

Nursing Department



Orientation/Reorientation Handbook 2011



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

CONTRIBUTORS

Calvin Kwan	Hospital Administrator
Susan Black, RN	QA/Resource Management
Nancy Lefcourt, RN, MSN	Risk Management
Thesia Nayagam, RN	Nursing Administration
Paula Siler, RN	Nursing Administration
Grace Chacon, RN, MBA	Nursing Education
Robin Watson, RN, MN, CCRN	Nursing Education
Jenelle Zambrano, RN, MSN	Nursing Education
Vince Jugo, RN, MSN	Nursing Education
Sreedevi Warriar, RN, MSN, MA	Nursing Education
Olivia Piedad, RN	Materials Management
Erika Sweet, RN, NP	Employee Health Services
Julie Rees	Compliance Officer
Clinton Coil, MD	Patient Safety Officer
Yvette Ruiz	Hospital Administration
Patrick Brady	Facilities Management
Sandy Mungovan	Information Systems
Valeriea Caesar	Health Information Management
Loren Miller, MD, MPH	Infection Prevention and Control
Monica Murphy, RN	Infection Prevention and Control
Alma Belis, RN	Infection Prevention and Control
Wesley Kamikawa, Pharm D.	Pharmacy
Donna Samuels	Health Information Management
Dana Denis, RD	Nutrition Services
Larry Schneider, LCSW	Clinical Social Work

SECTION REVIEWERS

James Freeman	Facilities Management
Essence Wilson, RN, BSN	Hospital Administration
Alma Belis, RN	Infection Prevention and Control
Patricia Strayer, RN, MSN	Nursing Administration
Theresa Carnes, RN, BSN	Nursing Education
Monique Eriksen, RN, MSN, CNOR	Nursing Education
Elizabeth Leon, RN, MSN	Nursing Education
Maria Morales, RN, BSN	Nursing Education
Susan Ulit, RN, MSN, CCRN	Nursing Education
Jo Ann Williams, RN, MN	Nursing Education
David Applebaum, MS	Radiation Safety

Publication Support:

Francisco Acevedo, Intermediate Typist Clerk

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Harbor-UCLA
MEDICAL CENTER
MetroCare Regional Health System

Welcome to Harbor-UCLA Medical Center and the Metrocare Regional Health Network!

We are pleased that you have chosen to join our healthcare team and made the commitment to help us provide quality, patient-centered healthcare services to our family, friends, neighbors and everyone who comes to us for care in their time of need. When you join Harbor-UCLA Medical Center or Long Beach Comprehensive Health Center, you also join the Metrocare Regional Health Network of Los Angeles County.

The Metrocare Regional Health Network encompasses Harbor-UCLA Medical Center, Long Beach Comprehensive Health Center, Wilmington Health Center, Harbor-UCLA Family Health Center, and Bellflower Health Center, as well as Martin Luther King, Jr., Multi-Service Ambulatory Care Center (MLK-MACC), Hubert H. Humphrey Comprehensive Health Center and Dollarhide Health Center.

Ours is the only public medical care network providing services to the indigent and underinsured in the South Bay areas of the County of Los Angeles, as well as South and Central Los Angeles. Our responsibility is great and clear: Provide services to everyone in a caring manner.

You have chosen an organizational network that includes Harbor-UCLA Medical Center, which for more than half a century has been recognized nationally as a provider of high-quality health care, a renowned academic medical center affiliated with the School of Medicine at UCLA, a major medical research institution, and an integral part of the healthcare safety net in the County of Los Angeles.

We welcome your creativity and desire to make a difference. You will have this opportunity every day. Take this opportunity and be counted as one of our leaders in our quest for excellence.

This handbook provides you with information regarding the Harbor-UCLA, Metrocare Regional Health Network and County policies. Please take time to thoroughly read and review these policies. If you have any questions or need additional information, you may discuss them with your supervisor or contact Human Resources for assistance.

INTRODUCTION

This section provides a broad organizational overview of the Coastal Cluster's service delivery. Included is the history, its Mission, Vision, Values and customer-service philosophy.

As a vital resource for the delivery of healthcare, Harbor-UCLA Medical Center and its affiliated Coastal Cluster Health Centers are committed to achieving the goals and objectives of the Los Angeles County Department of Health Services (DHS), improving service-delivery systems to our community and enhancing the quality of patient care provided by the Cluster's healthcare facilities. We also are committed to meeting our Mission, Vision, and Values. In addition, we must meet quality standards established by accrediting agencies as they evaluate our programs and services by way of surveys, reviews, and other indicating tools.

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

We have designed this handbook so that important information about the Coastal Cluster facilities is readily available. It provides you with general information about Coastal Cluster Harbor-UCLA and can be used as a quick reference guide to key policies and procedures. You are expected to know the material in this handbook and you may be tested on the information contained herein.

COASTAL CLUSTER – HISTORY AND HIGHLIGHTS

Harbor-UCLA Medical Center

For more than half a century, Harbor-UCLA Medical Center has been a prime provider of high-quality, cost-effective health care to insured and uninsured Los Angeles County residents, alike. Harbor-UCLA is an integral part of the County's healthcare safety net, a world-class academic medical center, and a major medical research site.

The medical center began as a military station hospital for the Los Angeles Port of Embarkation. In June 1946, the US Army sold the facility as war surplus to the County's Department of Charities. Opening one month later, Harbor General Hospital - as it was then known -- had 60 beds and a 70-person staff.

Since then, Harbor-UCLA's physical plant has evolved. Following the passage of a bond issue in the mid 1950's, an 8-story replacement facility opened in 1963. The Emergency Department has been enlarged, and wardrooms have been converted to a number of specialty care units. In 1994, the 50,000-square-foot Edward J. Foley Primary Care and Diagnostic Center was opened. Work is underway on a 190,000-square-foot expansion of the medical center's Operating Room and Emergency Department units and a three-story parking structure.

Today, Harbor-UCLA is a tertiary medical center, licensed for 538 beds. It is a key component in Los Angeles County's 4,000-square-mile health care safety net for its 10.3 million residents, many thousands of whom are uninsured or underinsured and dependent on the County's Department of Health Services.

Coastal Cluster Ambulatory Care Facilities

Extensive studies in the 1970s and 1980s determined that the south/southeastern part of the Los Angeles County was a "corridor of health care need." The study findings identified a decline in the use of hospitals and indicated that ambulatory care was a more effective mode of healthcare delivery. In February 1989, DHS created the Coastal Cluster Health Centers, one of five such organization structures created.

Long Beach Comprehensive Health Center was designated as the organization umbrella for Coastal Cluster health centers, which also include Harbor-UCLA Family Health Center, Wilmington Health Center, and Bellflower Health Center. These facilities provide personal health services including primary and limited

secondary care, referrals to tertiary care, and limited public health care such as immunizations, HIV and family planning.

HARBOR-UCLA MEDICAL CENTER FACILITY PROFILE

Harbor-UCLA Medical Center is a 538-bed acute-care facility, owned and operated by the County of Los Angeles, and affiliated with the UCLA Schools of Medicine, Nursing and Dentistry. The medical center has been providing healthcare service to the Greater South Bay community since 1946 through its inpatient, emergency and ambulatory care programs.

As a major teaching hospital and acute-care facility, the medical center also provides 24-hour emergency services for acute medical, surgical, pediatric, obstetrics/gynecology, and psychiatric problems. The medical center has earned designations as a Level I Trauma Center, and Emergency Department Approved for Pediatrics (EDAP), and as a Segment Elevation Myocardial Infarction (STEMI) Receiving Center.

Additionally, the medical center provides a wide range of primary and specialty ambulatory care, as well as support services including physical and occupational therapy, nutritional counseling, health education and psychosocial intervention.

Hours of Operations:

EMERGENCY AND OUTPATIENT TREATMENT

- Emergency Department: Daily round the clock
- Urgent Care: Weekdays, 8:00 a.m. to 11:00 p.m. and weekends, 10:00 a.m. to 6:00 p.m.
- Outpatient Clinics: Weekdays, 8:00 a.m. to 5:00 p.m.

PHARMACY LOCATIONS/HOURS

Outpatient Pharmacy

- Location: **1st Floor**, by the **Vermont Avenue public entrance**
- Hours of Operation:
Weekdays – 8:00 a.m. to 8:00 p.m.
Weekends & Holidays – 8:00 a.m. to 6:00 p.m.
- Telephone: (310) 222-1977
- New prescriptions only for ambulatory care clinics, emergency rooms, and hospital discharge medication orders.

Outpatient Pharmacy Satellite

- Location: **Building N-22**
- Hours of Operation: **Weekdays – 9:00 a.m. to 5:00 p.m.** (Closed weekends & holidays)
- Telephone: (310) 222-5663
- Refill prescriptions only

INPATIENT VISITING HOURS

Visiting hours are established to ensure patients get the rest they need and to allow hospital staff to do their work efficiently. Visiting hours may be suspended or changed during procedures or when the patient's condition warrants it.

- **General visiting hours are 9:00 a.m. to 9:00 p.m. daily**
- Different hours for individual units may be posted
- Children must be under the supervision of an adult other than the patient throughout the visit

For general information, please call (310) 222-2345. For TDD (Telecommunication Device for the Deaf), call (310) 212-5369 for appointments; (310) 533-9958 for the Emergency Department.

DEPARTMENTS AND CLINICS:

- Anesthesiology
- Community Health Plan
- Family Medicine
- Internal Medicine
 - Anti-coagulation
 - Cardiology
 - Chest/Pulmonary
 - Continuing Care
 - Dermatology
 - Diabetes
 - Endocrine
 - Endoscopy
 - Gastroenterology
 - Genetics
 - Hematology
 - Immunology
 - Infectious Disease
 - Infusion
 - Nephrology/Hypertension
 - Neurology Oncology
 - Pituitary
 - Renal Transplant
 - Rheumatology/Arthritis
 - Urgent Care
- Neurology
- Obstetrics/Gynecology
- Orthopedic Surgery
- Outpatient Surgery Staging Area
- Pediatrics
- Surgery
 - Breast
 - Eye
 - Head & Neck/ENT
 - Oral Surgery
 - Urology
 - Vascular Surgery

SERVICES:

- Patient Advocate
- Audiology
- Blood Donor Center
- CHP Appointment (Inquires only)
- Clinical Social Work
- Emergency Department
- Laboratory Information
- Medical Records
- Nuclear Medicine
- Nutrition Services
- Patient Financial Services – Ability to Pay (ATP)
- Patient Financial Services – Billing Information
- Patient Financial Services – Medi-Cal
- Patient Relations Center
- Pharmacy – Outpatient Pharmacy
- Pharmacy – Outpatient Satellite Pharmacy
- Public Relations
- Radiation Therapy
- Rehabilitation Services (Occupational Therapy)
- Rehabilitation Services (Physical Therapy)
- Sleep Studies
- Speech Pathology
- TDD (Telecommunication Device for the Deaf)
- Volunteer Services
- Women's Health Center
- X-ray

VISION, MISSION, AND VALUES

HARBOR-UCLA MEDICAL CENTER

Vision

...the center of an integrated, regional health care delivery system which excels in patient-centered care, medical education, and research.

Mission

To provide high quality, cost-effective, patient-centered care through leadership in medical practice, education, and research. Services are provided through an integrated health care delivery to residents of Los Angeles County regardless of ability to pay.

Values

We are a community that cares about people and their health.

Each of us is a leader as well as a team player in our campus community.

Community means caring, belonging, trusting and sharing pride in our achievements.

All members choose to be active learners, listeners and innovators.

Recognition and commitment to excellence are values we cherish.

Energy is focused on patient care, education and research.

LONG BEACH COMPREHENSIVE HEALTH CENTER

Vision

A leader in providing high quality, community-based primary and preventive care. An emphasis is placed on patient safety, while improving the health status of the community served.

Mission

To provide high quality, cost-effective ambulatory care to the residents of the coastal region of the County of Los Angeles, regardless of their ability to pay. The services are provided in a safe, patient-centered environment that is accessible to our community.

Values

We care about people and their health.

Each of us is a leader as well as team player in our community.

Common goals lead to caring, trusting, and sharing pride in our achievements.

All team members chose to be active listeners, learners, and innovators.

Recognition and commitment to excellence are values we uphold.

Energy is focused on patient care, education, and outreach.

CUSTOMER SERVICE

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

- Personal Service Delivery
- Service Access
- Service Environment

Personal Service Delivery

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

Always:

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



Service Access

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

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

Service Environment

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

- Report any unsafe conditions to your supervisor or the Coastal Cluster Harbor-UCLA Environmental Safety Officer at (310) 222-2835.
- Provide a clean and comfortable waiting area/work environment.
- Protect the privacy and confidentiality of our customers.

TEAMWORK: COMMUNICATION, COLLABORATION, COORDINATION OR CARE & CONFLICT RESOLUTION

The essential element in a healthcare setting is teamwork. The successful elements of teamwork are achieved through a shared vision, positive attitudes, mutual respect and skills. Essential elements of teamwork are effective communication, collaboration, coordination of care and conflict resolution.

Effective Workplace Communication

Understanding and perceiving information in the same way as it is given is crucial in effective communication. Communication is the exchange of thoughts, messages, or information between individuals and groups through speech, signals, writing or behavior. Staff must communicate effectively with each other about patient care, treatment and services, such as the physician must communicate with the nurse or other physicians about a patient. There are many modes of communication which include written, verbal, nonverbal, electronic, formal as in a meeting, informal as in a hallway, two-way or multi-way as in a group. Ineffective communication can lead to failed patient outcomes (patient harm, pain), medical errors, high medical and malpractice costs, reduced patient trust, decreased staff satisfaction and retention, and poor productivity and motivation. Barriers to effective communication which include language, age, skill level, poor listening and verbal skills, attitudes, time constraints, cultures, etc. can lead to misinformation, embarrassment and failed outcomes. Good communication skills can be learned, practiced, and continuously improved.

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

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

Leadership must play a role in effective communication by communicating the facility and departmental goals, mission, vision, and values; establishing a culture and environment that encourages communication of ideas, reporting errors and failed outcomes without punishment, promoting and supporting effective strategies and methods for ensuring clear, consistent, open communications; and supporting an environment of learning, and encouraging the development of ideas and suggestions.

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

- Be clear and accurate in speech and make sure the other party(ies) understand you
 - Use short explanation, whenever possible
 - Demonstrate process/procedure
 - Ask questions to obtain feedback
 - Ask listener to repeat to confirm instructions
- Effective teams communicate in the workplace/across settings, and have an effective mechanism for information management and access
- Be a good "active" listener
- Don't take comments and suggestions personally
- Create a less stressful environment by having a positive attitude
- Be objective
- Document accurately
- Remember nonverbal communications such as facial expressions, tone of voice, body language and movements, and hand gestures relay messages (negative and positive) wanted and unwanted
- Remember to follow patient privacy and confidentiality laws and regulations when dealing with patient information in any information format.

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

Principles of Interdisciplinary Collaboration

Collaboration is interpersonal communication and decision-making based on the ability to work together to satisfy the needs of our patient population. The quality of patient care is achieved by the contribution of appropriate care by all workforce members. Hierarchy or perceptions of power should not be a barrier to the collaborative effort. Each DHS workforce member needs to contribute by offering their expertise; this includes all levels of the organization.

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

For Example: A Physical Therapist schedules to see the patient at 9:00 a.m. He/she notifies the RN and they collaborate and determine the patient needs pain medication prior to the visit. The RN collaborates with the physician to renew the medication order. The physician collaborates with the patient and assesses the patient's condition and concerns then renews the medication order.

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

Coordination of Care

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

- Increased conflicts between team members about a patient's care treatment and services
- Compromised patient health and safety
- Confusion between team members and for new team members regarding what is expected of them and what they can expect from others
- Crises created when members assume that someone else was responsible for handling the patient's care or treatment
- Patient care decisions not being carried out timely or effectively

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

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

Conflict Resolution through Team Building

It is not unusual for conflict to arise in the workplace; however, conflict in the workplace can lead to positive outcomes for team members as well as patients. Resolution of problems, if done effectively, can lead to a better understanding of processes, systems, and procedures and allows team members to view how other team members' responsibilities and views fit into the scheme of things; generate new ideas, approaches and process improvements; and foster new respect for each team member and better team cohesion. Workforce members should remember these strategies when dealing with conflicts in the workplace:

- Learn to respect the ideas, suggestions, processes, and contributions of all members of the team, however varied and diverse. For example, physicians, pharmacists, nurses, social workers, and psychologists have been educated to view and process problems in various ways, although each may have a unique and different perspective on the problem.
- Acknowledge and appreciate other disciplines processes and contributions to ensure thorough and complete care planning is patient and family-focused and outcome oriented.
- Minimize competition. Each party should feel a sense of contribution to the care plan and the resolution of patient care issues.
- Questioning of the approach to care should never be delivered in a manner that may be construed as criticism, but as a method to enhance knowledge and foster collaboration between team members to provide the best possible patient care.
- Evaluate the facts of the situation and make a determination of the problem.
- Promote open dialogue and allow all voices to be heard in the determination of appropriate methods to resolution of problems and issues.
- Keep an open mind and listen to the idea or suggestion being presented. Explore all options before discarding them.
- When discussing problems remember, the problem is not the person, separate the person from the equation so that the problem is the focus.

Optimism that you are using the most effective method of patient care delivery promotes success in team building.

THE JOINT COMMISSION

This section describes the Joint Commission's accreditation process. This includes a description of The Joint Commission's Shared Vision, New Pathways, the System Tracer Methodology, other survey activities and The Joint Commission Accreditation Participation Requirement (APR) standard 09.02.01.

THE JOINT COMMISSION'S "SHARED VISION, NEW PATHWAYS"

"Shared Visions, New Pathways" is an initiative that The Joint Commission has undertaken to progressively sharpen the focus of the accreditation process on care systems critical to the safety and quality of patient care. Our focus in preparation for re-accreditation is to use The Joint Commission's standards for achieving and maintaining efficient and effective systems to support patient care. The components of the "Shared Vision, New Pathways" are:

- Periodic Performance Review (PPR) – a self-review of compliance with standards conducted annually following our survey.
- Priority Focus Process (PFP) – process created to collect and analyze information collected about the organization. This helps to focus the survey on areas critical to our quality of care and safety processes.
- 14 Priority Focus Areas (PFA) – processes, systems, or structures that can significantly impact the provision of safe, high-quality care and reduce the risk for negative outcomes.
- System Tracer – sessions devoted to evaluating high-priority safety and quality-of-care issues on a system-wide basis: Environment of Care, Emergency Management, Human Resources, Infection Control & Prevention, Information Management, Leadership, Life Safety, Medication Management, Medical Staff, National Patient Safety Goals, Nursing, Provision of Care, Performance Improvement, Record of Care, Patients Rights and Responsibilities, Transplant Safety, and Waived Testing.
- Elements of Performance (EP) – specific performance expectations in place for each of the standards.
- Measure of Success (MOS) – a quantifiable measure, usually related to an audit that can be used to determine whether an action has been effective and is being sustained.
- Tracer Methodology – process used by the surveyors to analyze the hospital's systems by following individual patients through their hospitalization in the sequence actually experienced. The surveyor visits the multiple care units, departments or areas to 'trace' the care, treatment and services rendered to a patient.

SURVEY PROCESS – (Tracer Methodology)

When the Joint Commission surveyors visit our facility, they will spend 70% – 80% of their time in patient care areas conducting **tracers**. This means the surveyors will select specific inpatients and review their medical records to determine the services each patient received during their hospitalization. By tracing the course of care and services experienced by the patient (a real time review), the surveyors will interact with direct care providers and/or other applicable workforce members to determine the relationship among departments involved in the care, the integration and coordination of important processes, opportunities for improvement and education (as appropriate) and validation of findings through review of additional records. The surveyors will observe:

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

OTHER SURVEY ACTIVITIES

- System Tracers
 - Medication Management
 - Data Management
 - Infection Prevention and Control
 - Medical Staff Functions/CDPH Regulatory Review

- Medical Staff Leadership Session
- Dietetic Service and Food Service Visit
- Pharmaceutical Services and Clinical Unit Inspection
- Life Safety Building Code Tour
- Environment of Care Review and Facility Tour
- Environment of Care Session with Emergency Management Tracer
- Program Tracers – Patient Flow and Laboratory Integration
- Leadership Session
- Human Resources Interview
- Medical Staff Credentialing and Privileging
- Competence Assessment Process

Key Point: *All triennial surveys are unannounced. It is important to maintain continuous compliance with all Joint Commission's standards.*

THE JOINT COMMISSION ACCREDITATION PARTICIPATION REQUIREMENTS (APR 09.02.01)

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

Safety or quality of care concerns/complaints may be made through the workforce member's supervisor, the facility risk manager, and/or the DHS Quality Improvement Program hotline at (800) 611-4365.

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

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

Complaint Hotline:	(800) 994-6610
Fax Number:	(630) 792-5636
E-mail:	complaint@jointcommission.org
Online:	www.jointcommission.org/GeneralPublic/Complaint
Mailing Address:	Office of Quality Monitoring The Joint Commission 1 Renaissance Boulevard Oakbrook Terrace, IL 60181

PATIENT SAFETY

PATIENT SAFETY PROGRAM

We are committed to providing safe and quality health care to all patients. The primary objective of the Patient Safety Plan is to create a safe environment for patients, visitors and workforce members by:

- ✚ Improving patient safety, patient safety awareness, and reduce the risk of harm to patients
- ✚ Ensuring that Coastal Cluster leadership and staff demonstrate a consistent effort to evaluate, monitor, improve, and document patient safety activities
- ✚ Establishing systems to assess and improve institutional compliance with current Joint Commission (JC) National Patient Safety Goals (NPSGs)
- ✚ Promoting a “Just Culture” within Coastal Cluster which encourages the reporting of errors and near misses. After an incident occurs, there is an emphasis on learning and improving systems, not on finding someone to blame.

Patient Safety Council

The Patient Safety Council is a multi-disciplinary committee established to manage the organization-wide Patient Safety Plan and ensure compliance with current Joint Commission National Patient Safety Goals. The Patient Safety Council is chaired by the Patient Safety Officer. The Patient Safety Council also provides leadership and direction for patient safety initiatives and activities.

Key Point: *Know that we have a proactive, multifaceted, and integrated Patient Safety Program. The purpose of the Program is to ensure that Coastal Cluster facilities comply with current patient safety standards as required by The Joint Commission National Patient Safety Goals and standards.*

Patient Safety Brochures

Coastal Cluster Harbor-UCLA provides inpatients with a **DHS Patient Safety “Tips for Patients”** pamphlet; surgery patients with an **“If You Need Surgery”** pamphlet; outpatients with a **“Living Healthy Staying Safe”** pamphlet. We encourage each patient to review the pamphlet and apply the safety tips to their care. *Encouraging a patient’s active involvement in their own care will provide a better means of communication between patients and staff; and ultimately a safer environment.*

How you can report patient safety issues/concerns/suggestions?

- Patient Safety Net (a web-based DHS-wide system)
- Discuss your concerns or issues/suggestions with your supervisor
- Patient Safety Hotline at **(213) 989-SAFE** or e-mail at patientsafety@dhs.lacounty.gov
- Executive Leadership Rounds
- The Joint Commission at (800) 994-6610 or by e-mail at complaint@jointcommission.org
- Submit patient safety issues/concerns/suggestions in the suggestion boxes
- See *Risk Management Section* for additional reporting

How you can stay updated on Patient Safety Initiatives

One of the ways you can keep updated is by reviewing the current **National Patient Safety Goals** on the mini badges which are distributed to each workforce member annually. The mini badge should be worn with your identification badge. The current NPSG workforce member mini card serves as a constant reminder that we must keep patient safety as our first priority. Each workforce member is responsible for knowing the current NPSGs and which NPSGs apply to their work environment.

Additional ways to keep current with patient safety initiatives include:

- Participating in patient safety discussions in your unit staff meetings;

- Speaking up during Executive Leadership Rounds in your department;
- Reviewing the Patient Safety Committee webpage on the intranet;
- Attending Coastal Cluster-sponsored educational presentations; and
- Attending the annual DHS Patient Safety seminar.

SAFE AND JUST CULTURE

A safe and just culture is one in which safety is a personal and organizational priority, where frontline staff feel comfortable reporting errors, including their own, while maintaining professional accountability and knowing that they will not be retaliated upon. A safe and just culture provides a fair and balanced environment in which human behaviors and the systems that support those behaviors are evaluated in response to an event.

DHS strives to build, maintain, and support a safe and just culture. This goal is achieved by recognizing the difference between the system failures and human behaviors that lead to an event.

Create and Maintain a Just Culture by:

- Encouraging staff to recognize and report patient safety issues, and suggest ideas on how we can improve
- Acknowledging that errors in healthcare do occur and provide a supportive environment for the staff should an error occur
- Viewing mistakes as opportunities to learn and then identify system failures
- Focusing on designing/re-designing systems that will ultimately prevent mistakes
- Partnering with patients and their families and letting them know how much we appreciate their active participation in making their care as safe as possible

Key Point: *It is your responsibility to report any unexpected event, situation, environmental condition, or “near miss” that causes you concern for the safety of patients, visitors, or staff as soon as possible. The Patient Safety Net (PSN) web-based reporting system is the best way to report an unsafe event or conditions. Additionally, an incident may be reported directly to the Patient Safety Officer, Patient Safety Hotline by calling (213) 989-SAFE or by e-mailing at patientsafety@dhs.lacounty.gov, or The Joint Commission.*

NATIONAL PATIENT SAFETY GOALS

The Joint Commission approved the first set of National Patient Safety Goals (NPSGs) in July 2002 with specific requirements for improving the safety of patient care in healthcare organizations. The Joint Commission-accredited healthcare organizations are surveyed for the implementation of the NPSGs and requirements, or acceptable alternatives. Our Patient Safety Program initiatives are based on meeting the NPSGs, and focusing on system-wide solutions. Coastal Cluster is required to consistently comply with all of the NPSGs. Each workforce member should be knowledgeable of the NPSGs and how to directly apply them to their service units.

Key Point: *You are responsible for reviewing and complying with current National Patient Safety Goals that are applicable to your duties.*

2010 NATIONAL PATIENT SAFETY GOALS FOR HOSPITALS Harbor-UCLA Medical Center

GOAL 1 Improve the accuracy of patient identification

- NPSG 01.01.01 Use of two patient identifiers when providing care, treatment, and services.
- NPSG 01.03.01 Eliminate transfusion errors related to patient misidentification.

GOAL 2 Improve the effectiveness of communication among caregivers

- NPSG 02.03.01 Report critical results of tests and diagnostic procedures on a timely basis.

GOAL 3 Improve the safety of using medications

- NPSG 03.04.01 Label all medications, medication containers and other solutions on and off the sterile field in perioperative and other procedural settings. *Note: Medication containers include syringes, medicine cups, and basins.*
- NPSG 03.05.01 Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. *Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.*

GOAL 7 Reduce the risk of health care-associated infections

- NPSG 07.01.01 Comply with either the current Center for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
- NPSG 07.03.01 Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. *Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.*
- NPSG 07.04.01 Implement evidence-based practices to prevent central line-associated bloodstream infections. *Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.*
- NPSG 07.05.01 Implement evidence-based practices for preventing surgical site infections.

GOAL 8 Accurately and completely reconcile medications across the continuum of care

- NPSG 08.01.01 A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the hospital. *Note: This standard is not in effect at this time.*
- NPSG 08.02.01 When a patient is referred to or transferred from one hospital to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the hospital's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service. *Note 1: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient and, as needed, the family the list of reconciled medications is sufficient. Note 2: This standard is not in effect at this time.*
- NPSG 08.03.01 When a patient leaves the hospital's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family. *Note: This standard is not in effect at this time.*
- NPSG 08.04.01 In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. *Note 1: This requirement does not apply to hospitals that do not administer medications. It may be important for health care organizations to know which types of medications their patients are taking because these medications could affect the care, treatment, and services provided. Note 2: This standard is not in effect at this time.*

GOAL 15 The hospital identifies safety risks inherent in its patient population

- NPSG 15.01.01 Identify patients at risk for suicide. *Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.*

UNIVERSAL PROTOCOL

The Joint Commission's Universal Protocol (UP) was developed to assist in preventing wrong site, wrong procedure, and wrong person surgery/procedure. The UP, as a National Patient Safety Goal, establishes a process for a defined series of pre-procedure verifications to take place prior to surgery or a procedure. Coastal Cluster has adopted each component of the UP and it applies to invasive procedures performed in the operating room as well as those performed in non-operating room settings (e.g., endoscopy, interventional radiology, cardiac catheterization, and the bedside). Workforce members share in the responsibility of conducting the pre-procedure verification process with the patient.

- UP.01.01.01 Conduct a pre-procedure verification process.
- UP.01.02.01 Mark the procedure site.
- UP.01.03.01 A time-out is performed before the procedure.

2010 NATIONAL PATIENT SAFETY GOALS FOR AMBULATORY HEALTH CARE Long Beach Comprehensive Health Center

GOAL 1 Improve the accuracy of patient identification

- NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment, and services.
- NPSG.01.03.01 Eliminate transfusion errors related to patient misidentification.

GOAL 3 Improve the safety of using medication

- NPSG.03.04.01 Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. *Note: Medication containers include syringes, medicine cups, and basins.*
- NPSG.03.05.01 Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. *Note: This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.*

GOAL 7 Reduce the risk of health care-associated infections

- NPSG.07.01.01 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.07.05.01 Implement evidence-based practices for preventing surgical site infections.

GOAL 8 Accurately and completely reconcile medications across the continuum of care.

- NPSG.08.01.01 A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization. *Note: This standard is not in effect at this time.*
- NPSG.08.02.01 When a patient is referred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the organization's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service. *Note 1: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the patient and, as needed, the family the list of reconciled medications is sufficient. Note 2: This standard is not in effect at this time.*
- NPSG.08.03.01 When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family,

and the list is explained to the patient and/or family. *Note: This standard is not in effect at this time.*

NPSG.08.04.01 In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. *Note 1: This requirement does not apply to organization that do not administer medications. It may be important for health care organizations to know which types of medications their patients are taking because these medications could affect the care, treatment, or services provided. Note 2: This standard is not in effect at this time.*

UNIVERSAL PROTOCOL

UP.01.01.01 Conduct a pre-procedure verification process
UP.01.02.01 Mark the procedure site
UP.01.03.01 A time-out is performed before the procedure

DETERIORATING PATIENT CONDITION

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

If you are in a patient care area, always notify the patient's nurse immediately. If you cannot tell which nurse to notify, please tell any doctor or nurse in the area that you are concerned about the patient/visitor. Some areas of the hospital are covered by Harbor-UCLA's Rapid Response Teams. Registered nurses in the areas covered by Rapid Response Teams have been trained in how and when to activate the teams. In other areas, nurses may call the patient's doctor, call a code blue or code white, or call 9-1-1, in response to a change in patient condition. This is why notification of the patient's nurse is the first step if any workforce member is concerned. At **Harbor/UCLA Medical Center** it is important that you know that anyone can call for emergency medical assistance by **dialing Ext. 112** from a hospital phone.

If you are outside the main hospital building, you should **call 9-1-1 for any medical emergency**, (e.g. buildings other than the main hospital, parking lots or parking structures, adjacent streets or areas near the facility, etc.). Please note that 1 South CRU is considered part of the main hospital, dial Ext. 112. **If you encounter a situation that you feel requires emergency assistance, then you should always act on it by calling for help!**

Harbor-UCLA Medical Center:

Cardiac or Respiratory Arrest <ul style="list-style-type: none">○ Adult patient: Code Blue○ Pediatric patient: Code White	Inside the main hospital, including 1 South CRU: Call Ext. 112
	Outside the main hospital: Call 9-1-1

Comprehensive Health Care Centers:

- ◆ Call 9-1-1 for **ALL** medical emergencies

FALL PREVENTION AND RESPONSE

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

A fall is a sudden and unintentional changing of position causing a person to land on the ground, floor, an object, or on a lower level. This may be due to a trip, slip, loss of balance, or change in gait, and can be the result of many risk factors.

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

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

Prevention

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

- Identifying and Eliminating Hazards: If you see a hazard and you can fix the hazard (e.g. a water/liquid spill), do so. If you can't fix the hazard, promptly notify the proper department, maintenance worker, clinician, and/or area supervisor; according to your facility protocols. Try to secure the area to avoid a potential fall victim.
- Environmental risks and hazards include: wet or slippery floors, spills, debris, clutter, obstructions, stairs, change in surfaces, rugs/floor mats, extension cords, power cords of equipment in use or not in use, ladders, etc.
- Physical/Cognitive Risks: The elderly and the very young make up the highest percentage of fall victims. Some factors that contribute to fall risk for elderly are: medication usage, confusion, unsteady gait, declined hearing and vision. Some factors that contribute to fall risk for children are: running, climbing, jumping, illness or injury.
- Fall Risk Communication: Communicating potential hazards that you see, from the parking lot to the waiting rooms, common areas, hallways and restrooms can keep staff, visitors, and patients safe from falls and injuries and provide a safer, healthier environment. When a patient is identified as high risk for falls, the nursing staff will place them on "fall risk" alert. Through verbal communication and report, signage on door or wall, patient wristband, documentation, and/or other modalities according to the facility's protocols, we can take precautions to prevent patient falls.

Some Tips for Preventing Falls

Environmental:

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

Inpatients:

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

Response

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

- Expectations to respond to a fall victim: If the person who has fallen is alert and oriented, ask them if they are alright. If there is no apparent injury and the fall victim indicates that they have sustained no

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

Process for obtaining medical assistance:

- Notify your supervisor
- Dial Ext. 112
- Document the incident via Patient Safety Net and follow other facility reporting procedures

Environmental hazards are reported to Facility Management or the Facility Safety Officer. Safety concerns/complaints may be made through the workforce member's supervisor, the facility risk manager, and/or the DHS Quality Improvement Program hotline at (800) 611-4365.

In order to monitor, measure and analyze conditions associated with falls, it is critical that you report **ALL** falls. If you encounter, witness a fall, help or assist someone whom has fallen; follow the facility's reporting process (or notify your supervisor immediately) so conditions associated with falls can be corrected and documented. **Falls are to be reported in the Patient Safety Net (PSN) system.** Patterns and risks leading to falls can be identified and processes can be developed to improve the safety of the environment. Workforce members without access to the PSN should report falls to their supervisor, or the facility risk manager, patient advocate or patient safety officer.

Eliminating Occupational Hazards

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

Tips for a safer workplace environment:

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

Be a Good Samaritan

If you encounter a co-worker who looks as though they need assistance, (e.g. carrying an unstable load, or following unsafe practices), offer assistance to eliminate potential falls or injury.

If you see a handicapped person struggling to get out of the car, to stand up, or any other needs that are apparent, then you should offer to help in a respectful manner. The goal of the DHS system is to be proud of our services and our motto is:

“To enrich lives through effective and caring service”

STAFF RIGHTS AND RESPONSIBILITIES

This section discusses your rights and responsibilities as a workforce member in the Coastal Cluster. Included in this section are DHS emergency protocol, your rights in the delivery of patient care; compliance awareness and Code of Conduct; procurement process; your responsibilities for attending training and demonstrating competence; policies on attendance/tardiness, health screening, the Employee Assistance Program, sexual harassment prevention, cultural competence and sensitivity, preventing and reporting of abuse/neglect, Workforce Behavioral Expectations, Safe Haven/Safely Surrender Baby Law, and Americans with Disabilities Act (ADA).

DHS COUNTY WORKFORCE MEMBER EMERGENCY PROTOCOL

Chapter 2.68, Los Angeles County Code, Emergency Services Ordinance establishes the County Emergency Organization. County departments, commissions, agencies, boards, districts, officers and workforce members have emergency duties, responsibilities, and assignments for war and non-war incidents as prescribed in the Los Angeles County Operational Area Emergency Response Plan for Emergency Operations.

DHS County workforce members are members of the County's Emergency Response Team and in the event of an emergency are expected to report for emergency-related duties once their critical personal and family emergency responsibilities have been met.

Disaster Service Worker

The California Emergency Service Act designates public employees as Disaster Service Worker (DSW) that may be deployed to perform activities outside the course and scope of their regular employment which promote the protection of lives and property or mitigate the effects of a disaster (such as fire, flood, earthquake, or other natural or man-made disasters). This is mandatory for all eligible County employees and requires DSWs to receive training on basic emergency management principles, take the oath, and sign an affirmation of allegiance (also referred as the affirmation of loyalty) card and document specialized skills.

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

STAFF RIGHTS

Coastal Cluster Harbor-UCLA seeks to provide high quality patient care in an environment that protects all members of our service delivery team and respects their cultural values, ethics, and religious beliefs. Network leadership recognizes that situations may occasionally arise in which your cultural, ethical, or religious belief conflicts with the rendering of patient care. The policy titled "Staff Rights in Patient Care" describes the procedure by which you may formally submit a request to your supervisor for such considerations. Non-County workforce members should contact the facility contractor administrator for terms and conditions of their contract.

DHS COMPLIANCE PROGRAM AND CODE OF CONDUCT

The DHS Compliance Program is a comprehensive strategy to prevent, detect and correct instances of unethical or illegal conduct. DHS is committed to conducting its business with honesty, integrity and in full compliance with all applicable laws and regulations.

The Chief Compliance Officer located at DHS headquarters is responsible for directing the DHS Compliance Program. Each hospital has a Local Compliance Officer who is responsible for implementing compliance-related activities at each of their respective facilities. The Local Compliance Officer for Coastal Cluster Harbor-UCLA can be reached at (310) 222-2106.

A significant element of the DHS Compliance Program is the Code of Conduct. The Code of Conduct provides guidance to our workforce on the basic standards and principles the workforce member must follow to carry out their jobs in a legal and ethical manner. These legal and ethical standards apply to our relationships with patients, workforce members, affiliated providers, third-party payors, contractors, subcontractors, vendors, and consultants. Each workforce member has a personal responsibility to comply with the Code of Conduct and

must sign an acknowledgement stating that they will abide by the Code of Conduct and understand that non-compliance with the Code of Conduct can subject them to disciplinary action up to and including discharge from County service or termination of assignment.

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

- His/her supervisor or manager
- Local Compliance Officer
- DHS Audit and Compliance Division:
313 North Figueroa Street, Room 801
Los Angeles, CA 90012
Telephone: (213) 240-7901
Fax: (213) 481-8460
Compliance Hotline: (800) 711-5366.

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

Please note that the Los Angeles County Fraud Hotline (800-544-6861), operated by the Auditor Controller continues to be available to report fraudulent activity.

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

Compliance awareness training is provided to workforce members at the start of service and every two (2) years thereafter. This training provides workforce members with a better understanding of the Code of Conduct and their role in the Compliance Program.

False Claim Act

It is the policy of the Department of Health Services (DHS) to ensure compliance with all state and federal laws, rules, and regulations and to establish, maintain, and enforce policies and procedures to detect and prevent fraud, waste and abuse regarding claims to the federal government. DHS is compelled, by Section 6032 of the federal Deficit Reduction Act of 2005, to provide information to all workforce members regarding liabilities with respect to false claims and statements; protections for workforce members who report wrongdoing (whistleblower protections) under those laws and regulations, policies and procedures to detect and prevent fraud, waste and abuse and workforce training (*Federal False Claims Act, 31 U.S.C §§3729-3733*).

DHS workforce members are also required to abide by the Federal False Claims Act as well as other federal and state laws, rules and regulations. Workforce members are also afforded with whistleblower protection through these laws, rules and regulations.

The Federal False Claims Act (FCA) 31 U.S.C. §§ 3729-3733

The Federal False Claims Act was enacted in an effort to reduce fraud, waste and abuse in federal programs, purchases and contracts. It allows private parties to bring suit on behalf of the federal government against businesses and persons alleged to have committed fraud. The Act also contains language protecting whistleblowers from retaliation by employers.

Actions that violate the FCA include:

1. Presenting or causing to be presented a false or fraudulent claim for payment;

2. Making or using, or causing to be made or used, a false record or statement to get a false claim approved;
3. Conspiring to defraud the federal government by getting a false or fraudulent claim paid or approved; and
4. Making, using or causing to be made or used, a false document to avoid or decrease the amount to be paid or delivered to the federal government.

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

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

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

The FCA protects whistleblowers. Under FCA, any workforce member who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the workforce member to support or assist an action under the Act is entitled to all relief necessary to make the workforce member whole. Such relief may include reinstatement, double back pay, and compensation for litigation costs and reasonable attorney’s fees.

Administrative Remedies for False Claims

In addition to administrative procedures that may exist under a particular government program such as Medicare, federal law gives certain federal executive departments such as the Department of Health and Human Services and the Office of the Inspector General, the right to issue administrative penalties (i.e., penalties that cannot be imposed by the courts) for false claims and statements. Administrative penalties can consist of monetary penalties as well as exclusion from participation in federal healthcare programs. These penalties may be imposed, for a variety of offenses which include violation of program rules, kickbacks or other inappropriate behaviors, as well as for false claims and statements.

The federal administrative penalty provisions found at 31 U.S.C §§3801-3812, allow penalties to be imposed for the following actions:

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

A civil penalty up to \$5,000 will be assessed for each claim submitted. In addition, if a false claim was paid, the responsible person will have to repay an amount equal to two times the amount of the claim. This second amount acts as payment for the government’s damages.

California False Claims Act (Government Code §§ 12650-12656)

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

Actions that violate the CFCA include:

1. Presenting or causing to be presented to the State or county government a false or fraudulent claim for payment;
2. Making or using, or causing to be made or used, a false record or statement to get a false claim approved or paid;
3. Conspiring to defraud the State or county government by getting a false or fraudulent claim approved or paid;
4. Making, using, or causing to be made or used, a false document to avoid or decrease the amount to be paid or delivered to the State or county government; and
5. Failing to inform the State or county government within a reasonable period after discovery, that it is the beneficiary of an inadvertent submission to the State or county government of a false claim. In essence, this provision makes individuals responsible for telling the State or county government about a payment they received which they should not have received, even when they did not intend to get the incorrect payment.

If a person or entity has been found to violate the California False Claims Act, the person/entity will be responsible for paying three times the amount of actual damages and a penalty of up to \$10,000 per claim. These can be reduced by self-disclosure of the facts and cooperation with the government.

Individuals or qui tam plaintiffs can sue for violations of the CFCA. Individuals who bring an action under CFCA may receive between 15 and 33 percent of the amount recovered (plus reasonable costs and attorney's fees) if the state prosecutes the case, and between 25 and 50 percent (plus reasonable costs and attorney's fees) if the qui tam plaintiff litigates the case of his or her own. The individual must have knowledge of the circumstances around the false claim and the information must not be public information unless he or she is the source of the information. A civil suit must be filed within three years after the violation is discovered by the state or local governmental entity responsible for investigating the action (but no more than ten years after the violation was committed).

The CFCA does not apply to false claims of less than \$500, workers' compensation claims; claims made under the Government Code; or claims, records, or statements made under the Revenue and Taxation Code.

Such as with the FCA, the CFCA bars employers from interfering with an individual's right to action under CFCA. Workforce members who report fraud and are discriminated against may be awarded by (1) reinstatement at the seniority level they would have had except for the discrimination (2) double back pay plus interest; (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.

Other State laws prohibiting false claims include:

- Penal Code §72 – Makes it a crime to knowingly and deliberately submit a fraudulent claim to the government
- Penal Code § 550 – Makes it a crime to conduct certain types of improper billing practices
- Welfare & Institutions Code § 14107 – Makes it a crime, under certain circumstances, to submit false claims or support false claims, or obtain an authorization with false documents, where the claim is to the Medi-Cal Program
- Welfare & Institutions Code § 14107.4 – Makes it a crime to submit false information in a cost report to falsely certify a cost report
- Welfare & Institutions Code § 14123.2 – Imposes administrative fines for presenting or causing to be presented various kinds of improper claims to Medi-Cal
- Welfare & Institutions Code § 14123.25 – Allows civil monetary penalties to be imposed and/or a provider to be excluded from participation in Medi-Cal for improperly billing Medi-Cal or making improper calculations on a cost report; providers may also be excluded for a variety of other prohibited behaviors

- Business & Professions Code § 810 – Makes it unprofessional conduct, punishable by the various licensing agencies, to make false claims under an insurance policy, or to create false or fraudulent supporting documents, among other prohibited behaviors
- Health & Safety Code § 100185.5 – Allows the California Department of Health Services, under certain circumstances, to suspend or disenroll from any program a provider who is suspend or disenrolled from another program it administers
- Labor Code § 1102.5 – Protects, under certain circumstances, workforce members whose employers are violating State or federal laws or regulations and prohibits employers from retaliating against any workforce member who refuses to participate in a violation of law.

PROCUREMENT PROCESS

No Department of Health Services workforce member has independent authority to purchase supplies, equipment or services, or commit County funds.

County Authority

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

Department of Health Services (DHS) Authority

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

DHS Facility Authority

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

Unauthorized Purchases

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

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

TRAINING & COMPETENCY

You are mandated to complete Coastal Cluster Harbor-UCLA's orientation within 30 days of hire/assignment or transfer to the hospital. Coastal Cluster Harbor-UCLA will document completion in your official personnel folder and/or area file. Your supervisor will also document your unit-based, job-specific orientation and initial competency assessment in your area file, as applicable. Documentation of initial competency assessment must be completed within the first 30 days of your assignment to the actual unit/division. Your supervisor should ensure that you know how to use equipment in the performance of your



job and should apprise you of the policies and procedures you must follow. Assignments shall include only those duties and responsibilities for which competency has been validated. Ongoing competency assessment is required annually or as needed (i.e. new equipment, new procedure/policy, remedial education process, etc.) and must be documented in your area file. You must also complete all mandatory training and competency certification requirements for your position (e.g., orientation, infection control, fire/life safety, emergency management, patient safety, CPR and other core competencies).

MEDICAL PROFESSIONALS LICENSE/REGISTRATION/CERTIFICATION/PERMIT

Any workforce member whose position requires a current valid license, certificate, registration and/or permit to perform the duties of his or her position shall produce evidence of license, certificate, registration and/or permit to Human Resources upon entering County service or assignment.

Some positions require secondary or additional licenses to fulfill regulatory/legal requirements. It is the responsibility of the licensed professional to renew all required licenses or other requirements and to ensure the license is kept in good standing with the appropriate issuing board or agency. Failure to comply with licensure requirements may subject the person to corrective action, which may include discharge/release from County service or assignment.

Primary source verification must be conducted during in-processing, upon new assignment, promotion, licensing renewal, contract renewal (independent contractor), transfer to new work location, and during the performance evaluation process. Primary source documents dated after the initial date of hire/assignment/promotion or greater than five (5) days prior to the initial date of hire/assignment/promotion as invalid/untimely.

It is the workforce member's responsibility to provide a copy of a renewal license, certificate, registration or permit to his or her supervisor and/or the Human Resources office prior to the expiration date. A workforce member will not be allowed to work with an expired, suspended, or revoked, license, certificate, registration and/or permit.

A workforce member must notify his or her supervisor within 24 hours of being notified by the issuing agency that a disciplinary action is being brought against the license, certificate, registration and/or permit.

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

Workforce members may only work within the scope of their license, certificate, registration, and/or permit or within any restrictive conditions, as applicable.

However, if you observe behavior in a licensed professional that may compromise patient or environmental safety, you should immediately report the behavior by notifying your immediate supervisor or to the House Supervisor at Ext. 3434 during after hours.

Medical Staff	Medical Administration – (310) 222-2901
Nursing Staff	Nursing Administration – (310) 222-3434
Non-Physician/Nurse Clinical Staff	Hospital Administration – (310) 222-2106
Long Beach CHC Administration	Medical Administration -- (562) 599-8636
Bellflower HC Administration.....	Medical Administration -- (562) 599-8636
Family Health Center Administration	Clinic Director – (310) 534-6221
Wilmington Health Center	Clinic Director – (310) 233-4981

CRIMINAL BACKGROUND CHECKS

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

All candidates selected for hire, promotion to a sensitive position or transfer from another department and non-County workforce members will participate in a criminal background check. The criminal background check will include fingerprinting and Live Scan (CADOJ) and/or the FBI, as applicable. State and federal licensing and administrative agencies may also be contacted. As part of the criminal background check process all candidates are also screened through the:

- Office of Inspector General (OIG) exclusions list on the OIG Internet website to ensure the workforce member has not violated any federal regulations pertaining to Medicaid or Medicare or any other healthcare related regulations.
- General Services Administration/Excluded Parties List System (GSA/EPLS) exclusions list to ensure the non-County workforce member has not violated any administrative or statutory federal regulations, or is listed as a suspected terrorist or person barred from entering the United States.
- Medi-Cal Suspended and Ineligible Provider List (S&I List) to ensure eligibility to participate in Medi-Cal programs.

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

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

Prospective workforce members who do not answer questions related to conviction information will be rejected.

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

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

- positions that involve the care, oversight, or protection of persons through direct contact with such persons;
- positions having direct or indirect access to funds or negotiable instruments;

ATTENDANCE/TARDINESS

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



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

HEALTH SCREENING

All workforce members within the Coastal Cluster Harbor-UCLA's service delivery team as well as all students, volunteers, and non-DHS/non-County workforce members must have an initial and annual health assessment, including, but not limited to, a tuberculin skin test, chest x-ray (if needed), respirator fit test (if needed), medical questionnaire, communicable disease status, and/or any other medical tests, as required. **It is your responsibility** to obtain a health screening annually as a condition of continued employment/assignment. You may contact Employee Health at (310) 222-2360 to find out when your health screening is due. Documentation that the annual health clearance was completed must be kept up to date in your area file. No person will be allowed to work inside a County medical facility without appropriate documentation of health clearance or required health evaluation.

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

EMPLOYEE ASSISTANCE PROGRAM (County Employees Only)

The County has an Employee Assistance Program (EAP). EAP provides counseling services to address both personal and job-related issues. To schedule an appointment, call (213) 738-4200. The first appointment is on County time, as long as you receive approval, in advance, from your supervisor. Subsequent EAP appointments, if any, will require you to use your own time. Again, you will need to advise your supervisor and request time off as you would any other time off if your appointment(s) are during work hours.

SEXUAL HARASSMENT PREVENTION

All workforce members have a right to work a work environment that encourages workforce members to treat each other with dignity and respect and is free from any form of harassment; therefore, sexual harassment in any facility within the Department of Health Services is unacceptable and will not be tolerated from any workforce member. It is illegal under federal and State law and DHS policy. The County of Los Angeles has established a "zero tolerance" policy for any conduct that could reasonably be interpreted as harassing, offensive or inappropriate in the workplace.

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors and/or other verbal or physical conduct of a sexual nature. It may present in three forms: when a supervisor or manager makes sexual advances as a condition of your employment/assignment; it is a consequence of employment/assignment; or when inappropriate behavior or conduct of a sexual nature substantially interferes with your work performance or creates an intimidating, hostile, or offensive work environment.

Facts about Sexual Harassment

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

Examples of Prohibited Activities (not a complete list):

- ◆ Sexual propositions, stating or implying that sexual favors may be required as a condition of employment/assignment or continued employment/assignment, preferential treatment or promises of preferential treatment to a workforce member for submitting to sexual conduct; repeated unwanted sexual flirtations, advances, or invitations; unwanted physical conduct, such as touching, pinching, grabbing, kissing, patting, or brushing against another's body;
- ◆ Sexually oriented or suggestive jokes, comments, teasing, or sounds; unwelcome comments about a person's body or questions about or discussions of another person's or one's own sexual experiences/preferences; sexually derogatory or stereotypical comments; verbal abuse of a sexual nature or based on sex/gender; sex/gender-based hostility; sexual orientation/preference;
- ◆ Offensive leering, unwelcome flirtatious eye contact, staring at parts of a person's body, sexually oriented gestures;
- ◆ Displays or distribution of offensive, sexually suggestive pictures or objects, drawings, cartoons, graffiti, calendars, posters, printed material, or clothing containing sexually oriented language or graphics; and/or
- ◆ Inappropriate e-mail usage and transmissions containing sexually explicit messages, cartoons, jokes, and unwelcome propositions; as well as accessing or viewing pornographic websites, computer/video games depicting sexual situations or behaviors.

Preventing and Reporting Sexual Harassment

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

- DHS Audit & Compliance:
313 North Figueroa Street, Room 801
Los Angeles, CA 90012
Telephone: (213) 240-7901
Fax: (213) 481-8460
Hotline: (800) 711-5366
- County's Office of Affirmative Action Compliance (OAAC):
Kenneth Hahn Hall of Administration, Room 780
Los Angeles, CA 90012
Telephone: (213) 974-1251
TDD: (213) 974-0911
Fax: (213) 613-2258

The workforce member may complete a Discrimination Complaint form to report instances of sexual harassment and submit it through the normal chain of command, if possible. Managers/supervisors are responsible to take all reports and allegations of sexual harassment seriously, to meet with the reporting party to obtain additional information and to immediately notify the facility Human Resources office. All reported matters will be promptly investigated and appropriate corrective action taken, if necessary.

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

During an investigation, an investigator will visit the worksite and interview potential witnesses mentioned in the complaint. Information obtained from witnesses will only be released on a "need-to-know" basis in order to complete the investigation. Also, the involved parties may be separated or other personnel actions may occur. If it is determined that a violation has occurred, appropriate corrective action up to and including discharge from

County service or termination of assignment. Staff may also be required to attend a sexual harassment training to reinforce the sexual harassment policy.

All workforce members are required to be trained on sexual harassment at least once every two (2) years. California law mandates managers/supervisors to attend training within six (6) months of being promoted or hired to a supervisory position and every two (2) years thereafter.

CULTURAL COMPETENCE

What Is Cultural Competency?

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

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. *(Adapted from Cross, 1989).*

And why is it important?

Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culture and language may influence:

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

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

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

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

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

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

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

As new workforce members, you will receive more in-depth training on cultural competence and diversity in the near future.

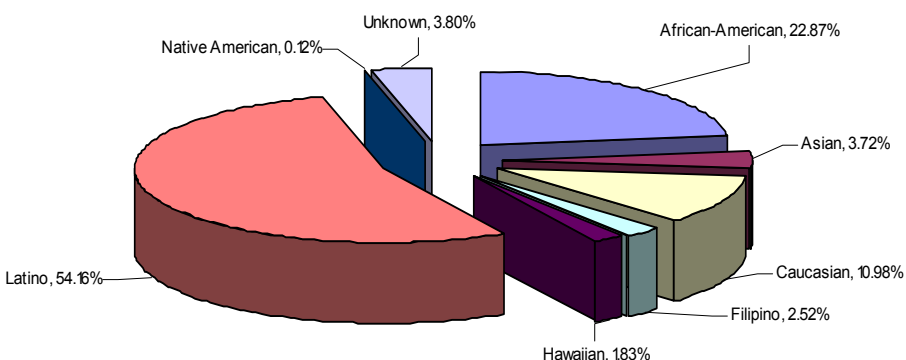
HARBOR-UCLA PATIENT POPULATION

Culturally competent patient care is not just a right; it's also a key factor in the safety and quality of patient care.

As of June 30, 2009, our patient ethnicity was as follows:

Patient Population

African-American	22.87%
Asian	3.72%
Caucasian	10.98%
Filipino	2.52%
Hawaiian	1.83%
Latino	54.16%
Native American	0.12%
Unknown	3.80%



Legend: African-American (blue), Asian (red), Caucasian (yellow), Filipino (green), Hawaiian (purple), Latino (orange), Native American (light blue), Unknown (grey)

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

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

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

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

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

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

Any workforce member who witnesses or reasonably suspects a patient was or is being subjected to inappropriate sexual conduct and/or sexual abuse shall report it to his or her supervisor and to the facility Los Angeles County Sheriff's Department. The reporting party shall report the suspected abuse using a Security Incident Report (SIR) and in the Patient Safety Net (PSN) in accordance with Departmental policy.

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

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

A workforce member determined to have violated this policy shall be subject to appropriate corrective action which may lead up to termination. The workforce member may also be subject to criminal and/or civil prosecution and reporting to the appropriate licensing, certification, registration, or permit board/agency. Non-County workforce members will be subject to termination of assignment and placed on the "Do Not Send" database.

Each DHS facility has a complaint/grievance process which must be followed to ensure appropriate actions are taken to provide the patient with adequate protections and that a timely investigation is completed.

WORKFORCE BEHAVIORAL EXPECTATIONS

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

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

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

There will be no retaliation against anyone who reports a violation of this policy in good faith. However, any workforce member who deliberately makes a false accusation will be subject to appropriate corrective action. Moreover, reporting a violation does not protect individuals from appropriate corrective action regarding their own misconduct.

Workforce members should report disruptive, inappropriate or unprofessional behavior. Some inappropriate or unprofessional behavior will need to be reported to the appropriate licensing, certification, registration or permit agency/board.

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

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

THREAT MANAGEMENT “ZERO TOLERANCE”

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

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

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

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

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

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

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

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

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

Immediate Danger or Imminent Threat of Violence

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

- Immediately notify on-site security personnel/L.A. County Sheriff's Department
- Warn potential victim(s)
- Seek personal safety
- Post event, the victim or supervisor/manager shall contact the Office of Security Management (OSM) within 24 hours

Non-Imminent Threats

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

- On-site facility security personnel/L.A. County Sheriff's Department
- A Department supervisor or manager
- The potential victim(s)

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

REPORTING OF ABUSE/NEGLECT INCIDENTS

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

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

- **Child Abuse** includes emotional, physical, or sexual abuse, as well as neglect of a person under the age of 18 years, including the unborn child where mothers harm the unborn because of substance abuse. Healthcare providers are mandated to report incidents of suspected abuse to Department of Children and Family Services **Child Abuse Hotline at 1-800-540-4000** immediately or as practicably as possible. A written report must be submitted within 36 hours of the telephone report. Abuse that is sexual in nature also must be reported to law enforcement by calling the Los Angeles County Sheriff's Department at Ext. 3311 or other local law enforcement agency with jurisdiction.
- **Elder Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals over 65 years of age. Healthcare providers are mandated to report incidents of suspected elder abuse immediately or as practicably as possible by calling the **Elder Abuse Hotline at 1-877-477-3646**. A written report must be submitted within two (2) working days of the telephone report.
- **Dependent Adult Abuse** includes physical harm, abandonment, neglect or intentional emotional/psychological abuse, violation of personal rights and financial abuse of individuals between the ages of 18-64. This includes individuals who are mentally or physically challenged. Healthcare providers are mandated to report incidents of adult abuse by calling the **Adult Abuse Hotline at 1-877-477-3646** and submit a follow-up report immediately or as practicably as possible.
- **Intimate Partner Abuse** involves any individuals who have been abused by their intimate partner. Intimate partners are those individuals who are currently dating, married, and cohabitating or separated. The abuse

includes physical violence, sexual assault, severe emotional distress and economic coercion. Intimate partner abuse must be reported if there is a current injury. Healthcare providers are mandated to report the violence as soon as practicably possible to local law enforcement or the Sheriff's Department at Ext. 3311 or to the **Domestic Violence Hotline at 1-800-978-3600** and follow up report within 48 hours.

In addition, contact the Clinical Social Work Department at (310) 222-3278 for assistance with evaluations, reporting forms and referrals.

SAFE HAVEN/SAFELY SURRENDERED BABY LAW

In compliance with Senate Bill 1368 (Brulte) Chapter 824, Statutes of 2000, per Coastal Cluster Harbor-UCLA's Newborn Abandonment Policy No. 376, it is the policy of the Network to take physical custody of an infant 72 hours old or younger when surrendered to the Emergency Department by the parent or other person having lawful custody. The Emergency Department assesses the baby and provides necessary medical care (consent of parent/surrendering party is not required to provide care). EMTALA regulations apply to the care of the infant.

Actions taken when a baby is surrendered:

- A band with a unique, coded, confidential identification number is placed on the baby's ankle and a duplicate band is given to the surrendering party for reclaiming the baby within 14 days if they should change their mind.
- A good faith effort is made to get information about the baby and the birth, along with a completed Newborn Family Medical Questionnaire from the surrendering party.
- The Pediatric Emergency Department Attending Physician shall arrange admission of the newborn based on the appropriate level of medical care required.
- The Department of Children and Family Services is notified by the Clinical Social Work Department or by the Emergency Department during after hours and weekends by calling (800) 540-4000.

The Department of Children and Family Services assumes custody of the baby upon notification. If the surrendering party returns to reclaim the baby, contact the Clinical Social Work Department at (310) 222-3278, or during after hours contact the Shift Nurse Manager at (310) 222-3434.

The Emergency Department staff documents the abandonment on the infant's medical record, along with the baby's identification number on the band. All information pertinent to the abandonment and all related telephone calls are documented in the medical record. An Event Notification Report is completed. In addition, information regarding the parent or individual surrendering the infant should not be shared under any circumstances.

Newborn babies may also be safely surrendered at hospitals with emergency rooms and fire stations designated by the County Board of Supervisors. For a list of Los Angeles County's Safely Surrender Baby (SSB) Sites visit www.babysafela.org or call 1-877-BABY SAFE.

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

accommodation. For specific information on reasonable accommodations, contact DHS Human Resources, Return to Work Unit, at (323) 869-7122.

If you have a disability that is covered under the ADA and you are a qualified individual, you are entitled to reasonable accommodation. Please contact Human Resources (323) 869-7122 for assistance.

PATIENT RIGHTS AND SERVICES

This section explains Coastal Cluster Harbor-UCLA's patient rights and services such as patient advocacy, interpreter services, the Chaplaincy Program, advance directives, Americans with Disabilities Act (ADA), Service Animals, organ/tissue donation, and Emergency Medical Treatment and Active Labor Act (EMTALA).

To ensure that you are protecting our patients' rights, Coastal Cluster Harbor-UCLA has a Bioethics Committee. This committee is multidisciplinary, with members from medical staff, nursing, social work, administration, and clergy. This committee considers ethical issues, advises Coastal Cluster staff concerning such issues related to patient care decisions and offers consults to Coastal Cluster departments.

If you, your patient or the patient's family are facing a difficult choice or are struggling with decisions that involve ethical, moral or spiritual concerns, help is available, contact the Clinical Social Work Department at (310) 222-3278, or during after hours contact the Shift Nurse Manager at (310) 222-3434.

Patients of Coastal Cluster Harbor-UCLA have both rights and responsibilities. Upon admission, each inpatient receives a Harbor-UCLA Medical Center Admission Pamphlet, which provides information about patients' rights and responsibilities. Additionally, each *Coastal Cluster Harbor-UCLA* facility has posted these rights and responsibilities for easy reference.

If a patient comes to you with a complaint about any part of his/her medical care or treatment, refer the patient to the accountable supervisory staff to resolve the complaint at the first level whenever possible. Complaints that cannot be resolved at the first level will be referred to the Administrative Patient Advocate at (310) 222-2151. At Long Beach CHC and Bellflower CHC, such complaints will be referred to (562) 599-8601. Patients may contact Patient Relations Department directly with a complaint at (310) 222-5350.

PATIENT'S RIGHTS

Patients have the right to:

1. Considerate and respectful care, and to be made comfortable. They have the right to respect for their personal values and beliefs.
2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of other physicians and non-physicians who will see them.
4. Receive information on their health status, course of treatment and prospects for recovery in terms that they can understand. Patients have the right to be informed, when appropriate, of outcomes of care, including unanticipated outcomes. They have the right to participate in the development and implementation of their plan of care. They have the right to participate in ethical questions that arise in the course of their care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding their medical care, and receive as much information about any proposed treatment or procedure as needed in order to give informed consent or refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, a patient does not have the right to demand inappropriate or medically unnecessary treatment or services. They have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Assessment and management of pain.
10. Formulate advance directives. This includes designating a decision maker if they become incapable of understanding a proposed treatment or become unable to communicate their wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on the patient's behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Patients have the right to be told the reason for the presence of any individual. Patients have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to their care and stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by the patient. Written permission shall be obtained before medical records are made available to anyone not directly concerned with the patient's care, except as otherwise required or permitted by law.
13. Access information contained in their records within a reasonable time frame, except in certain circumstances specified by law.
14. Receive care in a safe setting, free from verbal or physical abuse or harassment. They have the right to access protective services including notifying government agencies of neglect or abuse.
15. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
16. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing care.
17. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital.
18. Know which hospital rules and policies apply to their conduct while a patient.
19. Designate visitors of their choosing, if they have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
 - No visitors are allowed.
 - The facility reasonably determines that the presence of a particular visitor endangers the health or safety of the patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
 - The patient has told the health facility staff that they no longer want a particular person to visit.
 - However, a health facility may establish reasonable restriction upon visitation, including restrictions upon the hours of visitation or the number of visitors.
20. Have their wishes considered, if they lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include persons living in the patient's household.
21. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
22. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
23. File a grievance and/or file a complaint with the state Department of Health Services, The Joint Commission and/or the health facility and be informed of the action taken.

These Patient Rights incorporate the requirement of The Joint Commission, Title 22, California Code of Regulations, Section 70707, and Medicare Conditions of Participation.

PATIENT ADVOCATES

Patient Advocates are available for the Coastal Cluster Harbor-UCLA and can provide assistance to ensure that patient rights are protected. If a patient, family member or visitor comes to you with a complaint about any part of his/her hospital visit or clinic appointment, make every attempt to resolve the issue or refer them to your supervisor. If the problem cannot be resolved in your department or is not related to your department, the Patient Advocate is available to assist to resolve the problem.

The Patient Advocate will assist in a wide range of issues from billing conflicts and difficulty making appointments, to general complaints and patient rights violations. Every attempt will be made to immediately resolve the verbal and/or written complaints made by patients, and their family and friends. Patient complaints are assessed and used to identify, resolve and prevent risk exposure and problems that have a negative impact on patient satisfaction and delivery of services.

The Patient Advocate is located at Room 8, East-5 or can be contacted by phone at (310) 222-2151. Patients may contact Patient Relations Department directly with a complaint at (310) 222-5350. The Patient Advocate for Long Beach CHC and Bellflower CHC can be contacted at (562) 599-8601.

INTERPRETER SERVICES

It is our responsibility to provide interpreter services, free of charge, for our Limited English Proficient (LEP) and non-English speaking patients. The patient's family, friends or other non-Network personnel may not be used as interpreters unless expressly requested by the patient or in an emergency. **It is prohibited to use minors as interpreters in any situation and overhead interpreter paging is not allowed.**

TO REQUEST AN INTERPRETER:

Use local area bilingual staff for interpreters or refer to the Interpreter Staff or Bilingual Bonus list for assistance. If an appropriate bilingual staff person cannot be located in your area, use the Video Medical Interpreter (VMI) equipment to call (310) 222-6557. This telephone number will automatically link you to Health Care Information Network and contract language interpreters. Refer to the laminated cards on the VMI and other interpreter equipment for details regarding VMI and telephone interpreter services.

- For further language assistance at Harbor-UCLA Medical Center: Call the Language Center anytime at (310) 222-5405.

At the Coastal Cluster Health Centers use local bilingual bonus staff or call the (310) 222-5405 to request an interpreter. For bilingual staff, contact the following:

- **Long Beach CHC Administration** (562) 599-8601
 - **Bellflower HC Business Office** (562) 804-8112
 - **Harbor-UCLA Family HC Business Office** (310) 534-7600
 - **Wilmington HC Business Office** (310) 518-8800
- TTY (teletypewriter) Devices or the California Relay Service is available for the deaf, hard of hearing or speech disabled patients. Numbers can be obtained from the Patient Relations Office at (310) 222-5350 or Hospital Administration.
 - Speech to Speech (STS) for patients with speech disabilities can be reached at (800) 854-7784.
 - Remember the HIPAA Privacy rules and be careful not to break patient confidentiality.

SPIRITUAL NEEDS OF PATIENTS

The Pastoral Care Service provides for the spiritual health and well being of the patients, their families, friends and staff through active listening, prayer, sacred texts (e.g. Bible, Koran) and administration of sacred rituals such as Sacraments. We seek to promote wellness by giving comfort for those desiring the services of our interfaith along with our staff Christian chaplains. Our chaplains are available to minister to all patients, their family members, friends and hospital staff, regardless of their religious preference.

Emergency chaplains are available 24 hours a day through referrals by nurses at any unit. Referrals to the Pastoral Care Service may be made by having a nurse contact (310) 222-2166 or by Affinity request, or by calling the medical center operator.

Chaplaincy services offered include: Pastoral care visits, spiritual and grief support, Holy Communion/Anointing of the Sick/Confession, spiritual literature, Sunday worship services, Bible study (staff), prayer and spiritual support groups. The Chapel is located on the medical center's first floor across from the Gift Shop.

ADVANCE HEALTH CARE DIRECTIVES

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

If you are directly involved in the care of a patient who wishes to execute an AHCD, or to discuss this option, please contact the Clinical Social Work Department at (310) 222-3278 or the patient's physician. Remember patients can change their minds at any time regarding AHCDs.

AMERICANS WITH DISABILITIES ACT (ADA)

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

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

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

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

SERVICE ANIMALS

Service animals are individually trained to perform tasks for people with disabilities – such as guiding people who are blind, alerting people who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks. **Service animals are working animals, not pets.**

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

Business may ask if an animal is a service animal or ask what tasks the animal has been trained to perform, but cannot require special ID cards for the animal or ask about the person's disability.

A person with a disability cannot be asked to remove his service animal from the premises unless: 1) the animal is out of control and the animal's owner does not take effective action to control it (for example, a dog that barks repeatedly during a movie) or 2) the animal poses a direct threat to the health or safety of others. In these cases, the business should give the person with the disability the option to obtain goods and services without having the animal on the premises.

Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

Violators of the ADA can be required to pay money damages and penalties. If you have additional questions concerning ADA and service animals, please call Human Resources at (323) 869-7122 or the U.S. Department of Justice Civil Rights Division ADA Information Line at (800) 514-0301.

ORGAN/TISSUE DONATION

Harbor-UCLA Medical Center recognizes the need for organ/tissue donations, the importance of managing the patient prior to donation, and supporting the needs of the patient's family members. All deaths must be communicated to *OneLegacy* 24-hour donor referral line at (800) 338-6112 by the nursing staff. *OneLegacy* is a nonprofit, federally designated transplant donor network serving 18 million people in seven Southern California counties. It is extremely important to call in a timely manner as defined as within one hour following the identification of a clinical trigger that would identify the patient as a potential donor.

CLINICAL SOCIAL WORK

SCOPE OF SERVICES

The Department of Clinical Social Work provides recognition of and attention to the psychosocial needs of patients and their families consistent with Federal, State and County regulations and The Joint Commission standards. Psychosocial needs are defined as the biological/medical, psychological, social, economic, cultural and spiritual factors that influence the patient/family wellbeing. Services are available to all inpatients, outpatients and staff. Priority is given to high-risk patients as defined by those patients who, because of their severe medical diagnosis and/or treatment combined with their psychosocial situation, are at risk for a maladaptive response.

The Department of Clinical Social Work provides services in five major domains and administrates the division of Pastoral Care:

1. Patient/family counseling

- a. Assess and address safety issues: suicidal/homicidal ideation or child, elder and partner abuse, sexual assault.
- b. Provide bereavement support for sudden loss.
- c. Conduct psychosocial evaluation to assess psychological, social, and economic factors bearing on the patient's illness, medical care, and maintenance of health or rehabilitation. Determine if the patient and/or family are in crisis and appropriately prioritize interventions.
- d. Determine the need for further assessment/intervention in relation to patient's diagnosis, treatment, home environment, the patient's motivation for treatment (including capacity for change), and patient's responses to any previous treatment. Interventions may include the practice of individual, group, marital, family and educational counseling. Modalities of service range from crisis intervention and brief problem-focused therapy to brief or on-going case management.
- e. Provide consultation and staff development services to hospital personnel.
- f. Act as a consultant to community groups, organizations and institutions.

2. Discharge planning and coordination

- a. Develop, coordinate and implement discharge plans.
- b. Provide linkage to community resources to address unmet needs.
- c. Confer with representatives of appropriate agencies.

3. Communication regarding patient needs

- a. Advocate for the patient within the health care system or the community.
- b. Assist the patient and family with ethical issues: Advance Directive, right to self-determination, informed consent.
- c. Establish lines of communication and a working relationship between the hospital, the community health care system (including psychiatric), community groups, organizations and institutions.

4. Education and Research

- a. Provide field instruction to social work graduate students from UCLA, USC and CSULB.

5. Pastoral Care

- a. Recognize and provide spiritual and emotional support for the sick and recovering and/or the dying patient.
- b. Maintain a pool of spiritual leaders in the community who will respond when called to meet the needs of patients with diverse religious backgrounds.
- c. Coordinate worship services available to patients, families and staff.

Supervise and conduct ongoing training for all pastoral care volunteers.

PERFORMANCE IMPROVEMENT

This section includes a description of organizational performance procedures; various review processes, data collection activities, Performance Improvement Model, the ORYX initiatives and Process Improvement activities.

IMPROVING ORGANIZATIONAL PERFORMANCE

Performance Improvement (PI) focuses on outcomes of care, treatment and services. An important aspect of improving our performance is our ability to effectively reduce those factors that contribute to unanticipated adverse events and/or outcomes. We accomplish this by:

- Measuring performance (collecting data on important indicators)
- Assessing current performance (How are we doing?)
- Improving performance (What are the opportunities to improve? What have we done to make improvements? How do we know if we have made a difference?)

What Are Performance Improvement Indicators?

- **Data Collected:** Data is collected on various inpatient and outpatient process and outcome indicators, including, but not limited to, assessment and reassessment of patients, pain management, nutritional care, surgical and other invasive procedures, medication usage, blood and blood components usage, patient and family education, infection control, and patient safety.
- **Criteria are Identified:** Criteria are specific measurable events or outcomes used to assess resolution of identified problems. For example, use of aspirin for acute myocardial infarction patients, discharge instructions for heart failure patients, smoking cessation advice/counseling, pneumococcal screening/vaccination, and timelines for antibiotics for surgical patients.
- **Indicators are Developed:** Indicators are measures to document aspects of service performance or care delivery. Examples of performance indicators might include the following:
 - Percent of Inpatients Diabetics Who Receive Teaching: This is calculated by dividing the number of diabetics who receive teaching by the total number of inpatient diabetics.
 - Percent of Patients Understanding Their Anti-Hypertensive Medications: This is calculated by dividing the number of patients who understand their anti-hypertensive medications by the total number of patients on anti-hypertensive medications.
- **Problems are Identified:** Aspects of care that do not meet the standard of practice provide opportunities to improve care or services, such as diabetics not receiving teaching, patients are not taught about anti-hypertensive medications or systems that break down.
- **Corrective Actions are Taken to Address Problems that are Identified:** For example, an instructional video is produced to help patients on anti-hypertensive medication to understand precautions that should be taken when using these medications. This video is shown within 24 hours of the patient beginning their course of treatment with the medication.

Core Measures

Core measures were developed by The Joint Commission based on standardized, evidenced-based measures, or “best practices” that have been shown in the medical literature to improve healthcare outcomes. See also “ORYX Initiative”.

Currently Harbor-UCLA Medical Center is collecting data on the following ORYX Core Measures:

- Acute Myocardial Infarction (AMI)
- Heart Failure (HF)
- Pneumonia (PN)
- Surgical Care Improvement Project

PERFORMANCE IMPROVEMENT MODEL

Teamwork is the key to performance improvement. We call our Performance Improvement Model **FOCUS-PDCA**:

- **F**ind a process to improve
- **O**rganize a team that knows the process
- **C**larify the current knowledge of the process (data collection/analysis)
- **U**nderstand cause of process variation
- **S**elect the improvement
- **P**lan the improvement (key quality characteristics)
- **D**o the improvement (implement)
- **C**heck the results and lessons learned
- **A**ct (to hold gain, continue improvement, or abandon the change)

PERFORMANCE IMPROVEMENT ACTIVITIES

Current Performance Improvement Activities/Improving Organization Performance Goals:

- Improve Patient Flow
- Promote Patient Safety
- Improve Patient and Employee Satisfaction
- Improve Compliance to Publicly Reported ORYX Core Measures and California Hospital Assessment and Reporting Task Force (CHART) Process and Outcome Measures
- Improve Physician Documentation and Financial Performance

In addition to the FOCUS-PDCA, another PI model that is used is the Failure Mode and Effects Analysis (FMEA). The performance of at least one new or high-risk process is measured and analyzed annually using this proactive, prospective technique. The following are examples of events needing FMEA Project:

- Patient Safety Adverse Occurrences
- Risk Management (e.g. Patient Safety Net events)

Key Point: *Know what has been done in your department or area to make improvements. How have you been involved in the improvements made in your department in the past 12 months? How can you work with other departments to improve care/services? If you do not know, speak to your supervisor. If you questions, contact Quality Assessment at (310) 222-2047.*

ORYX INITIATIVE/CORE MEASURES

What is ORYX?

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

The Joint Commission developed the ORYX performance measures or indicators based on standardized, evidence-based measures, or factors that medical literature showed to make a positive difference in patient health outcomes.

Currently, the medical center is collecting data on the following ORYX measurement sets:

- Acute Myocardial Infarction (AMI)
- Heart Failure (HF)
- Pneumonia (PN)
- Surgical Infection Prevention (SIP)

Each Core Measure has multiple data elements that are collected and these are based on ***your*** chart documentation. It is very important that you document all medications administered as well as patient education. Reports of our hospital's performance will be available to The Joint Commission surveyors at the time of our survey as well as the general public through the Center for Medicare/Medicaid Services (CMS).

How are we doing compared to other hospitals?

Overall, Harbor-UCLA Medical Center is doing well. We do well in Core Measures such as 100% compliance in Acute Myocardial Infarction indicators and Surgical Care Improvement Project indicators.

What could a surveyor ask you about ORYX / or a Core Measure?

When performing tracers, if the patient has a diagnosis of congestive heart failure, pneumonia, acute myocardial infarction, the surveyor may ask you about the related ORYX indicators. Be prepared to speak to how you assure that we provide evidence-based care to our patients. Know what data is being collected in your area and how you are involved. You should be able to discuss what information is monitored by your department, when data results are discussed in your department (e.g. staff meetings, QI Clinical Monitoring Panel meetings), what your department is working on improving, and how you help to make a difference in your job. Analysis of data is the basis of all quality performance and patient safety improvement activities. Some other examples of data collection include:

- Falls
- Pressure Sores
- Restraints
- Infection Rates in the Intensive Care Units
- Patient Safety Goals (e.g., Hand Hygiene Compliance, Patient Identification, Surgical/Procedural Time-outs and Medication Reconciliation)

Some hospital-wide examples of data collection include:

- Care of patients with pneumonia, heart failure, and acute myocardial infarction

Remember all data collection is based on your chart documentation.

RISK MANAGEMENT

Risk Management involves the identification, evaluation, and reduction of the risk of injury and/or loss. This section provides policies and procedures on how to report adverse events, sentinel events and near miss incidents, documentation of all care and treatment, and responding to subpoenas and summons.

THE OFFICE OF RISK MANAGEMENT

The goals of the Office of Risk Management are to:

- Identify near miss, adverse, and sentinel occurrences
- Report and investigate such occurrences
- Educate all concerned in the causation of such incidents in order to prevent them from reoccurring

As a County workforce member, indemnification (legal protection) is provided while you are performing duties within the course and scope of your employment/assignment, while on duty at your assigned workstation. However, **you are not legally protected from:**

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

REPORTING NEAR MISS, ADVERSE AND SENTINEL EVENTS

Definitions of Events

- ◆ **Near Miss or Close Call:** An event, situation or unsafe condition that could have resulted in an adverse event but did not, either by chance or through timely intervention, but could reasonably be anticipated to result in harm if the event or unsafe condition recurs.
- ◆ **Adverse Event:** An untoward incident, therapeutic misadventure, medical injury, or other adverse occurrence directly associated with care or services provided; these events may result from acts of commission or omission. The California Health and Safety Code has identified specific adverse events that must be reported to the California Department of Public Health (CDPH). Reportable adverse events include those listed as sentinel events as well as:
 - Unexpected death after or within 24 hours of induction of anesthesia in a healthy patient
 - Death or serious disability from contaminated drug/device/or biologic
 - Death or serious disability associated with use/function of device in a way other than as indicated
 - Death or serious disability associated with intravascular air embolism
 - Death or serious disability associated with patient disappearance for more than 4 hours (excludes adults with capacity)
 - Attempted suicide resulting in serious disability that occurs within the facility
 - Death or serious disability associated with medication error
 - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
 - Death or serious disability related to hypoglycemia onset in a hospital
 - Death or serious disability with failure to identify and treat hyperbilirubinemia in neonates during first 28 days of life
 - Stage 3 and 4 ulcers acquired after admission
 - Death or serious disability from spinal manipulation at hospital
 - Death or serious disability associated with electrical shock
 - Oxygen lines or other gas lines with wrong gas or contaminated by toxic substances
 - Death or serious disability associated with burn in the facility
 - Death associated with fall in the facility
 - Death or serious disability associated with restraint bedrails

- Care ordered or provided by someone impersonating a licensed health care provider
- Death or significant injury of patient or staff from physical assault
- Major permanent loss of function (disability) associated with: Neurological deficit not present at time of admission including coma, paralysis, nerve damage, blindness, related or unrelated to medical or surgical procedures; Medication Error/Adverse Drug Reaction; Healthcare Acquired Infection; Birth trauma; Unanticipated medical/surgical complication; Birth/brain injury unrelated to congenital condition; or Attempted suicide resulting in serious disability

California Department of Public Health Reportable Adverse Events must be immediately reported to your direct supervisor and entered into the Patient Safety Net (PSN), a web-based, DHS-wide system accessible from the Harbor-UCLA Intranet Webpage.

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

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

- Suicide of any patient in a setting where the patient receives around-the-clock care or suicide of a patient within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment or services
- Discharge of infant to the wrong family
- Rape (by another patient, visitor, or staff)
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery or invasive procedure performed on the incorrect patient or incorrect body part
- Unintended retention of a foreign object in an individual after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin >39 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >24% above the planned radiotherapy dose

You must immediately report all sentinel events at the time of the event to your direct supervisor and enter an event report into the Patient Safety Net (PSN) system accessible on the Harbor-UCLA intranet.

If you become aware of an event that relates to any of the above or an incident, event, or injury involving a patient, visitor, vendor, contractor, or workforce member, you must report it to:

- Your Direct Supervisor and
- Patient Safety Net (PSN) – a web-based, DHS-wide system accessible on the Harbor-UCLA intranet

Risk Management must be immediately notified via submission of a Patient Safety Net report when an Adverse Event or a Sentinel Event occurs. Please review Harbor-UCLA Medical Center Policy No. 612 B for information regarding adverse and sentinel event notification, reporting and documentation. “Near Miss” event, situation or unsafe condition, should be similarly reported.

REPORTABLE UNUSUAL OCCURRENCES

Title 22 requires the reporting of occurrences such as an epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe, or unusual occurrence which threatens the welfare, safety, or health of patients, staff, or visitors to the California Department of Public Health.

A workforce member who encounters such an occurrence will immediately notify his or her direct supervisor and submit a Patient Safety Net report within 24 hours of the occurrence.

TIMELY REPORTING

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

- **Immediately submit a Patient Safety Net (PSN) report via the Harbor-UCLA intranet.**
- **Immediately report Adverse and Sentinel events** (as defined above) to your Department Supervisor; during after hours, report to the Shift Nurse Manager.
- Your Department Supervisor is responsible for appropriate follow up.
- The Risk Management Office can be reached by calling (310) 222-2168 during business hours or through the Telephone Operator during after hours. For Long Beach CHC and Bellflower HC, call (562) 599-8601.
- **When in doubt, call the Risk Manager at (310) 222-2168.** For Long Beach CHC and Bellflower HC, call (562) 599-8601.
- Follow-up with all calls by submitting a Patient Safety Net report.

Note: You cannot be disciplined for the act of reporting an event. However, if you have knowledge of an event and fail to report it, which is against Coastal Cluster policy, there is a possibility that you may be disciplined for failure to report.

Remember: **Notify your Department Supervisor whenever possible before reporting a case to the Risk Management Office. Do not make copies of the PSN Report.** In addition, keeping separate notes regarding events may not be protected under the attorney/client privilege. Therefore, you are discouraged from keeping separate notes regarding events. All information related to the event should be included in the PSN report.

DOCUMENTATION – A KEY DEFENSE

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

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

Your documentation must include:

- Date
- Time
- Care and treatment provided
- Signature of the provider with title and assigned staff identification (SID) number

Make your documentation:

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

Correct errors in the medical record by:

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

SUBPOENA AND SUMMONS

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

If you receive a subpoena or summons relative to County business, immediately contact Risk Management. Also:

- Document the date and time you received the subpoena or summons
- Keep the original envelope that the notice came in
- Bring the documents to the Risk Management Office, Building N-25, Room 1-107, or fax them to (310) 320-3084. For Long Beach CHC and Bellflower HC, bring the documents to Long Beach CHC’s Risk Manager in Administration

CONTACTING RISK MANAGEMENT

Harbor-UCLA Medical Center	Nancy Lefcourt, RN	(310) 222-2168 **
Long Beach CHC	Jeffrey Barbosa, MD	(562) 599-8601
Bellflower HC	Jeffrey Barbosa, MD	(562) 599-8601
Harbor-UCLA Family HC	Nancy Lefcourt, RN	(310) 222-2168**
Wilmington HC	Nancy Lefcourt, RN	(310) 222-2168**

** Through the medical center Telephone Operator during after hours

ENVIRONMENT OF CARE

This section describes the requirements for a safe patient care environment. Included are descriptions of the Environmental Safety Program; emergency codes; security procedures; safety awareness; and policies and procedures concerning bomb threats, workplace violence, hazardous materials, emergency preparedness and management, fire/life safety, medical equipments and utilities, work-related injuries, injury and illness prevention, and body mechanics and ergonomics.

WORKFORCE SAFETY PROGRAM

It is an ongoing priority to provide a safe environment for our customers and workforce members. Our Environmental Safety Program looks for and identifies hazards through surveillance rounds and data collection. All identified hazards are investigated and acted upon by the Environment of Care Committee, Environmental Safety Officer and the department/service managers. Address any concerns you have regarding safety to your supervisor or the Environmental Safety Officer.

Facility Environmental Safety Officers

Harbor-UCLA Medical Center	Julie Rees (Acting)	(310)222-2106
Long Beach CHC	Thuy Bahn	(562) 599-8605
Bellflower HC	Thuy Bahn	(562) 599-8605
Harbor-UCLA Family HC	Julie Rees (Acting)	(310)222-2106
Wilmington HC	Julie Rees (Acting)	(310)222-2106

While at work, know:

1. How to eliminate or minimize safety risks

Examples include:

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

2. How to report safety concerns:

- Notify your Supervisor
- Notify the Environmental Safety Officer at (310) 222-2835;
For Long Beach CHC and Bellflower HC at (562) 599-8605
(Calls can be anonymous)
- Submit a Patient Safety Net (PSN) report via the Harbor-UCLA intranet

EMERGENCY CODES

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

HARBOR-UCLA MEDICAL CENTER CODES

INCIDENT	# TO CALL	PAGING CODE
Fire	Ext. 113	Code Red
Disaster	Ext. 111	Code Triage
Hazardous Material Spill/Radiation Incident	Ext. 111	Code Orange
Infant/Child Abduction	Ext. 111 or 3311	Code Pink
Cardiopulmonary Arrest – Adult	Ext. 112	Code Blue
Cardiac or Pulmonary Arrest – Pediatric	Ext. 112	Code White
Bomb Threat	Ext. 111	Code Gray
Behavior Response Team	Ext. 111	Code Green
Sheriff's Dept./Security	Ext. 3311	
Rapid Response Team – Medicine	Ext. 111	
Rapid Response Team – Obstetrics	Ext. 111	
Rapid Response Team – Pediatrics	Ext. 111	
Rapid Response Team -- Surgery	Ext. 111	
Poison Control	(800) 876-4766	

LONG BEACH COMPREHENSIVE HEALTH CENTER CODES

INCIDENT	# TO CALL	PAGING CODE
Fire	Ext. 8689	Code Red
Disaster	Ext. 8689	Code Triage
Hazardous Material Spill/Radiation Incident	Ext. 8689	Code Orange
Infant/Child Abduction	Ext. 8689	Code Pink
Adult Man Down or Cardiopulmonary Arrest	Ext. 8689	Emergency Team
Pediatric Cardiopulmonary Arrest	Ext. 8689	Emergency Team
Bomb Threat	Ext. 8689	Code Gray
Non-combative Person Requiring Immediate Security Response	Ext. 8689	Code Paul
Poison Information	(800) 876-4766	
Security	Ext. 8686	

COASTAL CLUSTER HEALTH CENTER CODES

INCIDENT	# TO CALL	PAGING CODE
Fire	A; 9-1-1	Code Red
Disaster	A	Code Triage
Hazardous Material Spill/Radiation Incident	A	Code Orange
Infant/Child Abduction	A; 9-1-1	Code Pink
Cardiopulmonary Arrest	A; 9-1-1	
Bomb Threat	A; 9-1-1	Code Gray
Poison Information	(800) 876-4766	

A = Call the facility-specific Business Office extension for code activation:

- Bellflower HC Business Office: (562) 804-8107
- Harbor-UCLA Family HC Business Office: (310) 534-6268 or use the overhead pager
- Wilmington HC Business Office: (310) 233-4952

Call 9-1-1 for fire department, paramedics, and/or law enforcement.

SECURITY

Each Coastal Cluster Harbor-UCLA facility has on-site sworn peace officers and/or professional security services at all times that the facility is open to the public. The Los Angeles County Sheriff's Department provides law enforcement and protective services of deputy sheriff's and sheriff's security officers at the medical center, and oversees and supervises the contract security guards who are responsible for basic security needs at the Coastal Cluster Health Centers. Combined, these personnel strive to provide a crime-free and secure environment for patients, visitors, patrons, and workforce members at Coastal Cluster Harbor-UCLA facilities.

Facility Security Contact Numbers

Harbor-UCLA Medical Center	(310) 222-3311
Long Beach CHC	(562) 599-8689
Bellflower HC*	Overhead page security guard
Harbor-UCLA Family HC*	Overhead page security guard
Wilmington HC*	Overhead page security guard

* = Facility does not have on-site law enforcement. **Call 9-1-1 for law enforcement emergencies**

The Role of the Los Angeles Sheriff's Department (LASD)

As full-time, State-certified peace officers, the on-site deputy sheriffs enforce California Penal codes, Federal and State laws, County ordinances, and assist in attaining compliance with the medical center policies. The deputy sheriffs and LASD security officers conduct foot and vehicle patrols of the medical center. They are on-site and available to respond and assist workforce members and the public.

The Role of Contract Security Guards

- Observe/report any suspicious activities to the LASD or other appropriate local law enforcement agency.
- Are posted at the entrances to all Coastal Cluster facilities, where they perform workforce member badge checks. At the medical center, these guards perform weapons screening.

SAFETY AWARENESS

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

- Walking in groups when leaving the workplace after dark
- Reporting any suspicious activities to the **facility security**
- Locking your vehicle, and leaving valuables in the trunk or out of sight

BOMB THREATS (CODE GRAY)

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

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

- What kind of bomb is it?
- When is bomb going to explode?
- Where is the bomb?
- What does the bomb look like?
- What will cause the bomb to explode?

Also, pay attention to details, such as:

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

Contact the facility security immediately as well as notifying your supervisor.

WEAPONS

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

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

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

Facility security will strictly enforce all weapons related violations at Coastal Cluster Harbor-UCLA facilities.

WORKPLACE VIOLENCE

The County and Coastal Cluster Harbor-UCLA will not tolerate any form of violence (for example: threatening gestures, intimidating behaviors or verbal/written threats). The County of Los Angeles promotes a safe work environment for all its workforce members.

The County of Los Angeles has a “zero tolerance” policy that addresses workplace violence and violent behavior. Violation of this policy may result in disciplinary action up to and including discharge from County

service or assignment. If you observe violence or signs of violent behavior, notify your manager or supervisor and the facility security. Please refer to Threat Management "Zero Tolerance" on page 33 or DHS policy on workplace violence for further information.

EVACUATION

A "Code Triage" incident may render all or a portion of a Coastal Cluster facility unsafe for occupancy or prevent delivery of necessary patient care, and necessitate partial or total evacuation.

Partial Evacuation

Patients are transferred within the facility. There are two levels of a partial response:

- **Horizontal evacuation:** Individuals move/are moved -- from one **smoke compartment**, beyond a set of barrier doors, to another smoke compartment on the same floor
- **Vertical evacuation:** Individuals move/are moved – up/down staircases and to an area of safe refuge

Full Evacuation

Patients are transferred from the medical center to other hospitals or health-care facilities, and/or are discharged home.

- Evacuate the building from the top down. Evacuation at lower levels can be accelerated easily if the danger increases rapidly
- Full evacuation **must be coordinated with the Los Angeles County Medical Alert Center**, which will:
 - Divert paramedic transport of "9-1-1" or transfer patients away from the medical center
 - Provide patient placement and/or transportation assistance

Evacuation Sequence

- Evacuate the most hazardous areas first -- those closest to danger or farthest from a safe exit
- Patients shall be evacuated in the following order:
 - Patients in immediate danger
 - Ambulatory patients who need little or no assistance to walk and go down stairs
 - Non-ambulatory/wheelchair patients
 - Non-ambulatory/special needs patients. This group includes patients who are bed-bound, bariatric, ventilator- or oxygen-dependent, on a legal hold, or require a transport monitor

Evacuation Means/Methods for Semi-ambulatory or Non-ambulatory Patients

- Medsleds: For vertical evacuation of non-ambulatory/wheelchair and non-ambulatory/special needs patients. Upon completion of descent, these patients will require a wheelchair or gurney
- Wheelchairs
- Gurneys

REPORTING WORK- RELATED INJURIES/ILLNESSES

If you sustain a work-related injury/illness, you must immediately report the injury/illness to your supervisor.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

In compliance with State regulations (Title 8, California Code of Regulations, Section 3203) and to provide for a healthy work environment, the Coastal Cluster Harbor-UCLA has established, implemented and maintained an effective Injury and Illness Prevention Program (IIPP). The IIPP includes the following Healthcare Network actions:

- Ensure that workforce members comply with safe and healthy work practices. This is accomplished through recognition, training, and discipline.

- Communicate with workforce members on matters relating to occupational safety and health. Workforce members can inform their supervisors/Safety Office of hazards at the worksite without fear of reprisal.
- Conduct periodic inspections to identify unsafe conditions and work practices.
- Investigate occupational injury or occupational illness.
- Correct unsafe or unhealthy conditions in a timely manner based on the severity of the hazard.
- Provide safety training and instruction to all workforce members.

ERGONOMICS AND BODY MECHANICS

Ergonomics is the application of scientific information concerning humans to the design of objects, systems and environment for human use. Body mechanics are the application of the laws of physics to the human body at rest or in motion. Understanding ergonomics and body mechanics can prevent injuries to yourself and others while at work.

Why Should You Practice Good Body Mechanics and Ergonomics?

- To prevent injury to yourself and others
- To prevent injury to the patient
- To prevent fatigue
- To maintain good general health
- To maintain good physical appearance
- To increase capacity to work comfortably

Principles of Ergonomics/Body Mechanics

Think of your body as a machine that you need to treat correctly in order to maintain your good health and work efficiently. Things that you can do to avoid injury include:

- Keep work equipment/document within reach
- Work at proper heights
 - Most work should be at elbow height
 - Keep all controls and working surfaces at a level suitable for standing or sitting
- Reduce excessive forces
 - Better push than pull
 - Use carts to transport supplies rather than carrying
- Work in good postures
 - Avoid forward inclinations of the head and neck
 - Avoid forward inclinations of the trunk
 - Avoid requiring the upper limbs to be used in a raised position
 - Avoid twisted or asymmetrical postures
 - Keep joints within the middle third of their range of motion, when possible
 - Position the limb in the position of greatest strength when muscular forces must be exerted
- Reduce excessive repetition
 - Such as using powered screwdrivers instead of manual ones
- Minimize direct pressure to body
 - Use knee pads when kneeling
 - Use desk with round and/or cushioned edges
- Provide adjustability and change of posture
 - Use a chair with adjustable features



Guidelines for Preventing Muscular and Skeletal Injury

- Plan your actions
 - ✓ Think before you act to avoid injury
 - ✓ Appraise the work you need to do
 - ✓ Get help when necessary

- ✓ Check Equipment for Safety
- ✓ Lock brakes on wheeled equipment such as bed, wheelchair, gurney, etc., before moving a patient from one place to another
- ✓ Maintain Proper Balance
- In performing everyday tasks, balance yourself by making sure your center of gravity is over your base of support
- Maintain sure footing: place feet apart to provide an adequate base of support. This will assist you in maintaining your balance
- When carrying an object, hold it as close to your body as possible, so that it is close to your center of gravity
- Place feet in direction of movement
 - Maintain a neutral spine; bend at your hips and knees to get down to the level of the work. Do not overreach, especially when handling large bulky objects. Do not twist the spine. Use a footstool to work at a higher level
 - Move, turn, and lift correctly
 - When moving a patient, get his/her cooperation. When working with another workforce member, plan timing of movement for smooth action
 - Grip objects securely when lifting or moving them

INFECTION PREVENTION & CONTROL

This section addresses general patient care principles and workforce member guidelines related to infection prevention and control practices. It includes Prevention of Acquiring and Transmission of Infections, Hand Hygiene, Bloodborne Pathogen Control Plan, Tuberculosis (TB) Control Plan, Airborne Transmissible Disease Plan, Pandemic Influenza Plan, and Waste Disposal.

INFECTION PREVENTION AND CONTROL

The goals of the infection prevention and control program are to:

- Prevent the transmission of infection to patients, visitors and workforce members
- Provide a safe work environment
- Improve patient care

Infections can be spread through direct contact, indirect contact or by airborne route, when infectious organisms enter the body or blood stream through open skin (cut, puncture, rash, wound, burn) or mucous membrane (eyes, nose, mouth). Infections can also be spread through frequently touched items, instruments, and articles that come in contact with the patient and/or the environment.

Components or processes that reduce risk for cross infection to the patient:

- **Cleaning:** Removal of visible soil and impurities
- **Disinfection:** Elimination of many or all pathogenic microorganisms except spores
- **High-Level Disinfection:** Complete elimination of all microorganisms except bacterial spores
- **Sterilization:** A process that destroys or eliminates all forms of microbial life

Categorization of instruments/items according to the degree of risk for infection in use of the item:

- **Critical:** Items used in sterile tissue or the vascular system that pose a high risk for infection if contaminated with any microorganism. Examples: surgical instruments, cardiac or urinary catheters, implant, and ultrasound probes used in sterile body cavities.
- **Semi-critical:** Items contact mucous membranes or non intact skin. These items minimally require high-level disinfection using chemical disinfectants. Examples: Ultrasound Vaginal probes, cystoscopes, esophageal manometry probes, endoscopes, laryngoscopes, respiratory therapy and anesthesia equipment.
- **Non-critical:** Items that come in contact with intact skin but not mucous membranes. Examples: bedpans, blood pressure cuffs, crutches, computers, gurneys, and wheelchairs. Non-critical items are frequently touched by hands and can contribute to secondary transmission of infection. Meticulous cleaning of items is an important process to reduce or eliminate organisms in patient areas

Hand hygiene (hand washing with soap and water or use of an alcohol-based hand sanitizer), implementation of Standard Precautions, Transmission-based Precautions, proper cleaning, disinfection and sterilization can reduce the risk for transmission of healthcare related infection.

Standard Precautions

Standard precautions are precautions designed to protect the health care worker from blood-borne pathogens and prevent the transmission of infectious agents between the health care worker and patients. These precautions are an important cornerstone of infection control and must be performed by all health care providers at all times and in all settings. Workforce members shall be trained and will use barrier devices provided for their safety to prevent contact with blood or other potentially infectious materials.

Transmission-based Isolation Precautions

Transmission-based isolation precautions prevent the transmission of infection between infected patients, care givers, and visitors. Transmission of infection within a health care setting requires three elements: a source of infecting microorganisms, a susceptible host, and a means of transmission for the microorganisms. A variety of

infection control measures are necessary to reduce and prevent the transmission of microorganisms in the health care setting. These measures make up the fundamentals of isolation precautions. When a patient is suspected or diagnosed of having an isolatable process he/she will be placed in the appropriated isolation precautions. Workforce members entering the patient area are to follow posted precautions.

The three types of precautions are:

- ◆ **Airborne** (Blue sign) Microorganisms transmitted by airborne droplet nuclei that remain suspended in the air for long periods of time and can be dispersed widely by air currents within the room or over long distances.
 - Patient to be placed in a single-bed negative pressure room, with the door closed at all times.
 - Staff to observe:
 - N-95 or greater NIOSH approved respirator,
 - Hand hygiene before entering and leaving the room or having contact with the patient
 - Dietary may not enter the room.
- ◆ **Droplet** (Green sign) Microorganisms are transmitted by patients during coughing, sneezing, and talking.
 - Patient placement in a private room is recommended, not required.
 - Staff to observe:
 - N-95 or greater NIOSH approved respirator when entering within 3 feet of the patient's face,
 - Hand hygiene before entering and leaving the room or having contact with the patient.
- ◆ **Contact** (Yellow sign) Microorganisms transmitted by direct contact with the patient or indirect contact with the patient's environmental surfaces.
 - Patient placement in a private room is not required.
 - Staff to observe:
 - Gown
 - Gloves
 - Hand hygiene before entering and donning gloves and after removing gloves

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

Refer to the Infection Prevention and Control (IP&C) Plan or IP&C Harbor website for the list of isolatable organisms and the type of transmission-based precautions to be implemented. Contact Infection Prevention & Control Department at (310) 781-3645 if you have questions regarding transmission-based precautions.

BLOODBORNE PATHOGEN CONTROL PLAN

The purpose of this plan is to minimize, if not prevent occupational exposure to blood or other potentially infectious materials (OPIM). All healthcare workers, who have potential of occupational exposure to blood or body fluids, must practice Standard Precautions.

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

Personal Protective Equipment (PPE)

- Gloves
- Gown
- Protective eyewear or face shield
- Mask

Blood Borne Pathogens

Some of the bloodborne diseases to which you can be exposed include:

- Hepatitis C (HCV) – Can cause serious liver disease and have no symptoms or flu-like symptoms (nausea, vomiting and fever). Many people with HCV become chronically infected. There is no vaccine for HCV.
- Hepatitis B (HBV) – Can cause serious liver disease and have no symptoms or flu-like symptoms (nausea, vomiting and fever). People infected with HBV may recover and clear the infection but some may become chronic carriers or have other serious effects of illness. HBV is a greater transmission risk to healthcare workers than HCV and HIV since it is more easily transmitted. HBV is preventable by the Hepatitis B vaccine series of three vaccinations.
- Human Immunodeficiency Virus (HIV) – HIV attacks the immune system and caused it to break down. A person infected with HIV may carry the virus without developing symptoms for years.

Exposure to Blood and Body Fluids

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

If you are exposed, **IMMEDIATELY:**

- Wash the cut or exposed skin area with soap and water
- Rinse out your eyes for a minimum of 2 minutes
- Report the exposure to your supervisor
- Go to Employee Health or the Emergency Department for follow-up

NOTE: The most effective treatment is treatment that is started within 2-4 hours of exposure.

Preventing Sharp Injuries

DO

- Use and activate needle/ sharps safety devices
- Get help with uncooperative patients at the bedside
- Let falling objects fall
- Dispose of sharps into covered, labeled, and rigid puncture-resistant sharps containers
- Use tongs or brush & dustpan to pick up broken glass
- Practice safe handling techniques

DO NOT

- Bend, break or recap needles
- Leave needles and sharps
- Rush or take shortcuts
- Reach into disposal containers
- Touch broken glass
- Overfill sharps container
- Carry loose sharps in your pockets

VACCINATIONS

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

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

AEROSOL TRANSMISSIBLE DISEASE (ATD) PLAN

On August 5, 2009 State of California adopted section 5199 to California Code of Regulations, Title 8, Chapter 4 to safeguard workers from the spread of airborne diseases such as tuberculosis, measles, influenza, and other pathogens spread through airborne transmission. It was designed to protect workers in healthcare and related industries with duties that increase their risk of exposure to infectious disease. The ATD standard

requires facilities with healthcare workers and others at increased risk to develop exposure control procedures and train the workforce to follow those procedures.

The Aerosol Transmissible Disease Plan was developed to prevent the transmission of respiratory infections in healthcare settings, which includes airborne infection isolation for avian influenza, severe acute respiratory syndrome (SARS), tuberculosis, measles, and varicella; and Droplet Precautions for seasonal influenza, meningitis, pertussis, and rubella. If there is evidence of Pandemic Flu present in the community, refer to "Emergency Preparedness Harbor-UCLA Pandemic Influenza Response Plan".

Infection control measures should be implemented at the first point of contact with a person who is potentially infected with an ATD. The recommendations are based on the Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings and recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Control and Prevention (CDC) and Cal/OSHA Aerosol Transmissible Disease Protections (2009). Guidelines are available on the website.

PANDEMIC INFLUENZA PLAN

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

Clinical Information

- Affects people of all ages. Typically, those at greatest risk of severe complications of influenza are infants, young children, elderly adults, pregnant women, and individuals with chronic disease although these risk groups may differ according to the circulating influenza strain.
- Incubation period and duration of viral shedding may vary depending on the novel strain.
- Symptoms may include fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Additional gastrointestinal symptoms may also be present, such as nausea, vomiting, and diarrhea.

Transmission

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

Infection Control

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

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

Guidelines may be amended as more is learned about the infectivity of the pandemic virus. Refer to Emergency Preparedness policies and procedures: Pandemic Flu Plan. Infection Prevention & Control Manual is located at each nursing station and on the Harbor-UCLA intranet.

Seasonal influenza vaccine is also available to all workforce members at Employee Health Services.

WASTE DISPOSAL

Biohazardous Waste *	Red container with Red Bag	Includes wastes containing secretions, exudates and excretions containing blood *Pathology Waste placed in white or red can with red biohazard label. Container labeled "Pathology waste, incinerate only"
Sharps and Pharmaceutical Waste	Blue and white (semi-transparent) puncture-resistant container labeled "Contents for incineration"	All needles, syringes and other devices which have edges or capable of cutting or piercing corners, and pharmaceutical waste (all expired, reconstituted not used, or unused portion drugs that cannot be returned for credit).
Chemotherapy Waste	Yellow puncture-resistant container	All cytotoxic drug-related waste / deposit sharps. (Biohazardous and hazardous)
Radioactive Waste	Radioactive waste must be properly labeled. The Radiation Safety Office must be called to remove this waste to the designated area, where it must be monitored by qualified staff, until its safe and appropriate terminal disposal.	
Regular Waste (Non-Biohazardous)	White or Neutral container	All waste (not glass) not listed in the other waste categories

For additional information contact:

- Your Manager or Supervisor
- Infection Control Hospital Message Line: (310) 222-3838
- Infection Preventionists Office: (310) 781-3645
- Employee Health Services: (310) 222-2360
- STD Liaison Nurse: (310) 222-2254
- Harbor-UCLA TB Control Liaison Nurse: (310) 222-3443
- **OR** TB Control: (213) 744-6160 or (213) 974-1234 during after hours
- Environmental Safety Officer: (310) 222-2835

Remember: Infection Control – It's in Your HANDS!

MANAGEMENT OF INFORMATION

CONFIDENTIALITY OF PATIENT INFORMATION (HIPAA)



This section is designed to help workforce members:

1. Understand the key elements of the Health Insurance Portability and Accountability Act (HIPAA), California State privacy laws and other relevant laws and regulations
2. Recognize the elements of confidential or patient information, including protected health information
3. Describe your responsibility in protecting the privacy and security of confidential or patient information
4. Understand that workforce members will be held responsible if they inappropriately view and/or misuse confidential or patient information
5. Describe how to report suspected privacy and security violations

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that, among other things, protects the privacy and confidentiality of an individual's **protected health information (PHI)**. It is the responsibility of every member of our workforce to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and confidentiality of our patients' PHI. In addition to HIPAA, there are other important State and federal laws that relate to the confidentiality of patient information. All of these laws apply to patient information in all forms including electronic, written, oral and any other form.

Safeguarding patient information against unauthorized or unjustified disclosure is a fundamental responsibility of all workforce members and essential in ensuring the trust of our patients. The HIPAA standards and State laws relate to privacy and security of our patients' health information as well as the electronic transactions associated with the care and treatment received. Privacy regulations require organizations to intensify their efforts to maintain patient confidentiality. Increased staff training and security of records is the key to success and compliance.

Hospitals and workforce members must take reasonable steps to make sure that protected health information is kept private; realizing that it is impossible to guarantee the privacy of patient information in all situations. For example, certain activities such as calling out a patient's name in the waiting area is necessary in caring for the patient; or a caregiver talking about a patient's condition or treatment over the phone or in an area shared with other patients. These are considered incidental disclosures and are not a violation. In such cases, reasonable care must be taken to protect the patient's privacy, such as moving close to the patient, closing doors or privacy curtains, using lowered voices, and talking in areas apart from other people. Also, patient care should not be discussed in public areas such as restrooms, hallways, elevators or cafeterias.

With few exceptions, patients have the right to access, inspect, and request copies of their health information. The Health Information Management Department (HIM) is responsible for providing patients access and/or copies of patients' health records when the patient has provided written authorization. Staff should refer all patients requesting health record information to HIM. Patients must receive a response to review their medical record within five (5) days, and all other requests for records within fifteen (15) days. The exceptions to this requirement include psychotherapy notes, information that a health care provider determines could be harmful to the patient, information that is compiled to be used in a criminal or administrative proceeding, and information that is protected by the Clinical Laboratory Improvements Amendment of 1988 (CLIA).

Facility staff shall use facility-owned cameras and digital camera memory cards when asking photographs of patients. Staff-owned digital cameras and cell phone cameras are prohibited and are not to be used for patient photographs even if the patient gives verbal permission. Photographs of patients require pre-approval of administration or by patient authorization according to Hospital Policy 118a "Non-Media Requests for Patient Photographs."

Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment, and healthcare operations (TPO).

Violations and Breaches of Patient Information

State law defines unauthorized access as the inappropriate access, review, or viewing of patient information without a direct need to know that information. For example, if a workforce member peeks at a patient's

medical record for the sake of curiosity, this should be reported to the state even if the information was not shared with another person or there was no proof of patient harm.

You have a responsibility to report any activity that appears to violate privacy or security laws, rules, regulations or policies. There will be no retaliation against anyone who reports a suspected or actual violation in good faith. However, any workforce member who deliberately makes a false accusation will be subject to discipline. Moreover, reporting a violation does not protect individuals from appropriate disciplinary action regarding their own misconduct.

You must immediately report any and all suspected or actual breaches to your supervisor or the facility Privacy Coordinator. If your concerns are not resolved through these means, or if you do not wish to use these means, you should contact any of the follow resources:

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

Additionally, computer or electronic related security incidents must be reported to your supervisor or the Information Systems. A computer security incident is the attempted or successful unauthorized viewing, access, use, disclosure, or destruction of information, e.g., looking at any files without a business need, sharing passwords and/or user codes, sharing confidential information without authorization, or deliberately misplacing files. An incident may include the interference with system operations in an information system, e.g., hacking into electronic systems, computer theft, alteration or destruction of electronic information/equipment.

Fines and Penalties

Workforce members should use good judgment when dealing with patient information. Violations will not only result in disciplinary action, but may result in civil penalties for Coastal Cluster Harbor-UCLA and civil and/or criminal penalties/prosecution for the workforce member. Licensed professionals may be reported to their licensing agency for disciplinary action.

At the State level, if a privacy breach is substantiated, Coastal Cluster Harbor-UCLA could be fined up to \$25,000 per patient and up to \$17,500 per subsequent breach of same patient medical record, up to a combined total of \$250,000.

Additionally, individual providers and workforce members may be fined:

- Up to \$2,500 for negligent disclosure
- Up to \$25,000 for knowing and willful access, disclosure and use
- Up to \$250,000 for knowing and willful access and use for financial gain
- Up to \$250,000 for anyone not permitted to receive medical information who knowingly and willfully obtains, discloses or uses such information without patient's authorization

Coastal Cluster Harbor-UCLA may also be fined by the federal government for HIPAA privacy violations based on the circumstances of the violation, which include:

- Violations in which the offender didn't realize he or she violated the Act and would have handled the matter differently if he or she had known. This will result in a \$100 fine for each violation, and the total imposed for such violations may range from \$25,000 to \$1.5 million.
- Violations due to reasonable cause, but not "willful neglect." The result is a \$1,000 to \$50,000 fine for each violation, up to a maximum of \$100,000 to \$1.5 million for the calendar year.
- Violations due to willful neglect that the organization ultimately corrected. The result is a \$10,000 to \$50,000 fine for each violation, up to \$250,000 to \$1.5 million for the calendar year.
- Violations of willful neglect that the organization did not correct. The result is a \$50,000 fine for each violation, and the fines cannot exceed \$1.5 million for the calendar year.

Additionally, individuals who committed a breach may also receive prison time based on the severity of the breach.

Patient Confidentiality Quick Reference

As a healthcare workforce member, it is very important that you keep patient health information confidential. Here are some key points about patient confidentiality.

Four primary ways patient confidentiality is most often violated:

- Printed or electronic patient-related information that is left exposed where visitors or unauthorized individuals can see it
- Discussing patient information in a public place or with inappropriate, unauthorized individuals
- Unauthorized people hearing patient –sensitive information
- Unauthorized persons accessing information for the wrong reasons

Privacy Do's

- Immediately remove all PHI from printers, fax machines, and photocopiers.
- Discard PHI appropriately, using confidential bins or shredders.
- When conducting a conversation regarding a patient, do so in a private place or speak quietly to minimize the possibility of being overheard.
- Keep medical records and other documents containing PHI out of public view.
- When possible, close patient/exam room doors or draw curtains and speak softly when discussing patient care.
- Treat other people's confidential information as if it were your own.
- Report suspected HIPAA violations by means of an entry in the Patient Safety Net system AND by phone to the HIPAA Privacy Liaison at (310) 222-8049 or HIPAA Security Liaison at (310) 222-2181.
- Transport medical records so that patient's names are not visible.



Privacy Don't

- Don't share your computer user codes or passwords or leave them posted in areas where others may see them.
- Don't share confidential patient information with anyone who doesn't need to know it to do his/her job.
- Don't use your password to provide access to another individual. You are responsible for all information viewed using your password.
- Don't send patient information through internet-based e-mail sites such as Yahoo Mail, Google Mail, Hotmail, etc.
- Don't use online web-based document sharing services (e.g., Google Docs, Microsoft Office Live, Open-Office, etc.) to store or share patient data.
- Never access information about a patient unless you need it to do your job.
- Don't walk away from open medical records, lab results, etc. Make sure all medical records and lab results are placed in a secure location, not in public view, when not in use.
- Don't discard any documents containing PHI in the trash can.

Security of Patient Information

The HIPAA Security Rule covers all electronic Protected Health Information (ePHI) while stored and during electronic transmission. Some types of electronic media include:

- Computer networks, desktop computers, laptop computers, personal digital assistants (PDAs) and handheld computers;
- Computer software applications and databases;
- Magnetic tapes, diskettes, compact discs, USB storage devices, and other means of storing electronic data.
- Coastal Cluster Harbor-UCLA must provide safeguards to ensure the integrity, confidentiality, and availability of electronic patient information. These include Administrative Safeguards, policies and procedures that ensure prevention, detection, containment, and correction of electronic protected health information (ePHI) security breaches and/or violations. The policies and procedures also ensure that all

workforce members have appropriate access to ePHI in order to perform their job. Other safeguards include:

- Physical Safeguards, which protect electronic information system hardware, software and related buildings such as limiting access to locations housing computer systems and limiting access to data viewed on workstations. The security measures also include protection from natural or environmental hazards and unauthorized access.
- Technical Safeguards, include the use of computer technology solutions to protect the integrity, confidentiality and availability of patient information (such as user ID's and passwords, data integrity checks and data encryption).

Security Tips

- Be familiar with and adhere to policies and procedures regarding access and handling of PHI.
- Follow policies on the destruction of paper documents containing PHI.
- Store paper records and medical charts properly to prevent unauthorized access.
- Wear workforce member identification badges at all times while on duty.
- Position computer workstations and monitors away from public view and log off the computer when you are away from the work area or when the computer is not in use.
- Do not share your computer user codes or passwords or leave them posted in areas where others may see them.
- Secure PHI.
- Encrypt and password-protect PHI and other confidential information stored on mobile media (e.g., USB thumb drives)
- Protect data integrity.



HOSPITAL INFORMATION MANAGEMENT

Patient Information Safeguards

We use the following safeguards to protect patient-specific information:

- Shredders and locked bins to discard PHI documents
- Covered carts to transport medical records
- Locked doors and sign-in logs to limit access to the Health Information Management (HIM) Department and other areas where confidential documents and equipment that store confidential information are located
- Required Comprehensive Privacy and Security Awareness training for all staff
- A “need to know” level of security to access PHI
- Automatic log-off of PC's after non-use of systems
- User-ID and Password to access PHI
- Regular reports to HIM and Information Systems (IS) staff showing outgoing, incoming and transferring workforce members to ensure valid users
- Remote access is limited to user by Virtual Private Network (VPN)

Loss Data Recovery

In the event of a disaster, we ensure against loss of data by activating the Information Technology (IT) Disaster Recovery Plan. Additionally, IS staff performs daily data backup on all servers and stores the backed-up information in an off-site location.

Information Needs

Coastal Cluster Harbor-UCLA management conducts an annual IT Needs Assessment Survey to determine information needs of all staff, including physicians. The information is included in the County-wide Business Automation Plan for budgeting.

Communicating Information

In an effort to improve communication among care providers, we have instituted “read back” procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider.

Sharing Clinical Information

Coastal Cluster Harbor-UCLA’s direct patient care staff obtain clinical information from other treatment sites by requesting the patient’s medical record from the HIM Department. Patient information may also be accessed through “Affinity”, an electronic patient information computer software system. Access to the system is controlled through a security clearance process.

Medical Record Entries

Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.

Knowledge-based Data and Information

Coastal Cluster Harbor-UCLA provides "knowledge-based data and information" through the medical libraries at Harbor-UCLA’s Parlow Medical Library. Leaders and care providers can access journals, text books, audio visual materials, etc. Library resources are also accessible online. Contact Parlow Medical Library for further information at (310) 222-2372.

Note: If you have difficulty in understanding any of the material in this handbook, please ask your supervisor or call a member of the DHS Human Resources Regulatory Compliance Section for assistance.

KEY POINTS TO REMEMBER – ALL STAFF (What a Joint Commission Surveyor Is Likely to Ask You About)

COASTAL CLUSTER HARBOR-UCLA

LEADERSHIP

- Our mission, vision and values statements are included in various training programs.
- All licensed medical professionals are expected to adhere to the highest ethical and professional standards of behavior and performance.
- If you observe behavior in a licensed professional that may compromise patient or environmental safety, you should report it to the appropriate office (see telephone numbers listed under “Medical Professionals License/Registration/Certification/Permit”).
- It is important that you understand, whether you are a healthcare practitioner, technician, clerical or housekeeping member of our staff, that your job supports our organization’s mission to provide fully-integrated, accessible, affordable and culturally competent care, one person at a time.

THE JOINT COMMISSION ACCREDITATION

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

PATIENT SAFETY

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

- You are responsible for performing your duties in a safe manner, protecting your own safety as well as the safety of the patients you serve. It is your responsibility to report any unexpected event, situation, environmental unsafe condition, or “near miss” that causes you concern for the safety of patients, visitors, or staff as soon as possible.
- The Joint Commission establishes National Patient Safety Goals (NPSGs) annually which Coastal Cluster Harbor-UCLA workforce members follow. You are responsible for reviewing and complying with the NPSGs that are applicable to your duties.
- Universal Protocol **applies to all surgical and non-surgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery.
- If you notice a patient/visitor who you believe is in distress or a state of medical emergency, you should initiate your facility’s response mechanism and stay with the patient/visitor until help arrives.
- Prevention of patient falls is the responsibility of **every** workforce member.
- Be aware of your surroundings and identify risks for falls, eliminate environmental hazards and/or report any unsafe condition(s) to the appropriate department/unit.

STAFF RIGHTS AND RESPONSIBILITIES

- All Coastal Cluster Harbor-UCLA workforce members must complete all mandatory training and competency certification requirements for their respective positions [e.g., Network Orientation, Area or Unit Orientation, infection control, fire/life safety, emergency management, patient safety, CPR (if required) and other core competencies].
- Workforce members are responsible for reporting any activity that appears to violate the Code of Conduct. DHS will not retaliate against anyone who reports a suspected violation in good faith.
- Compliance Awareness training is provided to workforce members at the start of service and every two years thereafter.
- The County of Los Angeles has established a “zero tolerance policy” for any conduct of a sexual nature that could possibly be interpreted as harassing, offensive or inappropriate in the workplace.

- It is the responsibility of the licensed professional to renew required license (certification, registration, or permit). Failure to comply with licensure requirements may subject the person to disciplinary action, up to and including discharge/release from County service or release from a contracted assignment.
- It is your responsibility to obtain a health screening annually.
- Please refer to the Training Matrix at the end of this handbook for additional training requirements.

PATIENT RIGHTS AND SERVICES

- Each Coastal Cluster Harbor-UCLA facility posts Patient Rights and Responsibilities for patient, visitor and staff reference.
- Each inpatient receives a Harbor-UCLA Medical Center Admission Pamphlet.
- Administrative Patient Advocates are available to each Coastal Cluster Harbor-UCLA facility and can provide assistance to ensure that patient rights are protected.
- It is prohibited to use minors as interpreters in any situation.
- An Advance Health Care Directive (AHCD) is a legally recognized written document that allows a person to give orders regarding their healthcare decisions.
 - The AHCD allows a person to give directives regarding healthcare decisions, such as whether or not they want life-sustaining treatment if they become terminally ill or permanently unconscious. It also allows patients to name representatives to state their desires about their healthcare, when they are unable to do so.
 - Clinical Social Work staff inform patients of their options concerning AHCDs.
 - Patients can fill out an AHCD document or give oral direction to a physician who will document the directive in the patient's medical record.
- If a patient or family member comes to you with a complaint about any aspect of medical care/treatment, refer them to the accountable supervisory staff to resolve the complaint at the first level whenever possible.

PERFORMANCE IMPROVEMENT (PI)

- Using our PI model, we measure our performance, assess how well we are doing, seek opportunities to improve, and look for evidence that we are making a difference.
- We use the FOCUS-PDCA performance improvement model.
- How have you been involved in the improvements made in your department in the past 12 months? How have you worked with other departments to improve care/services? If you don't know, speak to your supervisor.
- How have you worked with other departments to improve care/services? If you don't know, speak to your supervisor.
- Know what has been done in your department or area to make improvements in patient care/patient education and other areas.

RISK MANAGEMENT

- A **sentinel** event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof not related to the natural course of the patient's illness or underlying condition. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.
- If you become aware of sentinel event or near miss you **MUST immediately** report it.

You may report events in one of the following ways:

- Direct Supervisor **AND**
 - Patient Safety Net system accessible from the Harbor-UCLA Intranet Webpage, **OR**
 - Risk Manager's Office at (310) 222-2168

Note: For Long Beach CHC and Bellflower HC only, call (562) 599-8601

ENVIRONMENT OF CARE

- Environmental safety concerns must be reported to your supervisor and the Environmental Safety Officer. You can report safety concerns anonymously via the Patient Safety Net.
- Know what all emergency codes mean and how you should respond to each, for example at Harbor-UCLA Medical Center:
 - **Code Blue means cardiac (or cardiopulmonary) arrest involving an adult**
 - **Code White means cardiac (or cardiopulmonary) arrest involving a child**
 - **Code Red means fire emergency**
 - **Code Green means Behavior Response Team**
 - **Code Pink means child/infant abduction**
 - **Code Triage means disaster situation**
 - **Code Gray means bomb threat**
 - **Code Orange means Hazardous Material Spill/ Radiation Incident**
- The Material Safety Data Sheet (MSDS) tells what hazards a chemical presents and how to handle spills/exposures. You must know the names of the hazardous materials that you work with and that you may come into contact with in your area. You have the “Right to Know” this information.
- You should know the location of the MSDS sheets in your work area. If you don’t know where they are kept, ask your supervisor. The MSDS manual is also located in the Environmental Safety Office.
- In the event of a fire, follow the RACE and the PASS procedures, as appropriate.
- You must know where the fire alarm, fire extinguisher, fire box and fire evacuation route for your work area are located. If you are unable to find them, check with your supervisor.

INFECTION PREVENTION & CONTROL

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

MANAGEMENT OF INFORMATION

Protecting Patients’ Rights to Personal Privacy

- Immediately remove all PHI from printers, fax machines, and photocopiers.
- Dispose of PHI appropriately, using confidential bins or shredders.
- When conducting a conversation regarding a patient, do so in a private place or speak quietly to minimize the possibility of being overheard.
- Keep medical records and other documents containing PHI out of public view.
- When possible, close patient/exam room doors or draw curtains.
- Speak softly when discussing patient care.
- Treat confidential information as if it were your own.
- Report suspected HIPAA violations by means of the Patient Safety Net AND by phone to the HIPAA Privacy Liaison at (310) 222-8049 or HIPAA Security Liaison at (310) 222-2181.
- It is the responsibility of every member of our service delivery team to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and confidentiality of our patients’ PHI. The Privacy Rule applies to PHI in all forms including electronic, written, oral, and any other form.
- Unless otherwise authorized by the patient, PHI may only be used and/or disclosed for purposes of treatment, payment, and healthcare operations (TPO).

- We use the following safeguards to protect patient-specific information:
 - Shredders and locked bins to dispose of PHI documents
 - Covered carts to transport Medical Records
 - Locked doors and sign-in logs to limit access to the Health Information Management Department
 - Required HIPAA Privacy and Security training for all workforce members
 - A need to know level of security to access PHI
 - Automatic log-off of PC's after non-use of systems
 - User-ID and Password to access PHI
 - Regular reports to HIM showing outgoing, incoming and transferring staff, to ensure valid users
 - Remote access is limited to user by Virtual Private Network (VPN)
- In the event of a disaster, we ensure against loss of data by activating the IT Disaster Recovery Plan. Additionally, HIM performs daily data backup on all servers and stores the backed-up information in an off-site location.
- Coastal Cluster Harbor-UCLA management conducts an annual IT Needs Assessment Survey to determine information needs of all staff, including physicians. The information is then included in the County-wide Business Automation Plan for budgeting.
- Coastal Cluster Harbor-UCLA provides "knowledge-based data and information" through the Parlow Medical Library at Harbor-UCLA Medical Center. Leaders and care providers can access journals, text books, audio visual materials etc. The library is accessible online.

PATIENT CARE PRACTICES

This section addresses general patient care principles related to population-specific guidelines, pain assessment/reassessment, and nutrition services.

POPULATION-SPECIFIC GUIDELINES AND CARE OF SPECIAL PATIENT POPULATIONS

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

1. NEONATES (BIRTH TO 28 DAYS)

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

2. INFANTS (1 MONTH TO 12 MONTHS)

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

3. CHILDREN (1 YEAR TO 12 YEARS)

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

4. ADOLESCENTS (13 YEARS THROUGH 18 YEARS)

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

5. ADULTS (19 YEARS THROUGH 64 YEARS)

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

6. GERIATRICS (65 YEARS & OLDER)

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

PATIENT FOOD SERVICES/NUTRITION SERVICES

Nutrition Services provides a highly specialized level of Medical Nutrition Therapy by Registered Dietitians that includes nutrition assessment, patient education and consultation for enteral and parenteral nutrition.

NUTRITION CONSULTS

Registered Dietitians are available for consultation between the hours of 7:00 a.m. to 6:00 p.m. on weekdays and 7:30 a.m. to 4:00 p.m. on weekends. A written consult order or referral, which should include reason for consult or referral, is required for each patient.

DIET ORDERS

A written diet order, which may include NPO or a specialized nutrition regimen, is required for each patient. A change in the diet order will automatically cancel all previous diet orders written. Patient meal service includes meal delivery and hospitality services, operated by Morrison Healthcare Food Service, Inc. Patient meals are served according to the table below, as well as the cut-off times for entering meal changes into Affinity to receive a hot meal for a patient. Enteral products are provided by Nutrition Services during meal delivery times. Nourishments (between meals snacks) must also be ordered by the physician at 10:00 a.m., 2:00 p.m., and 8:00 p.m. daily.

In accordance with state laws, meals, supplements and/or nourishments cannot be provided to the patient until it has been ordered by a physician and is entered into the Affinity system.

	Meal time	Cut-off time for hot meals
Breakfast	6:45 a.m. – 8:20 a.m.	10:00 a.m.
Lunch	11:15 a.m. – 1:00 p.m.	2:00 p.m.
Dinner	5:00 p.m. – 6:30 p.m.	7:00 p.m.

NUTRITION SERVICES PHONE LIST:

Dietitian Office: (310) 222-5398
Outpatient Nutrition Clinic: (310) 222-3376
Nutrition Services: (310) 222-3374 or (310) 222-3375

PATIENT SAFETY

This section addresses general patient care principles related to patient safety including “read back” requirements, Universal Protocol, medication management, unapproved abbreviations, behavioral restraints, medical record requirements for physicians/licensed independent practitioners (LIP), and medical review checklist.

“READ-BACK” REQUIREMENTS



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

- **Telephone Orders** – while the physician issues the order, the nurse writes the order down on his/her order sheet. Before ending the telephone call, the nurse “reads back” the order to the prescriber to confirm that he/she understood and transcribed it correctly.
- **Verbal Orders** – It is not always feasible to do a formal “read back” for a verbal order (e.g., during a code blue or in surgery). In such circumstances, a “repeat back” is an acceptable means of confirming the accuracy of the order.
- **Critical Test Results** – The Cluster communicates the Critical Laboratory Values/Results in a timely manner to the physician providing care for the patient. When a Critical Laboratory Value/Result is called, the licensed staff member who accepts the critical test result is asked to do a verification “read back”. If the licensed staff member is not able to act on the result (such as a nurse, or a physician who is no longer is taking care of the patient), that person should pass the information on to the person who can take appropriate action, and document this steps as soon as possible.

UNIVERSAL PROTOCOL

We have adopted all components of the Joint Commission’s Universal Protocol intended to prevent wrong site, wrong procedure and wrong person surgery or procedure. The Protocol establishes a process for a defined series of pre-procedure verifications designed to maximize patient safety and well being. It applies to invasive procedures performed in the operating room as well as those performed in non-operating room settings (e.g., bronchoscopy, endoscopy, interventional radiology, cardiac catheterization, and the bedside). You share in the responsibility of conducting this verification process in cooperation with the patient.

The main components are:

- **Pre-Operative/Pre-Procedure Verification:** We use a checklist to ensure all relevant documents are available and correct before sending a patient for an invasive procedure. Ensure that the patient’s history and physical is present and current, that we obtained the patient’s informed consent, and that the patient agrees to the planned surgery/procedure. If you find any information missing or any discrepancy, postpone the procedure until the information is clarified and/or corrected.
- **Marking the Operative Site:** We require site marking for all surgical sites/invasive procedures involving right/left distinction, multiple structures, or levels, where the procedure does not involve an obvious wound or lesion. The site should be marked by one of the practitioners who will be participating in the procedure. In most cases, the patient’s skin should be marked with the word “YES” to indicate the intended site. Site marking must be visible after the patient is draped and positioned for the procedure. Alternative methods of marking the site may apply to certain patients, such as neonates. Whenever possible, involve the patient in the marking process.
- **“TIME OUT”** – Harbor-UCLA Medical Center employs”: We employ two “time outs”: one: One just before administration of anesthesia, and one just before the start of the procedure. All those who will be participating in the start of the procedure conduct a final verbal verification to confirm the correct identity of the patient, planned procedure, operative site, side, and level. In the Operating Room (OR) and other dedicated procedure areas, the nurse documents the “TIME OUT” on the back of the Pre-Op/Pre-Procedure Record. In non-specialty areas (e.g., bedside procedures), the provider documents the occurrence of the “TIME OUT” in his/her procedure note.



- **Procedures for non-OR settings including bedside procedures:** Site marking must be done for any procedure that involves laterality, multiple structures or level, when there is not an obvious wound or lesion. Procedures for verification, site marking, and “Time Out” procedures should be consistent as in the OR setting.

DETERIORATING PATIENT CONDITION

Responding to the Decline in Patient Condition

As patient caregivers, you need to know the signs and symptoms of the decline in a patient’s condition, within your scope of practice. The assessment and recognition of the deteriorating patient is an ongoing challenge throughout the patient’s stay or visit to your facility. Every patient is unique, so recognizing changes can be different from one patient to the next. Baseline assessment of health condition, on-going health assessments, handoff communication reports, chart documentation and other communication modalities are good methods to use in recognizing declination in the patient’s condition. It is **every** member of the healthcare team’s responsibility to ensure that they give the highest level of care, and to immediately react upon emergencies, potential emergencies and/or incidents.

Signs and Symptoms:

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

- Acute change in mental status.
- Acute change in heart rate
- Acute change in respiratory rate or effort
- Acute decrease in oxygen saturation
- Acute decrease in systolic blood pressure
- Acute decrease in urinary output
- Uncontrolled bleeding
- You are worried that the patient is deteriorating for some other reason

If you are concerned that a patient is deteriorating, notify the RN responsible for that patient right away, and explain what concerns you. That patient’s nurse will assess the situation and call for additional assistance if needed. For patients admitted in wards and PCU areas as well as the infusion and dialysis centers on 5 East, Harbor has rapid response teams set up to evaluate and stabilize patients who are deteriorating. RNs in those areas are trained on when and how to activate a rapid response team, if necessary. In other areas of the main hospital, nurses should contact a physician or nurse manager for assistance if they are concerned about a patient. Anyone can call a Code Blue or Code White for respiratory or cardiac arrest by dialing Ext. 112 from a hospital phone. In areas outside the main hospital building, call 9-1-1 for a medical emergency (Note: The 1 South CRU is considered part of the hospital and is covered by the Medical Rapid Response Team and Code Blue Team).

FALL REDUCTION AND PREVENTION

Prevention of patient falls is the responsibility of **EVERY** workforce member. Creating a safe environment, enforcing fall prevention through education and training, and teaching patients reduces fall rates.

A fall is a sudden and unintentional changing of position causing a person to land on the ground, floor, an object, or a lower level. This may be due to a trip, slip, loss of balance, and change in gait, and can be the result of many risk factors:

Inpatient settings require patient fall risk assessment to occur; upon admission, within 24 hrs of admission, if there is a change in the patient’s condition, after a fall, and/or when the patient is transferred. If it is determined that the patient is at risk for falling, then ongoing assessment must continue during the patient’s hospital stay. Specialty areas require unit-based criteria for high risk patient falls (e.g. Dialysis, Post-op Anesthesia, PICU patients). Follow your unit and facility guidelines and protocols. Children can be at risk for falls because of developmental, environmental and situational risks such as learning to walk, unfamiliar environment, and

balance disturbances. Geriatric patients falls can be caused by weakness, dizziness or disorientation when they get up too quickly from the bed, medications, unfamiliar environment, reduced vision, balance disturbances, etc.

Fall prevention in an outpatient clinical, diagnostic or therapeutic setting is different from an inpatient setting. Detailed assessments and patient teaching are vital in fall prevention for outpatient/clinic patients inclusive of environmental risk. Particular attention should be shown to patient using a walker, cane, wheelchair or other assisted device.

Intrinsic Risk factors are those factors that are integral to the patient's system or medical condition, many of which are associated with age-related changes such as confusion, vision, acute illness, history of falls, and balance-affecting medications. Assessment of risk factors is done by the Nursing staff and includes a history of falls, medication usage, health conditions, gait and balance, hearing and eyesight, activity level, injuries, nutritional status, orientation status and cognitive level, including detailed assessment of all body systems. Home environment, family status and psychological status are also assessed. When patients are identified for fall risk, workforce members can implement interventions to reduce the risks.

Extrinsic Risk Factors are those relating to the physical environment such as unfamiliar environment and wheeled furniture, medications, lighting, improper use of or inadequate medical devices (bedrails, walkers), condition of ground surfaces, type and condition of footwear, existence of grab bars in showers and around toilets, obstructions, wet or slippery floors, etc. Patients/family are encouraged to share with staff their experiences and concerns about falls and other safety issues that may effect the patient's environment while on any of the facilities grounds.

Interventions

- Instruct the patient to request assistance, as needed.
- Instruct the patient and family members to wear non-skid footwear.
- Provide an appropriate armchair with wheels locked at the patient's bedside.
- Ensure the path to the restroom is free of obstacles and properly lighted.
- Ensure hallways are clear of obstacles.
- Place assistive devices such as walkers and canes within a patient's or resident's reach.
- Raise the side rails as appropriate for access to bed controls, support and repositioning.
- Ensure call buttons and personal items are placed within reach of the patient.
- Observe environment for potentially unsafe conditions. Notify appropriate departments of hazardous conditions.
- Do not leave "at risk" patients or residents unattended in diagnostic or treatment areas.
- Include the patient's family in the development of an individualized safety plan, considering age-related criteria and patient cognition when planning care.
- Educate patient and family regarding identification of hazards and use of fall prevention interventions and safety in their home.
- Teach patient the proper ambulation and use of assistive devices: use handrails in hallways, bathrooms and tub rooms; wheelchair safety (brakes, pedals); and do not pull down on walkers when rising to a standing position.
- Teach patient to sit on the edge of the bed for several minutes before rising.

Post-Fall Procedure - If a patient falls, initiate the following:

- Assist the patient immediately and call for help, as needed.
- Assess for injuries and pain/discomfort.
- Notify physician and report any changes in the patient's clinical condition.
- Remain with patient as needed.
- Document the fall in nursing notes including any post fall interventions/treatment rendered and diagnostic procedures performed.
- Enter event and event details into the Patient Safety Net.
- For patients already identified as high-risk, review and revise plan of care, as necessary.
- For patients not previously identified as high-risk, complete the appropriate Fall Risk Assessment Tool.

- Initiate Fall Prevention Measures, and place a 'fall risk' alert arm band on the patient, signage on room, door, wall or bed, or per your facilities protocol.

***NOTE:** Each facility has policies and procedures in place that should be reviewed regularly. Use your facility's report mechanism for falls and medical response. Documentation and assessment tools for patient fall risks and high fall risk patient alerts vary for each facility. Follow your facility's protocols and guidelines as set forth.

MEDICATION MANAGEMENT



Managing the use of medications to enhance patient safety is very important and involves multiple services and disciplines working closely together. When ordering/prescribing medications, it is important to remember the following:

- There is a documented diagnosis, condition, or indication for use for each medication ordered.
- As applicable, weight-based dosing for pediatric patients is required.
- Medication orders are written clearly.
- Dangerous abbreviations, acronyms or symbols are not used when writing orders. Enforcement/feedback policy and procedures are in effect.

Medication Use

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

Medication Prescribing

As a practitioner, you have the responsibility of ensuring the appropriate prescribing of medications to your patients in an effort to decrease the potential risk for medication errors. You must clearly understand the correct indication, dose, route, and the pharmacological effects of each medication that you prescribe to avoid adverse drug events. We encourage you to review the formulary on an ongoing basis, and utilize formulary-approved medications.

Safety Tips for Safe Medication Prescribing

Write **CLEARLY, BOLDLY, AND LEGIBLY** in the patient's orders, specifying the name of the medication, drug dosage, route, and frequency. Make your medication orders clear and complete by:

- Identifying your patient with **TWO** identifiers (***Patient Name and MRUN for inpatients; Patient Name and Date of Birth for outpatients***)
- Placing the date and time on all orders
- A complete medication order requires the name of the medication, dose route, and frequency
- Not using range orders (Pharmacy will not accept ranges such as 1-2 tabs; q 4-6h in orders)
- Writing a specific indication for all as needed (PRN) orders (e.g., PRN pain)
- Signing all orders and printing your name and physician and pager number so that you may be located for any questions
- Entering the patient's diagnosis, allergies, and height/weight on all admitting orders to avoid delay in dispensing
- Using weight-based dosing on all pediatric patients less than 40 kg of weight
- Avoiding the use of unapproved abbreviations. When in doubt, do not abbreviate! To prevent any confusion, spell out the entire name of the drug.



Harbor-UCLA will NOT accept the following abbreviations/symbols

Illegible prescriptions and medication abbreviations/symbols may lead to medication errors. To avoid confusion and facilitate safe medication use practice, the Pharmacy & Therapeutics Committee and Medication Safety Committee have designated that the following abbreviations/symbols are **unacceptable** at Harbor-UCLA Medical Center. Dangerous abbreviations/symbols apply to **all patient-specific documentation**.



Dangerous Abbreviations	Intention Alternative	Misinterpretation
U or u	Unit (write "unit")	Read as zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44")
µg	Microgram (Use the abbreviation of "mcg" or write "microgram")	Mistaken for "mg" when written resulting in an overdose
Zero after decimal point (1.0)	1 mg (do not use terminal zeros for doses expressed in whole numbers)	Misread as 10 mg if the decimal point is not seen
No zero before decimal dose (.5 mg)	0.5 mg (always use zero before a decimal when the dose is less than a whole unit)	Misread as 5 mg.
IU	International unit (Avoid use)	Misread as IV (intravenous)
X3d	For three days (Write "days")	Mistaken for "three doses"
t.i.w or T.I.W	3 times weekly or three times weekly	Mistaken for three times a day or twice weekly
q.d. or QD	Every day (write "every day" or "daily")	Mistaken as q.i.d. especially if the period after the "q" or the tail of the "q" is misunderstood as an "l"
q.o.d. or QOD	Every other day (write "every other day")	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written
MS MSO ₄ MgSO ₄	Morphine sulfate Or Magnesium sulfate	Confuse for one another. Can mean morphine sulfate or magnesium sulfate

"Look-Alike/Sound-Alike" Medications

To further enhance medication safety, the Medication Safety and Pharmacy and Therapeutics Committee has developed the following Look-Alike/Sound-Alike (LASA) Medication List. These medications are stored apart in the Pharmacy and in patient care areas. Special attention should be given when administering one of these drugs to ensure that it is the correct drug.

Be aware that "**Tall-Man**" lettering is used to differentiate look alike/sound alike drugs.

Look-Alike/Sound-Alike Medication List

1.	CARBO platin (antineoplastic)	CIS platin (antineoplastic)
2.	clon AZEPAM (anticonvulsant)	Clon IDINE (alpha-adrenergic agent)
3.	DAUN Orubicin (antineoplastic)	DOX Orubicin (antineoplastic)
4.	DOP Amine (adrenergic agonist)	DOBUT Amine (adrenergic agonist)
5.	ePHED rine (bronchodilator)	EPINEPH rine (alpha-beta agonist)
6.	foLIC acid (vitamin)	foLINIC acid (antidote)
7.	hydromor PHONE (narcotic analgesic)	MORPH ine (narcotic analgesic)
8.	hydro OXYzine (anti-histamine)	hydr ALAZINE (anti-hypertensive)
9.	LAMIV udine (anti-retroviral)	LAMO trigine (antiepileptic)
10.	LOR azepam (benzodiazepine)	ALPRA zolam (benzodiazepine)
11.	Suf SALazine (anti-inflammatory agent)	Sulfa DIAZINE (antibiotic)
12.	Vin BLAS t ine (antineoplastic)	Vin CRIS t ine (antineoplastic)

Medication Dispensing

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

Medication Administration

If you administer medication to patients, you are responsible for proper patient identification, using two identifiers, (***Patient Name and MRUN for inpatients; Patient Name and Date of Birth for outpatients***), per hospital policy. Bring the Medication Administration Record (MAR) into the patient's room to identify patient, verify and document the medication and dose administered. The Pharmacy routinely provides a daily copy of a printed MAR, generated from the pharmacy computer system. The nurse reviews all physician orders, reconciles and initials each medication on the pharmacy-generated MAR on a daily basis before use, sending the reconciled MAR copy to the pharmacy daily.

Adverse Drug Reaction (ADR) Reporting

Report all adverse drug reactions by submitting a Patient Safety Net report. Provide the patient's name, MRUN number, location, date of occurrence, name of the suspected medication, type of reaction, and your name.

Medication Errors

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. Such events may be related to professional practice, health care products, procedures and systems,

including prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use. Report all medication events, (including an identified potential medication error), through the Patient Safety Net reporting system.

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

- Begin your medical record entry with an identifier (e.g., Attending note, Cardiology Fellow note).
- Legibly sign and indicate your identification number and degree on all entries. You must use your four (4) digit stamps on all your entries. If you do not have your Provider Identification Stamp available at the time you are signing documents, you MUST print your complete name and title in large uppercase letters with your provider quality improvement number next to your signature (e.g., JOHN DOE, M.D. ID # 9999).
- You must countersign all verbal orders as soon as the emergency permits and before you leave the patient. Coastal Cluster Harbor-UCLA pharmacies accept verbal orders from a prescribing physician only in extreme emergencies, in the course of treatment, or during a surgical procedure.
- Specify why you are prescribing the medication on all as needed (PRN) orders (i.e., conditions/symptoms, etc.).
- If you fail to rewrite the following orders, the pharmacy will stop dispensing the medication.

Type of Order	Renewal Time
Opioid Narcotic Analgesic	72 hours
Propofol	24 hours
TPN	24 hours for ICU patients 72 hours for non-ICU patients
All other Inpatient Medications	30 days

- If you make an error while charting in a medical record, make your corrections by drawing a line through the error and write the word "ERROR" above the line with the date, time and your initials. You are not allowed to make any erasures nor use "white out" in a patient's medical record.

KEY POINTS TO REMEMBER (CLINICAL STAFF)

PATIENT CARE PRACTICES

Provision of Care

- Know the characteristics of each population group that you serve.
- Coastal Cluster Harbor-UCLA supports every patient's right to have his/her pain assessed and treated promptly, effectively, and for as long as the pain persists.
- Know that "Code Blue" means adult cardiac (or cardiopulmonary) arrest and "Code White" means pediatric cardiac (or cardiopulmonary) arrest.

Patient Safety

- Coastal Cluster Harbor-UCLA has instituted "read back" procedures to confirm the accuracy of orders issued over the telephone, verbal orders issued during an emergency or in the course of a procedure, and critical test results reported either by telephone or verbally to a patient care provider. Use "READ BACK" procedures to ensure important information is accurately communicated and recorded.
- When it is not feasible to do a formal quote READ BACK for a verbal order (i.e. during a code blue), a REPEAT BACK is an acceptable means of confirming the accuracy of the order.
- Universal Protocol **applies to all surgical and non-surgical invasive procedures** and establishes a process for preventing wrong site, wrong procedure and wrong person surgery or procedure.
- The Universal Protocol's three main components are: **conduct the pre-procedure verification process, mark the operative site, and perform a "Time Out" before the procedure.**
- Harbor-UCLA Medical Center is committed to using non-physical interventions to control and prevent emergencies that have the potential to lead to the use of restraints.
- Use of restraints should be limited to those emergency situations in which the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or visitors, and when maintaining safety requires an immediate physical response.
- Harbor-UCLA Medical Center will dispatch a Code Green Team for a "Code Green" emergency.
- Before you administer medication to patients, identify the patient using two identifiers, **Patient Name and MRUN number for inpatients; Patient Name and Date of Birth for outpatients** per hospital policy.
- The medication process must ensure that the right medication is administered to the right patient, at the right dose, at the right time, using the right route.
- Adverse drug reactions must be reported by submitting a Patient Safety Net report.
- Report all medication events, whether an actual medication error or an identified potential to lead to a medication error, through the Harbor-UCLA Patient Safety Net reporting system.
- Avoid the use of unapproved abbreviations. **When in doubt, do not abbreviate!** To prevent any confusion, spell out the entire name of the drug.
- Data collection for any of The Joint Commission processes will be based on your chart documentation or other appropriate documentation.
- All medical records must contain an identifier, legible signature and identification number, counter signature for verbal orders, and a rationale for medicine prescribed.
- Coastal Cluster Harbor-UCLA's direct patient care workforce member obtains clinical information from other treatment sites by requesting the patient's medical record from the Health Information Management (HIM) Department. Patient information may also be accessed through "Affinity", an electronic patient information system. Access to the system is controlled through a security clearance process.
- Staff authorized to make entries in the medical record (paper or electronic) is limited to medical, nursing and ancillary staff.

ADDENDUM

RAPID RECOGNITION AND RESPONSE TO CHANGES IN PATIENT CONDITION

INTRODUCTION

The Rapid Response Team (RRT) is designed to improve staff's ability to recognize and respond quickly and appropriately to a deteriorating patient.

Harbor-UCLA patient care staff are trained to recognize signs of clinical deterioration. Any staff member who recognizes these signs will initiate a rapid response by notifying a specially trained team. The team will be responsible for responding immediately to the patient's bedside, performing initial assessment and intervention, and notifying the patient's existing care team (if they are not already part of the team or aware of the response).

The nurse's role is ongoing assessment of the patients status. It is the responsibility of the nurse to identify changes in the patients condition and decide an appropriate response. If the nurse assesses that the patient's condition is deteriorating, the nurse may choose to activate the rapid response team. The nurse may choose not to activate the rapid response team if a resident (PGY 2 or above) from the primary team is already present and managing the patient, although activation is still an option if additional resources are needed. The RRT will respond for admitted patients only on the ward and Progressive Care Unit (PCU)/Trauma Transitional Care Unit (TTCU) areas. Nurses working in other areas would not activate the rapid response team though they should be aware of the rapid response team process and assess changes in their patients.

BACKGROUND

Patients who are initially stable can deteriorate clinically in a short period of time. The ultimate form of clinical deterioration is a respiratory or cardiac arrest. The hospital has created Code Blue and Code White teams to provide immediate response in these cases. Information from researchers and healthcare improvement agencies shows that many patients who have a Code Blue/Code White response actually begin to show signs of deterioration many hours before the Code Blue/Code White is called. Rapid Response Teams are now widely used to provide immediate assessment and stabilization, long before a Code Blue/Code White occurs.

The patient observation/assessment includes the ongoing collection and analysis of patient data to determine the need for additional data, the patient's care needs, and the care to be provided. The interpretation of information obtained from the patient and others, is integrated to identify and prioritize the patient's needs of care.

SIGNS OF DETERIORATION

1. Acute change in heart rate.
2. Acute change in systolic blood pressure.
3. Acute change in respiratory rate or effort.
4. Acute change in oxygen saturation.
5. Acute change in mental status.
6. Acute change in urinary output to less than 50 mL in 4 hours (adults only).
7. Severe, uncontrolled bleeding.
8. Any staff member is worried that the patient is deteriorating even in the absence of any of the above criteria.

Age-specific vital signs parameters are summarized in the table below and the RRT should be activated for acute changes.

Table 1. Age Specific Vital Signs Parameters.

Age	Heart Rate	Respiratory Rate	Systolic Blood Pressure	Oxygen Saturation
Adult	Less than 40 More than 130	Less than 8 More than 28	Less than 90	Less than 90%*
Pre-teen/Adolescent (over 10 years)	Less than 50 More than 100	Less than 5 More than 25	Less than 90 More than 140	Less than 94% [†]
School Age (6-10 years)	Less than 60 More than 120	Less than 8 More than 25	Less than 90 More than 120	
Toddler/Preschooler (1-5 years)	Less than 60 More than 180	Less than 10 More than 30	Less than 90 More than 110	
Infant (30 days-1 year)	Less than 70 More than 180	Less than 15 More than 50	Less than 80 More than 110	
Neonate (0-30 days)	Less than 80 More than 200	Less than 20 More than 60	Less than 60 More than 90	

* Despite oxygen.

† Despite supplemental oxygen therapy or the patient requires a non-rebreather mask.

RAPID RESPONSE TEAMS

There are four different rapid response teams covering the different clinical services in the hospital:

Rapid Response Team Coverage	Clinical Service
Medical RRT – consists of: <ul style="list-style-type: none"> • Day float resident from 8am-5pm or ward call resident for nights, weekends, and holidays • Respiratory care provider (RCP) • ICU nurse (when available) 	Medicine Family Medicine Hospitalist Neurology Psychiatry
Surgical RRT – consists of: <ul style="list-style-type: none"> • Trauma surgery junior resident on call • RCP • ICU nurse (when available) 	Trauma Surgery Colorectal Surgery GI/Oncology Surgery Vascular Surgery Cardiothoracic Surgery Endovascular Surgery Orthopedic Surgery Head and Neck Surgery (ENT) Oral/Maxillofacial Surgery (OMFS) Plastic Surgery Urology Neurosurgery
Pediatric RRT – consists of: <ul style="list-style-type: none"> • Pediatric Intensive Care Unit (PICU) resident or designee • RCP from PICU or Neonatal Intensive Care Unit (NICU) • A NICU nurse will respond to pediatric RRT requests initiated from 7E Level II Nursery, 7E L&D or 7W; a PICU nurse will respond to all other pediatric RRT requests. 	Pediatrics
OB/GYN RRT – consists of: <ul style="list-style-type: none"> • Resident carrying Gynecology consult pager • RCP • ICU nurse (when available) 	Obstetrics Gynecology

The Patient Flow Facilitator will also respond to all RRT activations to help coordinate any needed transfers or resources.

ACTIVATING THE RAPID RESPONSE TEAM

A. Activation

1. Any staff member who recognizes criteria for a deteriorating patient admitted to a ward or Progressive Care Unit (PCU)/Trauma Transitional Care Unit (TTCU) should notify that patient's nurse at once. Patients and families are also informed as part of unit orientation that they should notify the patient's nurse if they think the patient is getting worse. The nurse will then assess the patient and determine if RRT activation is needed. In the rare instance that a patient's nurse cannot be identified and/or contacted, any staff member may activate the rapid response team by calling the page operator's stat paging line ext. 111.
2. The nurse will tell the page operator which of the four RRTs they wish to activate based on the patient's clinical service. If the nurse is unsure, the Medical RRT will be activated.
3. The patient's nurse will begin documenting the response by completing section 1 of form HH 1013, the *Rapid Response Record* and document assessment in the nursing notes.

B. Response

1. Upon notification of a rapid response, the RRT members will respond to the patient's bedside immediately. The goal is to have all members of the team at the patient's bedside within 5 minutes of the call being placed.
2. Telephone orders for treatments will not be accepted by the nurse once a rapid response has been called. Telephone orders for urgent diagnostic studies will be accepted.
3. The first job of the RRT responders will be to assess the situation and provide immediate stabilizing treatment.
4. The physician member of the team will determine the identity of the patient's existing medical team and contact the intern currently covering that patient, if he/she is not already present.
5. The patient's nurse will provide any needed medical information and nursing interventions. The nurse remains accountable for the patient during the RRT response.

C. Disposition

1. The respiratory care practitioner from the RRT may be released when the RRT physician determines that he/she is not needed and/or he/she is relieved by another respiratory therapist.
2. The physician from the RRT may be released when care is turned over to another R2 or higher, or he/she has determined that the patient is stable and does not require further urgent intervention. The RRT physician will complete section 2 of Form HH 1013, the *Rapid Response Record* prior to leaving the immediate area. If care is immediately handed over to another resident (PGY 2 or above), completion of the form may also be delegated to that person.
3. The patient's nurse documents assessments, interventions, and outcome in the patient's chart.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute under the larger umbrella of the Consolidated Omnibus Budget Reconciliation Act (COBRA). EMTALA is designed to enhance access by all persons to emergency services and prohibit discrimination in the provision of emergency services to persons presenting with similar types of conditions regardless of financial or insurance status. EMTALA is also referred to as the antidumping law. The current definition of EMTALA includes patients anywhere on the campus. This includes the **outpatient clinics, emergency department, labor and delivery, psychiatric emergency department and any port of entry to the hospital or grounds.**

Although there are many components of the EMTALA law, some basic requirements include: providing a medical screening examination to all patients seeking examination or treatment for a medical condition, providing stabilizing treatment to those patients with emergency medical conditions and maintaining logs of all patients that present for care, and transfers in and out of the facility. Compliance with all portions of EMTALA is mandatory for any hospital receiving Medicare reimbursement. Failure to comply with the EMTALA regulations may subject the medical facility to monetary penalties and risks termination of its Medicare provider status.

A central log must be kept in each area that receives walk in or emergency patients. If a patient presents for medical care, the log must include the patient's name and whether the person was transferred and where the patient was transferred to. A medical screening examination must be provided to all patients who request examination or treatment for a medical condition regardless of ability to pay. This applies to patients who present at clinics requesting services. The medical screening examination cannot be delayed to determine the patient's ability to pay or insurance coverage. If the facility is unable to provide a medical screening examination, then the patient must be appropriately transferred to an area such as the emergency department.

EMTALA also applies to emergency patients transferred into or out of Harbor-UCLA Medical Center. Caring for patients transferred into the facility requires knowledge of previous treatment. Adequate documentation and information must be received from the hospital sending the patient. EMTALA requires notification of the receiving hospital and copies of the patient's chart, X-rays, EKGs, laboratory work and any other necessary information to be sent with the patient. Requests from other hospitals to transfer a patient should always be accepted when the patient is requiring higher level of care.

Patients transferred out of Harbor-UCLA must be sent with all documents listed above that would aid the receiving facility. The patient must be informed of the risks and benefits of transfer. The benefits of transfer should outweigh the possible risks. Consent to transfer must be evident. The patient must be stabilized prior to transfer. All transferred patients must be transferred with appropriate equipment and personnel for the medical condition for which the transfer is initiated by the appropriate mode. Transfer patients must have evidence of EMTALA requirements documented by both the sending and receiving hospitals.

Failure of a hospital to comply constitutes a violation. The hospital noting the failure is mandated to report the violation within 72 hours. Failure to report a violation can result in a fine. Violations of EMTALA regulations are investigated by the Center for Medicare & Medicaid Services (CMS). Hospitals and physicians that are found to be in violation of EMTALA can be fined up to \$50,000 per violation and the hospital's Medicare participation agreement can be terminated. EMTALA violations can be detrimental to a facility. In order to avoid citations, staff members must be informed and comply with EMTALA regulations.

INFANT/CHILD ABDUCTION: CODE PINK

If an infant/child is abducted or suspected to have been abducted, a "CODE PINK" is called. The procedure involves 1) immediately calling the hospital operator at ext. 111 and informing the operator to activate a CODE PINK and stating the age of the infant/child and the floor area of occurrence; 2) immediately calling the Sheriff at ext. 3311 with the description of the infant and abductor if it was observed and 3) notifying the Nurse Manager and/or Shift Nurse Manager. The staff of the floor of occurrence should activate the panic alarm if their floor has one and notify the charge nurse, nurse manager, Sheriff Dept. and shift nurse manager as appropriate. Nursing staff on the unit of occurrence should check the surrounding areas and rooms, count all babies/children if applicable, and secure the medical records of the mother and infant/child involved.

When the CODE PINK is activated, the affected unit is secured. Only staff with identification badges can enter or exit that ward or unit. Sheriff Deputies become involved. The hospital is secured. Staff are directed to look for

and report any suspicious persons or bundles to the Sheriff's Dept. at ext. 3311. Persons leaving the Medical Center will be routed to a single exit by the Outpatient Pharmacy/Gift Shop lobby exit. The only open entrance to the facility during the CODE PINK will be the Emergency PCDC West entrance.

If the abduction is observed it is important to obtain a description of the infant/child and abductor. Attempt to note the sex, hair, skin color, height, weight, clothing, and any distinguishing characteristics (e.g., glasses, tattoos etc.)

HAZARDOUS MATERIALS COMMUNICATION AND SAFETY PROGRAM

The LABEL on a container holding a hazardous material must be marked with the CHEMICAL IDENTITY and HAZARD CLASS of the most dangerous components. There must be a Materials Safety Data Sheet (MSDS) available at the location where a hazardous chemical is present. The MSDS contains necessary safety information for proper management of the hazardous material.

It is the SUPERVISOR'S RESPONSIBILITY to ensure that labels and the MSDS are available and appropriate. It is the EMPLOYEE'S RESPONSIBILITY to read and make sure he/she understands the information on the labels and the MSDS. The information on hazard class in the MSDS will guide the employee as to how to manage the material for proper storage, protective equipment, spill and emergency response, and disposal.

Whenever there is an actual release or spill of a hazardous material/waste, remove all individuals from immediate danger if condition permits safe removal. Block off contaminated area and deny entry. Report the incident by calling for a "Code Orange" at ext. 111. Provide your location, name, hazardous material and quantity, if known. The operator will notify the Environmental Safety Officer (and at the medical center notifying the Los Angeles Sheriff's Department. "**Code Orange**" will be announced over the public address system three times at 15 second intervals giving location and room number. The Fire Department will be notified, if necessary. Obtain the Material Safety Data Sheet (MSDS) for the spilled hazardous material. Should you encounter a hazardous materials spill or if you or anyone else is exposed to hazardous materials, perform the following first aid procedures:

1. Eye Contact – Wash the eye with copious amount of water for 10-15 minutes.
2. Ingestion – Drink a lot of water but do not induce vomiting.
3. Skin Contact – Flush the affected area with water for 10-15 minutes.
4. Inhalation – Remove victim to fresh air.

Report a HazMat spill or incident to one's supervisor and to the HazMat Safety Office at ext. 2835 and County Sheriff's at ext. 3311 for clean-up response. Report to HazMat even if it has been cleaned up. Report an industrial injury to your supervisor, to Employee Health at ext. 2360 and to HazMat at ext. 2835.

Report a threatened release or spill to one's supervisor, the HazMat Office at ext. 2835, and the Director of Environmental Safety at ext. 2836. Complete an online Patient Safety Net report. An Unsafe Condition Report should also be filed.

RADIATION SAFETY PROGRAM

Keep the length of exposure time to a minimum. Plan patient care to accommodate minimal exposure to the radioactive patient. Keep one's distance (away) from a source of radiation. Always maintain an appropriate distance (away) from the patient, except when it is necessary for the patient's care. The farther away one is from the source of radiation, the less radiation one absorbs. Wear lead aprons as appropriate (e.g., for use with x-ray/fluoroscopic equipment). Whenever possible, without harm or discomfort to the patient, encourage the patient to do self care. Wear film badges as assigned in units (e.g., 4E, 5E, OR). Place shielding between the employee and the source. Whenever possible, use the patient's body as a shield by standing in a position not directly adjacent to the site of the radioactivity. Confine the spread of radioactive contamination. Excreted radioactive waste can be dispersed around the room and contaminate staff and visitors. For example, the patient who receives radioiodine for therapy excretes radioiodine in the urine.

Use precautionary measures in caring for radioactive patients. All signs and safety measures are placed and removed by the Radiation Safety Office. A **sign** indicating "Caution-Radioactive Material" is placed on the **door** and on the **bed** in the patient's room. A "**Caution-Radioactive Material**" label is placed on the outside cover

of the patient's chart. Anyone providing direct care to patients who receive therapy with radionuclides must read and be familiar with the information on the Radiation Protection Guide for Hospital Staff.

For fires or other major emergencies when radiation is involved, follow the RACE response (Rescue, Alarm, Contain, Extinguish). Call ext. 113 to state the location of the fire. Notify Radiation Safety Officer at ext. 2835. During non-business hours, call the Nursing Shift Supervisor for instructions on how to notify the Radiation Safety Officer. Notify all personnel in the area.

Avoid tracking contamination or passing contaminated equipment into clean areas by emergency workers. A Radiation Safety representative will provide input related to fire fighting or other activities where radiation is involved and supervise the area. Monitor all persons involved in combating the emergency.

EMERGENCY PREPAREDNESS

The Emergency Preparedness and Management Manual is found on the Harbor intranet by clicking on the "Code Triage" link. Critical resources, including manpower, can be obtained or replenished by calling the Command Post at ext. 2141, submitting a written request to the Command Post Staging Area., or e-mailing the Command Post at HUCLACodeTriageCommandPost@dhs.lacounty.gov.

If you are off duty and know a disaster has occurred, do NOT automatically report to work on your off-shift unless your department's Emergency Management Plan so specifies. Plan on reporting for your next regularly scheduled shift. Wait to be contacted by your supervisor (designee). Turn on a radio to KNX AM-1070. If telephones are inoperable, this radio station will broadcast call-back notifications. Report to work if so directed by your supervisor (designee) or radio call-back notifications. Wear your hospital identification in order to cross police lines.

The "**Emergency Conditions & Basic Staff Response**" poster provides a description of each emergency condition, the appropriate phone extension to report the emergency condition, and a description of the basic initial, secondary, and follow-up responses to the emergency condition. The poster is displayed at each inpatient nurses' station, outpatient clinic, and the office of each Department Chair and Service Director.

FIRE/LIFE SAFETY

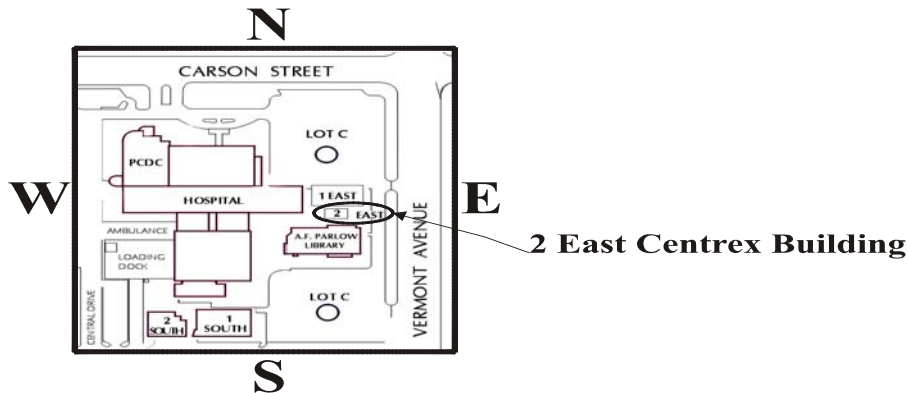
For the procedure to follow when a fire occurs in areas occupied by patients, please refer to Fire Manual for more explicit instructions.

Follow the RACE response: Remove, Alarm, Contain, Extinguish

Remove all persons from immediate danger. Activate the nearest fire alarm box (pull station) to summon the fire department. Fire engines will arrive at the hospital within minutes of alarm activation. Dial ext. 113 to state the location of the fire. All employees are to return to their unit immediately. Contain fire using appropriate fire fighting method. Close all doors and clear all corridors. Extinguish the fire (when safe to do so).

Send a messenger to the Centrex Building (Building 2 East, Telecommunications) if a power failure has blocked the alarm and/or telephone systems [Building 2 East is located next to the Parlow Library]. The messenger should use the phone at the east side entrance of the Centrex Building to dial "O" or ext. 113 and the operator inside the building will respond. If appropriate, the messenger should return to the work area and assist co-workers as needed.

MAP SHOWING LOCATION OF BUILDING 2E CENTREX BUILDING



Use the proper extinguisher for the type of fire you are trying to extinguish. (See table below)

Type of Fire Extinguisher	Effective For These Types of Fires
Class A or H ₂ O	Paper, wood or linen fires
Class BC or CO ₂	Chemical or electrical fires
Class ABC or Dry Chemical	All types of fires
Halon - ABC Rated	All types of fires
K-Type	Combustible cooking media (vegetable or animal oils and fats)

Follow the PASS method to use a fire extinguisher: Pull, Aim, Squeeze, Sweep

Pull the pin out. Some extinguishers require release of a lock hatch, pressing a puncture lever or other motion. Aim the extinguisher nozzle (horn or hose) at the base of the fire. Squeeze or press the handle. Sweep from side to side at the base until the fire goes out

***Note:** It is important to know the location of the fire alarm, fire extinguisher, and emergency exits closest to your work area.

MEDICAL EQUIPMENT AND UTILITIES

All new medical electrical/electronic equipment used in patient care areas is checked by the Bio-Med Electronics Department to make sure that the current leakage is below 300 microamperes. Patients and staff are protected from excessive current leakage by the use of the third prong on the power plug. Therefore, equipment used in patient care areas must have a three-pronged plug.

Electrical and electronic equipment are checked at regular time intervals depending on the device. Bio-Med Department places a sticker on the equipment indicating preventative maintenance has been performed on the equipment and the unit is safe to use on a patient. Notify the Facilities Management at ext. 3301 for any equipment displaying a date **beyond** the due date on the sticker.

Defibrillators that were put into service within the last 5 years are tested for output accuracy every 6 months, and defibrillators that have been in service for more than 5 years are tested on a 4 month cycle by the Bio-Med Department. Red outlets are emergency outlets that should be used for life support equipment (e.g., ventilators, defibrillators, balloon pumps, heart bypass pumps). Critical medical equipment without battery backup also should be plugged into the red emergency outlets. A cardiac bedside monitor would be considered a critical medical equipment.

Before using any piece of electrical equipment, always check the general appearance of the equipment. Check body of the equipment for cracks, holes, protruding wires, etc. Check the cord condition for cracks, breaks, and

presence of the third prong on the plug (if applicable). Assess the intactness of the plug (plastic portion) and ensure that the cord fits the outlet and the fit is snug. Check the on/off switch for proper function. The switch must work 100% of the time. Never compromise this standard.

Never use any electrical equipment if the cord or plug feels warm, any suspicious odors are coming from equipment, or if the equipment operates erratically.

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

In the event of a fire or emergency, it may be necessary to shut off oxygen or medical gases. Only Clinical Staff or the Facilities Management and/or the Fire Department, **with the guidance of clinical staff**, are authorized to shut off this medical gas valve.

To report equipment in need of repair, or to report a mechanical emergency: call ext. 3301 Monday-Friday, 0700-1630 (On county observed holidays and at all other times, call ext. 3326).

Important: **Any time** a patient in contact with electrical or mechanical equipment complains of feeling an electrical tingling, shock or burn, immediately assess the patient and disconnect/replace the equipment. Then notify the physician, Facilities Management, the Nurse Manager, and complete a Situation Report.

HAND HYGIENE

Hand hygiene is one of the most important infection control measure for preventing healthcare-associated infections.

1. Hands should be washed with soap and water:
 - a. When visibly dirty or visibly soiled with blood or other body fluids
 - b. After caring for patients with *Clostridium difficile* (C. difficile) or *Bacillus anthracis* (anthrax)
 - c. After using the restroom
2. Use an alcohol-based hand product as the preferred means for routine hand antisepsis in all other clinical situations described in items a to f listed below if hands are not visibly soiled. If alcohol-based hand product is not obtainable, wash hands with soap and water.
 - a. Before and after having direct contact with the patient;
 - b. Before handling an invasive device for patient care, regardless of whether or not gloves are used (e.g., central lines, urinary catheters, intravenous catheters) and do not require a surgical procedure;
 - c. After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings;
 - d. If moving from a contaminated body site to another body site during care of the same patient;
 - e. After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient;
3. Before handling medication or preparing food perform hand hygiene using an alcohol-based hand product or wash hands with soap and water.
4. Soap and alcohol-base hand product should not be used at the same time.
5. Use of gloves:
 - a. Use alcohol-based hand product or wash hands with soap and water after removing gloves. The use of gloves does not replace the need for hand hygiene.
 - b. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials (OPIM), mucous membranes, and non-intact skin will occur.
 - c. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient.
 - d. When wearing gloves, change or remove gloves during patient care if moving form a contaminated body site to either another body site (including non-intact skin, mucous membrane or medical device) within the same patient or the environment.
 - e. Do not reuse gloves.

6. Artificial fingernails and long natural fingernails are not permitted for those who have direct contact with patients, handle instruments or patient care equipment, or with food.
 - a. Artificial fingernail is defined as any material applied to the fingernail for the purpose of strengthening or lengthening nails (e.g., tips, acrylic, porcelain, silk, jewelry, overlays, wraps, fillers, superglue, any appliques other than those made of nail polish, nail-piercing jewelry of any kind, etc.).
 - b. Natural nails must be clean, with tips less than ¼ inch long.
 - c. Fingernail polish must be in good condition, free of chips and preferably clear in color.

TUBERCULOSIS (TB) CONTROL PLAN

For adults and children who do not display signs of the active disease (have a negative chest x-ray), but have recently tested positive with a PPD skin test, preventive therapy with isoniazid is given for 6-12 months to decrease the risk of TB. Such persons may continue to work during this time. Once a person is found to have signs and symptoms consistent with tuberculosis treatment is begun. The person may not work until a physician certifies that the disease is no longer communicable. Treatment for active disease should always include two or more tuberculosis medications to prevent the emergence of resistant tuberculosis bacilli. Multidrug-resistant tuberculosis can occur in two ways: Infection by tuberculosis bacteria that is already resistant to the drugs and patient non-compliance or mismanaged treatment, where the patient takes inadequate types or doses of appropriate medication

Patients with known or suspected active TB are to be placed in a negative pressure room and have an airborne precautions sign posted on the door. Patients and families must be educated about the need for airborne precautions and their responsibility to adhere to the precautions. Patient education booklets are available on each unit. Patients must remain in their rooms except as necessary to leave for diagnostic tests or with permission, to go outside. They are not permitted free access to the wards, lobbies, clinics, other patient rooms or cafeteria, and must wear a mask anywhere in the facility outside their isolation room. When leaving their rooms for diagnostic tests, patients must be escorted and must wear properly applied masks.

When in an airborne precaution room, healthcare workers must wear a N-95 respirator. The respirator must be "fit tested" to the employee and must be refit tested per OSHA Regulations annually. The N-95 respirator used at Harbor-UCLA is disposable and should be used only once. Patients and visitors wearing a mask are not required to be fit tested. Apply a respirator before entering the room. Remove the respirator **OUTSIDE** the room. **Remember -- "Don't share the air!"**

The door to the respiratory isolation room is to be kept **COMPLETELY** closed at all times -- even if the patient is temporarily out of the room. This is the only way to reduce aerosol escape and to prevent microbial contamination of the air outside the isolation area.

Negative pressure isolation rooms have directional airflow devices which contain a pink ball in a tube, and the ball moves back and forth, depending on the direction of the airflow between the room and the corridor. Staff entering the room should check the directional airflow prior to entering a room in use for airborne precautions.

- a. If the pink ball is on the outside of the room, it means the air is flowing from the patient's room into the corridor (ie, positive pressure).
- b. If the pink ball is on the inside of the room, the air is flowing from the corridor into the patient's room (ie, negative pressure).

Patients placed in airborne precautions require negative pressure rooms (ie, pink ball should be inside the room), potentially preventing contaminated air from the patient's room from flowing out into the corridor. The door to the room must be kept closed and properly posted with an airborne precaution sign.

TB patients may **not** be grouped together (cohorted) in a shared room. A patient isolated for **suspected** TB should be isolated until an alternative diagnosis is established or the patient has had 3 consecutive negative sputum AFB smears collected on different days.

For patients with TB, airborne precautions may be discontinued when the patient has met the following criteria: on effective therapy, is improving clinically, and has had three consecutive negative AFB sputum smears collected on different days.

Healthcare providers are required by law to provide written notification for all TB cases and suspected TB to LAC DHS TB Control. At Harbor-UCLA, the current method of notification is to call the TB Liaison Nurse (310-222-3443). Any patient placed in airborne precautions and worked up for TB constitutes a TB suspect and must be reported. In addition to phone notification to the TB liaison, there is a case report form that must be completed by the physician and placed on the chart.

By law, the physician must notify the TB Control Liaison prior to the patient's discharge or transfer and there must be a written treatment plan approved by the health officer prior to discharge. LA County TB Control requires that this notification occurs at least 24 hours prior to anticipated discharge. At Harbor-UCLA, the TB Control Liaison (310-222-3443) is responsible for approval of discharged/transferred TB patients or suspects.

PAIN ASSESSMENT AND REASSESSMENT

Pain treatment is based upon underlying principles of pain management and analgesic pharmacology, standard guidelines for opioid dosing/titration/equivalency, non-opioid treatment of chronic pain syndromes, and pain management protocols.

When possible, provide treatment that is specific to a patient's diagnosis as well as to potentially painful procedures. Do not use a placebo in the assessment or management of pain unless it is a part of a clinical study approved by the hospital's Institutional Review Board. Assess the results of treatment and adjust therapy accordingly until the best possible outcome is achieved. Use pharmacological and non-pharmacological interventions to achieve optimum pain relief. Provide the patient with realistic goals and expectations. A "pain free" hospital or healthcare experience is not always realistic, but minimizing pain and managing unavoidable induced pain are realistic goals. Healthcare providers will work collaboratively to provide the best pain management regime/treatment plan for the patient.

Reassessment is key in achieving an effective pain management regimen. Nurses are to monitor pain routinely and record it as a fifth vital sign. Reassessment should occur on a regular basis after an initial report of pain and following each intervention taken to relieve the pain. Reassessment following an intervention should occur in a time frame appropriate to the intervention. It is very important to document the effectiveness of the interventions provided. Patient reassessment and outcome documentation provide valuable information that will guide and dictate the patient care plan for pain management.

Patients and their families will be informed of their right to adequate pain management and the role they can play in working with our staff to assure effective pain management. Patients and/or caregivers will be counseled by pharmacy personnel regarding the use of pain medication(s). Instructions regarding the use of non-pharmacologic interventions for pain management as well as when and how to contact a healthcare professional will also be provided.

Initial screening of pain will be documented in the nursing admission flowsheet. Subsequent assessments, treatments, reassessments, and patient/family education will be documented on the appropriate forms.

PRN orders for analgesic medications **must** include the pain level or pain score when more than one pain medication is prescribed. The prescriber will indicate the pain level (or pain score) as mild (0-3), moderate (4-6), or severe (7-10). When an order other than 0-10 pain assessment tool is used (e.g., neonates), the identified PRN pain score will be appropriate to that tool.

Evaluation of pain management begins when the nurse first assesses the patient's pain by performing a complete pain assessment of the physiological and behavioral changes, including the patient's own self report. This is followed by pharmacological and/or non-pharmacological modalities identified by the multi-disciplinary care team. After an identified period of time, patients are reassessed as to the relief of pain, or for further analysis of the effectiveness of the intervention used. At this time, the nurse can choose to continue with the same intervention, or call the physician to discuss other alternative interventions. This process of assessing, treating, and reassessing the patient's pain is a circular process that may continue on for a long time until the patient's pain is relieved.

USE OF RESTRAINTS AND SECLUSION

Harbor-UCLA Medical Center is committed to preserving the dignity, safety, comfort, and personal freedom of each individual seeking medical or psychiatric care. Our goal is to prevent, reduce, and attempt to eliminate the use of restraints and seclusion throughout the facility by raising the level of awareness and competence among staff through education focused on the use of restraint or seclusion. *Restriction of a patient's physical freedom of movement by the application of restraints will only be carried out in those situations where appropriate, alternative, non-physical interventions have been considered, attempted and deemed ineffective.* The organization is committed to utilizing non-violent physical crisis interventions to control and prevent crisis situations that have the potential to lead to the use of restraints and seclusion.

This section addresses the use of restraints **in all clinical areas**. As defined by the Centers for Medicare/Medicaid Services (CMS), a **restraint** is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely or a drug or medication when it is used as a restriction to manage the patient's behavior or restricts the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is used only for management of violent or self-destructive behavior.

Restraint does not include devices for medical immobilization (e.g., use of arm board during IV therapy, surgical positioning), orthopedically prescribed devices, surgical dressings or bandages, protective helmets or methods to protect the patient from falling out of bed (side rail use). The physical holding of a patient for the purpose of conducting routine physical examinations or tests is also not considered a form of restraint.

All Harbor-UCLA Medical Center employees including both direct and indirect care providers need to be aware of the hospital's philosophy regarding the use of restraints and seclusion as well as general factors to consider when restraints are utilized. This section of the reorientation study guide will provide the individual with the philosophy regarding the use of restraints and seclusion. Factors to consider, justification for the use of restraints and safety considerations for both patients and staff, will be emphasized.

There are two distinct types of classifications and guidelines related to the use of restraints.

Behavioral justifications: Used in emergency situations when the patients exhibit violent, aggressive and/or destructive behaviors, which represents imminent risk of an individual's self harm or harm to others.

Non-behavioral justifications (medical/surgical): Used as an adjunct to medical/surgical care. Includes patients that are restrained for reasons other than violent, aggressive or destructive behaviors (i.e., attempting to pull out lines, tubes, or other necessary medical devices*).

Restraints are to be used only when alternative measures are ineffective in protecting the patient or others from injury. Attempts of alternative measures to control the patient's physical activity in order to protect the patient or others from injury are critical and must be documented prior to placing the patient in restraints. Restraints cannot be used as a punishment, aversive treatment, or for the convenience of staff. The patient and family (with the consent of the patient in the psychiatric areas) will be notified of the reason for placing the patient in restraints. **Restraints should be applied only when a need is supported by patient behavior that will result in harm to self or others and alternative methods have proven to be ineffective.**

Behavioral indications for restraints include the patient being physically threatening to self/staff/other patients by attempting to hit, kick, bite, etc., verbally threatening staff or other patients with bodily harm and indicates intent to carry out threat, physically destroying property, throwing objects, breaking windows, etc., forcefully grabbing people, or expressing a suicidal plan such as jumping out of a window with intent to carry out the plan.

Involuntary Holds

Being on a Psychiatric Involuntary Hold (5150) is not a behavioral justification for use of restraints. Restraints may be used on voluntary or involuntary patients. The patient's behavior is the determining factor.

Non-behavioral indications for restraints include the patient attempting to remove lines, tubes, or disrupt other essential medical devices, or requiring bedrest to limit mobility along with the inability to follow the plan of care.

Alternative methods and specific examples that can be considered include moving the patient closer to the central nursing station, providing the patient closer access to nursing staff, and separating the patient from other patients to allow the patient to experience a less stimulating and quieter atmosphere or different environment (e.g., move the patient from a 4 bed to a 2 bed or a single bed room). It is also a good idea to move a patient away from the window if the patient is at risk of suicide. In the psychiatric areas, the patient may be placed in open seclusion.

When alternatives have failed to de-escalate violent, aggressive behavior in patients that represents an immediate and serious danger to safety, a Code Green will be called to activate the Crisis Response Team (CRT). Restraints shall be implemented in the least restrictive manner possible, in accordance with safe and appropriate restraining techniques, and used only when less restrictive measures have been found to be ineffective. The patient's plan of care will be modified as appropriate. The patient shall be evaluated and treated for any injuries.

THE USE OF RESTRAINT AND SECLUSION			
Criteria	Behavioral Justification		Non-Behavioral Justification (medical/surgical)
	Psychiatric Areas	All Other Areas	All Areas
Prior to Initiation (Assessment)	<ul style="list-style-type: none"> Considers any pre-existing conditions/disabilities/limitations that would place the patient at greater risk for harm from the application of restraint/seclusion. Determines the patient's condition or symptom that warrant use of restraint or seclusion Determine benefits to patient and whether a less restrictive intervention would offer the same benefit at less risk. 		
	<ul style="list-style-type: none"> Determines whether patient has an advance directive with respect to behavioral health care and ensures that direct care staff is aware of the behavioral health advance directive. 		
Initiation	Restraints/seclusion can be initiated by an MD or Crisis Response (CRT) RN Team Leader.or behavioral health RN	Restraints initiated by Crisis Response (CRT) RN Team Leader.	Restraints may be initiated upon order of physician (telephone order accepted).
<i>Application</i>	CRT will place patient in seclusion or apply restraints.		Clinical staff apply restraints.
In-Person Evaluation by Licensed Independent Practitioner	Within 1 hour.	Within 1 hour.	Within 1 hour.
Physician's Orders	May never be written as a standing order or PRN		

THE USE OF RESTRAINT AND SECLUSION			
Criteria	Behavioral Justification		Non-Behavioral Justification (medical/surgical)
	Psychiatric Areas	All Other Areas	All Areas
<ul style="list-style-type: none"> Obtaining Time limitation 	Within one hour.	Within one hour.	Prior to application.
	Maximum <ul style="list-style-type: none"> 4 hours for ages 18 and older 2 hours for ages 9 – 17 1 hour for ages under 9 		Maximum <ul style="list-style-type: none"> 24 hours all ages
<ul style="list-style-type: none"> Include the following 	<ul style="list-style-type: none"> Specific violent, aggressive, or destructive behavior. 		<ul style="list-style-type: none"> Medical/Surgical justification e.g., trying to pull out lines, tubes.
<ul style="list-style-type: none"> Renewal 	Requires face to face physician re-evaluation before expiration of original order to determine the patient's response to the intervention including the rationale for continued use of the intervention.		
<ul style="list-style-type: none"> Trial release 	Trial release is unacceptable for non-behavioral and behavioral orders. Removing the restraints before the order expires would require a physician's order for reapplication.		

Licensed Independent Practitioners and qualified nursing staff are authorized to remove restraints prior to the expiration of the order, if appropriate. The Licensed Independent Practitioner's responsibilities include completing a face-to-face assessment of the patient's current clinical condition, providing a written order if restraint and/or seclusion is clinically justified, conducting an in-person re-evaluation prior to expiration of original order (PRN orders are not accepted), participating in daily reviews of restraints and/or seclusion use related to his/her patients, and consulting with support services (e.g., Social Work, Occupational Therapy/Recreational Therapy, and Dietary Services, as needed).

*The above is applicable for the physician primarily responsible for the patient's ongoing care orders. For behavioral restraint, an attending physician is consulted as soon as possible if he/she did not order the restraints/seclusion.

The Registered Nurse's responsibilities include ensuring that the behavior necessitating the use of restraints and alternatives considered/tried are documented in the medical record, ensuring the patient is advised on the purpose of restraints and/or seclusion and the circumstances under which the restraints and/or seclusion shall be discontinued, completing and documenting an initial assessment and ongoing reassessment, assuring that patients in restraints are appropriately monitored and receive necessary interventions, and ensuring the patient is assessed for any potential injuries that may have occurred during the restraint process.

Under appropriate circumstances other properly trained members of the healthcare treatment team may monitor patients in restraints and/or seclusion and provide necessary intervention.

Risks and potentially harmful effects of use of restraint include increased incidence of injury, increased incidence of nosocomial infection and new pressure ulcers, regression, helplessness, decreased autonomy, and low self-esteem, expression of strong feelings of humiliation and vulnerability that may persist for months after being placed in restraints, expression of strong feelings of humiliation and vulnerability that may persist for months after being placed in restraints, and increased feelings of anxiety.

Do not restrain a patient in a prone position. Restraining a patient in a prone position may predispose the patient to suffocation by restricting the ability to breathe and decreasing the supply of oxygen. This leads to disturbances in the rhythm of the heart. Prone position is a hazardous and potentially lethal restraint position. Some people are more at risk for positional asphyxia than others. Factors that increase the risk include obesity, extreme physical exertion or struggling prior to or during restraint use, pre-existing heart or respiratory problems, and use of alcohol or other drugs. Because of the known risks identified with prone positioning, patients are to be placed and maintained in the supine position when restrained in bed.

Physical restraints can lead to death by strangulation. Patients who are restrained have an increased tendency to try to get out of bed or restraints. Healthcare providers often have a false sense of security and may believe that patients who are restrained cannot get out of bed.

While in restraints, a patient must receive continuous in-person observation by a nursing staff member. In the psychiatric area when a patient is in seclusion only, he/she must be continually observed by a nursing staff member in person for the first hour. After the first hour, further observation may be performed by continuous audiovisual monitoring. Continuous in-person observation is accomplished by utilizing a sitter.



When a patient is being continually monitored, the sitter policy must be followed. A sitter will be provided for patients restrained for behavioral reasons in the Adult Medical/Surgical Wards, Adult/Pediatric Emergency areas, 7 West Ward, and Pediatric Ward. A sitter will also be provided for patients in restraints and for patients in seclusion for the first hour in the locked psychiatric units. The sitter's duties include remaining within view and immediate contact of the patient at all times, providing general nursing care to the patient being observed (e.g., turning, repositioning), providing continuous in-person observation, providing a safe environment, including removal of potentially dangerous objects from the room and screening any items brought by family and friends, reporting ongoing behavioral observations to the RN responsible for the patient, and documenting appropriately on the observation record. If at any time the sitter is unable to remain within view of the patient, he/she must notify the RN responsible for the patient so an alternate sitter can be made available to remain and monitor the patient.

15 Minute Observations for Patients in Physical Restraints

- **Any signs of injury associated with restraint or seclusion (e.g., such as swelling and/or color change on the restrained limbs)**
- Circulation and range of motion in the extremities (not applicable for side rail restraint)
- Nutrition and hydration
- Hygiene and elimination
- Vital signs (respiratory rate for behavioral justification; for non-behavioral justification routine per unit vital signs are sufficient)
- Physical and psychological comfort
- Readiness for reduction or discontinuation of physical restraint and seclusion

For non-behavioral justification, monitor patient every 15 minutes, or more frequently, if indicated. When the patient is placed in restraints for Behavioral or Non-behavioral justifications, the patient is immediately assessed for appropriate application and then every 15 minutes for the following:

Note: Patients in Behavioral restraints require continuous in-person observation. Observations are documented on the Behavioral Restraint Nursing Observation and Care Record or the Non-behavioral Restraint Nursing Observation and Care Record by checking the appropriate boxes and initialing the column. All adverse effects are documented when observed and described in the Nursing Evaluation and Progress Notes. Checking the awake/asleep column every 15 minutes indicates that the patient was evaluated for all of the above assessments. When the patient is restrained for behavioral reasons, vital signs (minimally, respiratory rate) are recorded every 15 minutes.

The following must be documented a minimum of every 2 hours for all patients in restraints:

- a. Fluids provided if patient is not NPO (while patient is awake)
- b. Toileting provided (urinary and bowel measures while patient is awake)
- c. Range of motion provided while patient is awake (not applicable for side rail restraint)
- d. Rotation of restraints when clinically indicated

If elimination or food/fluid intake are contraindicated because of the medical condition or plan of care, a notation must be made on the appropriate Nursing Observation and Care Record. Any adverse effects from the use of restraints such as swelling and/or color change on the restrained limbs are documented at the time of occurrence and a note is entered on the Nursing Evaluation and Progress Note. Any related interventions and responses must also be documented in the Nursing Evaluation and Progress Note.

For restraints used with behavioral justification, document ongoing assessment, interventions and evaluations (AIE). However, this does not eliminate the need for AIE documentation in the nurses' notes.

The date and time that restraints are removed must be documented on the appropriate Nursing Observation and Care Record.

BABY FRIENDLY

At Harbor-UCLA our mission is to inform all pregnant women of the benefits of breastfeeding so they can make informed decisions on how to feed their babies and to offer them the support needed to maintain that choice. Our staff are able to confidently support, establish and protect early mother-infant attachment for all mothers and honor the mother's beliefs and choices of infant feeding.

All mothers and infants will have skin-to-skin time immediately after birth and remain together for the hospitalization unless medically contraindicated.

A nurse will show her how to hold the baby and how to help him or her latch on. The nursing and medical staff will support on demand feedings according to baby's cues; anticipate 8 -12 times in 24 hours per American Academy of Pediatrics (AAP) guidelines. Time at the breast for feedings will not be restricted. The baby will not be supplemented with formula, glucose water, etc., or given a pacifier unless this is needed for a medical reason. Mothers will be encouraged to exclusively breastfeed their infants while in the hospital and to continue exclusively breastfeed for six months.