Health Services
LOS ANGELES COUNTY

Risk Management and Employee Patient Safety Handbook

2017

Risk Management and Patient Safety Program

PREFACE

The LA County Department of Health Services Risk Management and Patient Safety Program is proud to present this year's revised Employee Risk Management and Patient Safety Handbook. Input for the handbook was received from patient safety officers, risk managers, and members 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 risk management issues.

Patient Safety and Risk Management are issues important to all workforce members, whether you interact directly with patients, or provide a vital service to support the provision of 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 and preventing lawsuits.

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

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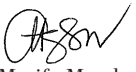

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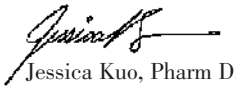

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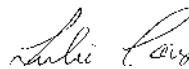

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2017 EMPLOYEE RISK MANAGEMENT AND PATIENT SAFETY HANDBOOK LEARNING OBJECTIVES:

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

1) Discuss the concepts and principles surrounding patient safety onthe following specific areas: 2017 NPSGs, Communication,Event 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) Give at least one example of a patient safety best practice or recommendation mentioned in the handbook specific to each of the patient safety areas listed above (#1).
3) Describe common reasons for litigation in health care.
4) Discuss actions DHS workforce members can take to prevent complaints, claims, and lawsuits.

Nursing Continuing Education Information:

There will be a 5.0 contact hours provided by Los Angeles County Department of Health Services Office of Nursing Affairs. Additional CE information located at the last page of the handbook.

INTRODUCTION

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

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

The 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 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 through a system of reporting of patient safety events which include adverse events, no-harm events, near misses, and hazardous (unsafe) conditions, supported by our Safe and 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)
- Assistance with disclosure of adverse events and medical errors to patients and/or families
- Patient safety education for patients, families, and health care providers through various modes of communication

The Risk Management and Patient Safety Program is under the direction and supervision of the Director Risk Management and Patient Safety. The Director works collaboratively with the 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 risk management and patient safety principles in their daily work to keep patients 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 the Joint Commission National Patient Safety Goals and Standards.

In July 2002, the Joint Commission 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. The Joint Commission 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 the Joint Commission's website at http://www.jointcommission.org for more information.

2017 National Patient Safety Goals (NPSG) and Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

2017 NPSGs

Goal I

Improve the accuracy of patient identification.

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

B. Eliminate transfusion errors related to patient misidentification (NPSG. 01.03.01)

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)

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

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 and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines (NPSG. 07.07.07)

B. Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals (NPSG. 07.03.01 Hospital setting only)

C. Implement evidence-based practices to prevent central line-associated bloodstream infections (NPSG. 07.04.01 Hospital setting only; covers both short and long term central venous catheter and peripherally inserted central catheter (PICC) lines)

D. Implement evidence-based practices for preventing surgical site infections (NPSG. 07.05.01)

E. Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI) (NPSG. 07.06.01 Adult Hospital setting only)

Goal XV

The organization identifies safety risks inherent in its patient population.

A. Identify patient at risk for suicide (NPSG. 15.01.01 Hospital setting only; only applies to patients being treated for emotional and behavioral disorders)

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 standardized Time Out checklists. The DHS Standardized Surgical Final Time Out checklist must be used for each procedure perform in the surgical suite or operating room. The DHS Standardized Non-OR Time Out checklist must be used for any procedures that require an informed consent and is perform 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 plays 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 a similar sounding or looking name as someone else). Since we can not 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/workflows in order to eliminate if not minimize the likelihood of errors and impact of errors when they occur. Human factors is not directly about humans it is about understanding the human limitations and workplace design and equipment that staff use at work which should allow for variability in humans and 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 at any situation. Studies shown that fatigue and stress are the two major factors that mostly impact human performance which predispose a person to error. In addition, fatigue, stress, and performance deterioration are known risk factors in patient safety. High stress and fatigue are something that everyone can relate in health care at the time same, 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 from 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 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 communication strategies that are fewer in number but more clear 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

For more information about human factors and human performance, visit http://www.who.int/patientsafety/education/curriculum/who_mc_topic-2.pdf

A SAFE AND JUST CULTURE

DHS strives to build, maintain, and support a Safe and Just Culture. A Safe and Just Culture is one in which safety is an individual and organizational priority and where errors, near misses, adverse events, and safety or quality concerns can be easily reported. These reports are viewed as an opportunity to learn and improve upon the delivery of care.

Every DHS WFM is responsible for reporting these events in a timely manner. All WFMs are encouraged to report these conditions by way of the Safety Intelligence™ (SI) online reporting system. WFMs will not be punished or retaliated against for reporting an error, near miss, adverse event, or safety and/or quality concerns. Leadership however, will hold WFMs accountable and take appropriate corrective action in concert with DHS Discipline Manual and Guidelines, County Civil Service Rules, and DHS policies and procedures for:

- Behavior that knowingly puts patients, visitors or staff at risk of harm.
- A conscious or willful disregard of organizational policies and procedures.
- Behavioral choices that are disruptive to the workplace environment (e.g., substance abuse).
- Commission of repetitive human errors, repetitive justifiable choices, or repetitive at-risk behaviors that demonstrate an inability to fulfill legitimate work requirements and/or assigned job duties/responsibilities.

The WFM will not carry the burden for system flaws over which they have no control. **The DHS Safe and Just Culture Response Guide** will assist leadership in determining the underlying behavior and corresponding response to errors, near misses, and adverse events.

Please see DHS Policy "A Safe and Just Culture" 311.4 for more information.

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 victimized in the sense that the provider is traumatized by the event. Frequently, these individual 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 the 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 a predictable recovery trajectory. Dr. Scott and her team built a robust for YOU Team at 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.

Stages 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 is working incorporating early disclosure and resolution in order to allow for second victims to heal and the organization to learn and grow from adverse events.

Resources Available to DHS Staff

Department of Health Services has been working on creating a second victim program for the past year. The initiative is being led at LAC+USC Medical Center with the hopes to pilot a sustainable model that can be spread not only throughout DHS but all Los Angeles County agencies. 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
- Medically Inducted Trauma Support Services (MITSS): 888-366-4877
- National Suicide Prevention Lifeline: 800-273-8255

LAC+USC Employees

- Incident Debriefs: Social Work (323-409-5253) or Psychiatry (323-409-1665)
- Second Victim Committee: 323-409-6535

USC Faculty

- USC Center for Work & Family Life: 213-821-0800

USC Students

- Eric Cohen Student Health Center: 323-442-5631

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 Events

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. Near misses are much more common than adverseevents. It is extremely important for a WFM to report these events as they identify system vulnerabilities that can produce harmful events. Your Patient Safety Officer or Risk Manager may review your facility's near miss reports and determine priorities for patient safety initiatives at your facility. The DHS Risk Management and Patient Safety Program (RMPS) also uses near miss data to identify system-wide opportunities for improvement. RMPS collaborates with facility leadership and DHS-wide workgroups to design high reliability systems to prevent patient harm.
- 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 defined as the failure of a planned action to be completed as intended, or the use of a wrong plan to achieve an aim with actual or potential negative consequences for the patient. WFMs who become aware of a patient safety event (of any type) are expected to report it as soon as possible via online Safety Intelligence™ (SI) system. The Risk Manager or Medical Director may then decide if the event meets the criteria for a California Department of Public Health (CDPH) reportable event, Joint Commission Sentinel Event or other significant event that requires reporting and 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.

Examples of 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;
- 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 temporary harm of the patient;
- hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups);
- rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services or staff member, licensed practitioner, visitor, or vendor while on site at the organization;
- invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is wrong (unintended) procedure;
- unintended retention of a foreign object in a patient after an invasive procedure, including surgery;
- severe neonatal hyperbilirubinemia (bilirubin > 30mg/dl);
- prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose;
- fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care;
- any intrapartum (related to the birth process) maternal death; and
- severe maternal morbidity when it (not primarily related to the natural course of the patient's illness or underlying condition) reaches a patient and results in permanent harm or severe temporary harm

Above listed events are considered "sentinel" because they signal a need for immediate investigation and response. It is important to report a sentinel event to your department manager, facility risk manager, or facility patient safety officer as soon as you become aware of one to prevent further injury and harm to patients. In

addition, Joint Commission accredited facilities are required to complete a root cause analysis and action plan within 45 calendar days of the event or of becoming aware of the event.

For more information, read TJC's Sentinel Event Policy and Procedures

California Department of Public Health 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 CPDH include:

Surgical Events

- Surgery on the wrong body part
- Surgery on the wrong patient
- The wrong surgical procedure performed on the patient
- Unintentional retention of a foreign object
- Unexpected death within 24 hours of anesthesia

Product or Device Events

- Patient death or serious disability associated with a contaminated drug, device or biologic
- Patient death or serious disability associated with the use or function of a device in which the device is used other than as intended
- Patient death or serious disability associated with intravascular air embolism

Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient disappearance for more than four hours (excluding patients with competency or decision-making capacity)
- Patient suicide or attempted suicide resulting in serious disability after admission to the facility

Care Management Events

- Patient death or serious disability associated with a medication error
- 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 and delivery in a low-risk pregnancy (including events that occur within 42 days post-delivery)
- Patient death or serious disability directly related to hypoglycemia
- Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life
- Stage III, IV, or unstageable ulcer, acquired after admission to the facility (does not include stage III ulcers that progress from a stage II ulcer that was identified on admission).
- Patient death or serious disability due to spinal manipulative therapy

Environmental Events

- Patient death or serious disability associated with an electric shock
- 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
- Patient death or serious disability associated with a burn while being cared for in a health facility
- Patient death associated with a fall while being cared for in a health facility
- 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 provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of a health facility
- Death or significant injury of a patient or 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 (a) within five days after it has been detected or (b) within 24 hours after it has been detected if it is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors. Your facility Risk Manager or Administrator will make these reports to CDPH. 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, fire, 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 SI, LACDHS workforce members 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 agenciesimmediately. Abuse must be reported for all cases involving children, domestic partners, and dependent adults to County Police and Social Services. 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 a "zero tolerance" policy (LACDHS Policy #792). Threats, threatening behavior or acts of violence against workforce members, patients, visitors or other individuals 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 injury as a result of a violent episode must report the occurrence immediately to the facility's law enforcement officer and file an event notification in SI.

Completing an Event Report

When reporting a patient safety event in SI, all mandatory fields noted in red must be completed. However, workforce members are encouraged to add additional

specific details including the names of individuals involved in the event or any other known details not documented in the patient's chart. The reports should be objective, factual, and thorough. SI report will automatically be routed to the appropriate people for follow-up once submitted.

Even 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 a report was filed.

Reporting Safety or Quality of Care Concerns

Any workforce member who has concerns about the safety or quality of care provided in the health care setting may report these concerns to the LACDHS Patient Safety Hotline at (213) 989-7233 or by email at patientsafety@dhs.lacounty.gov. Workforce members may also report concerns directly to the Joint Commission 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 adverse events, errors, close calls, or safety or quality concerns.

Reporting Safety or Quality of Care Concerns
In addition to reporting concerns through your supervisor or manager, there are several external mechanisms for reporting concerns:
- LACDHS Patient Safety Hotline: (213) 989-7233 or patientsafety@dhs.lacounty.gov
- The Joint Commission www.jointcommission.org or (800) 994-6610

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 system
- Document facts about the event clearly, factually, and objectively in the medical record
- Consult with your facility's Risk Manager for advice and coordination in disclosing the event with the patient or family (see Communication of Unanticipated Outcomes below)

- Maintain confidentiality of the patient and staff involved; do not discuss the event unless directed to do so

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 root 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 assists them 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 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://cao.lacounty.gov/EAP

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 that record is missing key documentation.

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, assessments 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.

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 or 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 Communication

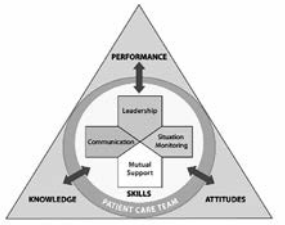
The receipt, documentation, and timely communication of critical results of tests and diagnostic procedure reports to the responsible licensed provider of care is an important component of patient safety. Communicating these abnormal results within an established timeframe may help to prevent life-threatening 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 when 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 arise from casual conversations between providers about a particular patient that has been overheard by a friend or relative of the patient. There are exceptions for law enforcement with mandatory reportable crimes and when public safety is at risk. These exceptions can be found on the US Department of Human Health Services website at: http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_ purposes/505.html. 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?

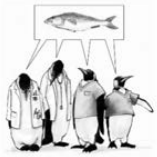


TeamSTEPPS An evidence-based patient safety curriculum designed for health care professionals. It was developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD). Teamwork has been found to be one of the key initiatives within patient safety that can transform culture. Patient safety experts agree that communication and other teamwork skills are essential for the provision of quality health care and for the prevention and mitigation of medical errors and of patient injury and harm.

What are the four major pillars in TeamSTEPPS?

1. Communication: Process by which information is clearly and accurately exchanged among team members.

2. Leadership: The ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared, and team members have the necessary resources.



3. Situation Monitoring: Process of actively scanning and assessing situational elements to gain information understanding, or to maintain awareness to support functioning of the team.

4. Mutual Support: The ability to anticipate and support other team members' needs through accurate knowledge about their responsibilities and workload.

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 problem is?

d. Recommendation—What would I recommend?

2. Call-out: is a tactic used to communicate 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 strategy used to verify a request is received. Sender initiates request or message, receiver confirms he/she has received the request

4. Handoff: is designed to enhance information exchange at critical times such as transitions in care. More importantly, it maintains continuity of care despite changing caregivers. Each facility should determine a standard protocol for delivering handoffs and make the protocol known to staff.

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: 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 situation awareness.

3. Debriefs: can be a brief (about 3 minutes or less) team event, typically initiated and facilitated by the team leader after a clinical event.

What is Situation monitoring?

Process of actively scanning behaviors and actions to assess elements of the situation or environment. 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, which is commonly referred to as "backup behavior," is critical to team performance. Mutual support is derived from situation monitoring through the ability to anticipate patient needs, as well as other team members' needs, with accurate knowledge of their responsibilities.

One method of providing mutual support is through **task assistance**. This includes both asking for assistance when needed and offering assistance to 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 or the loss of situation awareness. 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 challenge should provide some support for your concern.

CUS:

The CUS technique is another tool for conflict resolution, advocacy, and mutual support. Signal words, such as "danger," "warning," and "caution" are common in the medical arena. They catch the reader's attention. In verbal communication, "CUS" and other signal phrases have a similar effect. If all team members have a shared mental model and are on the same page, when these words are spoken all team members will clearly understand the issue and its magnitude.

Source: TeamSTEPPS 2.0. Content last reviewed May 2015. 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 communication 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 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.

DHS Patient Safety Program is working on a standardized executive safety and operational briefing for all its facilities. The proposed checklist includes the following items:

- Green light/red light 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
    - Patients in droplet precautions
    - Patients in airborne isolation
    - Patients with C.diff
- Patient Safety Tip of the Week
- 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 executive safety and operational brief, 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:

- Unit census
- Staffing levels
- Specific patients on fall risk precautions
- Central lines (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 actually 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 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 Sentinel Event Alert Issue #40.

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 will 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" 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 while continue helping the other patient groups with developmental delays, vision and hearing impairments, limited language skills, and religious issues.

For more information, review TJC's Roadmap for Hospitals and patient-centered 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 by 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 action 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) Ask Me 3 program - 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 has 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 have developed various patient safety education brochures in multiple languages. These brochures are accessible via DHS Patient Safety Sharepoint® website under Patient Education.

Use of Interpreters

LEP may lead to communication barriers that impede access to health care, compromise the quality of care, contribute to medical errors, and adversely affect patient satisfaction. For LEP patients, it is important that active communication

take place with the assistance of an interpreter. Since 2012, TJC's standards have required the availability of qualified interpreters. LACDHS Policy also requires the use of an interpreter and completion of an Interpreter Attestation Form any time an interpreter is needed to translate the discussion between a patient (or legally authorized representative), and a physician for the purpose of obtaining an informed consent. An interpreter is a designated bilingual employee, staff interpreter, contracted telephone or in-person interpreter, or designated bilingual volunteer, who is qualified to interpret the information given to a patient and any questions that the patient may have. Key points to remember when caring for LEP patients include:

- The patient has to be offered the services of a qualified interpreter if needed
- If the patient chooses to use a family member for interpretation, document their choice by stating the reason and the name of the person serving as the interpreter
- A person younger than 18 may not serve as an interpreter
- If using a video/phone interpreter, it must be documented in the patient's medical record including the interpreter's identification number
- The Interpreter Attestation Form must be completed for those discussions that involve informed consent. If a telephone interpreter is used, staff must document the operator's ID number, and the date and time the activity took place

For more information on the use of interpreters see DHS Policy 314.2 "Documenting Use of Interpretation Services During Informed Consent Discussions", DHS Policy 318 "Non-English and Limited English Proficiency", "Providing Healthcare to Limited English Proficient Patients", and "A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations" by the US Department of Health and Human Services.

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 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 through the use of and Advance Directive or Physician Orders for Life Sustaining Treatment (POLST).

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:

- the nature of the proposed care, treatment, services, medications,

interventions, or procedures

- potential benefits, risks, or side effects, including potential problems that might occur during recuperation
- the likelihood of achieving goals
- reasonable alternatives to the treatment and relative risks, benefits and side effects related to alternatives, including the possible result of not receiving care, treatment, and services
- 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 physician'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 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

If the patient or legally authorized representative has the capacity to make an informed decision, but is physically unable to write his or her name, the person's mark must be obtained. This is done by the physician first writing the person's name in full and then having the person place an "X" beneath it. Two people must witness the signer place his or her mark on the consent form.

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 Risk Manager if you are unsure of who may consent.

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 thepatient (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.

Telephone Consent

Consent should be obtained by telephone only if the person having the legal ability to consent the patient is not otherwise available. If telephone consent is used, the physician must provide the patient's legal representative with all of the information the physician would disclose if the person was present. The iMed form shall also be used to document telephone consent. The telephone discussion should be witnessed by a second authorized workforce member and noted on the iMed form.

> *The 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 refuse

treatment as well. When a patient refuses drugs, blood, or other medical treatment ordered, the physician must determine if the patient has the legal authority and competence to refuse such treatment. If the patient is determined to be competent,

the physician must ensure that the patient is aware of the possible risks and complications that may occur as a result of refusal. The physician has a duty to give the patient all of the information that is relevant to a meaningful decision to refuse.

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

Do Not Resuscitate Order

Informed refusal 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 measure in the event of cardiac or respiratory arrest. A DNR order authorized 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). This 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 documents 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 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, when harm does occur, the results can be fatal. Medication errors are often related to inadequate communication, inaccurate or lack of documentation, insufficient knowledge or training, inattention, and distraction.

Patient Identification

Every time a patient receives care, treatment or services (including medications), he/she must be identified using at least two DHS-approved identifiers. Examples of acceptable identifiers include the individual's 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 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 resulting from medical intervention related to a drug. This includes Adverse Drug Reactions (ADRs), medication errors, allergic reactions, and overdoses. 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 UHC Safety Intelligence 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 in turn promoting patient safety and contributing to the quality of care provided to our patients.

Abbreviations

Abbreviations save time and are commonly used as a convenience in medical documentation. However, some abbreviations, symbols and dose designations are

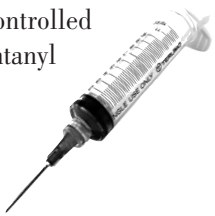
dangerous and should not be used. Many of these dangerous abbreviations are frequently misread and lead to serious mistakes which compromise patient safety. The Joint Commission (TJC) requires accredited organizations to develop and implement a list of prohibited abbreviations. Although TJC maintains their own official "Do Not Use" list of abbreviations which must be incorporated by each organization, your facility may have additional "Do Not Use" abbreviations. Be sure to check your facility's complete list and remember that these prohibited abbreviations should never be used in any physician's orders or medication-related documentation. If you notice the use of an unapproved abbreviation, notify your immediate supervisor and/or the Medication Safety team at your facility. Visit http://www.jointcommission.org/assets/1/18/dnu_list.pdf for TJC's list of restricted abbreviations.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, the Joint Commission 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 > 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
- Parenteral nutrition



The following DHS Expected Practices specifically address some of the above:

- DHS Expected Practice: Fentanyl Transdermal Patch Standard Procedures
- DHS Expected Practice: Safe Handling and Storage of Neuromuscular Blocking Agents
- DHS Expected Practice: Adult Use of Concentrated Heparin

Look-Alike Sound-Alike Medications

The Joint Commission (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 differences 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 not presently addressed by DHS procedures, please notify your immediate supervisor and/or Medication Safety Team for investigation.

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, and as a result, is included in the DHS Expected Practice list of High Alert Medications. 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 usually involves 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"

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 tables 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 dose tables like those above provide good guidance, but clinical judgment based on patient characteristics (age, co-morbidities, and hepatic/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 "Safe Use of Controlled Substance Medications in Non-Cancer Chronic Pain Conditions" contains further information about safety considerations when prescribing controlled substance medications.

Anticoagulant Safety

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant.

Anticoagulants such as unfractionated heparin, low molecular weight heparins, and warfarin when used at therapeutic doses, are more likely than others to cause harm and lead to 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 evaluation and monitoring by healthcare providers

A critical component of anticoagulation safety includes education of patients, family and staff. Patient/family education includes the following:

- Signs and symptoms of bleeding
- The potential for adverse drug reactions and interactions
- Medication and treatment compliance
- The importance of follow-up monitoring
- Drug-food interactions

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

For more information regarding anticoagulant safety, go to https://www.jointcommission.org/assets/1/6/NPSG_Chapter_HAP_Jan2017.pdf

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 when not used within 24 hours, and if expiration 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

For more information, review the NPSG 03.04.01.

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.

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

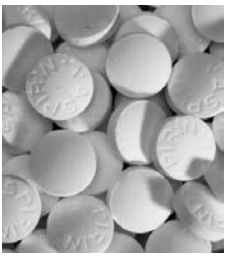
- Request training or in-service on how to use new connectors and devices
- Emphasize the risk of tubing misconnections in orientation and training curriculum
- Inform non-clinical staff, patients, and their families that they must get help from clinical staff whenever there is a real or perceived need 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 based on the 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/

https://www.jointcommission.org/sea_issue_53/

Medication Reconciliation

Medication reconciliation is important in order to maintain and communicate accurate patient medication information, and is an important step in meeting meaningful use requirements with each clinical encounter. Most importantly, medication reconciliation is a crucial step for preventing medication errors.



Medication errors frequently occur during transitions of care, including admission 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. Medication reconciliation is a process where all of the patient's medications, including over the counter, as needed, and herbal medications and supplements, are reviewed and compared with the prescribed medications. The information on this list is updated when the patient's medication regimen is modified. 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 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 writing or renewing prescriptions, particularly with respect to commonly used medications with high interaction potential (e.g. warfarin, phenytoin). Our DHS pharmacists can be an excellent source of information and support for checking for potentially harmful drug-drug interactions.

For more information, please visit :
http://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:
http://www.merckmanuals.com/professional/geriatrics/drug-therapy-in-the-elderly/drug-related-problems-in-the-elderly
http://www.americangeriatrics.org/files/documents/beers/BeersCriteriaPublicTranslation.pdf

Opiates for Non-Cancer Pain

The DHS Expected Practice "Safe Use of Controlled Substance Medications in Non-Cancer Chronic Pain Conditions" outlines the DHS expectations for prescribers starting or continuing controlled substances for non-cancer pain. In brief, it is expected that prescribers:

- Utilize available non-pharmacologic pain management options
- Maximize use of non-controlled substance medications and therapies
- Manage and offer appropriate referral for co-morbid conditions such as

mood disorders, substance abuse disorders
- Consider co-morbid conditions such as sleep apnea, COPD, and advanced age when dosing controlled substances
- Counsel patients on the risks and benefits of chronic use of controlled substances
- Work to develop a plan and timeline for controlled substance discontinuation
- Review and have the patient sign a *Controlled Medication Agreement and Consent* if the controlled medication is anticipated to be continued for more than 3 months
- Utilize the prescription drug monitoring program/controlled substance utilization review and evaluation system (PDMP/CURES) database to review the patient's previous controlled substance prescription history prior to initiating or renewing prescriptions in order to avoid duplication of therapy (and to identify potentially problematic medication use)
- Routinely re-assess the safety and efficacy of the controlled substance therapy
- Update the medication list in ORCHID with each new prescription for a controlled substance
- Consider urine toxicology screening to assess for use of non-prescribed substances (or the absence of prescribed substances which may indicate drug diversion)
- Update the problem list with the ICD 10 code "Long term (current) use of opiate analgesic" (Z79.89) for patients using chronic opiate therapy
- Minimize the co-administration of medications that may potentiate the risks of controlled substances. For example, administering a benzodiazepine with an opiate may increase the risk of respiratory depression.

Additional information is available in the DHS Expected Practice "Safe Use of Controlled Substance Medications in Non-Cancer Chronic Pain Conditions" and via the e-consult Pain Management Advice Portal.

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 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

medication for your patient, you need to follow your facility's existing protocol to (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. This technology can potentially reduce medication errors and prevent patient injury; however, it cannot prevent all programming and administration errors. Many infusion pumps are equipped with safety features, such as alarms or other operator alerts, which are intended to activate in the event of a problem. However, 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 "five rights" of medication administration – the right patient, the right drug, the right dose, the right route, and the right time – and have another nurse perform an independent double check with high risk infusions. It is very important for clinicians to select the right medications and fluids from the preloaded lists, which are mostly tailored to each facility and/or patient care area.

Inform your facility pharmacy and/or immediate supervisor if the medications or fluids you need to administer to your patient cannot be found in your smart pump drug library. In addition, ensure accurate patient information is entered into the smart pump when needed (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.

You can take the following precautions to prevent errors when using a smart pump for your patient:

- Before starting an infusion or changing an infusion setting, confirm that the infusion pump is programmed correctly.
- When infusing a high-risk medication, have a second clinician perform an independent double check of the infusion pump settings according to your facility's policy.
- If the infusion pumps at your facility contain a drug library feature, use it according to facility policy.
- When a patient is receiving multiple infusions, consider labeling the infusion pump channels and corresponding tubing with the name of the medication or

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 attention to displayed alerts and cautions, and investigate them appropriately.

The facility pharmacy should continuously re-evaluate drug library settings and modify them to align with the standard of care and facility policies and procedures. 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-risk medications throughout the institution. Staff who are going to use these infusion pumps must be adequately trained and educated about the device. 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 Diabetic Patient

During the course of patient's stay in the hospital their food intake 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 may 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. 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. That morning dose of subcutaneous intermediate (NPH) or long-acting (glargine) insulin should be administered at approximately one-half to two-thirds of the usual dose and administered at the usual time, unless hypoglycemia is already present. The subcutaneous dose of intermediate (NPH) or long-acting (glargine) insulin given the night before may not require any adjustment if previously dosed properly. However, use of long- acting insulin at night may increase the risk of morning hypoglycemia. One alternative to prevent this, is to use long-acting insulin in the morning rather than in the afternoon. 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 all healthcare providers involved in the patient's care.

TRANSFUSION SAFETY

Transfusion safety involves the overall process of correctly selecting and delivering blood or blood components to a patient. Transfusion of the wrong blood or blood component remains a hazard of transfusion has the potential to cause serious harm or death to the patient. 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), miscollected 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 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 on the compatibility label, and the TRF (unit number, ABO blood group of the component, ABO blood group of the patient, name of blood component).
5. Date and time of expiration 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, ensure to review, verify if all information is correct, and sign the "Crossmatch Transfusion Record". 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).

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

Hospital Associated Infections (HAI)

HAI 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 25 hospital patients has at least one healthcare-associated infection. There were an estimated 722,000 HAI in U.S. acute care hospitals in 2011. About 75,000 hospital patients with HAI died during their hospitalizations. More than half of all HAI occurred outside

of the intensive care unit. These infections include:

- Catheter associated urinary tract infections
- Surgical site infections
- Central line associated bloodstream infections
- Methicillin resistant *Staphylococcus aureus* infections
- *Clostridium difficile* infections

Your facility leaders track the rates of HAI as they are now required to be reported to the CDC through the National Healthcare Safety Network (NHSN). 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 (CAUTI)

Catheter associated urinary tract infections (CAUTI) are the fourth most common type of healthcare associated infection accounting for about 13% of infections in acute care hospitals. Urinary drainage systems can serve as a reservoir for multi-drug resistant bacteria and a source of transmission to other patients. CAUTI may 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.

- Use hand hygiene and appropriate precautions.
- Ensure that only properly trained healthcare workers insert and maintain catheters.
- Insert catheters using aseptic technique and sterile equipment (acute care setting).
- Following insertion, maintain a closed drainage system and unobstructed urine flow.
- **Limit the use and duration of urinary catheters where possible**

Surgical Site Infections (SSI)

Surgical site infections (SSI) occur in patients undergoing surgery. Certain risk factors may contribute to the occurrence of SSI including, absence of surgical antibiotic prophylaxis, use of razors for hair removal, improper aseptic technique, choice of skin antisepsis preparation and patient factors (e.g., diabetes, obesity, smoking, a weakened immune system, current infected status, etc).

There are several best practices and prevention strategies for reducing the incidence and risk of SSI. 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.
- Use appropriate antiseptic agent and technique for skin preparation.
- Maintain immediate postoperative normothermia. .

Central Line Associated Bloodstream Infections (CLABSI)

Central line associated bloodstream infections (CLABSI) can occur in any patient who has (or had) a short or long term central line catheter (e.g., triple lumen catheters, peripherally inserted central catheters, Hickman/Groshong catheters, dialysis catheters). Certain risk factors may contribute to the occurrence of CLABSI, 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 administration, and patient factors such as a weakened immune system and prematurity. Outcomes associated with CLABSI 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 CLABSI. 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 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.
- Use a checklist and standardized protocol.
- Use standardized protocol for sterile barrier precautions.
- Use a standardized supply cart.

Some Drug Resistant Organisms

Methicillin-Resistant Staphylococcus Aureus

Methicillin-Resistant Staphylococcus Aureus (MRSA), is an antibiotic resistant type of bacteria that can cause skin, blood, surgical site, urinary, and respiratory

infections. 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 education to patients/family on MRSA colonization and infection.

Clostridium Difficile

Clostridium difficile infection (CDI), is the most common cause of antibiotic associated diarrhea and can lead to the development of pseudomembranous colitis, an inflammatory condition of the colon that can lead to dilation of the colon, sepsis, and 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 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.

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) in the health care industry and related occupations 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. Example of these pathogens include Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and others. To prevent exposure to bloodborne pathogens, 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 such as 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 membrane (eyes, nose, mouth) with water, report incident to 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 handrubs by health care providers because they overcome many of the obstacles to traditional hand washing measures.

In those areas where alcohol based handrubs 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 handrubs, the product should be applied to the palm of one hand, and then rubbed with 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.

Artificial Nails

The CDC also recommends against the wearing of artificial nails by health care providers. Health care workers who wear artificial nails are more likely to harbor gram-negative 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 1/4 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 prevent the transmission of infection between infected patients, caregivers and 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, 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. Airborne microorganisms (such as tuberculosis and varicella) can be dispersed widely by air currents. Precautions include:

- Putting the patient in a private room with a negative air pressure and frequent air exchanges with door closed, wearing respiratory protection (N95 Respirator) or higher when entering the room, and limited movement and transport of the patient.
- When a patient is transported, the patient must also wear a 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 types of pneumonia, pertussis, or scarlet fever) are propelled a short distance through the air and are deposited on the host's eyes, nasal mucosa or mouth. Precautions include:

- Putting the patient in a private room, when available, or
- Cohorting of patients with the same organisms;
- Wearing a mask when in close contact with the patient;
- Limiting movement and transport of the patient outside of the room; and
- When the patient is transported, the patient must also wear a mask

Contact – involves direct and or indirect contact with microorganisms such as: Clostridium difficile, diphtheria, herpes simplex/zoster, impetigo, scabies and multi-drug resistant bacteria such as MRSA. These exposures are initiated by skin-to-skin 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 when leaving)
- Limiting transport of the patient, and dedicating the use of patient-care equipment to one patient

Care of Patient Care Equipment

Patient care equipment is a common potential source of infection. All patient care equipment should be cleaned with a hospital approved detergents/ disinfectants following manufacturers' instructions for appropriate contact time after use. Equipment that is dirty shall be placed in a designated dirty equipment area, or sent to the appropriate cleaning services department for decontamination. Only soiled equipment is stored in the "dirty" area. Only clean equipment is stored in the clean equipment area. Equipment will not be stored on, or immediately

around, the sink. If it is unclear whether the patient care equipment is clean, it should be considered dirty and cleaned before patient use.

Use of Personal Protective Equipment (PPE)

PPE's 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 or removing PPE
- When using PPE be sure to discard PPE per facility procedures

Safe Injection Practices

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

- Use aseptic technique to avoid contamination of sterile injection equipment.
- Do not administer medications from 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 administration 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

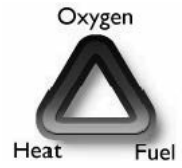
The DHS Policy 334.200 requires all WFMs to receive an influenza vaccine. WFM who decline for any reason will be required to sign a declination form and wear a surgical mask during influenza season while performing work in a health care area.

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

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 (e.g., obesity), 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 there are 550 to 650 surgical fires occur in the United States per year, some causing serious injury, disfigurement, and even death. Three elements must be present for fires to take place: oxygen, heat (to light the fire), and fuel (something to catch on fire).

Removal of one of these elements extinguishes a fire. The most common ignition sources (heat) are electrosurgical equipment and lasers.

The following are recommendations to reduce the risk of surgical fires:

- Conduct a fire risk assessment (part of the DHS Standardized Surgical Final Time Out). The highest risk procedures involve an ignition source,delivery of supplemental oxygen, and the operation of the ignition source near theoxygen (e.g., head, neck, or upper chest surgery)

Use appropriate precautionary measures when using the following:

- oxygen
- (flammable) alcohol-based skin preparation
- surgical equipment and other devices

Ensure that you are familiar with your facility's plan on how to manage surgical fires. For example, understand how to extinguish a fire burning on a patient, know the evacuation procedures, participate in fire drills, and keep water/saline available for extinguishing fire. For more information, visit FDA information on Preventing Surgical Fires.

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 team's understanding of the intended patient, procedure and site. Preprocedure 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 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 amd DHS Standardized Non-OR Time Out checklists have been developed and recently 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. Finally, the conduction and performance of time out 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 patient's 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. According to TJC, from 2005 to 2012, there were about 772 incidents of URFOs, 16 deaths resulted from these incidents, and 95% of these cases resulted in additional care and/or extended hospital stay. 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 xray 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 careful 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

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 if appropriate.

Restraint and/or seclusion require an order from an 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 restraint 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 can not 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. Face to face evaluation by the LIP is required before initiation of physical restraints for violent behavior.

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 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 patients 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 on Violent and Non-Violent Restraint and Seclusion.

Patient Falls

Falls resulting in injury are a common patient safety problem. Every year in the United States, hundreds of thousands of patients fall in hospitals, with 30-50 percent resulting in injury. In one study, a fall with injury added 6.3 days to hospital stay. 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.

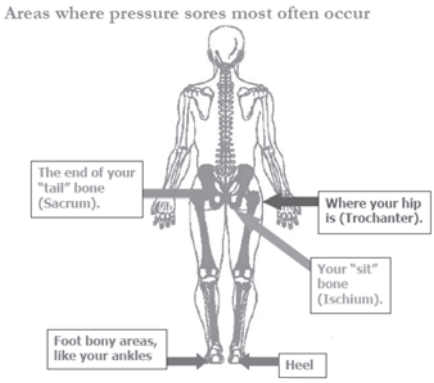
Appropriate risk assessment is a key tool in fall prevention. While most patient falls occur with elderly patients, elderly and frail patients with fall risk factors are not the only ones who are vulnerable to falling in health care facilities. Any patient of any age or physical ability can be at risk 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. Reducing the risk of falls requires all members of the health care team collaborate on falls prevention, including admitting clinicians, pharmacists, nurses, and patients, and their family members. Some best practices for falls 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 change 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 possessions 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 Ulcer Advisory Panel (NPUAP), defines a pressure injury as localized damage to the skin and/or underlying tissue, usually over a bony prominence or related to a medical or other device. Pressure injuries develop as a result of intense and/or prolonged pressure or pressure in combination with

shear. A common scenario is when the hard surface of a bed against a bony prominence such as the sacrum. The tissue between these two surfaces is crushed and begins to die. The tissue closest to the bone is typically the first tissue to die. Visible skin discoloration or redness may actually be an indicator of underlying fat or muscular death. Tissue death can serve as a host for bacteria and infection. It may be difficult to detect skin "redness" for individuals with dark skin tones. In this situation the only sign may be a darkening of the skin tone. The picture above shows common areas for the development of pressure injuries.



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. Pressure injuries are estimated to cost $11 billion dollars annually in the United States. Several steps can be taken to help prevent the occurrence of pressure injuries:

- Perform and document a head to toe skin assessment on admission and regularly throughout the hospital stay. Evaluate for skin color changes, blanching, and localized heat, edema, or skin consistency changes (induration).
- Perform and document a structured risk assessment (such as the Braden score) on admission and with any significant change in clinical condition. The risk assessment should include assessment of activity/mobility and skin status.

  a) Consider bedbound and/or chairbound individuals to be at risk for pressure injuries.

  b) Common clinical risks include: presence of an existing pressure ulcer, history of stage III or IV pressure ulcers, hypoperfusion states such as sepsis or heart failure, chronic medical conditions such as diabetes, smoking, and peripheral vascular disease, restraint use, spinal corddevelop as a result of intense and/or prolonged pressure or pressure in combination with shear. A common scenario is when develop as a result of intense and/or prolonged pressure or pressure in combination with shear. A common scenario is when injury,

prolonged operating room and emergency department stays (prolonged time on a hard surface or in one position), and patients receiving enddevelop as a result of intense and/or prolonged pressure or pressure in combination with shear. A common scenario is when of life of care.

- Make a care plan for prevention and to address modifiable areas of risk for development of pressure injuries.
- Regularly reposition all patients unless contraindicated. A "turn clock" as recommended by the ICU Effective Practices Committee can be used to remind staff when to turn patients.
- Identify and correct nutritional deficits.
- Recognize that patients with medical devices are at higher risk for pressure injuries. Perform at least twice daily assessments of skin under and around medical devices for signs of pressure-related injury.
- Consider preventive measures for high-risk patients including preventive skin care (moisture, barriers, lotions), prophylactic dressing, protective support devices, and specialized mattresses. Consider involving your facility's wound care team for additional expertise.

The different stages of pressure injuries, as defined by the National Pressure Ulcer Advisory Panel (NPUAP), are summarized below.

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

Stage II: Partial thickness skin loss with exposed dermis. Presents as a shallow open ulcer with a red pink wound bed, or as a serum-filled blister. Slough, fat, and deeper tissues are not visible.

Stage III: Full thickness skin loss. Full-thickness tissue loss with the visibility of subcutaneous fat. Slough may be present.

Stage IV: Full-thickness skin and tissue loss. Full thickness skin and tissue loss with exposed or directly palpable bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed.

Deep Tissue Pressure Injury: Persistent non-banchable deep red, maroon or purple discoloration. 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. Discoloration may appear

differently in darkly pigmented skin.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness tissue loss in which the base of the ulcer is completely covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The true depth and staging of the wound cannot be determined until enough slough and/or eschar is removed to expose the base of the wound. However, stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels should not be removed.

A Stage III, Stage IV or unstageable pressure injury that is acquired after admission to a healthcare facility must be reported to the California Department of Public Health. Excluded from this reporting requirement is ulcer progression from Stage II to Stage III if the Stage II ulcer was recognized at the time of admission.

DIAGNOSTIC PROCEDURE SAFETY

Significant advances in technology have greatly improved the methods for diagnosis. Magnetic resonance imaging (MRI), computed tomography (CT) and other radiological studies, while improving diagnostic methods, also present new patient safety concerns. To prevent considerable risk of injury such as burns or any other adverse reactions from the 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 physician'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 x-rays. TJC, in reviewing recent events related to the use of MRIs, has reported that the most common injury from MRIs is related to burns. The 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 a 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. TJC has published a set of specific recommendations for ensuring MRI patient safety in their February 2008 Sentinel Event Alert.

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 the new 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 physician, patient's identification by using two facility-approved patient identifiers, imaging site, and correct patient positioning. Except for patients who require the radiological exam, only the staff needed for the procedure should be in the room during the exposure. Patients who are at a reproductive age should have the reproductive organs shielded when the radiological exam does not require exposure to that part of the body. Pregnancy status of women who are of reproductive age shall be determined prior any radiological exam except in

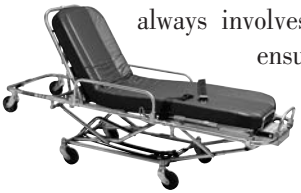
emergencies. If pregnancy exists or is suspected, the physician should be notified before the exam to determine whether the exam should proceed. For all patients, great care should be taken to keep the radiation exposure to a minimum requiring just enough to produce an acceptable diagnostic image. Be 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.

For more information, refer to Joint Commission's revised diagnostic imaging standards issued on December 2013:

Sentinel Event Alert on the Radiation risks of diagnostic testing issued on August 2011, and http://www.fda.gov/Radiation-EmittingProducts/RadiationSafety/RadiationDoseReduction/ucm299301.htm.Additional information could be obtained from ACR guidance document on MR safe practices http://onlinelibrary.wiley.com/doi/10.1002/jmri.24011/pdf

PATIENT TRANSPORTATION

Safe Transport of Patients



Transporting patients between facilities or from one unit to another always involves some degree of risk. These risks are related to ensuring that: patients are provided stabilizing treatment prior to transfer; adequate handoff communication occurs; and 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 hospitalsrefusing 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 a 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 seated walker to their clinic or hospital visits. Staff must not use the patient's seat walker as a substitute for a wheelchair when transporting the patient. The patient's chart and registration card should accompany the patient during intra-facility transfers to the receiving unit or diagnostic testing location. Confidentiality of the patient's health information should be maintained at all times during transport. Please review your facility's policy and DHS Policies 373, 373.1, 373.2, and 373.3 for additional information on both inter-facility and intra-facility transfers.

(seat walker should NOT be used as a wheelchair)

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 the changes in patient's condition that require immediate intervention. However, if these physiologic alarms are not managed appropriately it may compromise patient safety. In June 2013, TJC announced a renewed NPSG for hospitals on clinical alarm safety. According to FDA, there were about 560 medical alarm- related deaths over a recent four-year period. TJC reported 98 alarm related events from Jan 2009 to June 2012, 80 resulted in death, 13 in permanent loss of function, and 5 in unexpected additional care or extended stay. 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 inspects and ensures 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 06.01.01.

Preventative 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 Care of Patient Care Equipment section (pg. 32) for the recommendations on ensuring the use of clean patient care equipment.

Emergency Power

In the event that your facility should lose power, back-up generators are available to maintain core electronic functions. Red outlet plugs are located 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

Including the potential for fire in the operating room discussed earlier, fire remains a real and 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

Often chemicals are used for preserving tissue, treating medical conditions, and cleaning which may be toxic and harmful when in direct contact to the human skin. If you come across with a spill or release of a chemical, you should immediately remove patients/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 a 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 of 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 (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

Part of the healthcare provider's responsibility for patient safety comes in assuring that security measures are in place. Patients are dependent on their healthcare providers and have lost some of their ability to protect their person and belongings that they would normally have in their own homes. Strategies that can be used to increase a patient's security include:

- Wear a clear and visible DHS issued identification badge at all times 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 a 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 for great concern. Based on a study of cases from 1983 through September 2016, the National Center for Missing and Exploited Children reported 309 infant abductions, 12 infants were still missing. Out of the 309 cases, 139 were abducted from healthcare facilities, 127 from home, and 49 from other locations. California and Texas had the highest number of infant abductions with 40 and 38 abductions respectively.

The typical abduction from a healthcare facility involves an "unknown" abductor impersonating a nurse, healthcare employee, volunteer, or relative. In 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, the number of new and changing faces is constant, making 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.

Newborn Surrender

In January of 2006, the Safely Surrendered Baby Law was signed permanently into a state law. From January 1, 2001 to December 31, 2015, 770 newborns have been surrendered in California, and 84 newborns have been surrendered in 2015

alone. There were 169 infants abandoned since 2001, five of which occurred in 2015.

The law allows parents to give up their baby confidentially and without fear of arrest or prosecution as long as the baby has not been abused or neglected. A parent who is unable or unwilling to care for a baby within 3 days 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 policy on newborn surrender and determine the process to follow should someone present a newborn infant to you for surrender.

Patient Elopement and Patients Leaving Against Medical Advice (AMA)

While receiving treatment in the 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 station, and instructing patients to remain on their assigned units while they are receiving treatment. Should a patient elope from the assigned area, follow your facility 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 and is not on any holds, and requests to leave AMA, follow your facility policy on patients leaving AMA. Document the patient's desire to leave AMA on your facility approved AMA form. If the patient refuses to sign the form, do not attempt to force their signature. Document the details of the event in the patient's chart including how you learned of the patient's plan to leave AMA, what you and the patient discussed, and any discharge instructions that were provided.

Patient Suicide

Suicide rate in the U.S. has increased dramatically. It is currently the 10th leading cause of death, more lives lost from suicide than traffic accidents and more than twice as many as homicides.

Healthcare providers in the emergency, primary care, and behavioral health care settings have an important role in detecting suicide ideation and assuring appropriate evaluation. The patient's risk of suicide is three times as likely (200% higher) the first week after discharge from a psychiatric facility and continues to be high especially within the first year and through the first four years after discharge.

It is essential to identify the risk factors when considering or identifying patients who 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 a 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 at times do so.

TJC reported 1,089 suicides from 2010 to 2014 among patients receiving care, treatment, and services in a staffed, around-the-clock care setting or within 72 hours post discharge including the hospital emergency room. The most common root cause of these incidences was the shortcomings (mistakes) during patient's assessment.

TJC suggested the following actions in order to appropriately detect and treat suicidal ideation in all settings:

- review each patient's personal and family medical history for suicide risk factors.
- screen all patients for suicide ideations using a brief, standardized evidence-based screening tool (e.g., PHQ-2; PHQ-9).
- review screening questionnaires before patient leaves or is discharged.
- using the assessment results, implement safety measures (e.g., provide sitter; keep patient away from anchor points for hanging and material that can be used for self-injury; remove bell cords, bandages, restraint belts,

sheets, plastic bags, elastic tubing and oxygen tubing).

- collaborate with the patient, other providers, and patient's family and friends as appropriate.
- develop treatment and discharge plans.
- staff must be competent in identifying and responding to patients suicide ideation.
- document decisions on the care and referrals made for at risk patients.

For more information, read https://www.jointcommission.org/assets/1/6/SEA_56_Suicide_Infographic_2_10_16_FINAL.pdf and SEA # 56.

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 as a result of the employee s action or omission occurring within the scope of employment under Government Code 825. For the purposes of this 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.

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

Elements of Negligence

Negligence is failing to do something that a reasonably prudent person wouldhave done under similar circumstances. Medical-malpractice is a form of negligence where the act is committed in the course of a professional responsibility. With an

allegation of medical malpractice, the plaintiff must establish and prove all of the following elements:

1. That a duty was owed to the plaintiff;

2. That the health care provider breached that duty;

3. That breaching their duty proximately caused an injury; and

4. That the plaintiff suffered damages relative to the injury.

Duty

Duty begins when you enter into 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 practitioner s conduct, or lack thereof, and the patient s injury.

Damages

Damages are the losses the patient/plaintiff suffered as a result of the injury. They can be economic, emotional, related to future potential, or personal. These are the monetary awards levied on the defense to "pay" for the injury. In California, the maximum judgment that is allowed for pain and suffering is $250,000. But, judgment amounts for economic and/or future potential costs have no limit.

The Legal Process

Throughout the legal process and the steps involved, workforce members are expected to cooperate with the 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 County funds to pay 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. Workforce members 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 noncooperation may result in disciplinary action.

When a person begins a 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 you. 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 Risk Manager for appropriate handling and response.

Interogatories

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 on their respective sides. Generally, they are not sent directly to you, but to your defense attorney. However, if you receive an interrogatory, notify your facility Risk Manager. Do not communicate or correspond with any attorney unless specifically authorized to do so by your facility 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, 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 expected to, provide testimony in proceedings for 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.

Trail 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 Risk Manager, and 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

Pursuant to the laws that govern mandatory malpractice reporting to licensee 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. 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 money paid on behalf of a named provider. To view the current reportable limits and obtain additional information about mandatory reporting of licensees, review the LACDHS Policy #311.3, "Licensee Reporting to Licensing Board".

CONCLUSION

DHS is committed to building a safe and just culture, but we know this change does not happen 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 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 of 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 Risk Manager or DHS Risk Management at CRM@dhs.lacounty.gov.

If you need additional information on DHS patient safety activities, please visit the DHS Risk Management and Patient Safety Program website located under Quality, Risk & Safety on the DHS Sharepoint® Intranet at: http://myladhs.lacounty.gov/SitePages/Home.aspx.

If you have any questions or would like to report any patient safety concerns, inform the Patient Safety Officer at your facility, or you can email them to patientsafety@dhs.lacounty.gov or call the DHS Patient Safety Hotline at (213) 989-7233 or (800) 611-4365.

NURSING CE INFORMATION

Nurses! Earn 5.0 CE Contact Hours

Complete the ONLINE Course Evaluation via:

https://www.surveymonkey.com/r/2017RMPSHandbook.

Upon completion of your course evaluation, DO NOT close the browser, your CE certificate will be automatically generated. Print the CE Certificate and keep it for your records.

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