_53/

Medication History

Ideally, the "gold standard medication history/list" should be created by a licensed pharmacist by interviewing the patient to identify what medications the patient was taking prior to admission to the hospital. This may be in addition to any pre-admission medication list that was obtained by the care team. To identify unintended medication reconciliation discrepancies, the gold standard (also known as best possible) medication history is compared to the patient's admission and discharge medication orders to identify discrepancies in any of the patient's medications' dose, route, or frequency between the lists.

In DHS, the best possible medication history or list is primarily obtained by the admitting nurse before or during the admission process. To provide the best possible and safe care to patients, timely and accurate completion of the medication history/list is significantly important in order for the admitting provider to conduct and compete the medication reconciliation process within the required timeframe upon the patient's admission based on your facility's policy.

Medication Reconciliation

Medication reconciliation is essential to maintain and communicate accurate patient medication information. It is an important step in meeting the Meaningful Use requirements with each clinical encounter of a patient. Most importantly, medication reconciliation is a crucial step for preventing medication errors. Medication reconciliation is a process where a provider reviews and reconciles all of the medications a patient was previously taking, including over the counter, as needed, and herbal medications and supplements, with all currently prescribed medications. The best possible medication history list of medications and supplements for this comparison is generated by Nursing, Pharmacy, ORCHID or a provider themselves, for a provider to review and reconcile at each admission, discharge and at each transition in level of care. Medication errors frequently occur during transitions of care, including admission, change in level of care, and discharge. Administration of the wrong agent or the wrong dose of a medication, omitted and incorrectly timed doses, therapeutic duplication, and drug-drug interactions are potential issues that may arise if medication reconciliation is not done appropriately with each patient hand-off and encounter. Current and accurate medication reconciliation information is essential to safe transitions of care and day to day patient care. Patients (and/or their family members) should be provided with written information about the medications they will be taking when discharged from the hospital or at the end of an outpatient visit. The importance of managing medication should be explained to the patient, and should include examples, such as:

- Instructing the patient to give a list of their medications to their primary care physician
- Updating their personal medication list any time changes are made

- Bringing medication information with them at all times

Check for the procedures in place at your facility related to medication reconciliation, as different healthcare settings have different Joint Commission requirements.

Medication Interactions

Always consider drug-drug interactions when prescribing or renewing prescriptions, particularly with respect to commonly used medications with high and severe interaction potential (e.g. warfarin, phenytoin, tacrolimus). Electronic Drug Databases such as Micromedex and UpToDate, as well as the Pharmacist can be an excellent source of information and support for checking for any potentially harmful drug-drug interactions.

For more information, please visit:
https://www.merckmanuals.com/professional/clinical-pharmacology/factors-affecting-response-to-drugs/drug-interactions

Special Populations

Prescribers should take extra care in prescribing medications to women of childbearing age to avoid the risk of potential teratogens (e.g. ACE-inhibitors and statins). Prescribers should exercise caution when prescribing medications to elderly patients to avoid precipitating delirium, urinary retention, constipation and falls.

For more information, please visit:

https://www.merckmanuals.com/professional/geriatrics/drug-therapy-in-older-adults/drug-related-problems-in-older-adults?query=drug_related_problems_in_the_elderly

https://www.merckmanuals.com/professional/SearchResults?query=beers+criteria

Bar Coded Medication Administration (BCMA)
The BCMA system can improve medication safety by verifying that the right drug is being administered to the right patient. However, BCMA technology alone does not guarantee 100% safe medication-use system. Disastrous medication errors can still happen with the BCMA system especially when the BCMA technology is not implemented or used appropriately, when staff engage in workarounds or overriding alerts, when disruptions are present during medication administration and pharmacy dispensing, or when mislabeling errors occur (attaching a bar code associated with one product to a different product, bar code was affixed to the wrong strength of the correct medication), etc. If you encounter problems when scanning the mediation for your patient, please follow your facility's existing protocol (i.e., informing your facility pharmacy or immediate supervisor) to address the issue. It is important to address all identified barriers in using BCMA in your work unit to prevent patient harm, workarounds, and risky staff behaviors.

Smart Pump Technology

Smart pump technology allows infusion pumps to perform functions that assist healthcare providers with programming and calculating dose and delivery rates. The technology can

potentially reduce medication errors and prevent patient injury; however, it cannot prevent all programming and administration errors. Smart infusion pumps such as Alaris are equipped with safety features, such as alarms or other operator alerts, which are intended to activate in the event of a problem. This technology is not intended to replace clinical practices, institutional policies, and vigilant patient monitoring. Clinicians must use professional judgment and adhere to established standards of care and standard operating procedures for safe medication administration when using this or any other technology. Additionally, when using a smart pump, clinicians must continue to practice the "eight rights" of medication administration: the right patient, right medication, right dose, right route, right time, right reason, right documentation, and right response. CHS' other units (except CTC) may use "seven rights" (minus right response). In addition to the eight rights, the clinician should have another nurse perform an independent double check with high alert infusions. It is very important for clinicians to select the right medications and fluids from smart pump library, which is maintained by DHS Pharmacy.

The clinician must promptly inform the facility pharmacy and/or immediate supervisor if the medication or fluid that needs to be administered to the patient cannot be found in the smart pump drug library. Ensure that the accurate patient information is entered into the smart pump (i.e., patient's weight and medication concentration). Some of the programming and administration errors reported to FDA involve incorrect dose programming and nurses overriding soft limits.

The clinician can take the following precautions to prevent errors when using a smart pump with their patient:

- Use smart pump Guardrails and avoid use of basic infusion whenever possible. Notify facility pharmacy and/or immediate supervisor if medication is not found in the pump library
- Before starting an infusion of changing an infusion setting, confirm that the infusion pump is programmed correctly. At a minimum, correct programming includes verifying that a Guardrails Profile appropriate for patient and practice area is selected.
- When infusing a high-alert medication, have a second clinician perform an independent double check of the infusion pump settings according to your facility's policy
- When a patient is receiving multiple infusions, consider labeling the corresponding tubing with the name of the mediation of fluid to avoid programming the wrong channel or infusion pump
- Don't rely solely on the pump to identify problems. Monitor the patient and infusion according to nursing best practices and your facility's policies and procedures
- Pay prompt attention to displayed alerts and cautions to investigate them appropriate
- If a medication infused through a smart pump is suspected in an Adverse Drug Event (ADE), report the ADE and sequester the affected pump module, controller unit, all tubing, and bags, for further investigation. Refer to your facility's policy.

A multi-disciplinary team, including pharmacy, should routinely -evaluate drug library settings and modify them to align with the standard of care and facility's policies and procedures, and facility's medication safety experience. Re-evaluation may include implementing and altering soft and hard limits (when clinically relevant) as well as standardizing concentrations, dosing configurations, and names of high-alert medications throughout the institution. Staff who are going to use these infusion pumps must be proficiently trained and educated about the infusion management. Quality and compliance review of smart pump usage data is routinely performed by the facility medication

safety and patient safety teams. Finally, review your facility policy and procedures related to infusion pumps for more details.

You can also visit http://www.fda.gov/infusionpumps for more information about infusion pumps, including additional risk reduction strategies.

Insulin Use for Hospitalized Patient with Diabetes

Insulin Use for Hospitalized Patient with Diabetes
During the course of patient's stay in the hospital, the food intake of patients may be modified, diminished, or stopped completely due to intolerance and/or scheduled procedure or diagnostic test. If this happens, short or rapid acting insulin is typically discontinued, and the dose of intermediate/long-acting insulin should be reduced. Patient may also be placed on intravenous dextrose to avoid hypoglycemia.
If the procedure is done in the early morning, subcutaneous insulin (usual dose of short-acting and intermediate/long-acting) and breakfast can simply be delayed until after the patient is able to eat again. The basal insulin (NPH, Glargine) dose would be reduced by 25% of the prescribed dose. However, if the procedure is longer (i.e., an operation done in the afternoon with no food intake for the entire day), ideally the patient should not receive any short or rapid-acting insulin. The night before: give the usual dose of bedtime NPH; if on bedtime glargine, decrease the dose by 25%. In the morning of the procedure decrease the usual dose of morning NPH by 50%, or decrease the dose of morning glargine by 25%.
The patient's blood sugar may need to be checked more frequently and intravenous dextrose may need to be initiated. Lastly, it is important to ensure and maintain communication with the patient and family members and all healthcare providers involved in the patient's care

You can also review the Management of DM Before and After Elective Outpatient Surgery.
and Diabetes Mellitus related information in the DHS Clinical Library.

TRANSFUSION SAFETY

Transfusion safety is the process of correctly selecting and delivering blood or blood components to patient that will provide the most clinical benefit and minimize risk. Transfusion of the wrong blood or blood component is an uncommon but significant hazard of transfusion and can result in serious harm or death. Transfusion of the wrong blood or blood component is often the result of identification errors: mislabeled blood samples (correct patient's blood, but incorrect label), mis-collected blood samples (correct label, but incorrect patient's blood), or misidentifying the patient or blood unit at the time of transfusion. Patient identification, both at the time of the blood draw and prior to initiating the transfusion, is the most important step in ensuring safe transfusion. For this reason, TJC requires that all specimens (not just blood) are labeled in the presence of the patient. When administering blood or blood components, use a two-person identification process or a one-person identification process accompanied by automated identification technology, such as bar coding (although this may not be available at all DHS facilities). When using a two-person identification process, one person is the qualified transfusionist who will be administering the blood or blood component and the second individual is qualified to participate in the process (as defined by your facility). As with any procedure, treatment, or service, the patient must be identified using two facility-approved patient identifiers using two facility-approved identifiers (such as name, DOB, and/or MRN). Identification of the patient should always include active

communication when possible. Follow your facility's patient identification policy for the proper use of two identifiers.

Prior to administering the transfusion, the following must be verified using a two-person verification process:

1. Physician's order to transfuse. Match the type of blood or blood component to the order.
2. Informed consent including receipt of the publication "A Patient's Guide to Blood Transfusion".
3. Comparison of two patient identifiers between the patient and the blood Transfusion Record Form (TRF).
4. Comparison of information on the blood component bag with the information of the compatibility label, and the TRF (unit number, ABO blood group of the patient, name of blood component).
5. Expiration date and time of the blood component.
6. Visual inspection of the blood component to look for clots, color changes, or other abnormalities.

If any discrepancy or abnormality is found during the above steps, the transfusion must not be initiated until the discrepancy is resolved or abnormality explained. Before starting the blood transfusion, review, verify that all information is correct, and sign the "Transfusion Record Form". Note the exact time the transfusion started and ended, if reactions were noted, and the total amount of blood transfused to the patient. If a transfusion reaction is suspected:

1. Stop the transfusion immediately. Maintain an open IV line with normal saline.
2. Recheck the identification on the blood component bag and TRF against the patient's identification band.
3. Contact the patient's physician as soon as possible.
4. Initiate a transfusion reaction investigation following your facility's protocol (typically by contacting the Blood Bank).

Please refer to your individual facility's policy and procedure.

The Paul Gann Act

In 1991, Section 1645 of the California Health and Safety Code was amended to include a requirement that whenever there is a reasonable possibility that a blood transfusion may be necessary, the physician shall inform the patient of the positive and negative aspects of receiving either autologous blood (coming from the patient) or allogeneic blood (coming from a donor).

This information must be communicated to the patient through a standard written summary developed by, or based on, the California Department of Public Health's publication "A Patient's Guide to Blood Transfusion". The written summary does not replace the informed consent process which must occur prior to blood or blood product administration. The Paul Gann Safety Act also requires that, when there are no life-threatening emergency or medical contraindications, the physician shall allow adequate time prior to the procedure requiring blood donation, for pre-donation of autologous blood to occur.

INFECTION PREVENTION AND CONTROL

Healthcare-Associated Infections (HAIs)

HAIs are infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care. Every patient that enters a healthcare facility is at risk for developing a HAI. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 31 hospitalized patients will develop at least one HAI. There were an estimated 687,000 patients with an HAI in U.S. acute care hospitals in 2015 about 10% of whom died with an HAI. HAIs include the following:

- Catheter-Associated Urinary Tract Infection (CAUTI)
- Surgical Site Infection (SSI)
- Central line-associated Bloodstream Infection (CLASBI)
- Methicillin-resistant Staphylococcus aureus Infections (MRSA)
- *Clostridium difficile* Infection (CDI)
- **Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection**

Over the last several years, there has been a significant increase in the attention and sophistication of HAI detection, reporting, and prevention at the national and local levels. Indeed, the most recent data notes that from 2020 to 2021 there was a 5-14% increase in the incidence of CAUTI, CLABSI, MRSA, and C. difficile HAIs as many hospitals faced challenges related to the COVID-19 pandemic. For more details visit, https://www.cdc.gov/hai/data/portal/progress-report.html.

Your facility leaders track the rates of HAIs, and they are required to be reported to the CDC through the National Healthcare Safety Network (NHSN) database. NHSN is the source used by Federal and State Agencies for the public reporting of your facility's data related to HAI rates.

Catheter-Associated Urinary Tract Infections (CAUTIs)

Catheter-associated urinary tract infections (CAUTIs) may occur in patients who have indwelling urinary drainage systems. Such devices serve as a reservoir for organisms and can be a source of transmission to other patients. CAUTIs may also result in blood-stream infections, which lead to increased morbidity and mortality.

There are several best practices and prevention strategies for reducing the incidence and risk of CAUTIs. Check with your facility to determine how these practices are implemented in your setting.

- Always use hand hygiene and appropriate precautions
- Follow appropriate indications for inserting indwelling urinary catheter per established guidelines
- Ensure that only properly trained healthcare workers insert and maintain catheters
- Insert catheters using aseptic technique and sterile equipment
- Following insertion, maintain a closed drainage system and unobstructed urine flow
- Limit the use and duration of urinary catheters where possible; document daily in patient's medical record the reason(s) for continuation of indwelling urinary catheters

Surgical Site Infections (SSIs)

Surgical site infections (SSIs) occur in any patient having a surgical procedure as an inpatient or an outpatient. Certain risk factors may contribute to the occurrence of SSIs, including absence of surgical antibiotic prophylaxis, use of razors for hair removal, improper aseptic technique, choice of skin antisepsis preparation, and patient-related factors (e.g., diabetes, obesity, smoking, a weakened immune system, current infection status).

There are several best practices and prevention strategies for reducing the incidence and risk of SSIs. Check with your facility to determine how these practices are implemented in your setting.

- Administer antimicrobial prophylaxis in accordance with evidence-based standards and guidelines
- Whenever possible, postpone operations until remote infections have resolved
- Do not remove hair at the operative site unless the presence of hair will interfere with the operation; do not use razors when hair removal is indicated
- Use appropriate antiseptic agent and technique for skin preparation
- Maintain immediate postoperative normothermia

Central Line-Associated Bloodstream Infections (CLABSIs)

Central line-associated bloodstream infections (CLABSIs) can occur in any patient who has (or had) a short or long-term central line catheter (e.g., triple lumen catheter, peripherally inserted central catheter [PICC], Hickman/Groshong catheter, dialysis catheter). Certain risk factors may contribute to the occurrence of CLABSIs, including prolonged duration of catheterization, contamination at the insertion site or catheter hub, site of the catheter, prolonged hospitalization prior to catheterization, administration of intravenous total parenteral nutrition (TPN), and patient factors such as a weakened immune system and prematurity. Adverse outcomes associated with CLABSIs include increased mortality, increased length of hospital stay, and increased patient costs.

There are several best practices and prevention strategies for reducing the incidence and risk of CLABSIs. Check with your facility to determine how these practices are implemented in your setting.

- Conduct daily assessment of line necessity and remove unnecessary central lines
- Follow proper aseptic insertion practices
- Perform hand hygiene prior to catheter insertion or manipulation
- Use adequate skin antisepsis
- Choose proper central line insertion sites, avoiding the femoral vein unless other sites are unavailable
- Perform adequate hub/access port disinfection
- During insertion, use a checklist and standardized protocol
- During insertion, use standardized protocol for sterile barrier precautions
- Ensure to use a standardized supply cart when inserting a central line

Methicillin-Resistant Staphylococcus aureus

Methicillin-resistant Staphylococcus aureus (MRSA) is an antibiotic-resistant type of bacteria that can cause infection anywhere in the body. MRSA occurs most frequently among patients who undergo invasive medical procedures, have weakened immune systems, or are being treated in hospitals, nursing homes, or dialysis centers. Screening for MRSA in high-risk populations is required by California law.

There are several best practices and prevention strategies for reducing the incidence and risk of MRSA infections. Check with your facility to determine how these practices are implemented in your setting.

- Follow the CDC hand hygiene guidelines
- Use Contact Precautions for patients with active MRSA infection
- Recognize previously colonized patients (via ORCHID MDRO alert window)
- Rapidly report MRSA lab results
- Participate in MRSA education for healthcare providers
- Provide and document education to patients/family on MRSA colonization and infection

Clostridium difficile

Clostridium difficile infection (CDI) is a diarrheal syndrome usually associated with prior receipt of antibiotics. It can lead to the development of pseudomembranous colitis, and inflammatory condition of the colon that includes dilation of the colon, sepsis, and sometimes death. Risk factors for CDI include prior or current antibiotic administration, gastric acid suppression, hospitalization, and advanced age. It is important to note that C. difficile bacteria can survive in the environment for long periods of time in a spore form and therefore may be difficult to kill with usual cleaning products.

There are several best practices and prevention strategies for reducing the incidence and risk of CDI. Check with your facility to determine how these practices are implemented in your setting.

- Prescribe and use antibiotics appropriately
- Use Contact Precautions for CDI patients for duration of diarrhea
- Ensure proper cleaning and disinfection of equipment and the environment. **Bleach products are recommended**
- Perform strict hand hygiene at all times, either with soap and water or alcohol-based hand sanitizers
- Follow your facility's process for identifying readmitted or transferred patients that may have CDI
- Educate patients, families, housekeeping, administration, and healthcare providers about CDI and how to prevent its spread

COVID-19/ Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection

The COVID-19 pandemic is among the deadliest infectious diseases to have emerged in recent history. SARS-CoV-2, the virus that causes COVID-19, was first discovered in December 2019 among patients in Wuhan, a Chinese city, who had developed an aggressive form of pneumonia. In March 2020, the World Health Organization declared the outbreak a pandemic. The SARS-CoV-2 virus is constantly changing, and new variants of the virus are expected to

occur. Some variants may emerge and disappear, while other new variants persist and become the dominant strain in a community. In 2021, COVID-19 became the third leading cause of death in the US.

Symptoms are highly variable, ranging from asymptomatic to severe illness. Common symptoms include headache, loss of smell and taste, nasal congestion, cough, muscle pain, sore throat, fever and difficulty breathing. Most people (81%) develop mild to moderate symptoms, while 14% develop severe symptoms (dyspnea and hypoxia) and 5% develop critical symptoms (respiratory failure, shock or multiorgan dysfunction).

The virus is believed to spread mainly through the air when people are near each other, traveling in droplets. The development of the COVID-19 vaccines has allowed for effective defense against the virus. It has now been recommended that every health care worker get the COVID-19 vaccine to prevent the emergence of new variants and reduce the risk of severe illness, hospitalization, and death from COVID-19. Other preventative measures include social distancing, wearing face masks in public, ventilation and air-filtering, hand washing, disinfecting surfaces, and monitoring for potential symptoms.

Check with your facility to determine how these practices are implemented in your setting.

- Use Special (Droplet/Airborne, Eye, and Contact) Precautions for COVID-19 patients during their acute infectious state
- Wear face masks while in clinical areas
- Social distancing while working
- Always perform strict hand hygiene with either soap and water or alcohol-based hand sanitizers
- Disinfect surfaces regularly
- Follow your facility's process for admitting patients with COVID-19
- Keep up to date with the COVID-19 vaccine

For more information regarding COVID-19, check out the DHS COVID-19 Sharepoint site. Healthcare workers who have been exposed and/or infected with COVID-19 will need to follow Employee Health recommendations for when to return to work.

Healthcare Workers (HCW) and Infection Exposure Sharps Injuries

According to the CDC, about 385,000 sharps-related injuries occur annually among health care workers in hospitals. Nursing staff is the most frequently injured group, but laboratory staff, physicians, housekeepers, and other health care workers are also injured with sharps. Sharps injuries frequently occur during disposal-related activities, item disassembly, and with recapping a used needle. Any worker handling sharp devices or equipment such as scalpels, sutures, hypodermic needles, blood collection devices, or phlebotomy devices is at risk. The same techniques used to protect workers from sharps injuries can also protect patients. Simple measures to reduce the risk of sharps injuries include:

- Practice safe loading of reusable scalpels and needle drivers by using a disarmer or an appropriate device
- Do not recap used needles
- Use sharps containers for disposal of all single-use sharps

- Utilize devices with specifically designed sharps safety features, such as needleless and blunt tip systems

Bloodborne Pathogens

The Occupational Safety Health Administration (OSHA) estimates that healthcare workers (HCWs) are at risk of occupational exposure to bloodborne pathogens. Bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. Examples of these pathogens include Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV), Hepatitis C virus (HCV), and others. To prevent exposure to bloodborne pathogens, all HCWs must use Standard Precautions. Standard Precautions means you should treat all human blood and body fluids as if they were known to be infected with bloodborne pathogens. Treat all blood and other potentially infectious materials with appropriate precautions, which includes the use of gloves, masks, and gowns if exposure is anticipated.

If you sustain an exposure to bloodborne pathogens or a contaminated sharps injury occurs, wash the wound immediately with soap and water or flush mucosal membranes (i.e., eyes, nose, mouth) with water. Report the incident to your supervisor and seek prompt medical treatment per facility protocol.

INFECTION PREVENTION AND CONTROL MEASURES

Hand Hygiene

Successful hand hygiene has been shown to reduce the transmission of dangerous bacteria and reduce the overall rates of infection. In particular, the CDC has recommended the use of alcohol-based hand rubs by health care workers because they overcome many of the obstacles to traditional hand washing measures.

In those areas where alcohol-based hand rubs are not available, handwashing with soap and water remains a sensible strategy for hand hygiene compliance. When using soap and water, effective hand washing requires that you rub your hands together for at least 15 seconds. When using alcohol-based hand rubs, the product should be applied to the palm of one hand and then rub both hands together, covering all surfaces of the hands and fingers until the hands are dry. Any time the hands are visibly soiled, they should be washed with soap and water. Hand hygiene must be performed before and after contact with a patient or anything connected to a patient, **even if gloves are worn**.

Artificial Nails

The CDC recommends against the wearing of artificial nails by health care workers. Those who wear artificial nails are more likely to harbor bacteria on their fingertips, both before and after handwashing, than are those who have natural nails. In the LACDHS system, direct patient care staff and patient health care workers who have contact with patient supplies, equipment, food, and medications are prohibited from wearing artificial fingernails and long natural 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.

Consult the DHS policy 392.3 on hand hygiene for additional information. **NOTE: Compliance with the DHS hand hygiene policy is expected from all employees and is a strict condition of employment.**

Isolation/Transmission-Based Precautions

Isolation/Transmission-based Precautions are designed to minimize the transmission of infectious agents between infected patients, caregivers, other patients, and visitors. Patients are placed in isolation when they are known or suspected to have infections that can be transmitted through the air, by droplet, or by direct or indirect contact. The 3 types of Isolation/Transmission-based Precautions are listed below:

Airborne – occurs by dissemination of either airborne droplet nuclei or dust particles containing infectious agents that may remain suspended in the air for long periods of time and over great distances. Airborne microorganisms (such as tuberculosis, varicella, measles, and SARS-CoV-2 when doing aerosolizing procedures) can be dispersed widely by air currents. Precautions include:

- Putting the patient in a private room with a negative air pressure, frequent air exchanges, and with door closed
- Wearing respiratory protection (N95 respirator) or higher when entering the room
- Limiting movement and transport of the patient outside of the room
- When a patient is transported, the patient must wear a surgical mask

Droplet – droplets are generated from the source person during coughing, sneezing, or talking, and during the performance of procedures such as suctioning and bronchoscopy. Transmission occurs when droplets containing the microorganisms (such as influenza virus and SARS-CoV-2) are propelled a short distance through the air and are deposited on the hosts' eyes, nasal mucosa, or mouth. Precautions include:

- Putting the patient in a private room when available or
- Cohorting patients with the same organisms
- Wearing an N95 respirator for droplet precautions
- Limiting movement and transport of the patient outside of the room
- When the patient is transported, the patient must wear a surgical mask

Contact – involves direct and or indirect contact with microorganisms such as: Clostridium difficile, respiratory syncytial virus (RSV), herpes simplex/zoster virus, scabies, and multi-drug resistant bacteria such as MRSA. These exposures are initiated by skin-to-skin or skin-to-object contact, which causes physical transfer of microorganisms. Precautions include:

- Placing the patient in a private room when available
- Donning gowns and gloves upon entering the room, and removing them inside the room before exiting
- Performing hand hygiene before donning gown and gloves, and again after removing them
- Limiting transport of the patient outside of the room
- Using dedicated patient-care equipment for that patient

Care of Patient Care Equipment

Patient care equipment is a common potential source of infection. All patient care equipment should be cleaned and then disinfected with hospital-approved products, following manufacturers' instructions for appropriate "wet time". Equipment that is used/soiled should be placed in a designated dirty equipment area or sent to the appropriate cleaning services department for decontamination. Only used/soiled equipment is stored in the "dirty" area, and only clean equipment is stored in the clean equipment area. Equipment will not be stored on or immediately around a sink. If it is unclear whether the patient care equipment is clean, it should be considered dirty and cleaned before patient use.

In addition, there are some situations where surgical instruments and other critical devices (those that enter sterile tissues) are reprocessed and reused every day in the hospitals, ambulatory care centers, and other health care facilities. TJC published a Quick Safety #64 newsletter related to ensuring critical instruments and devices are appropriate for reuse – please read the newsletter if your organization is performing reprocessing of reusable instruments and devices.

Use of Personal Protective Equipment (PPE)

PPE such as gowns, gloves, masks, goggles, and face shields are barriers that can be used to prevent exposure to blood, body fluids, and airborne organisms during care and treatment of patients.

- Follow procedure for donning and removing PPE
- When using PPE, be sure to discard PPE per facility procedures
- Hand hygiene must be performed prior to donning and after removing PPE

Safe Injection Practices

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

- Use aseptic technique to avoid contamination of sterile injection equipment
- **Do not administer medications from a single syringe to multiple patients**, even if the needle or cannula on the syringe is changed
- Needles, cannula and syringes are sterile, single-use items. They should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient
- Use fluid infusion and administrations sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose of appropriately after use. Do not use bags or bottles supply for multiple patients
- 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. Used single-dose vials should never be returned to stock on clinical units, medication and anesthesia carts, etc.
- 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
- All multi-dose vials are to be labeled with a beyond use date at the time of opening. A beyond use date is an assigned expiration date of 28 days or the manufacturer's expiration date, whichever is less. Vaccines are exempt from the 28-day limit

Mandatory Influenza Vaccination Policy

The DHS Policy 334.200 requires all WFMs to receive an influenza vaccine. WFMs who decline for any reason with required to sign a declination form and wear a surgical mask during influenza season while performing work in a health care area.

Influenza (the flu) can be a serious disease than can lead to hospitalization and sometimes death. Flu can affect anyone. An individual with flu can easily transmit the disease to others, including before symptoms emerge in the infected. Getting vaccinated can protect yourself, your loved ones at home, and your patients at work.

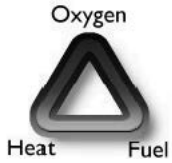
For more information about FLU Vaccine, read Influenza Vaccination for WFMs

SURGICAL AND PROCEDURAL SAFETY

The peri-operative environment poses many potential challenges to ensuring patient safety. Several factors contribute to these challenges including emergency surgery, patient risk factors multiple procedures, multiple practitioners, unusual equipment, and lack of access to pertinent information. The topics below present some of the obstacles to patient safety encountered in the peri-operative and procedural environment.

Surgical Fires

Surgical fires are fires that occur in, or around a patient who is undergoing a medical or surgical procedure. It is estimated that 600 surgical fires occur in the United States per year, some causing serious injury, disfigurement, and even death.



Surgical fires can occur at any time when all three elements of the fire triangle are present:

1. **Oxidizer** (e.g., oxygen, nitrous oxide)
2. **Ignition source** (e.g., electrosurgical units (ESUs), electrocautery devices, lasers, and fiber-optic illumination systems)
3. **Fuel source** (e.g., surgical drapes, alcohol-based skin preparation agents, the patient's tissue, hair, or skin)

Specific recommendations to reduce surgical fires include:

A fire risk assessment at the beginning of each surgical procedure (this is part of the DHS Standardized Surgical Final Time Out). The TJC Standard EC.02.03.01 EP 12 requires a surgical team to verify the following prior to the initiation of any surgical procedure:

- Conduction of a fire risk/precautions assessment at the beginning of each surgical procedure (just before the completion of the DHS Standardized Surgical Final Time Out). The TJC Standard EC.02.03.01 EP 12 requires a surgical team to verify the following prior to the initiation of any surgical procedure:
  a) Application site is dry prior to draping and use of surgical equipment
  b) Pooling of solution has not occurred or has been corrected
  c) Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices"
- Encourage communication among surgical team members (e.g., surgeon, anesthesiologist and operating room staff).
- Safe use and administration of oxidizers (eg., evaluating the need for supplemental oxygen, ensuring that the minimum possible concentration be used and if possible, using a closed oxygen delivery system).
- Safe use of any devices that may serve as an ignition source.
- Safe use of surgical suite items that may serve as a fuel source.
- Plan and practice how to manage a surgical fire.

For more information, visit FDA information of Preventing Surgical Fires and TJC's Sentinel Event Alert #64 on the updated Surgical Fire Prevention.

Wrong Site, Wrong Procedure, Wrong Person Surgery

The occurrence of wrong site, wrong procedure, or wrong person surgery can be devastating to the patient and staff involved. DHS is committed to eliminating the potential for surgical errors by following TJC's "Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery". The complete protocol can be viewed on TJC website at

http://www.jointcommission.org/standards_information/up.aspx

Wrong site/procedure/person surgery can be prevented by implementing the follow steps:

1. **Conduct a pre-procedure verification process** to make sure that all relevant documents and related information or equipment are: available prior to the start of the procedure; correctly identified, labeled and matched to the patient's identifiers; reviewed and are consistent with the patient's expectations and with the teams' understanding of the intended patient, procedure and site. Pre-procedure verification may occur at more than one time and take place before the procedure. It is best performed when the patient can be involved.
2. **Mark the surgical site before the procedure**, involving the patient in the marking process whenever possible. At a minimum, sites are marked when there is more than one possible location for the procedure. For spinal procedures special intraoperative imaging may be used in addition to site marking for locating the exact vertebral level. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. The site shall be marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure will be performed. In limited circumstances, the

practitioner may delegate this responsibility. The method for marking the site must be unambiguous, permanent enough to be visible after skin preparation, and used consistently throughout the facility. Check your facility policy to determine what method to use for site marking, when site marking can be delegated, and how to handle those circumstances where site marking may not be possible (such as patient refusal or extreme infant prematurity).

3. **Perform and conduct "time out"**. Time out activity is a verbal exercise which involves an active verbal communication among all members of the procedure team. This is the final assessment that at a minimum the correct patient, site, and procedure are identified. The DHS Standardized Final Surgical Time Out and DHS Standardized Non-OR Time Out checklists (using the ASK-NICE pneumonic) have been developed and implemented across all DHS facilities. During the time out activity, all activities are suspended to the extent possible and a time out caller or designee (i.e. anesthesia provider, physician performing the procedure, circulating nurse, or any other licensed staff) must be identified. The procedure is not started until all questions or concerns from any member of the team are resolved. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, a time-out shall be performed before each procedure is initiated. In addition, if there is a planned subsequent procedure that needs to be performed which involves sterilization, a pre-sterilization pause must be conducted before the second procedure is initiated. Finally, the conduction and performance of time out and pre-sterilization pause (if applicable) must be documented in the patient's medical record.

Unintended Retained Foreign Objects

The unintended retention of foreign objects (URFOs) also called as retained surgical items (RSIs) after any procedure can cause patients death and surviving patients may suffer from both physical and emotional harm. Some examples of URFOs are sponges, towels, broken parts of instruments, stapler components, parts of laparoscopic trocars, guidewires, pieces of drains, needles, sharps, and malleable retractors. URFOs dropped to second most frequent sentinel event reported to TJC's Sentinel Event database for 2019 (113 reported) and 2020 (106 reported). It's evident that Joint Commission-accredited organizations continue to struggle with URFOs. URFO is a CDPH reportable adverse event, a reviewable sentinel event by Joint Commission, and can also be an opportunity for litigation. Some of URFO risk factors are emergency operations/procedures, unplanned changes in the operation, and patients with higher body mass index. Majority of URFO occurs in routine uncomplicated cases and more commonly in the procedures which involve patient's chest and abdomen. However, they can certainly occur in any procedure or surgery in almost all operative/procedural areas (i.e., Cath lab, GI lab, interventional radiology, and emergency room). DHS encourages taking the following actions to prevent and minimize occurrence of unintended retained foreign objects:

- Sponges, sharps, instruments, and related miscellaneous items should be counted (without interruption) before, during, and after any surgery or procedure in which the possibility exists that an item could be unintentionally retained
- Surgical counts should be documented on the patient's intraoperative record
- Foreign objects that are to be removed from the surgical site should be x-ray detectable (radiopaque)

- Non radiopaque sponges should not be placed in the operative wound if it is possible
- Members of the operating room team should inspect the integrity of all instruments prior to use, and any instruments broken during a surgical procedure should be accounted for
- Individuals performing the procedures should execute a carful and thoughtful exploration of the operative or procedural site before the closure of the wound and/or operative or procedural field
- Distractions in the operating room should be kept to a minimum
- When a discrepancy is discovered, a search should be undertaken to recover the missing foreign object
- Radiologic tests should be performed when sponges, sharps, or instruments are unaccounted for
- Document the results of counts of surgical items, instruments, or items intentionally left inside a patient and actions taken if count discrepancies occur.
- Wanding should be completed as directed. Refer to your facility's practice on wanding or on the use of RFID technology.
- The provider responsible for managing the patient's care, treatment, and services, or his or her designee, informs the patient or his designee about the unintended retained foreign object.

For more information, refer to Joint Commission's Sentinel Event Alert on Preventing unintended retained foreign objects issued in October 2013.

RESTRAINTS AND SECLUSION, PATIENT FALLS, AND PRESSURE INJURIES

Restraints and Seclusion

Physical restraint is a specific intervention or device, that prevents the patient from moving freely or restricts normal access to the patient's own body. Chemical restraint is use of a drug or medication when it is used to restrict a patient's movement or behavior and is not a standard treatment or dosage for a patient's condition. Seclusion is an involuntary confinement of a patient alone in a room or area where the patient is physically prevented from leaving. Seclusion is only permitted to manage violent or destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. Restraint and/or seclusion use is not permitted for purposes of coercion, discipline, convenience, or retaliation by staff and is not a substitute for inadequate staffing. Both 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 order's expiration time. Both licensed independent practitioners (LIP) and qualified registered nurses (RN) are authorized to remove restraints prior to the expiration of the order I appropriate.

Restraint and/or seclusion require an order from the LIP who is permitted by both State law and the hospital as having the authority under his/her license to independently order restraints, seclusion or medications for patients. Orders for restraints and/or seclusion must be time limited, documented, and renewed in accordance with Federal/State and regulatory requirements and in accordance with the patient's plan of care. The restraint and/or seclusion order cannot be documented as standing order or on an as needed basis. In an emergency, an RN may initiate use of restraint and/or seclusion before an order is obtained from an LIP; however, a responsible LIP for the care of the patient must be consulted as soon as possible no later than one hour of restraint or seclusion initiation.

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 (i.e., time-out, redirection, de-escalation, verbal contracting, patient education, family involvement, increased observation, administration of medications which are considered standard treatment for clinical condition, etc.) have been found to be ineffective to protect the patient and others from harm. The patient's plan of care will be modified as appropriate.

The use of restraint is in 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.

There are specific requirements for staff training, monitoring, documentation, and quality assessment and reporting required when violent and/or non-violent restraint or seclusion is applied to a patient. For more information about restraint and/or seclusion, read your facility policy and DHS Policy 321.100 on Violent and Non-Violent Restraint and Seclusion.

Patient Falls

Pressure Injuries

Falls resulting in injury are a common patient safety problem. There are approximately 700,000 to 1 million people in the United States fall in the hospital. Fall incidents may result in fractures, lacerations, or internal bleeding which lead to increased or costly health care utilization. Close to one-third of fall incidents can be prevented. TJC defines a patient fall as a witnessed or unwitnessed, unplanned descent to the floor (or extension of the floor such as a trash can or other equipment) regardless of the cause (fainting, slippery floor, etc.) or extent of injury. Falls also include descents to the floor that may be eased by a staff member's attempt to minimize the impact.

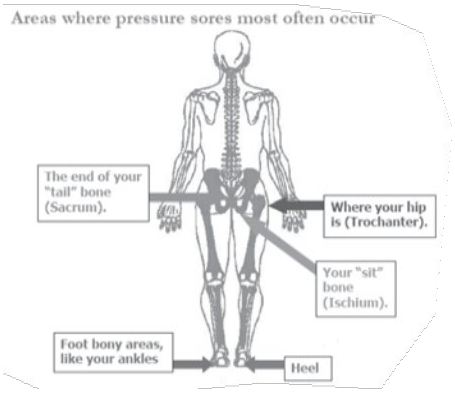
Appropriate risk assessment is a key tool in fall prevention. While most patient falls occur with elderly patients, elderly and frail patients with fall risk factors are not the only ones who are vulnerable to falling in health care facilities. Any patient of any age or physical ability can be at risk for a fall due to physiological changes related to a medical condition, medications, surgery, procedures, or diagnostic testing that can leave them weakened or confused. History of prior falls, anticoagulant use, urinary urgency, and recent environmental change are also associated risk factors in falls. On average a fall with injury approximately costs an additional $14,000. Reducing the risk of falls requires all members of the health care team collaborate on fall prevention, including admitting clinicians, pharmacists, nurses, and patients, and their family members. Some best practices for fall prevention include:

- Perform a standardized fall assessment (i.e., Morse Falls Risk Assessment) on all patients. Reassess falls risks regularly, including during inter-unit transfers, with any significant changes in the patient's clinical condition, and/or after a patient's fall incident. Screening tools are important, but also consider individualized risks outside of the screening tool
- Tailor risk prevention interventions to your patient
- Observe and follow the DHS Fall Prevention Program Policy 311.101

- Perform regular nursing rounds. The 4 P's is a useful mnemonic to help remember to focus on **P**ain, **P**osition, **P**ersonal needs (toileting), and **P**ossession (keep call button and patient possession in proximity)
- Instruct patients and family members to use the call light when help is needed. Ensure call lights are within reach before leaving the patient's bedside
- Respond to call lights quickly
- Report all patient falls through the SI online system to help the system analyze and improve performance regarding patient falls. Educate yourself about your unit's falls performance and quality improvement efforts

Pressure Injuries

The National Pressure Injury Advisory Panel (NPIAP), defines a pressure injury as localized damage to the skin and/or underlying tissue, usually over a bony prominence, but not limited to bony prominences, related to a medial or other device. Pressure injuries develop as a result of intense and/or prolonged pressure or pressure in combination with shear. Everyone's skin is unique to how much pressure and shear their skin can tolerate before breaking down (skin tolerance). The tolerance of soft tissue for pressure and shear forces may be affected by microclimate (moisture and temperature), nutrition or dehydration, perfusion, dementia, immobility due to any cause (e.g., neurological impairment, prolonged anesthesia), lack of sensory or pain perception (e.g., neuropathy, diabetes), obesity/low body mass index (BMI), prior history of pressure injuries, and co-morbidities and condition of the soft tissue. A common scenario that leads to pressure injury development occurs when a patient is lying supine in bed for ~~too~~ long without turning or repositioning. An additional scenario includes prone positioning used ~~more~~ commonly in the intensive care unit for patients with respiratory failure. The soft tissue on the face are subject to pressure and shear force injuries. In this case, tissues located over high pressure points such as the sacrum and/or heels are subject to constant unrelieved pressure and shear. This results in blockage of vital blood flow to tissues such as muscle, adipose, and skin resulting in tissue deformation, ischemia, and tissue death. Often the first signs of tissue damage are visible on skin when non-blanching "redness" but in individuals with dark skin tones; the only sign may be a darkening of the skin.



Pressure injuries are estimated to cost between $9-12 billion dollars annually in the United States. Individuals who develop pressure injuries during their hospitalizations are more likely to die in the hospital, have longer hospital stays, and higher rates of readmission. Common clinical risks include: pressure of an existing pressure injury, history of stage 3 or 4 pressure injuries, hypoperfusion states such as sepsis or heart failure, respiratory failure requiring prone positioning, chronic medical conditions such as diabetes, smoking, peripheral vascular disease, restraint use, spinal cord injury, and end of life.

The picture above shows common areas for the development of pressure injuries. Several steps can be taken to help prevent the occurrence of pressure injuries. Using a pressure injury prevention (PIP) bundle when caring for patients can help integrate individualized interventions

into daily patient care. The PIP bundle used at DHS is described in the acronym "S-S-K-I-N-E-D":

- **S (Skin Inspection):** Perform a head-to-toe skin assessment on admission and every shift throughout the hospital stay. Evaluate for skin color changes, blanching, temperature, edema, or skin consistency changes such as (induration). While performing a skin inspection complete a structured risk assessment (e.g. Braden) on admission, daily, and prn. Develop interventions for plan of care to address modifiable areas of risk development based on subscale sores. Patients "at risks" with Braden score of 16 or less require implementation of PIP interventions
- **S (Surfaces):** Includes mattresses, wheelchair cushions, operating room tables, emergency room gurneys. Consider bed bound and/or chair bound individuals to be at risk for pressure injuries
- **K (Keep Moving/Turning):** Turn/reposition the patient regularly while in bed, wheelchair, gurneys, etc. Offload "float" bony prominences or pressure areas (e.g. heels, scrum-coccyx)
- **I (Incontinent and Moisture Management):** Keep skin clean and protected from stool, urine, and wound drainage. Keep skin moisturized to avoid very dry skin. Use skin barriers (e.g. Calazime, Cavilon) to protect skin from moisture. Do not use diapers when patient is in bed. Develop and implement an individualized continence management plan
- **N (Nutrition and Hydration):** Encourage and monitor food and fluid intake: protein, supplements, and water. Identify and correct nutritional deficits
- **E (Educate Patient and Caregiver):** Provide teaching and hands-on materials to both patient and caregivers
- **D (Documentation):** Documentation of patient's skin status, care, assessments, individualized interventions, patient non-adherence, patient/caregiver response and plan of care to be documented as appropriate

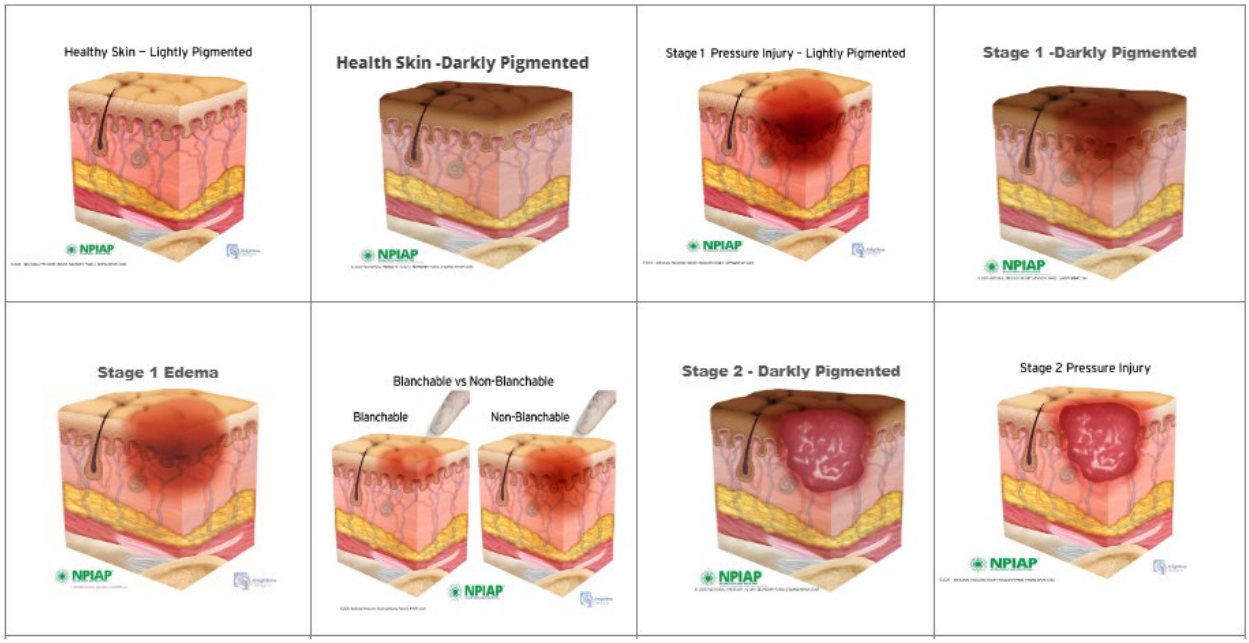
Clinicians should be advised to ask for a surgery consultation when the following are noted on examination:

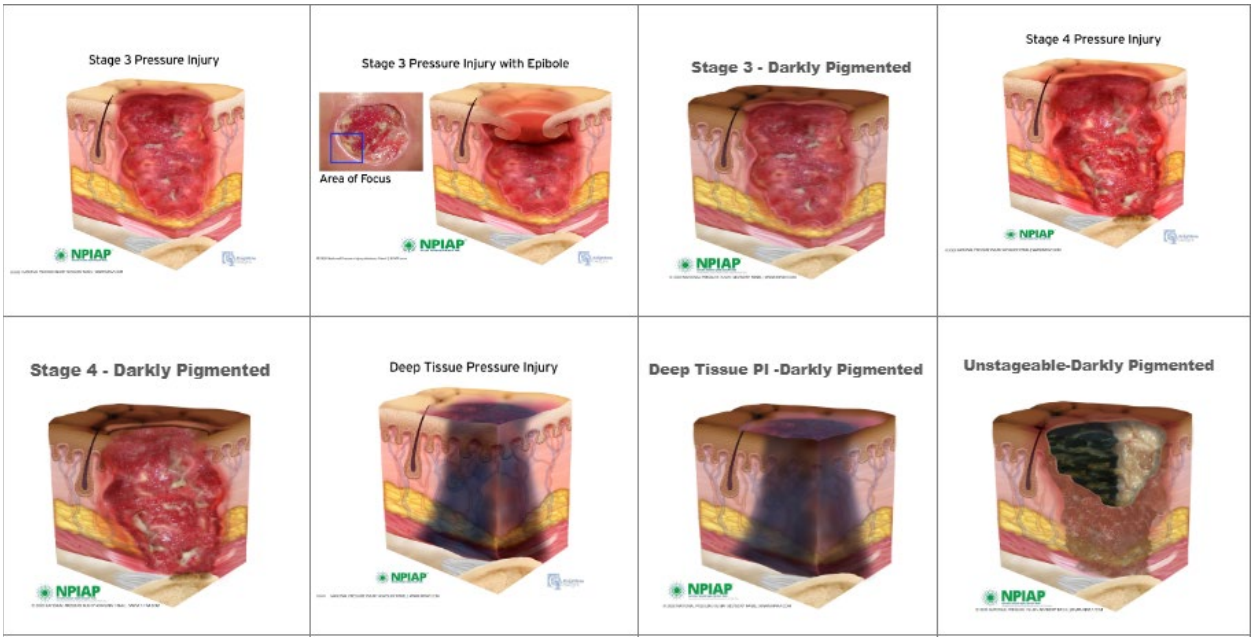
- When pressing on the injury, it expresses additional exudate and/or the top layer of the skin/site dislodges.
- A thin blister forms over the surface of the dark wound bed; the wound may become covered by thin eschar.
- The injury has intact skin but is a persistent non-blanchable deep red, purple or maroon color.
- In addition to the localized discoloration, the tissue is painful, differs in consistency (firm or boggy) or in temperature (warmer or cooler) as compared to adjacent tissue.
- The injury has non-intact skin or blood-filled blisters signifying damage to the underlying soft tissues.
- There is no elasticity in the skin surrounding the injury.
- If the patient develops systemic symptoms of infections."

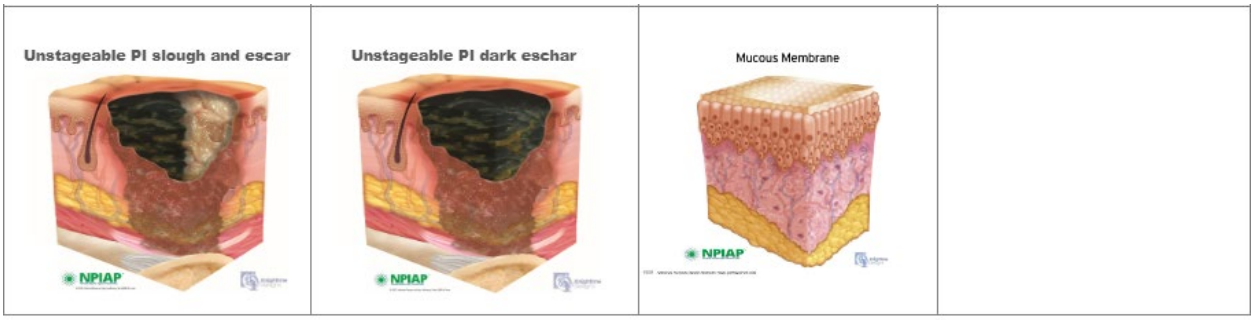
Recognize that patients with medical devices (e.g. call lights, bed footboards, casts, nasal cannulas, bedpans, tubing) as well as other devices (e.g. cell phones, utensils) are at increased risk for pressure injuries. These injuries often take on the shape of the device. For prevention, perform skin inspection more frequently around and under devices in use. Continually evaluate the need for continued use of medical devices and discontinue when no longer medically necessary. Ensure devices are secured/stored properly, tubing secured, correct size selected, and used according to manufacturer recommendations.

Staging of pressure injuries is used to classify and communicate the extent of the type of observable tissue damage caused from pressure and/or shear. DHS utilizes the pressure injury classification system defined by the National Pressure Injury Advisory Panel (NPIAP) and its stages are summarized below. It is important to note that staging does not always take a linear approach. It is also important not to reverse stage as a wound is healing:

See sample images of the different stages obtained from National Pressure Injury Advisory Panel (NPIAP).







Stage I: Intact skin with a localized area of non-blanchable redness, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.

Stage II: Partial thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Granulation tissue, slough and eschar are not present.

Stage III: Full-thickness tissue loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled would edges) are often present. Slough and/or eschar may be visible. Undermining and tunneling may be visible. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

Stage IV: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. Once the slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (dry, intact, and non-draining) on the heels should not be removed.

Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often occur before skin color is visible. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3, or Stage 4).

Mucosal Membrane Pressure Injury (MMPI): Found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

A Stage 3, Stage 4 or unstageable pressure injury that is acquired after admission to the hospital is considered an adverse event and must be reported to the California Department of Public Health no later than 5 days after discovery. Excluded from this reporting requirement is progression from Stage 2 to Stage 3 if the Stage 2 was recognized at the time of admission.

Other DHS resources:

DHS Pressure Injury Prevention & Wound Management Policy 321.007

DHS Pressure Injury Prevention & Wound Management Algorithm

Note: COVID-19 pandemic has increased the number of pressure ulcer injuries related to prone position, multiple devices and difficulty in rotating the patient's position. Please refer to the following available resources from NPIAP.

NPIAP COVID-19 Related Resources for Pressure Injury Prevention

NPIAP Pressure Injury Prevention PIP Tips for Prone Positioning

Other resources:

Pressure Injuries, Deep Tissue Pressure Injuries (DTPI), WoundSource

TJC Quick Safety #70 Newsletter on Early Identification and Evaluation of Severe Pressure Injuries

TJC Quick Safety #43 Newsletter on Medical Device-related Pressure Injuries

DIAGNOSTIC PROCEDURE SAFETY

Magnetic resonance imaging (MRI), computed tomography (CT) and other radiological studies, while being invaluable diagnostic methods, also present patient safety concerns. To prevent considerable risk of injury such as burns or any other adverse reactions from a diagnostic procedure, the patient's complete medical history must be obtained including but not limited to the presence of implanted prosthesis or devices and dye allergies. The ordering provider's order and patient's identity must be verified before initiation of each diagnostic procedure.

The facility staff must be educated and deemed competent in handling the medical devices. The facility must follow the manufacturer's recommendations on the equipment's quality control, testing, and preventive maintenance activities and should maintain the diagnostic imaging equipment properly calibrated as required and/or according to the facility's standard policy.

MRI Safety

The MRI machine uses powerful magnetic fields to obtain detailed images of organs and tissues in the body without the use of x-rays. TJC, in reviewing events related to the use of MRIs, has reported that the most common injury from MRIs is related to burns. Majority of these burns resulted from the use of wires and leads. Less common injuries, but potentially more deadly, are from the unintentional introduction of iron containing objects near the MRI magnet. These objects, if brought too close to the magnet, become missiles that can seriously injure a patient or staff member. Special care must be taken to screen patients and any individuals entering the MRI room. Patients should be asked to remove all personal belongings including hearing aids, wallets, coins, hair clips, electronic devices, and jewelry. Patients should also be screened for implantable items such as pacemakers, catheters, clips, cochlear implants, and medication pumps that might have iron in them and become dislodged during the MRI scanning process. Access to the MRI suite should be strictly restricted only to staff who have been appropriately trained and screened. The facility and staff are both responsible to safely manage all potential risks in the MRI room. Potential projectile items, such as oxygen tanks, monitors, sandbags, cleaning supplies, and fire extinguishers should be removed from the room, properly secured by an authorized MRI technician, or replaced with non-ferromagnetic equipment. Staff should remember that the MRI magnet is always on, even when a patient is not being scanned. Therefore, in the event of a cardiopulmonary arrest or code, resuscitation must never take place in the MRI room. In addition, any electrical connections, such as monitoring cables, must be visually checked for integrity and safely positioned by the technician. During the MRI procedure, patients should be provided with ear protection because of the loud noises associated with the MRI exam. In 2020, the American College of Radiology (ACR) updated its guidance and manual on MR Safety which can be accessed here.

For more information on MRI Safety please read TJC's updated Quick Safety #3 on Strong MRI safety programs to prevent safety events.

Radiation Safety

Many of the diagnostic tools used today use radiation to show detailed internal physical images. While patient exposure to radiation during routine testing is a relatively safe method for diagnosis, all attempts should be made to prevent patient injury resulting from radiation. It is important to maintain radiation doses as low as reasonably achievable (ALARA) when obtaining the needed diagnostic information. Under California law, the radiation dose given to the patient must be documented in the patient's medical record to help limit or prevent excess radiation doses. Prior to conducting any imaging study, verify the diagnostic order made by the ordering provider, patient's identification by using two facility-approved patient identifiers, imaging site, and correct patient positioning. Patients who are at reproductive age should have the reproductive organs shielded when the radiological exam does not require exposure to that part of the body. If pregnancy exists or is suspected

and wasn't noted by the ordering provider, the physician should be notified before the exam to determine whether the exam should proceed. If the exam is needed, appropriate shielding should be used when possible. For all patients, great care should be taken to keep the radiation exposure to a minimum requiring just enough to produce an acceptable diagnostic image. Be aware of potential exposure to radiation by observing for posted radiation warning signs. In addition, radiation rooms will have warning lights that illuminate during radiation exposure. In the event of a radiological incident, follow your facility's posted emergency procedures. Some radiological procedures require patients to stand or sit in certain positions. Caution should be taken to ensure that patients who are unsteady are not placed into positions that may allow them to fall. The positioning of the patient may need to be modified to prevent patients from falling or otherwise injuring themselves during the radiological exam.

ACR has recommendations and resources designed to assist you in providing effective imaging and therapy while minimizing the potential risk during exposure to ionizing radiation which is accessible here.

In addition, the revised TJC Sentinel Event Alert on "Radiation risks of diagnostic imaging and fluoroscopy" recommends that we ensure the:

- Right test
- Right dose
- Effective processes
- Safe technology
- Safety culture

PATIENT TRANSPORTATION

Safe Transportation of Patients

Transporting patients between facilities or from one unit to another always involves some degree of risk. To minimize these risks, ensure that the patients receive stabilizing treatment prior to the transfer adequate handoff communication occurs and the patients have the necessary equipment to maintain physiological stability.

Emergency Medical Treatment and Active Labor Act (EMTALA)

In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA), was passed by Congress as a part of the Consolidated Omnibus Reconciliation Act (COBRA). The purpose of the legislation was to address the problem of hospitals refusing to provide emergency care for patients based on their ability to pay.

Hospitals that provide emergency services are required to conduct a medical screening examination when request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with an emergency condition. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, transfer to another facility may be implemented. To ensure patient safety and to minimize the risks involved, it is important that transport personnel are provided with appropriate and suitable

equipment. Handoff communication should be given by the transporter to the receiving staff member upon arrival. Qualified and appropriately skilled staff members should accompany patients who require continuous physiologic (i.e. cardiac, ventilator, etc.) monitoring. During transport, all siderails should be raised until the patient is ready to be transferred to another stationary surface. Prior to transfer, the brakes should be securely locked to prevent patient falls or employee injury. Some patients bring their own walker to their clinic or hospital visits. Staff must NOT use the patient's walker as a substitute for a wheelchair when transporting the patient as this greatly increases the risk of the patient falling. Confidentiality of the patient's health information should always be maintained during transport. Please review your facility's policy and DHS Policies 373, 373.2, 373.3, and for additional information on both inter-facility and intra-facility transfers.

In addition, there may be additional steps you need to take in transferring and/or transporting COVID positive patients, ensure to check the DHS COVID SharePoint site to get the latest patient transfer/transport guidance.

EQUIPMENT SAFETY

Physiologic Alarms

Many medical devices have physiologic alarm systems which are essential to provide safe care to patients. These include cardiac monitors, bed, alarms, apnea alarms, pulse oximetry devices, ventilators, IV pumps, etc. The alarm signals from these devices alert caregivers to changes in patient's condition that require immediate intervention. However, it may compromise patient safety. Back in June 2013, TJC announced a renewed NPSG for hospitals on clinical alarm safety. TJC identified the following risk points that contribute to alarm and monitoring-related adverse events: alarm fatigue, communication breakdown, staff training issues, and equipment failures. To help prevent risks associated with physiologic alarms, staff must know how to use the medical devices used in their work unit, request for training if not completely familiar with the medical device, follow their facility-specific protocols on the medical device alarm settings, thoroughly inspect and ensure that the medical device is in good working condition prior to use, and appropriately prep the patient before connecting to a medical device. Remember, physiologic alarms must be audible despite background noise and should never be muted or turned off, even if they become distracting. Instead, investigate the cause of the alarm and take measures to address the cause. Ensure to read your facility's Clinical Alarms Management Policy and familiarize the standardized/set parameters of your alarms in your clinical area.

For more information on alarm system safety, read NPSG on Clinical Alarm Safety, TJC Sentinel Event Alert Issue #50 (April 8, 2013) Medical device alarm safety in hospitals.

Preventive Maintenance

Electronic medical equipment is generally maintained by your facility's Biomedical Department. Routine maintenance ensures that equipment is functioning properly and is free from potential hazards. As an employee, you are responsible for the safe operation of equipment including reporting when it is broken or involved in a patient care incident. To ensure the proper use of equipment and prevent patient harm, follow these guidelines:

DO

- Conduct any assigned daily checks on equipment
- Remove broken equipment from the patient care area
- Label/tag broken equipment
- Notify the Biomedical Department of the broken equipment

DO NOT

- Operate equipment if not trained
- Attempt to repair equipment
- Use unauthorized extension cords
- Calibrate or change settings on equipment if not authorized to do so

Please see the Care of Patient Care Equipment section of the handbook for the recommendations on ensuring the use of clean patient care equipment.

Emergency Power

If your facility should lose power, back-up generators are available to maintain core electronic functions. Red outlet plugs are in each unit and patient room and are directly connected to an emergency power supply. All critical patient support systems, (i.e. ventilators), should be plugged into these red emergency outlets. Your facility should have written contingency plans for staff to follow during a loss of electrical power. Be sure to find out where such plans are in your facility.

ENVIRONMENTAL SAFETY

Our environment can be rapidly and unexpectedly affected by a man-made or natural disaster such as fire, flood, or spill. It is critical that all WFMs assess for the risk of and respond appropriately to these situations.

Fire

The potential for fire in the operating room was discussed earlier. Fire is a devastating occurrence in the healthcare setting. The use of flammable gases and agents predisposes the healthcare setting to these risks. If a fire occurs in your area, follow these instructions (RACE):

- R – Rescue any patient(s)/person(s) from immediate danger and send/take to a safe location
- A – Activate the fire alarm and notify the emergency operator by dialing your facility's internal emergency number or 911 (when applicable)
- C – Contain/Confine the fire and smoke by closing the door(s) in the area if safe
- E – Extinguish the fire only if safe to do so by using the proper extinguisher, evacuate patients and/or persons from the area of the fire and move to a safe location

To extinguish a fire, follow the PASS system using an appropriate fire extinguisher.

- Pull the pin 
- Aim at the base of the fire
- Squeeze down on the lever
- Sweep from side to side

Earthquake

Severe earthquakes can and have occurred in Southern California. Although many healthcare facilities have been reinforced to prevent collapse and damage during an earthquake, this does not remove the danger altogether. If you are working at the time of an earthquake, remember these important points:

- Remain calm
- Secure and protect the patient, if safe
- Protect yourself – drop, cover, and hold
- After the movement stops, begin assessing patients or co-workers for injury
- Assess surroundings for damage
- Standby for instructions from your leadership

Spill/Release

Some chemicals used for preserving tissue, treating medical conditions, and cleaning, may be toxic and harmful when inhaled or when they come in direct contact to the human skin and mucous membranes. If you come across a spill or release of a chemical, you should immediately remove patient/staff from the surrounding area.

If possible, close the door to confine any vapors and call the facility's internal emergency number or 911 where applicable. Obtain the appropriate Safety Data Sheet (SDS), formerly known as Material Safety Data Sheet (MSDS) and provide the information to the responding team. Restrict access to the affected area until cleared by the appropriate responding team or per facility's policy.

Tips for a Safe Environment

There are few things that you can do to help keep your environment safe at all times. These include:

- Keep work areas free of clutter; items should be 18 inches from the ceiling and boxes should be placed on a pallet
- Doors and walls should not be cluttered with loose combustible items (i.e., paper, strings, tissue paper, etc.)
- Posted documents should be laminated
- Ensure that all exits, fire doors, fire extinguishers, fire alarms, and sprinklers are not obstructed
- Place cords safely behind desks and out of walkways
- Use proper facility approved electrical cords and small appliances

- Refrain from using any kind of wedges to keep doors open
- Conduct “drills” in your area to ensure that everyone is knowledgeable and comfortable with your facility’s safety procedures. These drills should be documented

OTHER SAFETY ISSUES

Emergency Codes

All WFMs are required to learn and familiarize themselves with the DHS standardized emergency codes used across all DHS facilities:

Code Assist – Urgent medical assistance to outpatients, visitors, and staff

Code Blue – Adult medical emergency

Code Gold – Mental health/behavioral response

Code Gray – Combative person (aggressive, combative, violent, or abusive behavior that is displayed by non-inpatients including outpatient visitors, and WFMs)

Code Green – Patient elopement

Code Orange – Hazardous material spill/release

Code Pink – Infant abduction

Code Purple – Child abduction

Code Rapid Response – Urgent medical attention to inpatients

Code Red – Fire

Code Silver – Person with a weapon and/or active shooter and/or hostage situation

Code Triage Alert – Potential disaster

Code Triage External – External disaster

Code Triage Internal – Internal disaster

Code White – Pediatric medical emergency

Code Yellow – Bomb threat

Ensure to check your facility’s response procedures related to the above standardized emergency codes. The use of a verbal modifier (during the announcement) is allowed to enhance communication and/or understanding (i.e., Code Pink with description of the infant – “Code Pink, female newborn with blue top”). For more information check your facility policy on Emergency Codes and DHS policy 905.

Patient Security
Healthcare facilities have the responsibility to ensure that security measures to protect patients are in place. Patients depend on their healthcare providers for reassurance and security, as many feel vulnerable and have lost their ability to protect their person and belongings in a setting that is different from their homes. Strategies that can be used to increase a patient's security include:

- Always wear a clear and visible DHS issued identification badge-when at work
- Introduce yourself to the patient
- Stop strangers in your work area and question who they are and why they are in your area
- Instruct patients to question anyone who attempts to render care without a facility ID badge (remind patients that a stethoscope or lab coat does not necessarily mean the person is a doctor)

Infant Abduction
Although the crime of infant abduction occurs very rarely, it is clearly a subject of great concern. Based on a study of cases from 1964 through August 2022, the National Center for Missing and Exploited Children reported 337 infant abductions; fifteen infants are still missing. Out of the 335 cases, 140 were abducted from healthcare facilities (most from the mother's room), 148 from home, and 49 from other locations. There are 16 remaining abducted infants under 6 months of age.

The typical abduction from a healthcare facility involves an "unknown" female abductor impersonating a nurse, healthcare employee, volunteer, or relative. On some occasions, the abductor becomes familiar with healthcare staff members, their work routines, and the victim's parents. It is also known that the length of stay in the obstetrical units is generally short and visitors are generally welcomed to visit. There are constantly changing, new faces that make recognition of a "stranger" more difficult. Newborn infants also spend a great deal of time with their mothers where there is easier access to the infant than in the nursery. Most abductors may use this fact to "con" the infant directly from the mother. Mothers should be carefully instructed about how to identify a staff member with whom they may entrust their infants.

Healthcare staff should be alerted to any unusual behavior and question anyone who looks out of place. Be aware that a disturbance may occur in another area of the facility creating a diversion for the abductor. Also, be mindful of the fact that infants may need to be taken to many areas within the facility, and thus their safety and security must be maintained even outside of obstetrical and pediatric units. For more information, read

http://www.missingkids.com/theissues/infantabductions

Newborn Surrender
In January 2006, the Safely Surrendered Baby Law was signed into state law.
From January 1, 2001 to December 31, 2021, 134 newborns were surrendered in California, and 94 newborns were surrendered in 2022 alone. There were 194 infants abandoned since 2001, one of which occurred in 2022.

The law allows parents to give up their baby confidentially and without fear of arrest or prosecution if the baby has not been abused or neglected. A parent who is unable or unwilling to care for a baby within 72 hours of birth can hand the baby to any employee at a Los Angeles

County emergency room or fire station and is not required to give any information as long as the infant shows no signs of abuse or neglect. The law allows a parent or person with lawful custody 14 days from the time of surrender to reclaim their baby. For this reason, staff will give the parent and the infant matching bracelets. The parent should be asked but is not required to fill out a medical questionnaire designed to gather important medical information, which is useful in caring for the child. If you work in the emergency room, review your facility's policy on newborn surrenders and the appropriate processes to follow in those situations.

Patient Elopement and Patients Leaving Against Medical Advice (AMA)

While receiving treatment in a healthcare facility, patients are expected to remain in their assigned areas and alert staff if they want to leave. Patients who leave the assigned area without staff awareness are considered to have "eloped." Measures for preventing elopement include thoroughly assessing patients for confusion, placing confused patients closer to the nursing stations, and instructing patients to remain in their assigned units while they are receiving treatment. Should a patient elope from the assigned area, follow your facility's policy on patient elopement and document in the patient's chart the time the patient was noted missing and what actions were taken when the absence was discovered.

Every competent patient has the right to refuse treatment and the right to leave the hospital AMA. If your patient is an adult or legally emancipated minor, is not on any holds, and requests to leave AMA, follow your facility's policy on patients leaving AMA. Confirm that the patient has decision-making capacity. Document the patient's AMA on your facility approved AMA form, citing risks and benefits reviewed. If the patient refuses to sign the form, do not attempt to force his or her signature. Document the details of the event and any discussion in the patient's chart including any discharge instructions that were provided.

Patient Suicide

Suicide is currently the tenth leading cause of death. More lives are lost from suicide than traffic accidents and more than twice as many as homicides. Because this statistic is not improving, TJC has re-evaluated NPSG 15.01.01 and, effective July 1, 2019, has added seven new and revised elements of performance. These new requirements are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide.

Healthcare providers in the emergency department, primary care, and behavioral health care settings have an important role in detecting suicide ideation and ensuring appropriate evaluation. The patient's risk of suicide is 200% higher during the first week after discharge from a psychiatric facility. It remains especially high during the first year and continues to be high through the first four years after discharge.

It is essential to identify the risk factors for patients who are at risk for suicide since most of them will not voluntarily disclose suicide ideation.

Suicide risk factors include patients with:

- Mental or emotional disorders (particularly depression and bipolar disorder)
- Previous suicide attempts or self-inflicted injury
- History of trauma or loss (i.e., abuse as a child, family history of suicide, bereavement, economic loss)
- Alcohol or drug abuse

- Social isolation or pattern/history of aggressive or antisocial behavior
- Within first year of discharge from inpatient psychiatric care
- Access to lethal means coupled with suicidal thoughts

However, there is no typical suicide victim. Most individuals who have these risk factors do not attempt suicide and others who do not have these conditions may do so. In 2021, according to CDC's Substance Abuse and Mental Health Services Administration (SAMHSA) database, there were 48,183 people died by suicide in the US (equivalent to 1 death every 11 minutes). In 2022 the easy-to-remember 988 number to reach the National Suicide Prevention Lifeline became operational. The Substance Abuse and Mental Health Services Administration (SAMHSA) encourages all healthcare providers to promote awareness of the 988 number and offers valuable resources for suicide prevention. SAMHA is the primary Federal agency leading efforts to advance the behavioral health of the nation. They developed a 988 Partner Toolkit with resources for partners to use and share information about the 988 Suicide and Crisis Lifeline (a nationwide help that is available to those who are emotionally struggling or in crisis). Visit SAMHSA to learn more about agency and its available resources.

Based on TJC Sentinel Event database, in 2022 there were approximately 73 patients who died of suicide while receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge from the hospital or from the emergency department. The NPSG 15.01.01 has been revised to take a high-level approach to suicide prevention and to, help organizations improve processes and environments for individuals at risk for suicide.

Specific areas addressed include:
- Environmental risk assessments and action to minimize suicide or environmental risks
- Use of validated screening tool to assess patients at risk
- Developing plans to mitigate suicide based on individual's overall level of risk
- Following established policies and procedures for counseling and follow-up care for individuals identified at risk for suicide.

To learn more about TJC's recommendations on suicide prevention, see Suicide portal https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/ on The Joint Commission website, for the Suicide Risk Recommendations from Suicide Risk Reduction Expert Panel (see "Compliance with Suicide Recommendations" section).

In 2018, TJC Journal on Quality and Patient Safety also published an article on the incidence and method of suicide in hospitals in the US and in 2019, TJC also revised their R3 report on Suicide Prevention.

OTHER MEDICAL-LEGAL INFORMATION

Being involved in a negligence or medical malpractice lawsuit can be frustrating and confusing. Understanding a few legal concepts, if ever confronted with this situation, may make the process easier.

Indemnification

As public employees of the County of Los Angeles, indemnification (legal protection) is provided for any injury arising because of the employee's action or omission occurring within the scope of employment under Government Code 825. For the purposes of the code the word "employee"

includes officers, employees, servants, and volunteers but excludes “independent contractors”. Independent contractors should consult their individual contacts for the terms regarding indemnification while working for LACDHS.

Employees and covered contractors of Los Angeles County are not protected from liability resulting from:

- Willful misconduct, corruption, malice, or lack of good faith
- Fraudulent activity
- Intentional infliction of an injury, or any act performed outside the course and scope of employment
- Criminal actions

Los Angeles County is self-insured. Essentially this means that the County does not have insurance and all costs related to litigation are ultimately borne by the Los Angeles County taxpayers.

Elements of Negligence

Negligence is failing to do something that a reasonably prudent person would have done, or doing something that a reasonably prudent person would not have done, under similar circumstances. Medical malpractice is a form of negligence where the act is committed in the course of professional responsibility. When there is an allegation of medical malpractice, the plaintiff must establish and prove all the following elements:

1. That a duty was owed to the plaintiff.
2. That the health care provider breached that duty.
3. That breaching the provider’s duty proximately caused an injury; and
4. That the plaintiff suffered damages relative to the injury.

Duty

Duty begins when you enter a relationship with a patient to provide care. In performing your duty, you must provide a reasonable level of care, similar to what others practicing in your field would provide under the same circumstances. If the standard of care is not met, then a breach of duty is said to exist.

Breach of Duty

In a malpractice action the breach of duty must have proximately caused an injury. This means that had the health care provider acted, or not acted in the manner alleged, the injury would not have occurred. Proximate cause attempts to establish a direct cause and effect between the provider’s conduct, or lack thereof, and the patient’s injury.

Damages

Damages are the losses the patient/plaintiff suffered because of the injury. They can be economic, emotional, related to future earning-potential, or personal. These are the monetary

awards levied on the defendant to "pay" for the injury. In California, the maximum judgment amounts for economic damages and/or loss of future potential earnings have no limit. There is a limit to compensation for pain and suffering which changes every year.

The Legal Process

Throughout the legal process and in all the steps involved, WFMs are expected to cooperate with County Counsel or other attorneys assigned by County Counsel. As part of the County indemnification rules, employees and covered contractors are provided legal counsel free of charge when they are being represented for a claim arising from actions made in the scope of their employment. Using the County's funds to pay for a private attorney for legal representation is prohibited. County Counsel (or County Counsel's designee) may attend hearings and trials, assist in making settlements, and secure or provide evidence on the employee's behalf. WFMs should not voluntarily make any payment, assume any obligation, or incur any expense related to claims against the county (County Code: Ord. 9022 § 1 (part), 1966: Ord. 8345 § 1 (part), 1963): Ord. 7552 § 1 (part), 1959: Ord. 4099 Art. 3-D § 93.88, 1942). Workforce members are expected to participate in the defense of an alleged claim and non-cooperation may result in disciplinary action.

When a person initiates legal action against the County, there are certain steps that must be followed. The first step involves the plaintiff filing a claim with the Board of Supervisors. The plaintiff then needs to serve a summons and complaint which outlines the alleged action against the defendant(s). Should you ever personally receive one of these items, or any other legal document related to a claim against you as part of your County employment, immediately forward the documents to your facility Clinical Risk Manager for appropriate handling and response.

Interrogatories

As part of the legal process, each side is allowed to ask and receive responses to written questions from the opposing party. These questions are called interrogatories and are prepared by attorneys for their respective clients. Generally, they are not sent directly to you, but to your defense attorney. However, if you receive an interrogatory, notify your facility Clinical Risk Manager. Do not communicate or correspond with any attorney unless specifically authorized to do so by your facility Clinical Risk Manager.

Depositions and Testimony

The deposition process is a means whereby you provide your testimony under oath. This testimony may later be used at trial to impeach or contradict you. Therefore, it is important that you prepare for your deposition, meet with the defense counsel provided prior to the deposition, and follow their instructions.

County code and conflict of interest policies restrict the type of depositions or testimony that employees may take part in. Specifically, employees are not allowed to provide expert testimony against the County in any legal action where the County is a party to the action. Employees are allowed, and are expected to, provide testimony in proceedings in defense of the County. Any

employee who is required to testify in any judicial proceeding in their official capacity shall be entitled to collect their usual salary while testifying.

Trial versus Settlement

Some cases will be taken to trial and others will be settled. The decision to act either way will be made by County Counsel with the County's and your interest in mind. Should County Counsel advise you to agree to a settlement, and you refuse (without a good and sufficient reason to do so) the County is not liable for any resulting judgments against you. Your facility Clinical Risk Manager, and the assigned defense counsel, will provide you with information regarding the status of a case if you are personally involved.

Licensee Reporting to Licensing Board and National Data Bank

There are laws that govern the reporting of medical malpractice payments to licensing boards and the National Practitioner Data Bank (NPDB). LACDHS is required to report licensees to their respective board and the NPDB when they are involved in malpractice cases where a payment was made on their behalf. The amount of money apportioned to the licensee, not necessarily the total amount of money awarded, usually determines when a licensee will be reported to licensing boards. Each licensing Board has determined their reportable limits for their licensees. The NPDB however, requires malpractice cases to be reported when there is any amount money paid on behalf of a provider named in a claim and settlement agreement. To view the current reportable limits and obtain additional information about mandatory reporting of licensees, please review the LACDHS Policy #311.3, "Apportionment and Reporting of Settlements, Judgments, or Arbitration to Licensing Boards and the National Practitioner Data Bank".

CONCLUSION

DHS is committed to building a just culture work environment, but we know this environment is not created overnight, nor can it happen without your participation. You, our employees, are on the frontline and are in the best position to identify issues and their solutions. We have developed this handbook to guide you in your daily practice and to assist you in making your patients' care safer.

This handbook is also designed to serve as a resource when navigating the legal complexities of health care. The scope of this handbook is limited, and all the legal topics in health care exceed well beyond its covers. Should you have clinical risk management or legal questions that are not answered in this handbook, please contact your Clinical Risk Manager or DHS Risk Management at CRM@dhs.lacounty.gov.

If you need additional information on the DHS patient safety activities, please visit the DHS Clinical Risk Management and Patient Safety Program website located under Quality, Risk & Safety on the DHS SharePoint® Intranet.

If you have any questions or would like to report any patient safety risks and/or concerns, inform the Patient Safety Officer at your facility, report it via the SI Reporting tool, or you can email them to patientsafety@dhs.lacounty.gov.

COPYRIGHT

NOTES