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INTRODUCTION: MANAGEMENT OF THE ENVIRONMENT OF CARE AND EMERGENCY MANAGEMENT

The goal of management of the environment of care and of emergency management is to provide a safe, functional, supportive and effective environment for patients, staff members, and other individuals in the hospital. Effective management includes using processes and activities to:

- Reduce and control environmental hazards;
- Prevent accidents and injuries;
- Maintain safe conditions for patients, visitors and staff;
- Maintain an environment that is sensitive to patients’ needs for comfort, social interaction, positive distraction and self-control;
- Maintain an environment that minimizes unnecessary environmental stresses for patients, visitors and staff.

The Joint Commission identifies six environment of care management plans. They are:

1. Safety Management
2. Hazardous Materials and Waste Management
3. Fire Prevention Management
4. Security Management
5. Medical Equipment Management
6. Utility Systems Management

In addition, The Joint Commission has extensive requirements for emergency management.

This training is provided to all new employees and to all other employees as annual refresher training. As you continue your career, your department will assume a greater role in providing you with the needed training.
SAFETY MANAGEMENT

Most safety related services are provided by Environmental Health & Safety.

The EH&S Office for UC Davis Health System is composed of three sections – Occupational Safety, Health Physics, Security and Emergency Preparedness.

All EH&S services are available by calling the numbers listed, by referring to your campus phone directory, or e-mail safety@ucdmc.ucdavis.edu

Occupational Safety and Emergency Preparedness ................................ 734-2740
Health Physics .............................................. 734-3355

The Health System’s Safety Management Plan guides implementation of the safety program including plans for preventing exposure to airborne and bloodborne pathogens, prevention of ergonomic injuries and safety measures for other common hazards. Copies of the Safety Management Plan are available on the Environmental Health and Safety website or by calling EH&S at 734-2740. You can access the Environmental Health and Safety web site from the intranet by typing safety in your web browser address bar. This plan sets the standard for safety management and is complemented by departmental safety programs and activities. Implementation of the Plan is a requirement of Federal and State regulations and of UCDHS P&P 1620. The Safety Committee and Health and Safety Officer play vital roles in ensuring the effective implementation of the plan. Department managers and supervisors implement the plan at the department level. Refer to the green Injury Prevention Plan binder in your department for more information on safety activities in your department. Your department will also have a safety coordinator, who plays a key role assisting with identification of safety hazards and distribution of safety information.

SAFETY TRAINING

Training is important for your safety. You will need to take a refresher on this training every year. You should also receive department and job specific safety training, which may be provided in a variety of ways including drills, in-services, bulletin board postings and educational posters. Ask questions if you are unsure how to perform a job safely.

HAZARD IDENTIFICATION & REPORTING

Work locations are inspected regularly and deficiencies noted by EH&S or by department Safety Coordinators. After an inspection, you may be required to implement corrective actions. You are encouraged to report hazards to your supervisor or safety coordinator. You may also report hazards directly to EH&S via a phone call to 734-2740, by e-mail, by using the on-line incident reporting system or by completing a Hazard Report Form (available as an attachment to UCDHS P&P 1605). If the hazard represents an emergency, arrange to have someone stay by the location to warn others, if necessary, and call 9-1-1. Hazard Report Forms may be submitted anonymously through the UC Davis Health System mail system. If other methods of reporting and correcting work place hazards are not successful, you have the right to contact Cal/OSHA or
The Joint Commission. Employees may not be disciplined for reporting problems in this manner. If the hazard represents an emergency, call 9-1-1.

INJURIES AND ACCIDENTS
As a part of the safety program accidents are investigated and corrective actions implemented to prevent future incidents. Report incidents, including any occupational injury or illness, to your supervisor as soon as possible. For a non-emergency workplace injury that requires the attention of a doctor or nurse, call Employee Health Services for an appointment. If after hours and the injury needs to be seen, go to the Urgent Care Clinic. Call Employee Health at 916-734-3572 to obtain information and numbers regarding the Urgent Care Clinic (information on the Urgent Care Clinic is included in their after-hours phone message). Incidents associated with occupational injury or illnesses are to be reported via the Worker’s Compensation System, not via the online Incident Report System. Call 9-1-1 for emergency medical care or an ambulance or damage caused due to a criminal act.

You should notify your supervisor of any incidents involving patient or visitor injury and report immediately via the on-line incident reporting system. Property damage involving a University owned vehicle requires an Auto Accident Form be completed and forwarded to Fleet Services within 24 hours. Additionally, the accident must be reported to the University's third-party claims administrator, Sedgwick CMS, by calling 1-800-416-4029.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
The proper use of personal protective equipment (PPE), such as respirators, protective gloves and impermeable gowns is vital to assure your safety and protection against workplace hazards. You should receive training so that you know: when to wear PPE; what PPE is required; how to properly put it on, adjust it, wear it and take it off; the limitations of the PPE; required maintenance; its useful life; and proper disposal. Notify your supervisor if you have questions or if you have any problems with defective or damaged PPE. Some workplaces, such as research laboratories, may have minimum PPE requirements that are posted at entryways. Read and follow posted requirements. Note that normal hospital scrubs do not function as personal protective equipment.

INDOOR TRIP AND FALL HAZARDS
Keep exits, stairways and hallways free from stored items and debris. Submit a service request to PO&M for problems that are not an immediate threat to safety such as a light that is out, loose carpets, loose tiles, and cracked or torn linoleum. All routine service requests must be submitted via the online Service Request System. Urgent requests may be placed by calling 734-2763. The link to the new Service Request System is available on the front intranet page of The Insider. From the “On-the-Job Resources” section, select “Administration” and click on “PO&M Service Request” from the “drop down” menu. Alternatively, type request in the address bar of your browser. Report spilled liquids (coffee, soda, etc.) to Environmental Services, 4-3777.

OUTDOOR TRIP AND FALL HAZARDS
Report to PO&M, using the process described above, damaged pavements, sidewalks, driveways and parking lots. Follow up with a call to Environmental Health & Safety (EH&S), 734-2740.
OXYGEN AND OTHER COMPRESSED GAS CYLINDERS:
Compressed gas cylinders are used in healthcare and many research and support activities. Cylinders present significant hazards due to high pressure gases contained within the cylinders and cylinders that contain oxygen and other oxidizers may contribute to fire hazards. See P&P 1685 for specific rules on labeling and management of oxygen cylinders. Persons using or handling cylinders should have basic training including a review of operating and safety protocols for tasks to be performed, review of appropriate Safety Data Sheets (SDS) for toxic gases, and hands-on training by an experienced gas cylinder user. Transport cylinders larger than lecture bottle size with a hand truck or cylinder cart. Rolling or "walking" cylinders is extremely hazardous. **Never transport a cylinder with a regulator attached!** Always protect the valve during transport by replacing the valve cover. Cylinders must never be left without some type of physical support or restraint such as a stand, a cart, or a cylinder storage rack. Store cylinders in a well-ventilated area away from ignition sources. Additional information on the management and storage of Compressed Gas Cylinders is available in Safety Net #60 and UCDHS Fire Net on Storage & Handling of Medical Gas Cylinders.

Report gas cylinder problems to Distribution (703-4040) with follow up to EH&S. For help understanding limitations on the storage of cylinders in buildings; contact Fire Prevention at 734-3036.

ALCOHOL-BASED HAND-RUB DISPENSERS
Alcohol-based hand-rub dispensers include those that are mounted as well as free-standing liquid containers. When dispensers are mounted in a corridor, the corridor must have a minimum width of 6 ft. Dispensers cannot be installed within 6 inches horizontally of an ignition source (light switch, electrical outlet, etc.). Additional information can be located at UCDHS Fire Net on Alcohol-Based Hand-Rub Dispensers at http://www.ucdmc.ucdavis.edu/fire/pdfs/Alcohol-Based_Hand-Rub_Dispensers.pdf

ERGONOMICS – BODY MECHANICS
The practice of maintaining proper body mechanics and using correct lifting techniques is important to prevent injuries, as is the importance of supporting neutral postures while operating a computer (sitting or standing). Learn how to adjust the relationship between your monitor, keyboard/mouse, and your chair with the Ergonomic Self-Evaluation tool on our website: http://www.ucdmc.ucdavis.edu/hr/hrdepts/work_comp/ergonomics.html

The self-evaluation should be completed and shared with your supervisor to assure appropriate adjustments to your workstation. In cases where additional assistance is needed or where an ergonomic evaluation is medically required, please contact the UC Davis Health System’s Ergonomics Unit at 734-6180.

If assistance is needed for staff in-services relating to body mechanics, safe patient handling equipment instruction, back safety, or office ergonomic awareness, please contact the UC Davis Health System’s Ergonomics Unit at 734-6180.
SMOKE AND TOBACCO-FREE CAMPUS
The UC Davis Health System buildings in Sacramento and all clinics are a completely smoke and tobacco-free environment. Smoking and tobacco use (including cigarettes, smokeless tobacco, and E-cigarettes) is prohibited in all buildings and outdoor areas on both the Davis and Sacramento campuses. UC Davis’ No Smoking and Tobacco-Free Policy, UC Davis Health System P&P 1628 provides details of the no-smoking and tobacco-free policy. Individuals who witness an employee smoking or using tobacco on the Sacramento campus are expected to report the violation to that employee's department.

USE OF CELL PHONES
In areas where there are signs indicating "Cell Phones Must Be Turned OFF", cell phone must be POWERED OFF, not simply in vibrate or silence mode. “Airplane” mode with WiFi ON is acceptable in “OFF” areas.

Three Foot Rule: Cell phone users, when conversing on their cell phones, shall stay a minimum of three feet away from all medical devices and instrumented patients (patients connected to medical devices). Three feet is approximately the length of the adult arm. Cell phone use, in accordance with the three foot rule, is allowed in all areas of UCDMC, except where signs indicate that cell phones must be turned OFF or UCDMC staff indicate that cell phones must be turned off.

Furthermore, cellular devices should never be placed on medical devices. If interference between a cellular device and a medical device is noted, the cellular device should be turned off or moved to a location greater than three meters (10 feet) from the medical equipment, and Clinical Engineering should be notified (916-734-2846). For additional information on cell phone use, refer to UC Davis Health System P&P 1331 for details of the cell phone policy.

PROPER FOOTWEAR
Wear properly fitted closed-toe shoes. Low-heeled shoes with slip resistant soles help prevent slips and falls, especially in rainy weather and in wet work locations. It is your responsibility to wear and maintain any special safety shoes required for your job.

SUPERVISORS AND EMPLOYEES
Supervisors play a key role. They assure that their staff are trained, routinely identify and correct hazards, and take corrective action as necessary. Supervisors are assisted by department Safety Coordinators. Open lines of communication between supervisors and their staff members are vital to ensuring effective implementation of the Safety Management Plan. Remember, as an employee, you have a right to know the hazards of your workplace, but you too must take an active role, by attending training classes, using safety equipment correctly and following safety protocols.
SAFETY MANAGEMENT CONCLUSION
The following is information on how you can participate in your safety and the safety of others.

First: Correct and report safety hazards;
Get involved in your department’s safety program; and
Know your job and perform it safely.

Second: Practice prevention by knowing and avoiding hazards.

Remember, safety is everyone’s responsibility
ENVIRONMENTAL AND HAZARDOUS MATERIALS MANAGEMENT

If you work with Hazardous Materials, your department will train you on the use of those materials, required protective equipment, proper disposal and spill response. Notify your supervisor if you feel you need additional information before working with a hazardous material.

I. Safety Data Sheets (SDSs)

HOW TO READ A SAFETY DATA SHEET (SDS)

A safety data sheet (SDS) includes the following information, in sections labeled 1-11 and 16. If no relevant information is found for any given subheading within a section, the SDS shall clearly indicate that no applicable information is available. Sections 12-15 may be included in the SDS, but are not mandatory.

1. Identification
   (a) Product identifier used on the label;
   (b) Other means of identification;
   (c) Recommended use of the chemical and restrictions on use;
   (d) Name, address, and telephone number of the chemical manufacturer, importer, or other responsible party;
   (e) Emergency phone number.

2. Hazard(s) identification
   (a) Classification of the chemical in accordance with paragraph (d) of §1910.1200;
   (b) Signal word, hazard statement(s), symbol(s) and precautionary statement(s) in accordance with paragraph (f) of §1910.1200. (Hazard symbols may be provided as graphical reproductions in black and white or the name of the symbol, e.g., flame, skull and crossbones);
   (c) Describe any hazards not otherwise classified that have been identified during the classification process;
   (d) Where an ingredient with unknown acute toxicity is used in a mixture at a concentration = 1% and the mixture is not classified based on testing of the mixture as a whole, a statement that X% of the mixture consists of ingredient(s) of unknown acute toxicity is required.

3. Composition/ information on ingredients

   FOR SUBSTANCES
   (a) Chemical name;
   (b) Common name and synonyms;
   (c) CAS number and other unique identifiers;
   (d) Impurities and stabilizing additives which are themselves classified and which contribute to the classification of the substance.
FOR MIXTURES
In addition to the information required for substances:

(a) The chemical name and concentration (exact percentage) or concentration ranges of all ingredients which are classified as health hazards in accordance with paragraph (d) of §1910.1200 and
   (1) are present above their cut-off/concentration limits; or
   (2) present a health risk below the cut-off/concentration limits.
(b) The concentration (exact percentage) shall be specified unless a trade secret claim is made in accordance with paragraph (i) of §1910.1200, when there is batch-to-batch variability in the production of a mixture, or for a group of substantially similar mixtures (See A.0.5.1.2) with similar chemical composition. In these cases, concentration ranges may be used.

FOR ALL CHEMICALS WHERE A TRADE SECRET IS CLAIMED
Where a trade secret is claimed in accordance with paragraph (i) of §1910.1200, a statement that the specific chemical identity and/or exact percentage (concentration) of composition has been withheld as a trade secret is required.

4. First-aid measures
   (a) Description of necessary measures, subdivided according to the different routes of exposure, i.e., inhalation, skin and eye contact, and ingestion;
   (b) Most important symptoms/effects, acute and delayed.
   (c) Indication of immediate medical attention and special treatment needed, if necessary.

5. Fire-fighting measures
   (a) Suitable (and unsuitable) extinguishing media.
   (b) Specific hazards arising from the chemical (e.g., nature of any hazardous combustion products).
   (c) Special protective equipment and precautions for fire-fighters.

6. Accidental release measures
   (a) Personal precautions, protective equipment, and emergency procedures.
   (b) Methods and materials for containment and cleaning up.

7. Handling and storage
   (a) Precautions for safe handling.
   (b) Conditions for safe storage, including any incompatibilities.

8. Exposure controls/personal protection
   (a) OSHA permissible exposure limit (PEL), American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Value (TLV), and any other exposure limit used or recommended by the chemical manufacturer, importer, or employer preparing the safety data sheet, where available.
   (b) Appropriate engineering controls.
(c) Individual protection measures, such as personal protective equipment.

9. Physical and chemical properties
   (a) Appearance (physical state, color, etc.);
   (b) Odor;
   (c) Odor threshold;
   (d) pH;
   (e) Melting point/freezing point;
   (f) Initial boiling point and boiling range;
   (g) Flash point;
   (h) Evaporation rate;
   (i) Flammability (solid, gas);
   (j) Upper/lower flammability or explosive limits;
   (k) Vapor pressure;
   (l) Vapor density;
   (m) Relative density;
   (n) Solubility(ies);
   (o) Partition coefficient: n-octanol/water;
   (p) Auto-ignition temperature;
   (q) Decomposition temperature;
   (r) Viscosity.

10. Stability and reactivity
    (a) Reactivity;
    (b) Chemical stability;
    (c) Possibility of hazardous reactions;
    (d) Conditions to avoid (e.g., static discharge, shock, or vibration);
    (e) Incompatible materials;
    (f) Hazardous decomposition products.

11. Toxicological information
    Description of the various toxicological (health) effects and the available data used to identify those effects, including:
    (a) Information on the likely routes of exposure (inhalation, ingestion, skin and eye contact);
    (b) Symptoms related to the physical, chemical and toxicological characteristics;
    (c) Delayed and immediate effects and also chronic effects from short- and long-term exposure;
    (d) Numerical measures of toxicity (such as acute toxicity estimates).
    (e) Whether the hazardous chemical is listed in the National Toxicology Program (NTP) Report on Carcinogens (latest edition) or has been found to be a potential carcinogen in the International Agency for Research on Cancer (IARC) Monographs (latest edition), or by OSHA.

12. Ecological information (Non-mandatory)
(a) Ecotoxicity (aquatic and terrestrial, where available);
(b) Persistence and degradability;
(c) Bioaccumulative potential;
(d) Mobility in soil;
(e) Other adverse effects (such as hazardous to the ozone layer).

13. Disposal considerations (Non-mandatory)
Description of waste residues and information on their safe handling and methods of disposal, including the disposal of any contaminated packaging.

14. Transport information (Non-mandatory)
(a) UN number;
(b) UN proper shipping name;
(c) Transport hazard class(es);
(d) Packing group, if applicable;
(e) Environmental hazards (e.g., Marine pollutant (Yes/No));
(f) Transport in bulk (according to Annex II of MARPOL 73/78 and the IBC Code);
(g) Special precautions which a user needs to be aware of, or needs to comply with, in connection with transport or conveyance either within or outside their premises.

15. Regulatory information (Non-mandatory)
Safety, health and environmental regulations specific for the product in question.

16. Other information, including date of preparation or last revision
The date of preparation of the SDS or the last change to it.
II. Hazardous Material Labeling Elements

The following information must be included on hazardous materials labels:

**Product Identifier:** a chemical name, code number, or batch number which identifies the hazardous chemical. The manufacturer, importer or distributor can decide the appropriate product identifier. The same product identifier must be both on the label and in Section 1 of the SDS (Identification).

**Signal word:** a single word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. The signal words used are "danger" and "warning." "Danger" is used for the more severe hazards, while "warning" is used for less severe hazards.

**Pictogram:** a symbol plus other graphic elements, such as a border, background pattern, or color that is intended to convey specific information about the hazards of a chemical. Each pictogram consists of a different symbol on a white background within a red square frame set on a point (i.e. a red diamond). There are nine pictograms under the GHS. However, only eight pictograms are required under the HCS.

**Hazard Statement:** a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.

**Precautionary Statement:** a phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling of a hazardous chemical. When there are similar precautionary statements for chemicals with multiple hazards, the most protective information will be included on the label.

**Name, address and phone number of the chemical manufacturer, distributor, or importer.**

Information on the labels can be used to ensure proper storage of hazardous chemicals and may also be used to quickly locate information on first aid when needed by employees or emergency personnel. Where a chemical has multiple hazards, different pictograms are used to identify the various hazards.

Information on the labels is related to the information on the SDS; for example, the precautionary statements on the label would be the same as on the SDS.
**Pictograms and Hazard Classes**

OSHA’s required pictograms on hazardous material containers are being standardized and are presented below. The pictograms must be in the shape of a square set at a point and include a black hazard symbol on a white background with a red frame sufficiently wide enough to be clearly visible. OSHA has designated eight pictograms under this standard for application to a hazard category.

| Oxidizers | Flammables  
Self Reactives  
Pyrophorics  
Self-Heating  
Emits Flammable Gas  
Organic Peroxides | Explosives  
Self Reactives  
Organic Peroxides |
<table>
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<tr>
<td>Acute toxicity (severe)</td>
<td>Corrosives</td>
<td>Gases Under Pressure</td>
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| Carcinogen  
Respiratory Sensitizer  
Reproductive Toxicity  
Target Organ Toxicity  
Mutagenicity  
Aspiration Toxicity | Environmental Toxicity | Irritant  
Dermal Sensitizer  
Acute toxicity (harmful)  
Narcotic Effects  
Respiratory Tract Irritation |
SPILL RESPONSE
If you work with hazardous materials, make sure you know chemical emergency information such as the location of the emergency eyewash and spill kit. For a spill, immediately assess whether the spill is a non-hazardous material, an identifiable hazardous material or an unknown. For unknown materials or for hazardous materials exceeding your capability to respond, call 911 and isolate the area. Stay in a safe location near the spill to provide information to responders. Avoid the possibility of spreading contamination beyond the affected area. Report details of the incident to EH&S via a phone call to 734-2740, by using the on-line incident reporting system or by completing a Hazardous Material Incident Checklist (available as an attachment to UCDHS P&P 1725). All staff should know how to respond to a Code White, indicating a hazardous material emergency, usually involving a chemical spill. Follow the directions of response personnel and stay out of affected areas. Be prepared to take an alternate route if your normal path is closed during a response. For additional information see Response to Hazardous Substance Spills – P&P 1725 and Management of Hazardous Drug Waste and Spills – P&P 1623.

EXPOSURE CONTROL AND ENGINEERING CONTROLS
To reduce your exposure to hazardous material the following rules can be applied: reduce the hazard class of the material whenever possible by substituting a less hazardous material, reduce your time of exposure, increase your distance from the hazard, and wear protective equipment as required. The proper operation and use of engineering controls, such as biological safety cabinets and fume hoods, is vital to assure your safety and protection against work place hazards.

CANCER CAUSING MATERIALS
Cancer causing materials, such as some chemotherapeutic drugs, asbestos or ionizing radiation, may be used or be present in your work area. Know these materials and treat them with respect. Refer to the section titled “What You Should Know About Asbestos” for additional information regarding asbestos in Health System buildings. Information regarding the safe handling of chemotherapeutic drugs is available in Patient Care Standard X-01. Information about the safe use of ionizing radiation is available in the UC Davis Radiation Safety Manual available on the EH&S website http://intranet.ucdmc.ucdavis.edu/safety/hp/index.shtml).

CODE WHITE: CHEMICAL SPILL RESPONSE
Code White indicates a hazardous material emergency, usually involving a chemical spill. Follow the directions of response personnel and stay out of affected areas. Be prepared to take an alternate route if your normal path is closed during a response.

PHARMACEUTICAL WASTE MANAGEMENT
Pharmacy and patient care areas are responsible for the appropriate handling of waste pharmaceuticals. With few exceptions, disposing of waste pharmaceuticals in the sink, toilet or trash is prohibited. Pharmaceutical waste containers in patient care areas have a white body and blue top. Pharmacy also has specially-designated containers. Additional information is available in Policy and Procedure 1630, Pharmaceutical Waste Management, as well as on the EH&S website.
CRYOGENIC LIQUID MANAGEMENT
Cryogenic liquids, usually liquid nitrogen, are used in many areas of the Health System, particularly in laboratories. Inappropriate handling of cryogenic liquids can lead to skin burns and frostbite (due to extremely low temperatures), container ruptures, and asphyxiation from oxygen displacement if large quantities of the liquid are released into a room. Safe work practice information is available at Policy and Procedure 1624, Safe Management of Cryogenic Liquid. A training presentation is available in the Hazardous Materials section of the EH&S website.

HAZARDOUS WASTE MANAGEMENT AND RECYCLING
EH&S provides hazardous waste pick-up and disposal services:

- **Chemical waste pick up** (this includes black and white pharmaceutical containers) - to request additional empty containers, or with questions, call EH&S - 4-2740.
- **Label your chemical waste** - download the Hazardous Waste Container Label from the EH&S website (type safety in your web browser address bar locate the EH&S website) to print your own labels. You are encouraged to use Word to prepare labels for recurring wastestreams, but do not modify the categories or other text, as the labels are designed to meet regulatory requirements. Be sure to fill in the date, location, chemical contents, and concentration on the label and secure it to the waste container before you begin filling it with waste. It is against the law to have waste in an unlabeled container!
- **Radioactive waste pick up** - call EH&S 4-3355.
- **Medical waste pick up** (this includes blue and white pharmaceutical containers and yellow trace chemotherapy containers) call Environmental Services - 4-3777 and make the request

UC Davis Health System Battery Recycling Program
EH&S also provides information and services related to battery recycling. Recycling and pick up request instructions are available on the EH&S website.

Batteries are hazardous waste, and cannot be thrown into trash, red bags, or sharps containers. Our recycling program lets us handle batteries under criteria less stringent than that for hazardous wastes, as long as we follow the rules. EH&S can accept all types of batteries except wet/lead/acid (automotive batteries), which can generally be handled by Fleet Services. Clinical Engineering manages sealed lead-acid batteries.

To recycle batteries:
- Establish a collection station. Containers are available through Eclipsys: Calcode 50024339 in Stores Inventory 136. EH&S does not provide containers.
- The container must be labeled using labels and instructions available on the EH&S website.
• Dissimilar battery chemistries should be prevented from contacting each other using individual plastic bags or by placing electrical tape over the terminals.
• Fill out a battery waste pick up request form online: visit the Environmental Health and Safety website (type safety in your web browser address bar) and click on Battery Pick Up Request under Quick Links.
• From the Medical Center campus, request a pickup within six months of the accumulation start date. EH&S will take the entire container and will not leave a replacement.
WHAT YOU SHOULD KNOW ABOUT ASBESTOS

PURPOSE OF THIS INFORMATION
To provide building occupants with basic information about asbestos containing materials commonly found in buildings.

WHAT IS ASBESTOS?
The term asbestos refers to a family of naturally occurring minerals. These minerals have unique properties of chemical and fire resistance.

“Asbestos containing construction materials” are those manufactured construction materials that contain more than one-tenth of 1 percent asbestos by weight. (Section 25195, Chapter 104, Division 20 of the State of California Health & Safety Code.)

Materials that contain asbestos may be friable, meaning they can be easily crumbled with hand pressure.

HEALTH RISKS
The most common exposure to asbestos material is from breathing airborne fibers. When asbestos fibers are introduced into the respiratory system they can contribute to the development of:
- Asbestosis – a serious lung disease.
- Lung Cancer – the most common cancer associated with asbestos exposure.
- Mesothelioma – a rare cancer of the lining of the lung or abdominal cavities.

MINIMIZE EXPOSURE TO ASBESTOS FIBERS BY FOLLOWING PROPER WORK PRACTICES

RECOGNIZING ASBESTOS MATERIALS
Common types of materials that could contain asbestos:
1. Sprayed on or towed on fireproofing and soundproofing installed prior to 1980.
2. Boilers and pipes installed prior to 1980 are often insulated with asbestos materials.
3. Floor tile in buildings constructed prior to 1985
4. Roofing felts and sheeting.
5. Floor and roof mastics and sealants
6. Gaskets

ACTIONS TO TAKE
- By taking the right action you can reduce the risk of exposure to asbestos.
- Know where the asbestos is in your building and avoid disturbing it.
- If you find materials that could contain asbestos report them to your supervisor.
- Ask your supervisor for training in proper ways to work around asbestos materials.
- If you see asbestos materials that have been disturbed report the damage to your supervisor.
• If the maintenance of asbestos in your building is not being done properly see that it is brought to your supervisor’s attention.

AVOID DISTURBING ASBESTOS MATERIALS

Avoid touching or disturbing suspect materials on walls, ceilings, pipes or boilers. Asbestos fibers can be released when the material is disturbed.

• DO NOT drill holes in asbestos materials.
• DO NOT hang plants or anything else from ceiling covered with asbestos materials.
• DO NOT pin or hang pictures on walls covered with asbestos materials.
• DO NOT sand asbestos floor tiles or backing material.
• DO NOT damage asbestos material while moving furniture, etc.
• DO NOT disturb asbestos material when replacing light bulbs, etc.
• DO NOT allow curtains, drapes, or dividers to damage asbestos materials.

For asbestos information and assistance at UC Davis Health System, call EH&S at (916) 734-2740.
QUESTIONS ABOUT RADIATION

The Health Physics Office answers questions about radiation safety at (916) 734-3355. After hours, the Health System Safety Officer can be reached by paging (916) 816-1994. Information is available on the intranet at:

Health Physics is responsible for overseeing the safe and effective use of ionizing radiation within the Health System. X-Ray machines and radioactive material are used at the University of California, Davis Health System and the Primary Care Network for diagnostic and therapeutic purposes, as well as in research and development. Law under Title 17 of the California Administrative Code regulates the use of radiation. The University of California, Davis is issued a broad scope license that details the use conditions for all radioactive material at the University. The campus-wide Radiation Safety Committee and the Radiation Use Committee at UC Davis Health System enforce these regulations. The yellow UC Davis Radiation Safety Manual details the requirements for use of radiation producing machines and radioactive materials at UC Davis. The manual can also be accessed at the website above.

Radiation producing machines or radioactive materials at UC Davis Health System are used under Radiation or Machine Use Authorizations (RUA or MUA) that are issued by the Health Physics Office to Department Managers and Principal Investigators. RUAs specify the conditions under which radioactive material may be used. MUAs specify conditions under which radiation-producing machines may be used. All radioactive materials and radiation producing machines must be labeled with the radiation symbol. Periodic inspections are made to assure that this technology is being used in a safe and effective manner. Only personnel properly trained by the Health Physics Office should handle materials or devices labeled with the radiation symbol. These persons are considered Radiation Workers.

Human subject research protocols and consent forms, which involve radiation from machines, or radioactive materials, must be approved by the Radiation Use Committee. Applications are available at the website above.

Only Health Physics staff are authorized to pick up and dispose of radioactive materials. If you see a box with the yellow and purple international radiation symbol (the trefoil) on it and the box is in a location that you do not think it should be, call Health Physics.

Radiation producing machines and radioactive materials are used throughout the hospital and research areas. Signs, such as the trefoil or the words “Caution X-Ray” or “Caution Radioactive
Materials”, located at the entrance to the work area will identify the presence of hazardous materials in the workplace. The trefoil alerts you so that you can minimize your potential exposure to radiation by following the established protocols. This includes limiting your time of exposure, increasing the distance between you and the radiation source, using radiation shielding, and wearing personal protective equipment as necessary. Basic rules to follow include:
1. Follow all room postings or instructions carefully.
2. Ask the laboratory personnel to identify areas that should be avoided.
3. Do not handle anything labeled with the radiation symbol (unless it is part of your job).
4. Call the Health Physics Office if you have any questions or concerns.
5. Leave the room locked when unoccupied.

Lead aprons must be worn in rooms when fluoroscopy is performed. Lead aprons are required to be inspected periodically to assure that they are in good condition. Refer to UC Davis Health System P&P 1728 for specific information about the care and handling of lead aprons. Staff are required to be trained and authorized to use radioactive material or radiation producing machines. The specific requirements that must be followed when operating fluoroscopy equipment are outlined in UC Davis Health System P&P 2717. Other than certain residents and fellows, all physicians who operate fluoroscopy equipment must possess a state-issued fluoroscopy supervisor and operator permit.

If you are assigned a radiation dosimeter, you should wear it at all times and leave it at the workplace at the end of your shift so that it will not get lost or damaged. You should not wear your dosimeter anywhere except while working at a UC Davis facility. If you are badged by another facility, it is your responsibility to provide dosimeter reports to the EH&S office. If you would like to have a dosimeter issued to you, contact the Health Physics Office.

Notice to Employee signs are posted in all areas where radiation or radioactive materials are used. It explains the employees’ responsibilities to know and understand California radiation protection standards and the employer’s operating and emergency procedures.

Remember, if you work in an area where radiation is used, follow safety protocols and regulations. Contact EH&S staff if you need assistance, if you are unsure of a protocol or if there is an incident or accident.

The Health Physics Office is also available to answer technical questions concerning radiation applications in medicine and research, as well as to provide information about the biological effects of radiation exposure to employees and patients. Radiation safety in-services are available and can be requested by calling the Health Physics Office at 734-3355.
FIRE PREVENTION

UC DAVIS HEALTH SYSTEM FIRE PREVENTION DEPARTMENT
The University of California, Davis Health System Fire Prevention Department is a component of UC Davis Health System Facilities Administration. The UC Davis Health System Fire Prevention Department is responsible for providing fire and life safety services to the campus facilities as well as off-site clinics and office buildings associated with the health system.

Services include: Incident response, fire and life safety plan review, construction inspections, assisting in maintaining hospital accreditation, development of Fire and Evacuation/Relocation plans, fire and life safety inspections of existing facilities, fire drills, fire protection systems inspections and auditing, fire extinguisher inspections, new and refresher fire and life safety training, chair the Life Safety Subcommittee, fire investigation/emergency incident follow up, and liaison with the Sacramento Fire Department and other regulatory agencies.

Fire Prevention Department staff serves as Designated Campus Fire Marshals (DCFM) on behalf of the Office of the State Fire Marshal (OSFM) and the Office of Statewide Health Planning and Development (OSHPD). The Sacramento Fire Department is responsible for fire suppression, hazardous material response and emergency medical response.

INTERIM LIFE SAFETY MEASURES (ILSM)
The UC Davis Health System Fire Prevention Department ensures ILSMs are developed for occupied buildings undergoing renovation or construction. Interim Life Safety Measures also ensure that an acceptable level of fire and life safety is maintained at all times. This is further accomplished by reviewing plans and other construction documents to ensure that all fire and life safety features required by code are included in all building plans. See P&P 1635

NOTIFICATION AND RESPONSE
If you work in or visit the hospital, the overhead paging system is used to supplement emergency alarms. Code announcements are used to define emergencies: Code Blue for Medical Emergency, Code Rainbow for child abduction, Code Red for fire, Code White for a hazardous material incident, and Code Green for internal or external disasters. A quick reference checklist is provided on department bulletin boards and should be used to confirm emergency action response. Health System staff have the responsibility to respond appropriately to fire and other emergencies and are alerted to an emergency by both visual and audible building alarms. Evacuation of a building or portion thereof can only be authorized by designated individuals in the following order: Designated Campus Fire Marshal, Public Safety Officer (Fire/Police), Chief Executive Officer, UC Davis Health System, or his/her designee; Administrator on Duty; on-site management (charge nurse, manager, nursing supervisor, practice manager, associate medical director).

TEAMWORK
Teamwork is essential (know your department’s fire and evacuation plan thoroughly). The fire and evacuation plan is a component of the disaster plan. If the fire is not in your area, observe
all points listed above and also: 1) remain calm especially with patients; 2) close patient doors, windows, and fire doors; and 3) ask visitors/patients to remain in their rooms.

CODE RED
Code Red indicates a fire situation. When a Code Red is announced, ALL hospital staff members are expected to respond regardless of the location of the Code Red. Staff in affected areas must initiate their appropriate emergency response procedures. Staff in the unaffected areas should discuss internal procedures, review fire plans and prepare to receive relocated patients, staff or visitors who may have to leave an endangered area. The Fire Prevention Department provides non-emergency incident response to a code red (24 hours-a-day, 365 days-a-year) to assist Sac Fire with building and room entry. The Fire Prevention Department can also provide information about a particular area due to their familiarity with the fire alarm system and practice of inspecting buildings. They help locate the alarm area for Sac Fire by checking and operating the fire alarm control panel. While trained in fire-fighting techniques, Fire Prevention Department personnel do not fight fires above incipient stages unless the Fire Department asks for their assistance. Response times may vary depending on time and day of the week. See Policy and Procedure 1606, Code Red Response.

SMOKE BARRIERS
Smoke barrier walls separate each floor of the hospital into two or more smoke compartments. Smoke barriers are intended to create adjacent smoke compartments to which building occupants can be safely and promptly relocated during a fire, thus preventing the need to have complete and immediate building evacuation. Smoke compartments create spaces that protect occupants from the products of combustion produced by a fire in an adjacent smoke compartment and to restrict smoke movement from the compartment of fire origin. Doors in smoke barrier walls are identified with a small black and white sign located on the door that reads SMOKE BARRIER. Additionally, each departmental fire plan includes a floor plan showing each smoke barrier on the floor for which the fire plan is written. Each department should know the location of smoke barriers and plan relocating patients to them in the event of an emergency.
FIRE DRILLS
The University of California, Davis Health System conducts regular fire drills and two disaster drills annually. Staff participation in these drills is essential for an effective response during an actual emergency. It is important to know your role prior to an actual disaster. All staff are required to participate in drills. You should respond to a “Code Red Drill” announcement the same as an actual “Code Red” or fire. During each fire drill in the hospital, four to six areas are evaluated at one time. Evaluators are members of the Life Safety Sub-Committee and Safety Committee or volunteer Health System staff. See Policy and Procedure 1652, Fire Drills

FIRE EMERGENCY – R.A.C.E.
R.A.C.E. is the acronym used to assist staff in remembering what to do in the event of a fire emergency. The individual letters of the acronym stand for the following:

R is for Rescue -- Remove all persons from the danger area, including yourself.
A is for Alarm -- Call 911 and activate the nearest fire alarm pull station. 911 calls initiated on Health System phones go to the UC Davis Dispatch Center. UC Davis dispatchers are familiar with the Health System and will promptly notify the appropriate agencies. 911 calls initiated on cell phones go to the California Highway Patrol 911 dispatcher.
C is for Confine -- Confine the fire to the smallest area possible. Closing doors to the fire room/area is a very important and required task to prevent the fire from spreading.
E is for Extinguish -- Extinguish the fire only if the fire is the size of an office waste container or smaller and you are competent in the use of a fire extinguisher.

CLASSES OF FIRE:
There are 3 basic classes of fire: A, B, and C.

Class A fires involve ordinary combustibles (such as trash, paper, and wood).
Class B fires involve flammables or combustible liquids, gas or grease.
Class C fires involve energized electrical equipment.
USE OF FIRE EXTINGUISHERS:
Remember to read the label on the extinguisher. Do not use a water extinguisher on a Class C (electrical) fire. UC Davis Health System has different types of fire extinguishers. The dry chemical or “multi-purpose” fire extinguisher is the most common. The multi-purpose extinguisher can be used on all classes of fires (A, B, or C).

If the fire is small (no larger than an office size trash can) attempt to extinguish the fire. However, DO NOT PUT YOURSELF IN DANGER and always ensure you have an escape route. Once a fire starts, it could double in size every 30 seconds.

An acronym utilized to assist you in remembering how to operate a fire extinguisher is P.A.S.S. The individual letters of the acronym stand for the following:

- **P** is for Pull - Pull the pin located in the handle.
- **A** is for Aim - Aim the extinguisher at the base of the fire not at the smoke.
- **S** is for Squeeze - Squeeze the handle.
- **S** is for Sweep - Sweep the base of the fire. Start with the edge of the fire nearest to you, sweep from side to side until the fire is out or the extinguisher is empty.

Discharge the extinguisher six to eight feet at the base of the fire. If the fire continues to burn, do not search for another extinguisher. Confine the fire by closing doors and leave the area immediately.

MEDICAL GAS SHUTOFF VALVES:
Know the types of medical gases and the locations of all medical gas shutoff valves in your area. The valve should be clearly labeled as to the areas/rooms they serve. If the valves are not labeled or incorrectly labeled, contact Fire Prevention, 734-3036. Review UCDHS P&P 1680, Emergency Shut-Off of Medical Oxygen in the Event of a Fire for more information.

BUILDING EVACUATION
In the event of an alarm, some buildings and floors require evacuation instead of relocation. If this is the case for your building or floor; proceed to lowest level of the building via the exit stairs. Do not attempt to use the elevators. Use handrails while descending. All emergency exits are clearly marked to properly guide you to the exterior of the building. From there, please proceed to your designated assembly area. Disabled individuals may be staged at the stair landing and need assistance with evacuation/descent. Assist, if able, or report the location of the individual to emergency personnel.
EMERGENCY MANAGEMENT

The UC Davis Health System Emergency Management Plan (Policy & Procedure 1611) describes the objectives of the emergency management program and the roles and responsibilities in support of the program. The goal is to be prepared for anticipated - and unanticipated - emergencies that could impair our ability to maintain patient care, education and research.

Oversight of the Emergency Management program is provided by the Emergency Preparedness Committee. The committee conducts an annual update of the hazard vulnerability analysis to identify potential emergencies that could affect the Health System. The top external hazards include catastrophic flooding, a mass casualty event and pandemic.

One major element of the emergency management program is an Emergency Operations Plan (EOP), which outlines the basic command structure and response procedures used to mitigate, prepare for, respond to and recover from emergency situations. The plan describes how the Health System will implement use of the Hospital Incident Command System – or HICS – to respond to a disaster. The Emergency Operations Plan is required by The Joint Commission and is available on the intranet on the Policies and Procedures page.

If you work in or visit the hospital, the overhead paging system is used to supplement emergency alarms. Code announcements are used to notify of emergencies: Code Blue for medical emergency, Code Rainbow for child abduction, Code Red for fire, Code White for a hazardous material incident and Code Green for an internal or external disaster.

RESPONSE TO ACTIVE SHOOTER
An Active Shooter is a person or persons who appear to be actively engaged in killing or attempting to kill people. In most cases, active shooters use a firearm(s) and display no pattern or method for selection of their victims.

If there is an Active Shooter in your area, the phrase to remember is RUN, HIDE, FIGHT. Plan ahead now and look around your work area to identify an escape route if you can RUN and also identify one or more places where you can lock or block the entry if you need to HIDE. As a last resort and only when your life is in danger, FIGHT in an attempt to incapacitate the active shooter.

If you work with patients and are not in the area affected by the Active Shooter, identify how to lock or barricade all perimeter doors into your area to HIDE; guide others to safety with you. Hide out of view, set all noise-making communication devices to silent with no vibration, and turn off the lights.

The presence of an Active Shooter will be announced in plain English. The notification will state “Active Shooter. Shooting in Progress. << announce location>>. Lockdown. This is not a drill.”. Depending on your location, the notification will go out via the overhead paging system in the hospital, via text pager in the clinics, or via WarnMe in the other buildings.
If you encounter the shooter, call 911 when it is safe to do so. If you cannot speak, dial the number and set the phone down. If you are not in immediate danger, answer the questions to provide the following information: location, number of shooters, physical description, number and type of weapons, and number of victims and hostages, if applicable.

When the UC Davis Police or other law enforcement officers arrive, follow the officers’ instructions. Keep your hands visible at all times. Avoid making quick movements toward officers such as attempting to hold on to them for safety. Avoid pointing, screaming and/or yelling.

The UC Davis Health System “Active Shooter Response” (P&P 1632) describes the expected response in more detail. In addition, a 5-minute video, called “Run. Hide. Fight. Surviving an Active Shooter Event”, was developed by the Department of Homeland Security. It is available on You Tube. The training video is intense and depicts a simulated active shooter event. [http://www.youtube.com/watch?v=5VcSwejU2D0](http://www.youtube.com/watch?v=5VcSwejU2D0)

A new video, called “Surviving an Active Shooter in a Healthcare Environment” addresses active shooter response in a patient care environment. Employees in inpatient and outpatient areas should view this 10-minutes video: [https://vimeo.com/112455575](https://vimeo.com/112455575)

**CODE GREEN**
Code Green, Internal, is for those incidents taking place within the hospital.

Code Green, External is for those incidents taking place in the community or widespread disasters, or in Sacramento campus facilities that do not provide inpatient care. This disaster may dramatically increase the number of patients arriving at the hospital and may affect the ability of the hospital to function or provide patient care. Examples could be a major event with multiple casualties, a flood that disrupts traffic to the extent that medical supplies could not reach the hospital, or a terrorist event resulting in injury or contamination of a large number of victims.

The UCDHS Emergency Operations Plan is implemented in response to a Code Green. Disaster exercises to test the effectiveness of the disaster plan are held twice annually.

**STAFF ROLES AND RESPONSIBILITIES:**
Your department manager and supervisor have the ultimate responsibility to implement the emergency management plan at the departmental level. Refer to your unit’s red Disaster Manual for specific information on your role and responsibilities in a disaster. The red binder contains the Health System’s Emergency Management Plan, an overview of the Emergency Operations Plan, Facility Evacuation policy, the Fire and Evacuation or Relocation Plan for your building or area, and your department specific emergency plan. It is essential that you become familiar with your department's emergency plans and procedures. A Quick reference flip chart is provided in department areas and should be used to confirm emergency action responses.
PERSONAL PREPAREDNESS
One of the best things you can do now is to be personally prepared at home for an emergency; such as having a home disaster supply kit. The Health System collaborated with several emergency response agencies and departments in Sacramento County to prepare a booklet called “Are You Prepared?” The booklet includes personal preparedness ideas on how to create a home evacuation plan, and special plans for taking care of children, seniors or persons with disabilities, and pets in your family. Ask your supervisor for a free copy of this booklet; it is available through Stores.

EVACUATION PROCEDURES
The decisions to relocate within the hospital or evacuate from a non-hospital building can be authorized by on-site management (charge nurse, manager, nursing supervisor, practice manager, associate medical director, building coordinator, or building manager) or emergency responders. Code Green, Internal must be initiated for any incident that triggers the relocation or evacuation of inpatients. The decision to evacuate an entire wing or the whole hospital can only be authorized by the Hospital Incident Commander.

Hospital buildings are designed to defend the patient and staff in place, to permit time to extinguish a fire; or control other hazards, and to move patients to safety, if needed. The preferred order of occupant-protection strategies in case of fire or a hazardous condition in the hospital buildings is to: (1) Defend in place or shelter in place in a safe location; (2) Horizontal Relocation; (3) Vertical Relocation; (4) Relocation to the Staging Area on first floor to prepare for evacuation to another facility upon direction from Incident Commander; and (5) Evacuation from building.

Be familiar with exit routes and with collection points as indicated in evacuation plans and departmental emergency response plans located in the red disaster binder. If directed, remove patients from immediate danger and, if necessary, request assistance when moving patients. Remember to stay calm and reassure patients when moving them.

Evacuation will be directed so that all patients are evacuated from the area and the disposition of patients is known.

New Fire and Evacuation/Relocation Plan templates are available on the UCDHS Fire Prevention website http://www.ucdmc.ucdavis.edu/fire/plans/index.html. The templates are to be filled in by the department / unit / building in coordination with UCDHS Fire Prevention. The final plan should be placed in the red Disaster Manual.
SECURITY MANAGEMENT

Your personal safety and security is important. The heart of the Health System’s Security Program is outlined in the Security Management Plan, which describes how the Health System and UC Davis Police Department manage the physical and personal security of patients, staff and visitors at Health System facilities. The plan is reviewed and updated annually.

The Security web site is an excellent resource for up to date security information (http://intranet.ucdmc.ucdavis.edu/safety/security/security_welcome.shtml). You can find the Security web site by typing safety in the address bar from the intranet and then click on “Security” on the left-hand side of the Environmental Health & Safety home page. On the Security home page, you will find links to an overview of the security program, the UC Davis Police Department web site and the Health System’s Workplace Violence and Hate Incidents site.

All telephone lines at the Health System campus are connected to the UC Davis dispatch center. You can dial 9-1-1 from any landline on the Sacramento campus and be connected directly to the dispatch center. From a cell phone, call (916) 734-2555. We recommend that you program this number into your cell phone. If you dial 9-1-1 from a cell phone, the call is received by the California Highway Patrol and may result in a longer response time for assistance.

IDENTIFICATION BADGES AND CARDKEYS

You must wear your photo identification badge at all times. Failure to do so may result in corrective or disciplinary action being taken in accordance with appropriate personnel policies or union contracts. Photo identification badges must be worn so that the photograph, name, working title and department are clearly visible.

Visitors to the Emergency Department are required to wear visitor badges at all times. Visitors to the rest of the hospital must obtain and wear a visitor badge after 9 pm. Access into the hospital is controlled after 9 pm; therefore, employees entering the hospital must show their badge to the Protective Service Officer, or PSO, at the visitor desk.

Your photo identification badge is attached to a cardkey. The majority of buildings require use of a cardkey to enter the building during non-business hours. Security sensitive areas have enhanced access control in place at all times and require use of your cardkey. These areas include cash handling areas, Emergency Department, infant and pediatric nursing units, research labs, and Pharmacy.

PERSONAL SAFETY

You can take several actions to enhance your personal safety. Put your personal belongings, such as your purse, wallet or laptop out of sight, preferably in a locked cabinet or drawer in your office or in the trunk of your car. Be aware of your surroundings when walking to and from your car and use the shuttle service if you arrive or leave after dark.
Parking and Transportation Services provide a shuttle service to and from outlying parking lots from 5:30 a.m. to midnight on a regular schedule. Protective Service Officers provide a safety escort service from midnight to 5:30 a.m. and 24 hours on weekends and holidays, upon request. To obtain an after-hours safety escort, call the dispatch center at (916) 734-2555. The goal of these services is to provide you with an alternative to walking alone on campus after dark. In addition, UC Davis Police Department conducts vehicle, foot bicycle and motorcycle patrols of the entire campus, including parking structures and parking lots.

**Safety Corridor:** The “Safety Corridor” is the preferred route to walk to the outlying parking lots as the “Safety Corridor” has additional lighting and emergency phones along the route. The “Safety Corridor” is highlighted in yellow in the map below. Employees are encouraged to avoid walking along Stockton Boulevard or V Street after dark.

What do I do in an emergency?
- Get yourself and others to safety as quickly as possible.
- Call 911 via landline or (916) 734-2555 via cell phone and the dispatcher will direct the police to you.
- If you cannot stay on the line, if possible, keep a line open to police until they arrive.
- The more information the police receive, the more likely they can bring a potentially violent situation to a safe conclusion.

**TRAINING**
All new staff, students, and researchers receive security familiarization during orientation sessions and as part of the annual refresher training. In addition, staff may receive in-service departmental-specific security training, such as for those who handle cash or have direct patient contact. UCDPD provides department-specific or hazard-specific security training, upon request.
CYBER SECURITY AWARENESS

Cyber security focuses on protecting computers, networks, programs and data from unintended or unauthorized access, change or destruction. Each member of the university has a responsibility to safeguard the information assets entrusted to him or her. Studies have shown that a substantial number of cyber-attacks involve the unintended actions of users of information systems, and this risk can be significantly lowered by following safe computing practices.

How can you protect yourself?
Cybercrime—whether from malware on a single computer or the recent high-profile hacks against Anthem, Sony, Target, Home Depot and others—impacts everyone. Below are some key practices you can use to help minimize your risk of being a victim:

- **Use strong passwords:** Never use simple or easy-to-guess passwords like “123456” or “password” or “football.” Cybercriminals use automated programs that will try every word in the dictionary in a few minutes. When creating a password, refer to the UCDHS Password/Passphrase Standard for assistance in the creation and maintenance of strong passwords/passphrases.

- **Be cautious about links and attachments:** Be cautious about all communications you receive including those purported to be from friends and family, and be careful when clicking on links in those messages. When in doubt, delete it.

- **Protect your personal information:** Be aware of financial and sensitive information you give out. Cybercriminals will look at your social networking webpage to find information about you--remember, many of the answers to website and bank security questions can be found online, like the color of your car (posting that picture of you standing in front of your car?) and your mother’s maiden name. Use privacy settings to limit who can see the details of your social network pages, and be smart about what you decide to share online.

- **E-mail threats:** Scammers rely on their deception to entice users to willingly do what the scammer wants. Their deception is based upon resembling legitimate sites or trusted sources. These email scams can be very realistic and difficult to identify. However, there are some telltale signs that may indicate an email scam. By being observant of these, you can help minimize your risk of becoming a victim. Be wary of the following types of emails that:
  - Set ultimatums such as “your account will be closed,” or “the deal will expire” to create a sense of urgency, and trick the victim into providing personal information.
  - Threatens a consequence for not responding to the email
  - Has incorrect spelling;
  - Use incorrect grammar or odd phrasing;
  - Include a downloadable document, usually in PDF format; these downloads may be populated with malware that can infect your computer.
• Appear to be from friends or family members, but the message is written in a style not usually used by that person, has numerous misspellings, or otherwise seems unusual. This is an indication your friend or family member’s account may have been hacked.
• Appear to be from official government agencies, such as Social Security Administration, or banks, requesting personal information.
• The URL does not match that of the legitimate site. Scammers cannot use the same URL associated with the legitimate websites, so they will tweak the address of their spoofed website so that at a quick glance it looks legitimate.
• The URL may use a different domain (ex: .com versus .net)
• The URL may use variations of the actual address, just spelled differently

If you receive an email that looks like it might be “phishing” for your information, please forward that e-mail to abuse@ucdavis.edu for verification before clicking!
If you have submitted your account credentials (username and password) on a phishing site, immediately contact the IT Operations Center at (916) 734-4357 to reset your passwords.

Web/Internet threats
To protect against these online threats, there are several basic precautions all Internet users should take, regardless of age or experience online.

• **Do not use public computers and public wireless access for sensitive transactions.** Wi-Fi spots in airports, hotels, train stations, coffee shops, and other public places can be convenient, but they're often not secure, and can leave you at risk. If you're online through an unsecured network, you should be aware that individuals with malicious intent may have established a Wi-Fi network with the intent to eavesdrop on your connection. This could allow them to steal your credentials, financial information, or other sensitive and personal information. It's also possible that they could infect your system with malware. Any free Wi-Fi should be considered to be “unsecure.” Therefore, be cautious about the sites you visit and the information you release.

• **Secure your computer and mobile devices.** Be sure your computer and mobile devices are current with all operating system and application software updates. Anti-virus and anti-spyware software should be installed, running, and receiving automatic updates. Ensure you use a strong password and unique password, which is not used for any other accounts. Set a timeout that requires authentication after a period of inactivity.

• **Use strong passwords.** Cyber criminals have developed programs that automate the ability to guess your passwords. To protect yourself, passwords must be difficult for others to guess, but at the same time, easy for you to remember. Passwords should have a minimum of eight characters and include upper case (capital letters), lowercase letters, numbers, and symbols. You have should have a different password for each online account. Make sure your work passwords are different from your personal passwords.
• **Do not respond to pop-ups.** When a window pops up promising you cash, bargains, or gift cards in exchange for your response to a survey or other questions, close it by pressing Control + F4 on Windows devices, or Command + W for Macs.

**Everyday security**

• **Think before you act:** Most organizations – banks, charities, universities, companies, etc., – will not ask for personal information via email. Be wary of requests to update or “confirm” your information.

• **When in doubt, throw it out:** Links in e-mails, social media posts, and online ads are often how scammers access your computer. If you are instructed to click a link in a message you don’t trust, even if you know the sender, delete the message or mark it as junk mail.

• **Carefully select the sites you visit.** Safely searching for topics online requires caution. Know the site. Know the company. Do not visit a site by clicking on a link sent in an email, found on someone’s blog, or on an advertisement. The website you land on may look just like the real site, but it may be a well-crafted fake.

• **Be cautious about all communications you receive** including those purported to be from “trusted entities” and be careful when clicking links contained within those messages. If in doubt, do not click.

• **Don’t respond to any spam-type e-mails.**

• **Don’t send your personal information via email.** Legitimate businesses will not ask users to send their sensitive personal information through this means.

For more information visit: [http://intranet.ucdmc.ucdavis.edu/it/units/security/security_tips.shtml](http://intranet.ucdmc.ucdavis.edu/it/units/security/security_tips.shtml)
INFANT / CHILD ABDUCTION (CODE RAINBOW)
Code Rainbow is the UC Davis Health System designation for suspected infant/child abduction.

There are three major components to a successful infant/child abduction prevention program at UC Davis Health System:

1) Quick and timely execution of the appropriate response to an abduction.
2) Education of staff and patients/parents on proper prevention and response procedures
3) Technological security measures.

In the main UC Davis Medical Center hospital facility, call the code line at 4-3666 to initiate a Code Rainbow. In external Health System facilities and Primary Care Network Clinics, call 911 to report a child abduction. It is the responsibility of all employees to be aware of their department’s response to a Code Rainbow. Read UC Davis Hospital Policy and Procedure #3304 – Child Abduction, Missing or Runaway Prevention and Response Plan and review Unit/Department specific responses to a Code Rainbow with your Manager or resource person.

The policy outlines the following prevention/response procedures:

- In the hospital, immediately dial 4-3666 to report an abduction. The hospital operator will begin announcing overhead “Code Rainbow and the unit, location, patient sex and age” until more information is available.
- For hospital-based clinics, immediately dial 4-3666 (Hospital Operator Code Line) and 4-2555 (UC Davis Police Department) simultaneously. The Hospital Operator will send out an Alpha group page for Code Rainbow to include the building name, floor, patient sex and age.
- For Primary Care Network Sites, dial 911 to contact local police; As soon as possible, call UCDMC Hospital Operator, who will initiate notification to UC Davis Police and Public Affairs Office
- The staff making the call will be expected to provide the following information: unit/department where abduction occurred, name of child on ID bracelet, sex of the child, ethnic background, age of child, description of abductor and description of any staff personnel following the abductor.
- Staff shall attempt to safely follow the abductor. If contact is made, do not physically restrain the abductor but request that the infant/child be released. If the abductor will not release the child, continue to follow until the police arrive or it is impossible to pursue. If threatened or fearful for personal safety, the pursuit should be discontinued. Be prepared to give police a complete, detailed description of the abductor, the exit used, direction of travel, vehicle and license number.
- Immediately secure the patient’s room or area where the abduction occurred and prevent all persons in the area at the time of the abduction from leaving until the police dismiss them.
- All personnel available in other patient care areas will observe their respective corridors and stairwells for suspicious activity. Notify the police by telephoning 911 if they encounter a suspicious person.
• All available staff in Patient Transport and Environmental Services Departments will respond to the building exits to assist in locating the child and abductor, until Code Rainbow is discontinued.
• When given the “All clear” by UC Davis Police, the operator will announce, “Code Rainbow all clear” three times in succession.

Preventing Infant Abduction

UC Davis Health System utilizes a new state-of-the-art electronic security system, called HUGS, that protects infants and children from the threat of abduction while in the hospital.
• HUGS creates a “safe area” where infants/children are monitored at all times. This is where infants/children are supposed to be.
• The system generates alarms when an infant/child is removed from the safe area, when a tag has been tampered with, when the tag is not seen by the system for a period, or when certain other conditions occur.
• Refer to Hospital Policy and Procedure 3302 – HUGS Infant/Child Security Program

WORKPLACE VIOLENCE AND HATE INCIDENTS

UC Davis Health System is committed to preventing and responding to violence and hate incidents in the workplace through education, adherence to policy and swift action to threats and acts of violence. UC Davis Health System’s Violence and Hate Incidents in the Workplace Policy (P&P 1616) states that the UC Davis Health System will not ignore, condone or tolerate disruptive, threatening, intimidating, violent, or hate incidents by or against any member of the University community or by any patient or visitor. Members of the University community engaging in such behavior will be subject to appropriate personnel action, up to and including termination or dismissal, as authorized by the applicable policy or collective bargaining agreement. The president of the University of California and the UC Davis chancellor have made it unequivocally clear that there is zero tolerance for any behavior that threatens personal safety, property and/or interferes with the mission of the University.

“Workplace violence”, as defined by UC Davis Health System Policy 1616 “Violence and Hate Incidents in the Workplace Policy” includes both violence and disruptive or threatening acts that can lead to violence. The terms in P&P 1616 include:

A. Disruptive Behavior--Aggressive behavior or conduct that may adversely affect the campus or workplace, may generate reasonable concern for personal safety, or may result in physical injury, including but not limited to the following:
B. Bullying--offensive or malicious behavior through persistent actions typically meant to undermine, intimidate or demean the recipient.
C. Domestic violence--abusive or violent behavior between individuals who have an ongoing prior intimate relationship that is disruptive in the workplace.
D. Intimidation--behavior that is intended to frighten, coerce, or induce duress.
E. **Property damage**--intentional damage to property owned by the University, its employees, students, visitors or vendors.

F. **Threat**--expression of intent to cause physical or mental harm, which may be direct, indirect, conditional or veiled.

G. **Violent behavior**--unwanted physical contact such as hitting, kicking, pushing, shoving, throwing of objects, or the use of a weapon.

H. **Hate Incident**--Any behavior or conduct that is disruptive, intimidating, threatening or violent, as defined above, and is committed against a person or his/her property because the person is, or is perceived to be, a member of a protected class (see UC Davis Personnel Policies for Staff Members [PPSM] 12 - Non Discrimination in Employment). Hate incidents may include, but are not limited to, expressions of bias, graffiti/vandalism because a person is, or perceived to be, a member of a protected class).

### Ways to prevent potential violence in the workplace

- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- Be vigilant throughout the encounter.
- Do not isolate yourself with a potentially violent person.
- Always keep an open path for exiting. Do not let the potentially violent person stand between you and the door.
- Do not turn your back to the person
- Stay two or three arm lengths away from the person
- Never ignore concerning behaviors. Promptly report and document incidents
- Ensure employees, students, patients and visitors are aware of and adhere to the Health System’s [Violence and Hate Incidents In the Workplace Policy](http://intranet.ucdmc.ucdavis.edu/policies/patient_care_standards/general_functions/IV-67.shtml)
- Utilize the Health System’s violence prevention resources including violence prevention classes, in-services, and other support services and departments identified below under resources


### Aggression and violence predicting factors

- Persons with a history of violent behavior
- Forensic patients (prisoners)
- Early release of acute and chronically mentally ill patients
- Patient refuses psychiatric medication or hospitalization

### Characteristics of aggressive and violent patients and victims

- Verbally expressed anger and frustration
• Body language such as threatening gestures
• Signs of drug or alcohol use
• Presence of a weapon

De-Escalation Techniques - Verbal and physical maneuvers to defuse and avoid violent behavior.

• Respond quietly and calmly
• Do not take the behavior personally – do your best to remain calm and professional. Don’t over react
• Demonstrate respect and concern
• Consider offering an apology, even if you've done nothing wrong.
• Summarize what you hear the individual saying. Make sure you are communicating clearly
• Focus on areas of agreement to help resolve the concern
• Use the person’s name
• Listen to the person’s concerns and acknowledge the person’s feelings
• Ask open questions

The assault cycle. There are five phases in the “assault cycle”.

1. Trigger Phase
   a. Factors that can make people angry and may trigger a violent response include: lack of respect, not being listened to, loss of control, sense of injustice, feeling of discrimination, or a lack of competence in others.
   b. Break the assault cycle by using de-escalation techniques described above.

2. Escalation Phase
   a. Person experiences physiological “fight or flight” response, which includes increased heart rate, tenseness of muscles, blood rushing to head, sweating, and dryness in the mouth.
   b. Continue use of de-escalation techniques.
   c. Avoid actions that can escalate the situation, such as asking too many questions, being too rushed, or patronizing the person.

3. Crisis Phase: Both parties are aroused and assault is imminent or occurring
   a. Reasoning with person is no longer possible.
   b. Manage your own physiological and physical responses with an emphasis on safety of all involved, such as escape or leave the area, use of barriers, use alarms or shout to summon help.

4. Recovery Phase
   a. Person is calming down.
   b. Be aware of the potential for “flare up” and do not attempt an exploration of the incident at this phase.

5. Post crisis Phase
   a. Person is low in mood, remorseful, guilty, ashamed, or despairing.
Resources available to employees for coping with incidents of violence:

a. University Police 734-2555  
b. Employee and Labor Relations 734-3362  
c. Risk Management 734-3883  
d. Academic and Staff Assistance Program (ASAP) 734-2727  
e. Equal Opportunity-Sexual Harassment Program 734-5335  
f. Campus Violence Prevention Program (CVPP) – through UCD Police Department (530) 752-1230  
g. The UCDHS Violence in the Workplace website

For training resources and information, refer to the UCDHS Violence in the Workplace website.

REPORTING CRIMINAL, SECURITY, WORKPLACE VIOLENCE and HATE INCIDENTS

In the event of an emergency or imminent danger, dial 911 via landline or (916) 734-2555 via cell phone.

Criminal events are reported to UCDPD by dialing 911 via landline or (916) 734-2555 via cell phone to report crimes and in-progress activities that require police response; you should be prepared to provide all available information to the dispatcher. The police department conducts criminal investigations and advises UCDHS personnel on crime prevention strategies. Incidents concerning suspicious people or circumstances are also reported to the police for investigation.

Mandatory Reporting of Workplace Violence: California regulations require mandatory reporting for certain workplace violence incidents. Any act of assault or battery against any on-duty hospital personnel that results in injury or involves the use of a firearm or other dangerous weapon shall be reported to UCDPD immediately by dialing 911 via landline or (916) 734-2555 via cell phone. Any act of violence (physical assault or threat of physical assault) against “community health care worker” (home health worker) shall be reported to UCDPD immediately.

Workplace violence incidents must also be reported as described in Health System’s Workplace Violence Reporting System. A report made via the Workplace Violence Reporting System is not a police report. Employees must contact the UCDPD to report an emergency and/or to file a police report by dialing 911 via landline or (916) 734-2555 via cell phone. The Workplace Violence Reporting System, may be accessed via the UC Davis Health System’s Intranet by typing the word violence in the address bar.

Hate Incident Reporting: The UC Systemwide Campus Climate Reporting System allows anonymous and identified reports of intolerance such as: Expressions of Bias Incidents, Hate Speech, Hate Crimes, Graffiti/Vandalism, Intimidation, Bullying or Physical Violence, Bias Incidents, Hostile Climate and other climate issues. The UC Systemwide reporting is available at the following website: https://secure.ethicspoint.com/domain/media/en/gui/23531/index.html
Security incidents are reported via the Incident Reporting System (http://incident.ucdmc.ucdavis.edu), as described in Hospital P&P 1466, “Confidential Incident Report”. Security-related Incident Reports are reviewed by UCDPD to determine if an investigation is necessary. If a determination is made that an investigation is needed, the UCDPD is responsible for conducting the investigation and disposition.

To report threatening or violent behavior:

1. Immediately call the UC Davis Police Department.
   - Dial 911 from a landline
   - Dial (916) 734-2555 from your cell phone.

2. Immediately notify your supervisor or manager about the situation.

3. Notify Human Resources Labor Relations as soon as possible: 734-3362

4. On the same day of the incident, document the incident by reporting it online using Incident Reporting system, RL Solutions (Safety/Security/Workplace Violence).

WEAPONS ON UC DAVIS HEALTH SYSTEM PROPERTY

It is a serious violation of the law and against UC Davis Health System policy and procedure to possess weapons on UC Davis Health System property unless you are a sworn peace officer.

The California Penal Code makes it a felony to bring or possess the following items on the grounds or within buildings of the University of California:

1. A firearm; or
2. Any dirk (a dagger), ice pick, or knife having a fixed blade longer than 2-2½ inches; or.
3. Other items that can inflict great bodily harm, such as BB gun, flare gun, slingshot, or bow/crossbow.

Possession includes, but is not limited to, possession of the aforementioned weapons on your person or in a vehicle.
MEDICAL EQUIPMENT MANAGEMENT

The Clinical Engineering Department is responsible for the repair, inspection, and maintenance of medical equipment throughout the UC Davis Health System.

All medical equipment must be inspected and tagged by Clinical Engineering prior to initial clinical use regardless of how the equipment was acquired (e.g., demo, borrowed, rental, purchase, lease, etc…)

TRAINING

All medical equipment users are required to be able to properly operate medical equipment that is under their control. Periodic equipment training is required and is the department’s responsibility. If there is a question about how to operate equipment, refer to the device’s operator’s manual on file in each department or ask your immediate supervisor or department manager.

EQUIPMENT FAILURE AND REPORTING

All equipment that is malfunctioning shall be taken out of service immediately. All equipment users are required to know where critical back up equipment is located and what procedures to follow when critical equipment fails. Broken equipment and/or equipment that is suspected to be out of calibration or otherwise not performing to its original specification must be reported to Clinical Engineering.

EQUIPMENT CAUSED INJURY

As required by the FDA’s Safe Medical Devices Act (SMDA), equipment that fails and causes or contributes to patient injury, patient illness or patient death is required to be formally reported to the FDA and the medical device manufacturer. At UC Davis Health System, the reporting procedure is to complete an online Incident Report through Incident Reporting system, RL Solutions (http://incident.ucdmc.ucdavis.edu). All equipment involved in the incident, including accessories and consumables must be sequestered and Clinical Engineering notified immediately.

EQUIPMENT INSPECTION

Before each use of any electrical device, inspect the power cord and plug for broken insulation, loose screws, or bent prongs. Special attention should be given to the point where the cord and plug join as well as the place where the cord enters the device.

ELECTRIC SAFETY

Water is a conductor of electricity.

- DO NOT place liquids on top of electrical devices
- DO NOT set equipment on wet areas.
- DO NOT use equipment on which liquids have been spilled. Turn off or unplug equipment.
- DO NOT touch electrical equipment with wet hands.
NO personally owned (staff, patients or visitors) line powered (including battery charger) electrical devices are allowed in patient care areas at UC Davis Health System. This restriction includes coffeepots, radios, and TV’s. All “loaned” devices must be inspected and tagged by Clinical Engineering as electrically safe. There is an exception for patient-owned, battery powered laptop computers that have grounded or double-insulated battery chargers.

NO adapters or two-pronged electrical devices shall be used at UC Davis Health System. Two-pronged electrical devices are not grounded and their use in hospitals is a violation of California Code of Regulation, Title 22, and paragraph 70837(e). Labeled (e.g., UL), double-insulated equipment is allowed.

Avoid using extension cords. If it is absolutely necessary to use an extension cord, use only the yellow “hospital grade,” three-wire, heavy-duty type of extension cord. Extension cords for non-patient care equipment may only be used as temporary wiring for portable hand tools, or while a permanent electrical service is being installed. In non-patient care areas, extension cords may be used to serve a short-term research experiment not exceeding six months. Surge protectors for computer equipment shall not be used as extension cords. Extension cords shall not be used as a substitute for fixed wiring. Do not use extension cords where subject to physical damage or hazardous locations, attached to buildings, walls, doors, windows, or under carpets.

Relocatable power taps (RPTs), also known as power strips, or plug strips, for use in patient care areas shall meet the following requirements: labeled by their manufacturer as hospital grade, mounted (e.g. on a rack, table, pedestal, or cart), have a total electrical current (amps) draw of less than 75% of the RPT’s listed capacity, and shall be plugged directly into a wall outlet (i.e, not “daisy-chained”).

SPECIAL PRECAUTIONS FOR ELECTRICALLY SENSITIVE PATIENTS
Special precautions need to be taken for “electrically sensitive patients”, e.g., patients with central pressure lines, patients with external pacemakers. Recognize that a very small amount of electrical current (less than a normal healthy person can feel) can cause cardiac fibrillation if applied directly to the heart. Possible routes to the heart include fluid filled catheters placed in or near the heart and external pacemaker wires that inadvertently come into electrical contact with an ungrounded or otherwise malfunctioning device. Electrically sensitive patients may commonly be found in critical care units, the cardiac catheterization laboratory, and the operating room.

CLINICAL ENGINEERING INFORMATION
For further information regarding medical equipment and/or Clinical Engineering services, call 734-2846. Additional information is available by referring to the Clinical Engineering website (http://cehelp.ucdmc.ucdavis.edu) or the online UC Davis Health System policy and procedure manuals.
MAGNETIC RESONANCE IMAGING (MRI)

Magnetic Resonance Imaging (MRI) uses magnetic fields, radio frequencies and a computer to produce images of the inside of the body. The magnetic fields are not known to be harmful and are painless. MRI is effective in visualizing soft tissue, the brain, the joints, and the musculoskeletal and vascular systems.

The MRI poses specific safety hazards in that any magnetic object (e.g., metal object) within the high magnetic field of the magnet will be pulled into the scanner itself. This could cause severe injuries to or even death of a patient or staff member as well as considerable damage to MRI equipment. To avoid a safety emergency, access to zones III and IV of the MRI is severely restricted. Screening of patients and staff is mandatory.

Hospital staff must be aware that the magnet is always on, and that the magnetic field cannot be seen or heard. The closer an object gets to the MRI the stronger the magnetic force. This force can pull metal objects into the machine at an incredible speed. Metal objects such as gurneys, oxygen tanks, infusion pumps, tools, and other patient-use items containing metal cannot enter the MRI environment. All personnel approaching the area must be aware of safety issues at all times.

Hospital staff will need to consult with MRI Staff if a patient has a pacemaker to determine if the device is MR conditional. Patients with pacemakers and defibrillators that are not MR conditional cannot be imaged or even come into the MRI prep area as the magnetic field may disrupt the function of these devices, which could result in death. Ventilator patients require special ventilators and monitoring devices. The MRI technologist or physician can supply the floor with the necessary instructions for these high-risk patients. Other devices, such as prosthesis, pumps, surgical clips or metal fragments, will be screened to determine if they are MRI compatible. Jewelry, hairpins, glasses, wigs, hearing aids, non-permanent dentures, etc…, must be removed.

Some of the safety precautions are:
1) Warning signs posted on doors.
2) The use of hand-held magnet scanners to help detect metal objects.
3) Being cleared by the MRI technologist

Refer to the UC Davis Health System Magnetic Resonance Imaging Policy (P&P 1727) for additional information. Any staff that enters controlled MRI spaces must complete periodic training in accordance with this policy.
UTILITY SYSTEMS MANAGEMENT

PLANT OPERATIONS AND MAINTENANCE
Plant Operations and Maintenance (PO&M) is responsible for the repair, inspection and maintenance of all utility systems throughout the UC Davis Health System. If you have any questions regarding utility systems, please call PO&M at 734-2763.

PO&M is open 7 days a week, 24 hours a day for any electrical safety, equipment maintenance, or utility system problems. Routine service requests should be submitted online using the PO&M Service Request System. Alternatively, type request in the address bar of your browser. Urgent requests, requiring work to be accomplished on a STAT basis involving conditions where patients’, visitors’, or employees’ lives or health are in danger, should be called to 734-2763 or submitted online using the Service Request System. Some examples of what is considered to be a bona fide emergency request include, but are not limited to the following:

- Code blue alarm failure
- Medical gas/air problems
- Patient call system failure
- Emergency power generator failure
- Roof leaks/plumbing failures
- Power failure/thermostat adjustment
- Security lighting/alarm failure
- Elevators not operating correctly
- Code red alarm failure
- Sterilizer problems/failures
- Water, steam, gas, air, sewer system failure
- Lighting directly related to patient care
- Broken window/door glass
- Flooding conditions
- Door failure

TRAINING
All utility systems users are required to be able to properly use the utility systems under their control. Periodic training is required and is the department’s responsibility. If there is a question about how to operate a utility system, refer to the operating instructions, the quick reference cards or ask your immediate supervisor or department manager.

UTILITY SYSTEM FAILURE AND REPORTING
All system malfunctions due to failure or improper use must be reported or, if authorized, taken out of service immediately. All utility system users are required to know how to notify PO&M of system problems and how to shut down the portion of the system under their control. The PO&M 24-hour notification number is 734-2763. Some electrical outlets have a red cover, or the outlets themselves are red. These outlets are connected to emergency backup and provide power that will be uninterrupted, even if there is a loss of normal power. Red telephones provide back up for incoming and outgoing calls in case of a major failure of the normal telephone system.

INFORMATION
For Further information regarding utility systems or PO&M services, call 734-2763.
REPORTABLE EVENTS

UC Davis Health System (UCDHS) is required by state law to report specific adverse outcomes and certain privacy incidents that occur in the hospital to the California Department of Public Health (CDPH) no later than five days after the event is detected or, if the adverse event poses an ongoing, urgent or emergency threat to the welfare, health or safety of patients, personnel or visitors, within 24 hours of detection. Failure to do so may result in a fine of $100 per day. Reports to CDPH involving adverse outcomes are made by Medical Staff Administration. Reports involving privacy incidents are made by the Compliance Department and/or the Privacy Officer.

For Adverse Outcomes, CDPH is required to conduct an onsite investigation within 48 hours (or two business days) of events that pose an ongoing threat of imminent danger of death or serious bodily harm.

The reportable events are described in UC Davis Health System Policy #1513, Reporting Serious Adverse Events. Categories of reportable events, with some examples, include:

- **Surgical events:** Surgery performed on the wrong body part, wrong patient, wrong procedure.
- **Product or device events:** Death or serious disability from use of contaminated drug or device.
- **Patient protection events:** Infant discharged to the wrong person.
- **Care management events:** Death or serious disability associated with a medication error.
- **Environmental events:** Death or serious disability associated with electric shock.
- **Criminal events:** Abduction of a patient of any age.
- **Or, Catch all:** Any adverse event or series of events that causes the death or serious disability of a patient, staff member, or visitor.

UCDHS is required to investigate all privacy incidents and any unlawful or unauthorized access to, or use or disclosure of, a patient’s medical information to CDPH within 15 business days. Reportable disclosures may include any access, use or release of patient information that is not in accordance with UCDHS Hospital Policy#2410, Allowable Uses and Disclosures for Protected Health Information (PHI).
**PATIENT IDENTIFICATION**

(Excerpts from UC Davis Health System Policies and Procedures #2702)

It is the policy of UC Davis Health System to ensure that all patients are properly identified prior to any care, treatment or services provided.

In the hospital setting, every patient shall have a tamper-proof non-transferable ID band applied securely to at least one extremity at all times. Exceptions: Small infants and patients with a disease process, injury, or treatment that prevents safe placement of the ID band on any extremity. The band shall include the patient’s first and last name, medical record number, date of birth and gender.

Before any procedure is carried out, the identification band shall be on the patient and will be checked for the following two identifiers to ensure that the correct patient is involved:

1. Patient name.
2. Patient medical record number.

Staff shall verbally assess the patient to assure proper identification, asking the patient’s name and date of birth and matching the verbal confirmation to the written information on the identification band.

Staff will identify the individual patient as the person for whom the service or treatment is intended and match the service or treatment to that individual patient.

No procedure shall be conducted when the patient’s identity cannot be verified because the imprinted band is illegible or missing. Patient identification must be confirmed using the two-identifier system prior to conducting any health care procedures.

Note: In outpatient settings where the patient is not required to wear an ID band, the two identifiers used to confirm patient identity are the patient’s name and date of birth.
VERBAL ORDERS
This section outlines the policy and procedures for use of verbal orders at the University of California, Davis Health System, as described in Patient Care Standard IV-75, Physician Orders.

Verbal orders are to be used infrequently and limited to those situations in which it is impossible or impractical for the ordering provider to enter the order in the EMR. It is expected that staff address patient care needs in a timely manner without routinely resorting to the use of verbal orders.

Verbal orders may be used in the following situations:
1. When the provider does not have access to the EMR.
2. When the provider is off-site between the hours of 2300 and 0600
3. During a procedure, in which case the order will be entered by appropriate staff, and signed by the ordering provider immediately following the procedure.
4. In an emergency/urgent situation when it cannot wait for the provider to enter the order.
5. When the issuing provider is participating in teaching rounds (not work rounds).
6. When the nurse or allied health professional has initiated the call to the provider requesting the verbal order and the provider reports that he/she does not have current access to the EMR.

Verbal orders must not be issued for complex or multiple orders due to the risk to patient safety when verbal orders are used (this includes admission, discharge and transfer orders). When verbal orders are used, they may only be issued by a licensed or registered physician, NP or CRNA.

Verbal orders for medication may only be accepted by registered nurses and pharmacists. Allied health professionals may accept verbal orders specific to their scope of practice. LVNs may not accept verbal orders. LVNs in the ambulatory care clinics may “pend” orders that are not acted upon until signed by a provider.

When verbal orders are issued, they must be read back to the prescriber (ordering provider). The person accepting the verbal order (communicator) enters the order into the EMR and reads it back to the ordering provider. Leading zeros and decimal points must be vocalized. The identity of the ordering provider must also be confirmed by verifying the name and PI number. If the communicator cannot reasonably access a computer, the order may be written down on paper, read back to the ordering provider, and later entered into the EMR. In any case, verbal orders are entered into the EMR using “Verbal with read back” as the order type and the name of the ordering provider who issued it. The communicator then electronically signs the order in the EMR, which records the date/time of the order and the communicator’s professional title. All verbal orders must be cosigned by the ordering provider within 48 hours from the date and time the order was entered.

Failure by providers to cosign verbal orders within 48 hours could result in the assessment of a fine against the department of the non-compliant provider. Providers are not required to sign erroneous verbal orders. Refer to Section V.B. regarding verbal orders entered in error.
ERGONOMICS, BODY MECHANICS AND SAFE PATIENT HANDLING

Body mechanics is defined as positioning and using the body safely and efficiently. Positioning the body safely means staying aware of your posture, and doing what you can to avoid awkward postures that put you at risk of injury. Using the body safely means not exerting yourself beyond your physical limits. It’s important not only to know your limits and the resources available to help you, but also to use those resources. Using the body efficiently means that you possess a baseline fitness level appropriate for your job duties and that you maintain that level of fitness so that you can perform your job efficiently. Combine consistent practice of good body mechanics and the use of training and equipment resources with an awareness of your posture and overall fitness, and you will feel better at work.

Postural Awareness

According to 2010 statistics, workers in the healthcare industry are more at risk for injury than in any other industry. The major cause of these injuries is due to awkward postures. It’s more important than ever to be aware of your own neutral posture, support it, and maintain it as you work.

Neutral posture is more difficult to maintain when you are active, but you know when you’re in an awkward posture because it’s uncomfortable. Consider the position of your body when your nose, hands, and toes are facing different directions. For instance, you could be sitting in your chair and awkwardly reaching in your bottom file drawer. You could be awkwardly reaching over a bedside cabinet to pull a plug from behind the bed.

Body Mechanics

Knowing how to position and use your body actively in a safe and efficient way is known as practicing good body mechanics. If you have a more active job, it would be to your advantage to be trained in body mechanics. More importantly, you should practice it consistently throughout your day – not just while you are at work. Consider these tips related to lifting:

- Give yourself a wide base of support by spreading your feet at least shoulder-width apart, if not wider for more stability and more mobility.
- Get close to your load. Loads carried at arm’s length away from you feel heavier and add stress to your back.
- Put your hands in the best position to carry the load. The handles may or may not be the ideal place. Grip the item so that the larger muscles of your arm work more and the small muscles of your hand work less (e.g., compare hands flat on the sides of a box to laying a box on the forearm and gripping the far edge).
- Test the weight before you lift it. Shift it, push it, or tip it to get a clue about an object’s weight. Know your own physical limits, and get help when needed, e.g., team lift, mechanical assist.
- Direct your body toward the load. Nose and toes face the same direction (no twisting). To change direction while carrying a load, take a step or pivot on the balls of your feet.
- When rising with a load, lift upward using the large muscles of the hips and legs.
- Plan ahead. Know where you are going, prepare a clear path, and remove barriers.
- Lower load with control, and maintain a neutral posture. Don’t get distracted during this important part of the lift.

Safe Patient Handling - Knowledge of Resources

Only staff that have been trained on approved techniques and equipment are allowed to move patients. If you have not been trained on how to move patients and come across a situation where a patient needs to be moved, notify the responsible nurse (in the main hospital you may also call the lift team). However, in the event of an emergency, you may assist in the movement of a patient.

UC Davis Medical Center has a [Safe Patient Handling Policy (PCS IV-04)](https://www.ucdmc.ucdavis.edu/), and supports it by providing equipment and training for the repositioning, transferring and lifting of our patients. Ongoing, unit-specific training is available to any department responsible for transferring patients, and focuses on active posture, body mechanics, and equipment. Contact the Lift Team for this training.

Patient handling tasks that result in body exposure are:

- **Vertical:** Movement from a lower position to a higher position or vice versa (i.e. supine-to-sit transfer, sit-to-stand transfer).
- **Lateral:** Movement across a horizontal plane (e.g. bed to gurney).
- **Repositioning:** Any task which involves moving a patient to shift positions within the bed (e.g. turning a patient on their side, shifting a patient toward head of bed.)
- **Ambulation/Mobilizing:** Patient movement in standing with advancing feet.

Many types of equipment are available to assist with the different ways our patients need to move. Patient lifts help our most immobile patients, with slings sized small to XXL (90-1,000 lbs.). UC Davis Medical Center has portable lifts, with varying weight capacities (350-1,000 lbs.). These portable lifts come with special features, like being able to assist someone out of a car, or help with standing or walking. Other devices available at UC Davis Medical Center include the Hover Matt system, Prevalon Turn & Position, and Sally Tube reduced-friction transfer sheet. All have standard and bariatric versions and are designed for single patient use (allowing repeated use for the same patient during their hospital stay). Innovative technology is driving this emerging group of products, and UC Davis Medical Center is committed to evaluating new products as they are introduced for integration into our safe patient handling practices.
Safe Patient Handling information, including the Banner Mobility Assessment Tool (BMAT), and additional resources available are located on the Lift Team webpage located at: http://intranet.ucdmc.ucdavis.edu/pcs/liftteam/index.shtml.

Selection of the appropriate method of Safe Patient Handling shall be determined by the RN in conjunction with the Lift Team and/or licensed personnel prior to the patient movement. The registered nurse (RN) shall be responsible for the observation and direction of patient lifts and mobilization and shall participate as needed in patient handling in accordance with the RN/s description, use of the BMAT and professional judgment.

**Maintaining Your Physical Fitness and Wellness**

Did you know that being physically fit and having a healthy lifestyle prevents injuries? If your job requires physical tasks, take responsibility for maintaining the strength, flexibility, and endurance required to complete those tasks. If your job entails being more sedentary, take responsibility for maintaining a healthy diet and active lifestyle to provide balance. Physical fitness and wellness can start at work, too. Consider how you take your breaks. Taking a physical and mental break means thinking and doing something different. If you have been on your feet and active, then your break may consist of putting your feet up or closing your eyes for a few minutes. If you have been getting drowsy in front of a monitor, then your break may be better spent walking briskly outdoors or getting some cold water with lemon. Periodic micro-breaks (1 minute per hour) may also help you through your shift. Physically break from what you have been doing for one minute. If you have been standing in one place for a long time, prop one foot up or lean back on a standing stool. If you have been sitting for an hour, stand up and stretch or do some active exercise to invigorate. If you have been staring into a computer monitor, focus on something about 20 feet away for about 20 seconds.

For additional guidance, contact the UC Davis Health System Wellness programs through Physical Medicine and Rehabilitation (Living Fit Forever) or Human Resources (WorkLife Balance).
INFECTION PREVENTION/CONTROL

AIRBORNE or AEROSOL TRANSMISSIBLE DISEASES (AirID)
The Aerosol Transmissible Diseases Plan is found in the UC Davis Health System P&P 2002. This policy applies to all diseases transmitted via the airborne route and requires either Airborne Precautions (i.e. pulmonary tuberculosis (TB), measles) or Droplet Precautions (i.e. influenza, pertussis). Please suspect symptomatic patients early and appropriately isolate immediately to prevent unprotected exposure. This includes donning appropriate personal protective equipment, in accordance with Patient Care Standards XI-25: Isolation – All Categories: Availability of Infection Control Devices, Waste and Waste Containers.

For Airborne Precautions or AirID, always use an Airborne Infection Isolation Room (AIIR), formerly called a negative pressure isolation room, and keep the door closed. Each occupied AIIR is to be checked daily by PO&M to assure negative pressure is maintained. Rooms are to remain vacant for one hour after a patient is discharged to allow the air in the room to be exchanged and any remaining microorganisms in the air to be eliminated. The room can be cleaned during this rest hour. Environmental Services staff are to wear a N95 mask while cleaning the room. Do not place a new patient into this room until one hour has passed.

A powered air purifying respirator (PAPR) is worn when performing a high hazard procedure on high hazard patient, that is, any patient in Airborne Precautions (i.e. TB patients). High hazard procedures include: bronchoscopy, open suctioning, sputum induction, aerosolized administration of pentamidine or other medications, pulmonary function testing, and procedures in autopsy, surgery or laboratory that may aerosolize pathogens.

Engineering Controls: AIIR are equipped with negative air pressure; air in patient room is vented directly outdoors with a minimum of six air exchanges per hour. Ultraviolet lights and HEPA filtration are adjuncts to engineering controls.

NIOSH APPROVED RESPIRATORS and RESPIRATORY PROTECTION
Always wear a NIOSH approved respirator for protection against AirIDs or patients in Airborne Precautions. This protection is an N95 mask or elastomeric mask, for which you have been fit tested, or a powered air purifying respirator (PAPR). For N95 and elastomeric masks, fit testing must be performed annually (refer to UC Davis Health System P&P 1603).

The following NIOSH approved N95 respirator instructions to be followed each time this mask is used:

1. Cup the respirator in your hand with the nosepiece at fingertips, allowing the headbands to hang freely below hands.
2. Position the respirator under your chin with the nosepiece up.
3. Pull the top strap over your head so it rests high on the back of the head.
4. Pull the bottom strap over your head and position it around neck behind ears.
5. Using two hands, mold the nosepiece to the shape of your nose by pushing inward while moving fingertips down both sides of nosepiece. Pinching the nosepiece using one hand may result in less effective respirator performance.

**N95 Face Fit Check:** The respirator seal should be checked before each use. Place both hands completely over the respirator and exhale. If air leaks around your nose, adjust the nosepiece as described. If air leaks at respirator edges, adjust the straps back along the sides of your head. Recheck.

**METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)**


As of September 2015, UCDMC has made a significant change to the MRSA Policy. Refer to Patient Care Standard XI-12: Methicillin/Oxacillin-Resistant Staphylococcus aureus (MRSA) Patient.

*Staphylococcus aureus* (SA) is a pathogen that commonly causes infections in humans. MRSA is a variety of SA that has developed resistance to the common antibiotics used to treat SA infections. Because MRSA infections are more difficult to treat, UCDMC has always had a policy to control its spread. We do this by controlling the use of antibiotics through the Antimicrobial Stewardship Program. In addition to this, important elements of the MRSA Control Program are as follows:

1. To preventing cross-transmission between patients is strict hand hygiene by staff and visitors. Refer to PCS XI-23: Handwashing (Hand Hygiene) Policy.
2. The use of Standard Precautions for ALL patients. In addition to appropriate and consistent hand hygiene, this requires the use of personal protective equipment (PPE) when caring for all patients. Refer to PCS XI-25: Isolation – All Categories: Availability of Infection Control Devices, Waste and Waste Containers.
3. Daily bath treatments with CHG (chlorhexidine gluconate) for all patients is required to reduce the numbers of organisms (including MRSA) on patients’ skin.
4. Careful and frequent cleaning of the patient’s environment, which includes the patient’s room and all equipment used by the patient.

Please note: MRSA patients are no longer routinely placed in Resistant Organism Precautions/Contact Precautions unless the patient has an infection where there is drainage (respiratory secretions or purulent wound drainage) that cannot be contained in a dressing.

As mandated by Senate Bil 1058 (Nile’s Law), an anterior nares swab will continue to be obtained on each patient admitted looking for the presence of MRSA. Nurses are required to educate patients about MRSA and document this education on the MPER. There is a brochure available to educate patients about MRSA; this brochure is available in multiple languages. Physicians are required to notify their patients of positive MRSA results. Refer to PCS XI-15: MRSA Active Surveillance.
BLOOD BORNE PATHOGENS (Hepatitis B, C, and HIV)

Exposure Control Plan is located in the UC Davis Health System P&P 2001. Please read the plan as your safety measure for preventing exposures. Hepatitis B virus (HBV), Hepatitis C virus (HCV), and Human Immunodeficiency Virus (HIV) cause severe disease and death. These pathogens are transmitted through contact with body fluids infected with the viruses, such as blood, semen, vaginal fluid, or any body fluids with blood present. Prevention is the key to protecting yourself against these diseases. Avoid blood contact; use personal protective equipment (face shield, mask, goggles, gloves, and gowns), use safety devices to avoid sharps injuries. Report exposures to Employee Health Services and fill out an incident report online by typing employeeexposure as one word in the intranet browser’s address bar or clicking onto the “EE” icon located on a PC desktop. Hepatitis B vaccine is available to prevent the disease. There is currently no vaccine for Hepatitis C. Hepatitis B and C carriers are placed on standard precautions to prevent blood exposures. Refer to REPORTING BLOOD OR BODY FLUID EXPOSURES section below.

STANDARD PRECAUTIONS

UC Davis Health System mandates the application of standard blood and body fluid precautions for all patients as recommended by the American Hospital Association and the Centers for Disease Control. These guidelines are implemented in order to protect all health care workers and patients from the transmission of infections and is inclusive of protection against the transmission of HIV in health care settings. Precautions must be strictly followed whenever there is a possibility of exposure to blood or other body fluids/substances. Health care workers need to exercise judgment in making decisions about anticipating exposure and when to use appropriate barrier precautions. Further, these guidelines do not negate the need for currently used isolation procedure, but rather emphasize standard blood and body fluid/substance precautions for all patients regardless of their isolation status or diagnosis.

Guidelines for Preventing Transmission of Infections in Health Care Settings

1. Handle the blood and body fluids/substances of all patients as potentially infectious.
2. Wash hands before and after all patient or specimen contact.
3. Wear gloves when contact with blood or body fluid/substances is anticipated. Remove gloves after each individual task.
4. Wear a gown or disposable plastic apron when splashing of blood or body fluid/substance is anticipated.
5. Wear a mask for protection against splashing of blood or body fluids/substances into the nose and mouth. Use an N95 mask for airborne transmitted diseases.
6. Wear protective eyewear (normal eyeglasses for everyday use are not enough protection) and face shield if facial splatter with blood or body fluid/substances is anticipated.
7. Activate any engineered device immediately and discard into Sharps container. Never recap needles on a syringe. Prepare two safety devices in the event of additional injections; may be needed for anesthesia.
8. Process all laboratory specimens as potentially infectious.
9. Place equipment needed for emergency resuscitation (e.g., resuscitation bags and/or mouth-to-mask devices) in areas where the need for resuscitation is predictable.

**REPORTING BLOOD OR BODY FLUID EXPOSURES**

An exposure to blood or body fluid occurs when you receive a needlestick, puncture wound, or cut from any object contaminated with another person’s blood or body fluid. An exposure occurs when patient’s blood or body fluid comes into contact with your open wound, non-intact skin, or mucous membrane (eye, nose, and mouth). Refer to P&P 2167: Blood/Body Fluid Exposure (Needlesticks).

If you sustain a blood/body fluid exposure, Employee Health Services will provide treatment and all follow-ups as indicated. All direct care providers are offered Hepatitis B vaccination at no cost.

It is your responsibility to report exposures to Employee Health Services and fill out the incident report online by typing `employeeexposure` as one word in the intranet browser’s address bar or clicking onto the “EE” icon located on a PC desktop. Paper exposure report forms are to be used by pre-hospital personnel. Please note that this is not the RL solutions incident reporting system.

Call Employee Health at 734-7585 to report your exposure after you have completed the exposure online. Do not go to the Emergency Department for treatment after sustaining an exposure. You have up to seven days before any lab work is required to be drawn from you. For after-hours high-risk exposure inquiries, call the Infectious Disease Fellow on-call.

Please be reminded that in accordance with OSHA and the UCDMC Bloodborne Pathogen Exposure Control Plan (P&P 2001), it is required that everyone use Personal Protective Equipment (PPE) to protect against direct exposure to blood/body fluids. Please note that lab coats and uniforms (scrubs) do NOT qualify as PPE because they are not impervious to fluids. They will not protect you from direct contact to blood/body fluids. Refer to P&P 2167: Blood/Body Fluid Exposure (Needlesticks) for the procedure to follow in case of accidental contamination with blood/body fluids.

**TO GLOVE OR NOT TO GLOVE?**

Appropriate glove use is well-supported by evidence-based science.

Gloves should be worn during patient transport when an employee anticipates contact with body fluids or open wounds. For example, it is appropriate to wear gloves to transport a trauma patient who is bleeding, or using a resuscitation bag on a patient during transport. It is appropriate to wear gloves during transport of a patient with burns (sterile gloves should be worn if burns will be touched). For all other circumstances, it is inappropriate to wear gloves during patient transport. When transporting a patient who will need care and requires isolation precautions, there must be an additional transporter who is not wearing isolation garb; this person may touch the environment (elevator buttons, door handles, etc.). All transporters wearing isolation garb
must avoid touching the hospital environment while transporting the patient in order to protect patients, visitors and other hospital personnel.

Protecting visitors, other patients, and healthcare workers means gloves are not used to touch elevator buttons, or opening doors. Visitors touch buttons on elevators, doors and door handles. It is inappropriate for staff (MDs, RNs, transporters) to wear gloves while touching these items. Furthermore, over-utilization of gloves results in moisture build up on the hands and increases the probability of developing skin infections or yeast infections under your nail beds. **Please use gloves appropriately.**

**TRANSPORTING BLOOD OUTSIDE THE LAB**

When transporting blood from the lab to the patient bedside, observe the following precautions:

- DO NOT transport blood for multiple patients at the same time.
- Maintain the blood at an even temperature.
- DO NOT set blood on a tray with or carry blood close to hot or cold packs, drinks, or other materials.
- Protect blood from sharp objects.

**AGENTS OF BIOTERRORISM**

Four diseases with recognized bioterrorism potential are anthrax, botulism, plague, and smallpox. The CDC does not prioritize these diseases in any order of importance. An act of bioterrorism may occur as a covert or announced event. Whether a situation is bioterrorist in nature would be determined with the assistance of the F.B.I. and state health officials.

**ANTHRAX**

Anthrax is caused by *Bacillus anthracis*. Humans usually become infected by contact with contaminated animals. Person to person transmission of inhalational disease does not occur naturally. Direct exposure to vesicle secretions of cutaneous anthrax lesions may result in secondary cutaneous infection, but not pulmonary infection. Pulmonary anthrax is associated with bioterrorist caused exposure to aerosolized spores. The incubation period is 1-8 weeks. Standard precautions are used in the hospital.

**BOTULISM**

*Clostridium botulinum* produces a potent neurotoxin, botulinum toxin. This toxin inhibits the release of acetylcholine, resulting in flaccid paralysis. Botulinum toxin exposure may occur following exposures to contaminated food or air. Standard precautions are implemented. A vaccine is available as an investigational drug.

**PLAGUE**

Plague is caused by *Yersinia pestis*, which is transmitted by infected fleas. A bioterrorism-related outbreak by airborne means can cause a pulmonary variant called pneumonic plague. Person to person transmission is possible via large droplets. Droplet precautions are implemented until the patient has had 72 hours of effective antimicrobial treatment.
SMALLPOX
Smallpox is caused by the *variola* virus. A single case is considered a public health emergency. It can be transmitted via the airborne route. The incubation period is 7-17 days. Patients are infectious at the onset of the rash and remain infectious until the scabs separate (3 weeks). A vaccine is available but it does not confer lifetime immunity. Previously vaccinated persons are considered susceptible to smallpox. Isolation procedures include standard precautions plus airborne and contact precautions. Health care workers wear respiratory protection when entering the patient’s room.

INFLUENZA VACCINATION MANDATED for ALL EMPLOYEES by UC DAVIS HEALTH SYSTEM
At the beginning of each flu season (as determined by the UCDMC Infection Prevention Officer and the Sacramento County Public Health Officer), all UC Davis Health System employees, students and vendors and contractors are required to be vaccinated against influenza or sign a declination form. A single flu vaccination will protect against three or four strains of the flu. Declinations allow Employee Health Services to track employee concerns so educational content can be updated to dispel myths and employee concerns about the value of vaccination. Our priority is to prevent the spread of the influenza virus to patients, coworkers, and family members.

Employees who have not been vaccinated by the start of the designated flu season will be required to wear a procedure mask (type with elastic ear loops) while at work to reduce the risk of spreading influenza among non-vaccinated employees, patients and visitors. This policy ([UCDHS P&P 2011 – Influenza Vaccination Requirements](#)) includes employees who work in the hospital and in remote buildings during the flu season. Individuals are reminded to be respectful and supportive of colleagues who will be wearing masks during the flu season. Remember to follow “Cover your Cough” during cold and flu season. If you feel you have flu symptoms, stay home. Wash your hands, exercise and eat healthy to stay well.
HAND HYGIENE

The Centers for Disease Control and Prevention (CDC) encourage hand hygiene by health care personnel. Hand Hygiene is the single most important procedure for preventing health care acquired infections. Studies show hand hygiene causes a reduction in the carriage of potential pathogens on the hands.

The World Health Organization promotes hand hygiene using the “Five Moments of Hand Hygiene” campaign. For more information, please visit the hand hygiene webpage by typing “hands” into the browser bar on any UCDMC intranet computer. There are five key moments in health care when employees should wash their hands:

1. before touching a patient,
2. before clean/aseptic procedures,
3. after body fluid exposure/risk,
4. after touching a patient, and
5. after touching patient surroundings

There are three types of hand hygiene:

1. Hand asepsis: to remove soil and to remove or destroy transient microorganisms using anti-microbial soap and tepid water for a minimum of 15 seconds.
2. Degerming using Antimicrobial Hand Sanitizer: to destroy transient and resident microorganisms on unsoiled hands using alcohol-based hand rub. Rub hands vigorously until dry, a minimum of 20 seconds.
3. Surgical hand scrub: to remove or destroy transient microorganisms and reduce resident flora using anti-microbial soap or detergent preparation and water with brush to achieve friction for at least 120 seconds.

The choice of plain soap, anti-microbial soap, alcohol-based hand rub or surgical hand scrub should be based on the procedure being conducted.

All personnel and physicians wash hands using:

Antimicrobial soap and tepid water

- Upon arrival to the occupational setting
- When hands are obviously soiled with blood or body fluids
- When gloves are torn or damaged
- After personal hygiene measures
- Prior to an invasive procedure or exam
- DURING AND AFTER CARING FOR A PATIENT WITH CLOSTRIDIUM DIFFICILE (C. diff, a spore-forming organism) OR NOROVIRUS (a highly communicable gastrointestinal virus) even though gloves are required when caring for these patients.
Alcohol gel/foam

- Before and after eating
- Before having contact with a patient or their surroundings
- After removing intact gloves
- After touching intact patient skin, e.g., taking a pulse or blood pressure
- After touching inanimate objects such as the over bed table or patient equipment
- When moving from one patient room to another
- When moving from a contaminated body site to a non-contaminated body site. Intact gloves are removed when moving from the contaminated body site; alcohol gel/foam is used before donning another pair of gloves.

Antimicrobial hand sanitizer and hand soap are not used at the same time. Use one product or the other. Antimicrobial hand sanitizer can cause stinging in the hands for some providers due to pre-existing skin irritations.

Artificial nails are more likely than natural nails to harbor pathogens that can lead to health care acquired infections. Therefore, artificial nails and nail tips are prohibited for all health care personnel providing hands-on patient care.

All incidents relating to a break in hand washing policy are reported using the Incident Reporting System (http://incident.ucdmc.ucdavis.edu).
ELDER ABUSE

HOW TO DETECT, HOW TO INTERVENE
Researchers estimate that nearly two million elderly people are abused each year in the United States. As our population becomes older and sicker, the problem is expected to worsen. In order to intervene effectively, you need to recognize the symptoms of elder abuse. Additionally, you are legally required to report to the authorities all suspected cases of elder abuse.

DETECTING ABUSE
Elder abuse is generally categorized under one of four headings: physical, psychological, financial, or neglect. It is not unusual for several types of abuse to occur simultaneously.

PHYSICAL ABUSE is defined as the infliction of physical harm or injuries, including sexual abuse or misconduct. Physical abuse commonly takes the form of hitting, slapping, pushing, punching, pinching, burning, or striking with objects. An abused older adult may be loyal or fearful of the abuser or ashamed to acknowledge dependency on the abuser, thus they are not willing to report physical abuse. Classic signs include:
- Wounds inconsistent with explanation of how the injury occurred.
- Bruises at several stages of healing.
- Delay in seeking treatment.
- Suspicious behavior by family member or caregiver.

PSYCHOLOGICAL ABUSE is defined as inflicting emotional pain or distress on the victim. It usually occurs with physical abuse but it can also occur alone. It may be difficult to detect psychological abuse unless you are able to witness such overt examples as threats, insults or humiliation. A red flag should be raised when:
- The elderly patient’s caregiver seems indifferent or angry toward him/her.
- The patient is withdrawn, isolated, depressed, demoralized or fearful toward their caregiver.

FINANCIAL ABUSE is defined as when a family member, caregiver or friend takes control of the elder’s resources either through misrepresentation, coercion, or theft. The victim of this type of abuse may or may not realize what is happening. A red flag should be raised when:
- The patient mentions they lack money for food, household supplies, and/or prescription drugs.
- The patient’s nutritional status is poor.
- The patient mentions they are no longer allowed by their caregiver to live in their home.

ELDER NEGLECT is a blanket term used to describe situations in which the well being of the older adult is judged to be at risk due to lack of attention to him/herself or their living environment. Neglectful behaviors range from failure to meet nutritional and hygienic needs to suicide or manslaughter. Elder neglect may occur when:
- The care needed exceeds the caregiver’s ability to deliver.
- The caregiver is ignorant.
- The patient no longer has the ability to care for him/herself due to declining capacity.
### RISK FACTORS FOR ELDER ABUSE

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<td>Shared living arrangements</td>
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<td>Family history of violence</td>
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<td>Lack of financial resources</td>
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### HOW TO REPORT ELDER ABUSE

Telephone the Department of Clinical Social Services immediately (734-2583) or after hours page the ER social worker (762-5585) to notify them of the patient’s name and location.

Telephone appropriate agency as soon as possible to notify them of the suspected abuse and that the report form will follow.

- If the elder or dependent adult lives in the community and outside a long term care facility, contact Adult Protective Services (in Sacramento County 916-874-9377) or local law enforcement agencies.
- If the elder or dependent adult lives in a long term care facility, contact the Ombudsman Program (in Sacramento County 916-448-3494) or local enforcement agencies.

Complete the Elder and Dependent Adult Abuse Reporting Form (SOC 341) promptly. Place a copy in the medical record and hand deliver the original and remaining copy to the Department of Clinical Social Services, Suite 1300, Professional Support Services Building.
CODE OF CONDUCT

WHAT IS THE CODE OF CONDUCT?
The UC Davis Health System (UCDHS) Code of Conduct is made up of 14 Standards, which each address a known area of risk for compliance violations. Each standard provides information on appropriate conduct to follow and suggestions for handling problems that may arise. Some standards will fully cover a topic. Other topics are too complex to be fully covered by the standard, in which case you should obtain further information, as needed. You can access additional information on the Code of Conduct at:
http://www.ucdmc.ucdavis.edu/compliance/conduct/.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (the “DRA”) into law. The DRA was intended to secure deficit reductions via the establishment of programs to slow growth spending in various areas including housing, education, and Medicare and Medicaid spending. Section 6032 of the DRA requires certain entities to create written policies that address the detection and prevention of fraud, waste, and abuse and to establish whistleblower protections. Many of the Standards in the UCDHS Code of Conduct address the DRA requirements pertaining to individuals responsibility with reporting known or suspected fraud. Additional University of California (UC) policies addressing DRA topics can be accessed at:
http://policy.ucop.edu/doc/1100563/WhistleblowerProtection and
http://policy.ucop.edu/doc/1100158/HealthScienceCompliance.

DOES THE CODE OF CONDUCT APPLY TO ME?
The Code of Conduct applies to all employees and students. For purposes of the UCDHS Code of Conduct, the term “employees and students” refers to all individuals who are either involved in the direct provision of patient clinical care services, or with providing staff, business, administrative, or patient care support services on campus, the medical center and clinics, School of Nursing and the School of Medicine. In general, the Code of Conduct applies to all individuals engaged in or supporting any of the health system’s activities.

What are the Code of Conduct Standards?
The following pages contain the 14 Standards presented in the UCDHS Code of Conduct.

Standard 1 — Quality of Care
The university’s academic health centers and health systems will provide quality health care in a manner that is appropriate, medically necessary, and efficient.

1. All patients will be afforded quality clinical services.
2. Urgent and/or medically necessary services will be provided independent of payment methodology. The University’s health care professionals will follow current medical and ethical standards regarding physicians and other health care providers’ communication with patients, and where appropriate, their representative, regarding the care delivered.
3. The University recognizes the right of patients to make choices about their own care, including the right to do without recommended care or to refuse treatment.
4. University personnel, generally the patient’s health care providers will inform patients about the alternatives and risks associated with the care they are seeking and obtain informed consent. To the extent possible, this information will be provided in a language that the patient can understand.

**Standard 2 — Medical Necessity and Appropriate Services**
The University’s academic health centers and health systems shall submit claims for payment to government, private, or individual payers for those services or items that are medically necessary and appropriate.

1. When ordering or providing services or items, University physicians (or other health care professionals authorized by law to order items or services) shall only order those services and items that are consistent with generally accepted medical standards for diagnosis or treatment of disease and are determined by the profession to be medically necessary and appropriate.
2. In some cases, a health care professional may determine that services are medically necessary or appropriate, but the patient’s health plan may not cover those services. In those cases, a patient should refer to his or her health plan administrator to receive information about the process for disallowed claims or uncovered benefits.
3. Patients may request services that are not covered benefits. Such services may be provided as long as the patient has been given advance notice and has agreed to pay for the services. In these cases, the patient may request the submission of a claim for the services to protect his or her appeal rights with respect to those services or to determine the extent of the coverage provided by the payer.
4. Professional coding and documentation will be consistent with the standards established in the University and Campus Programs and relevant policies.

**Standard 3 — Proper Coding, Billing, and Patient Accounting**
University personnel involved in the coding, billing, documentation and accounting for patient care services for the purpose of billing government, private or individual payers must comply with all applicable state and federal regulations and campus policies and procedures for detecting and preventing fraud, waste, and abuse.

1. The University will bill only for services actually rendered and shall seek the amount to which the University is entitled. The University does not tolerate billing practices that misrepresent the services actually rendered.
2. Supporting medical documentation must be prepared for all services rendered. University personnel shall bill on the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
3. All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws, and contracts and campus policies and procedures. In all cases, federal and state regulations take precedence; however, campus policies and procedures must accurately reflect those regulations.
4. All patients shall be consistently and uniformly charged. Discounts will be appropriately reported, and items and services consistently described so that comparability can be established among payers.
5. Government-sponsored payers shall not be charged in excess of the provider’s usual charges. Any questions regarding the interpretation of this standard should be directed to the chief compliance officer or university legal counsel.

6. Billing and collections will be recorded in the appropriate accounts. Credit balances must be processed in a timely manner in accordance with applicable rules and regulations. When the cost report process identifies any credit balances, University personnel shall direct those issues to the academic health center, the health system’s accounting or risk management departments, or other personnel responsible for patient accounts.

7. University personnel should be aware of the existence of system-wide and campus Professional Fee Billing Guidelines and Clinical Laboratory Billing Guidelines. These Guidelines, available through the campus Compliance Office, provide for the policies and procedures to be followed when the University bills payers for professional fees and laboratory services. University personnel responsible for coding, billing, and documentation should be knowledgeable about University policies and procedures, federal and state regulations regarding those activities. The University shall provide these individuals with opportunities for training to allow them to accurately code, document, and bill according to federal and state regulations and the University’s policies and procedures. Management at each academic health center campus should ensure that appropriate evaluation processes have been established to assess whether University personnel understand and carry out correct procedures.

8. Elective procedures that are not covered by governmental or private payer can be provided. However, before providing any elective services, the provider must inform the patient that these services may not be covered. The provider should obtain the patient’s agreement to pay for the services if payers deny the claim. A patient has the right to have a claim submitted even if services are excluded from coverage.

9. An accurate and timely billing structure and medical records system is critical to ensure that University personnel can effectively implement and comply with required policies and procedures. Demonstrated lapses in the information and billing systems infrastructure should be remedied in a timely manner by the campus executive management team, other designated University personnel and billing entities.

**Standard 4 — Proper Cost Reporting**

University personnel who are responsible for the preparation and submission of cost reports must ensure that all such reports submitted to government and private payers are properly prepared and documented according to all applicable federal and state laws.

1. In submitting and preparing cost reports, all costs will be properly classified, allocated to the correct cost centers, and supported by verifiable and auditable data.

2. It is the University’s policy to correct any cost report preparation or submission errors and mistakes in a timely manner and, if necessary, clarify procedures and educate employees to prevent or minimize recurrence of those errors.

**Standard 5 — Respect of Confidentiality**

All efforts will be made to protect personal and confidential or privileged information concerning the academic health center and health system’s patients and the respective health care
practices of those entities. University personnel will abide by applicable state and federal laws, including HIPAA privacy and security regulations.

1. University personnel shall not disclose confidential patient information unless authorized by the patient and/or when authorized by law. Approval for appropriate use of patient information for research purposes must be obtained from the Institutional Review Board.

2. Confidential patient information should only be discussed with or disclosed to appropriate University personnel as permitted by HIPAA policies.

3. Confidential patient information should not be discussed with or disclosed to non-University personnel unless authorized by the patient or permitted by law. Non-University personnel include the family or business and social acquaintances of the patient or of University personnel, customers, suppliers, or others.

4. In general, patients can request and are entitled to receive copies or summaries of their records with the exception of non-emancipated minors, some mental health patients, and patients being treated for alcohol and drug abuse, who may be provided with copies of the records if it is appropriate as judged by their clinician.

5. Some information may be sought under the *California Public Records Act*, the *Information Practices Act*, or other statutes requiring the release of information.

6. University personnel who have any questions regarding patient confidentiality should refer to University policies for additional information and consult with appropriate supervisor, manager, the Compliance Office, or the Privacy Officer.

7. University personnel shall not reveal or disclose confidential medical staff or peer review information. California and federal law bestows certain privileges and provides for confidentiality of certain records including the proceedings and records or organized committees of the medical staff and peer review bodies.

8. University personnel shall not reveal or disclose proprietary or trade secret information to unauthorized non-University persons. Proprietary information may relate to University business affairs or the affairs of a vendor or contractor.

9. Personnel records are considered confidential. Access to personnel files is limited to management, the human resources department staff, and internal auditors, and these individuals are held accountable for protecting the privacy of personnel records.

**Standard 6 — Creation and Retention of Accurate Patient and Institutional Records**

All patient and institutional records are the property of the University. University personnel responsible for the preparation and retention of records shall ensure that those records are accurately prepared and maintained in a manner and location as prescribed by law and University policy.

1. The complete and accurate preparation and maintenance of all records (medical, professional, electronic, paper, and institutional) by University physicians, clinicians, nurses, and others are important for providing quality care and conducting business of the University’s clinical enterprise. Accurate records are required in order for the University hospital or clinic to retain licensure and accreditation.

2. University personnel will not knowingly create records that contain any false, fraudulent, fictitious, deceptive, or misleading information.
3. University personnel must not delete any entry from a medical record. Medical records can be amended and material added to ensure accuracy of a record in accordance with Health System and Medical Staff policies and procedures. Whenever University personnel amend a record, they must indicate that the notation is an addition or correction and record the actual date that the additional entry has been made.

4. University personnel must not sign someone else’s signature or initials on a record unless they have been authorized and clearly marked that they are signing on behalf of another (e.g., by initialing the signature).

5. University records shall be maintained according to accepted standards and principles of the particular profession and applicable University policies and procedures.

6. Unless authorized by University policy, University personnel shall not destroy or remove any University records from the University’s premises.

7. The University’s record retention and record destruction policies and procedures must be consistent with Federal and State requirements regarding the appropriate time periods for maintenance and location of records.

**Standard 7 — Cooperation with Government Requests for Information**

University personnel should cooperate with appropriately authorized governmental investigations and audits.

1. The University has developed detailed policy to advise University personnel on the procedures to be followed when representatives of the government arrive unannounced. The policy establishes a procedure for an orderly response to the government’s request to enable the Health System to protect its and its patients’ interest while fully cooperating with the investigation.

2. When a representative from a federal or state agency contacts University personnel for information regarding the Health System or any Health System affiliated health care entity, or any other entity with which the Health System does business, the individual should contact the hospital director immediately. If the hospital director is not immediately available, the individual should contact the Compliance Office, or Health System Counsel or General Counsel. University personnel should ask to see the government representative’s identification and business card, if the government representative is there in person. Otherwise, University personnel should ask for the person’s name and office, address and telephone number, identification number and then call the government representative’s office to confirm his or her authority.

**Standard 8 — Prevention of Improper Referrals or Kickbacks**

University personnel must not accept or offer, for themselves or for the University, anything of value in exchange for referrals of business or the referral of patients.

1. Federal law generally prohibits anyone from offering anything of value to a Medicare, Medicaid or TRICARE patient that is likely to influence that person’s decision to select or receive care from a particular health care provider.

2. University personnel may not offer or receive any item or service of value as an inducement for the referral of business or patients to or from University providers or practitioners or
outside facilities. Regulations prohibit improper influence that could alter clinical decisions or purchasing decisions, increase costs, or lead to over or under utilization of services.

3. In addition to the prohibition regarding exchange of goods or money to induce referral, certain prohibitions exist with regard to receipt of gifts by University personnel.

4. Federal law prohibits a physician from referring a patient for certain health services to a facility where that physician (or a family member) has a financial interest (Stark regulations).

5. University personnel should adhere to the University’s policy as defined in the Compendium of University of California Specialized Policies, Guidelines and Regulations Related to Conflict of Interest, the University’s Gifts Policy, as well as the California Political Reform Act.

6. Each campus shall establish procedures for the review of all pricing and discounting decisions to assure that appropriate factors have been considered and that the basis for such arrangements are documented.

7. The following types of business arrangements must be reviewed and approved by one or more of the campus executive management teams to assure compliance with University policies and federal regulations. The executive management team may determine that certain business transactions must first be approved, in accordance with University policy, but the University’s Board of Regents is charged with taking action on such matters:
   a. Pursuing joint ventures, partnerships, corporations;
   b. Developing hospital financial arrangements with hospital-based physicians;
   c. Entering into an arrangement to lease or purchase equipment or supply items from a vendor; or
   d. Acquiring physician’s practices, hospitals, and other facilities, clinical, and ancillary services, or any other entities.

Standard 9 — Adherence to Antitrust Regulations
The university will comply with all applicable federal and state antitrust laws.

University personnel should not, for example:
1. Agree, or attempt to agree, with a competitor to artificially set prices or salaries;
2. Divide markets, restrict output, or block new competitors from the market;
3. Share pricing information with competitors that is not normally available to the public;
4. Deny staff privileges to physicians or allied practitioners, individually or as a group, when there is no academic programming decision to do so and when such decisions should be based on individual qualifications; and
5. Agree to participate with competitors in a boycott of government programs, insurance companies, or particular drugs or products.

Standard 10 — Avoidance of Conflicts of Interest
All University personnel shall conduct clinical enterprise and personal business in a manner that will avoid potential or actual conflicts of interest.

1. University personnel shall not use their official positions to influence a university decision in which they know, or have reason to know, that they have a financial interest. University personnel should follow the Compendium of University of California Specialized Policies,
Guidelines, and Regulations Related to Conflict of Interest and be knowledgeable about activities that may be an actual or potential conflict of interest. Examples of such activities may include, but are not limited to, the following:

a. Giving to or receiving gifts, gratuities, loans, or other special treatment of value from third parties doing business with or wishing to do business with the University in a manner that is not in accordance with the University’s Gifts Policy and the California Political Reform Act. Third parties may include, but are not limited to, customers, patients, vendors, suppliers, competitors, payers, carriers, and fiscal intermediaries;
b. Using the University facilities or resources for other than University activities;
c. Using the University’s name to promote or sell non-University products or personal services; and
d. Contracting for goods or services with family members of University personnel directly involved in the purchasing decision.

2. University personnel should consult with a supervisor, executive management, the campus conflict of interest coordinator, University general counsel or, if available, campus counsel prior to engaging in any activity that could raise conflict of interest issues.

Standard 11 — Respect for Patient’s Freedom of Choice
When referring patients to home health agencies, medical equipment suppliers or long term-care and rehabilitation providers, University personnel should respect the patient’s right to choose his or her own providers.

1. Some health care plans limit the patient’s choice of provider, or pay less than the full cost of a provider. The patient has the freedom to choose providers not in his or her health program or insurance panel, provided the patient is willing to pay for the non-covered care.

Standard 12 — Honest and Fair Business Practices
University personnel shall adhere to fair business practices and accurately and honestly represent themselves and the University’s services and products.

1. University personnel will be honest and truthful in all marketing and advertising practices pertaining to the business practices of the University’s academic health centers and health systems.
2. Vendors who contract to provide goods and services to the University’s academic health centers and health systems will be selected on the basis of quality, cost-effectiveness and appropriateness for the identified task or need, in accordance with University policy.

Standard 13 — Fair Treatment of Employees
The University prohibits discrimination in any work related decision on the basis of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or service in the uniformed services. The University is committed to providing equal employment opportunity and a work environment where each employee is treated with fairness, dignity and respect.
1. The University will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities. If an individual requires accommodations or needs assistance, he or she should contact the campus Employee Assistance Program or human resources.

2. The University does not tolerate harassment or discrimination by anyone based on the diverse characteristics or cultural backgrounds of those who work for the University pursuant to the University of California Non-discrimination and Affirmative Action Policy Regarding Academic and Staff Employment.

3. Any form of workplace violence or sexual harassment is strictly prohibited. University personnel should refer to campus specific policies dealing with workplace violence or sexual harassment.

4. For employees who observe or experience any form of discrimination, harassment or violence, the University provides a number of ways to report the incident, including, but not limited to the following: a supervisor, manager, the Chief Compliance Officer, UC Davis Health System Counsel, University general counsel, campus counsel, Human Resources, the campus Office of Equal Opportunity & Diversity, the campus Compliance hotline, and appropriate Academic Senate committee.

**Standard 14 – Clinical Research**

Integrity in research includes not just the avoidance of wrong doing, but also the rigor, carefulness, and accountability that are the hallmarks of good scholarship. University policies set forth expectations for high standards of ethical behavior for faculty, staff, and students involved in research. The rights of research study participants and their well-being and privacy are protected by the University through compliance with ethical standards and all applicable University policies and federal and state regulation.

1. All members of the University community engaged in research are expected to conduct their research with integrity and intellectual honesty at all times and with appropriate regard for human subjects.

2. To protect the rights, well-being, and privacy of human subjects, all research involving human subjects is to be reviewed by institutional review boards.

3. The University prohibits research misconduct. Personnel engaged in research are not to: fabricate data or results; change or knowingly omit data or results to misrepresent results in the research record; or intentionally misappropriate the ideas, writings, research, or findings of others.

4. All those engaged in research are expected to pursue the advancement of knowledge while meeting the highest standards of honesty, accuracy, and objectivity and to demonstrate accountability for sponsors’ funds and to comply with specific terms and conditions of contracts and grants.

5. In accordance with University policy (UCOP Operating Requirement No. 95-5, “Requirements for Administration of Agreements with Private Sponsors for Drug and Device Testing Using Human Subjects”), the cost to perform clinical trials conducted for a private sponsor must always be fully funded by the sponsor and may not be supported in whole or in part by other funds, including third party insurance payments, gift or foundation funds, or charges to the subject.
6. Goods and services are procured in a competitive, fair and timely manner in compliance with OMB Circular A-110 and University policies. Conflicts of interest are avoided. Educational or research grants or other funds received from commercial entities are not permitted to influence procurement decisions.

7. Ongoing monitoring and auditing processes, with initiation of appropriate corrective action, ensure the University’s clinical research programs are well managed.

8. The records retention program for clinical research ensures documents and other necessary supporting evidence are maintained for the appropriate length of time as required by federal and other regulations. This program evaluates and verifies the effectiveness of the systems and internal procedures implemented.

NOW THAT I KNOW ABOUT THE CODE OF CONDUCT WHAT ARE MY OTHER RESPONSIBILITIES?

In addition, to the Code of Conduct, UCDHS also recognizes and endorses the University of California Statement of Ethical Values, the University of California Standards of Ethical Conduct and the University of California Davis’ Principles of Community. The documents can be found online at: http://www.ucop.edu/ethics-compliance-audit-services/compliance/standards-of-ethical-conduct.html, http://policy.ucop.edu/doc/1100172/EthicalValuesandConduct and http://occr.ucdavis.edu/poc/. Like the Code of Conduct, Employees and students are responsible for understanding and following the guidance in these documents.

University of California Davis Principles of Community

In 1990, the Principles of Community were developed based upon contributions from a variety of staff and student groups at the UC Davis Campus and UCDMC. Reaffirmed in 1996 and 2001, the statement intends to confirm the UC Davis community’s commitment to providing an environment of civility, appreciation for diversity and respect for the personal dignity inherent in all of us.

The UC Davis Principles of Community are as follows:

"The University of California, Davis, is first and foremost an institution of learning and teaching, committed to serving the needs of society. Our campus community reflects and is a part of a society comprising all races, creeds and social circumstances. The successful conduct of the university's affairs requires that every member of the university community acknowledge and practice the following basic principles:

We affirm the inherent dignity in all of us, and we strive to maintain a climate of justice marked by respect for each other. We acknowledge that our society carries within it historical and deep-rooted misunderstandings and biases, and therefore we will endeavor to foster mutual understanding among the many parts of our whole.

We affirm the right of freedom of expression within our community and affirm our commitment to the highest standards of civility and decency towards all. We recognize the right of every individual to think and speak as dictated by personal belief, to express..."
any idea, and to disagree with or counter another's point of view, limited only by university regulations governing time, place and manner. We promote open expression of our individuality and our diversity within the bounds of courtesy, sensitivity and respect.

We confront and reject all manifestations of discrimination, including those based on race, ethnicity, gender, age, disability, sexual orientation, religious or political beliefs, status within or outside the university, or any of the other differences among people which have been excuses for misunderstanding, dissension or hatred. We recognize and cherish the richness contributed to our lives by our diversity. We take pride in our various achievements, and we celebrate our differences.

We recognize that each of us has an obligation to the community of which we have chosen to be a part. We will strive to build a true community of spirit and purpose based on mutual respect and caring."

The UC Davis Principles of Community sets forth the expectation that all members of the UC Davis community will treat others with dignity and respect. Similarly, the National Culturally and Linguistically Appropriate Services (CLAS) standards affirms the responsibility of health care workers to provide understandable, effective and respectful care in a manner compatible with a patient’s cultural health beliefs and practices and preferred language. UCDHS supports CLAS and the Principles of Community by recruiting, retaining and promoting a diverse employee population capable of meeting the needs of and serving our diverse patient population. The fourteen CLAS Standards can be reviewed at: http://www.ucdmc.ucdavis.edu/hr/hrdepts/eod/clas_1_14.html.

University of California Statement of Ethical Values and Standards of Ethical Conduct

The Statement of Ethical Values establishes the premise that all members of the University of California community are committed to the highest ethical standards in furtherance of the organization’s teaching, research and public service missions. The Statement lists the following values of commitment:

- **Integrity:** We will conduct ourselves with integrity in our dealings with and on behalf of the University.
- **Excellence:** We will conscientiously strive for excellence in our work.
- **Accountability:** We will be accountable as individuals and as members of this community for our ethical conduct and for compliance with applicable laws and University policies and directives
- **Respect:** We will respect the rights and dignity of others.

The purpose of the Standards of Ethical Conduct is to establish core values to guide the ethical conduct of all University activities engaged in by all members of the UC community. The Standards include:
1. Fair Dealing
Members of the University community are expected to conduct themselves ethically, honestly and with integrity in all dealings. This means principles of fairness, good faith and respect consistent with laws, regulations and University policies govern our conduct with others both inside and outside the community. Each situation needs to be examined in accordance with the Standards of Ethical Conduct. No unlawful practice or a practice at odds with these standards can be justified on the basis of customary practice, expediency, or achieving a “higher” purpose.

2. Individual Responsibility and Accountability
Members of the University community are expected to exercise responsibility appropriate to their position and delegated authorities. They are responsible to each other, the University and the University’s stakeholders both for their actions and their decisions not to act. Each individual is expected to conduct the business of the University in accordance with the Core Values and the Standards of Ethical Conduct, exercising sound judgment and serving the best interests of the institution and the community.

3. Respect for Others
The University is committed to the principle of treating each community member with respect and dignity. The University prohibits discrimination and harassment and provides equal opportunities for all community members and applicants regardless of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran.

Further, romantic or sexual relationships between faculty responsible for academic supervision, evaluation or instruction and their students are prohibited. The University is committed to creating a safe and drug free workplace. Following is a list of the principal policies and reference materials available in support of this standard:

- The Faculty Code of Conduct
- Academic Personnel Policy Manual
- The Faculty Handbook
- Personnel Policies for Staff Members
- Policies Applying to Campus Activities, Organizations and Students
- Policy on Sexual Harassment and Procedures for Responding to Reports of Sexual Harassment
- University policies on nondiscrimination and affirmative action
- Campus, laboratory and Office of the President Principles of Community

The University’s health sciences enterprises are committed to the ethical and compassionate treatment of patients and have established policies and statements of patient rights in support of this principle.
4. Compliance with Applicable Laws and Regulations
Institutions of higher education are subject to many of the same laws and regulations as other enterprises, as well as those particular to public entities. There are also additional requirements unique to higher education. Members of the University community are expected to become familiar with the laws and regulations bearing on their areas of responsibility. Many but not all legal requirements are embodied in University policies. Failure to comply can have serious adverse consequences both for individuals and for the University, in terms of reputation, finances and the health and safety of the community. University business is to be conducted in conformance with legal requirements, including contractual commitments undertaken by individuals authorized to bind the University to such commitments. The Office of the General Counsel has responsibility for interpretation of legal requirements.

5. Compliance with Applicable University Policies, Procedures and Other Forms of Guidance
University policies and procedures are designed to inform our everyday responsibilities, to set minimum standards and to give University community members notice of expectations. Members of the University community are expected to transact all University business in conformance with policies and procedures and accordingly have an obligation to become familiar with those that bear on their areas of responsibility. Each member is expected to seek clarification on a policy or other University directive he or she finds to be unclear, outdated or at odds with University objectives. It is not acceptable to ignore or disobey policies if one is not in agreement with them, or to avoid compliance by deliberately seeking loopholes. In some cases, University employees are also governed by ethical codes or standards of their professions or disciplines—some examples are attorneys, auditors, physicians and counseling staff. It is expected that those employees will comply with applicable professional standards in addition to laws and regulations.

6. Conflicts of Interest or Commitment
Employee members of the University community are expected to devote primary professional allegiance to the University and to the mission of teaching, research and public service. Outside employment must not interfere with University duties. Outside professional activities, personal financial interests, or acceptance of benefits from third parties can create actual or perceived conflicts between the University’s mission and an individual’s private interests. University community members who have certain professional or financial interests are expected to disclose them in compliance with applicable conflict of interest/conflict of commitment policies. In all matters, community members are expected to take appropriate steps, including consultation if issues are unclear, to avoid both conflicts of interest and the appearance of such conflicts.

7. Ethical Conduct of Research
All members of the University community engaged in research are expected to conduct their research with integrity and intellectual honesty at all times and with appropriate regard for human and animal subjects. To protect the rights of human subjects, all research involving human subjects is to be reviewed by institutional review boards. Similarly, to protect the welfare of animal subjects, all research involving animal subjects is to be reviewed by institutional animal care and use committees. The University prohibits research misconduct. Members of the
University community engaged in research are not to: fabricate data or results; change or knowingly omit data or results to misrepresent results in the research record; or intentionally misappropriate the ideas, writings, research, or findings of others. All those engaged in research are expected to pursue the advancement of knowledge while meeting the highest standards of honesty, accuracy, and objectivity. They are also expected to demonstrate accountability for sponsors’ funds and to comply with specific terms and conditions of contracts and grants.

8. Records: Confidentiality/Privacy and Access
The University is the custodian of many types of information, including that which is confidential, proprietary and private. Individuals who have access to such information are expected to be familiar and to comply with applicable laws, University policies, directives and agreements pertaining to access, use, protection and disclosure of such information. Computer security and privacy are also subject to law and University policy. Information on the University’s principles of privacy or on specific privacy laws may be obtained from the respective campus or laboratory information privacy office. The public right to information access and the individual’s right to privacy are both governed by state and federal law, as well as by University policies and procedures. The legal provisions and the policies are based upon the principle that access to information concerning the conduct of the people’s business is a fundamental and necessary right of every person, as is the right of individuals to privacy.

9. Internal Controls
Internal controls are the processes employed to help ensure that the University’s business is carried out in accordance with these Standards, University policies and procedures, applicable laws and regulations and sound business practices. They help to promote efficient operations, accurate financial reporting, protection of assets and responsible fiscal management. All members of the University community are responsible for internal controls. Each business unit or department head is specifically responsible for ensuring that internal controls are established, properly documented and maintained for activities within their jurisdiction. Any individual entrusted with funds, including principal investigators, is responsible for ensuring that adequate internal controls exist over the use and accountability of such funds. The University has adopted the principles of internal controls published by the Committee of Sponsoring Organizations (COSO) of the Treadway Commission.

10. Use of University Resources
University resources may only be used for activities on behalf of the University. They may not be used for private gain or personal purposes except in limited circumstances permitted by existing policy where incidental personal use does not conflict with and is reasonable in relation to University duties (e.g. telephones). Members of the University community are expected to treat University property with care and to adhere to laws, policies and procedures for the acquisition, use, maintenance, record keeping and disposal of University property. For purposes of applying this policy, University resources is defined to include but not be limited to the following, whether owned by or under the management of the University (for example, property of the federal government at the National Laboratories):

- Cash, and other assets whether tangible or intangible; real or personal property;
• Receivables and other rights or claims against third parties;
• Intellectual property rights;
• Effort of University personnel and of any non-University entity billing the University for effort;
• Facilities and the rights to use University facilities;
• The University’s name;
• University records, including student and patient records; and
• The University information technology infrastructure.

11. Financial Reporting
All University accounting and financial records, tax reports, expense reports, time sheets and effort reports, and other documents including those submitted to government agencies must be accurate, clear and complete. All published financial reports will make full, fair, accurate, timely and understandable disclosures as required under generally accepted accounting principles for government entities, bond covenant agreements and other requirements. Certain individuals with responsibility for the preparation of financial statements and disclosures, or elements thereof, may be required to make attestations in support of the Standards.

12. Reporting Violations and Protection from Retaliation
Members of the University community are strongly encouraged to report all known or suspected improper governmental activities (IGAs) under the provisions of the Policy on Reporting and Investigating Allegations of Suspected Improper Governmental Activities (Whistleblower Policy). Managers and persons in supervisory roles are required to report allegations presented to them and to report suspected IGAs that come to their attention in the ordinary course of performing their supervisory duties. Reporting parties, including managers and supervisors, will be protected from retaliation for making such a report under the Policy for Protection of Whistleblowers from Retaliation and Guidelines for Reviewing Retaliation Complaints (Whistleblower Retaliation Policy).

In addition to being knowledgeable about UCDMC Code of Conduct, the UC Davis Principles of Community and the UC Statement of Ethical Conduct and Standards of Ethical Conduct, you are also responsible for following all federal and state laws, regulations, and policies and procedures that apply to your area of work. Failure to do so could result in you being subject to corrective action and/or further disciplinary measures.
WHAT IF I HAVE A QUESTION, CONCERN OR SOMETHING TO REPORT?

The rules governing the healthcare industry can be complicated. For this reason, it is not always easy to make the right choices when it comes to health care compliance. If you have questions or concerns with any area of the UCDHS Code of Conduct or general compliance, please ask for help. It is always better to ask before taking an action that might be improper. UCDHS supports open discussion of ethical and legal questions. We have well-developed programs in these areas and will not tolerate retaliation against any employee who, in good faith, raises questions or reports suspected violations.

The opportunity for you to ask questions and raise concerns is a cornerstone of a successful corporate compliance program. UCDHS open discussion of ethical and legal questions and concerns regarding compliance issues. If you have a question or concern regarding the appropriateness of a decision or action, you can take any of the following steps:

1. **Communicate with an immediate supervisor or manager**
   You should immediately discuss the issue with your supervisor, manager, or team leader because these individuals should be the most familiar with the particular job requirements and business practices. The supervisor should provide a timely response or work to seek alternative solutions.

2. **Talk with higher level management**
   If you are not comfortable speaking with a direct supervisor or manager, you should contact a higher-level manager in the department or within the health system.

3. **Contact the Chief Compliance Officer and the Compliance Office**
   The Chief Compliance Officer (CCO) has been designated as the individual with lead responsibility for compliance issues. He/she reports directly to executive leadership within the health system. You can bring a question or concern to the CCO or staff within the Compliance Office at any time. This would include situations where you believe that you have not received an appropriate, timely or ethical response from a supervisor. You can contact the Compliance Office by calling: (916) 734-8808 or by emailing the CCO at: teresa.porter@ucdmc.ucdavis.edu

4. **Obtain help from other university resources**
   You can contact university management within other departments or the Office of the President. There are a number of resources within the university that are available to help, including the corporate compliance office, human resources, internal audit, and campus counsel.

5. **Call the Compliance Hotline**
   You may contact the Compliance Hotline to raise questions and clarify issues or to report suspected violations. Reports will be investigated or referred to appropriate personnel for resolution. If you contact the Compliance Hotline, you may choose to remain anonymous. The Compliance Hotline can be reached at the following telephone number:
HOW DOES THE HOTLINE WORK?
At any time, you can call the UCDHS Compliance Hotline to ask a question or report a concern. The people answering calls on the hotline are not employees of the health system. Here is what to expect if you make a call:

- The person answering the telephone will ask you if you want to remain anonymous. If you do, your call will be assigned a number. You can use this number to call back and obtain information on the status of your question or concern.
- Calls are not traced or recorded.
- The person taking the call will document the call and forward it to the UCDHS Compliance Office. For anonymous calls, no UCDHS employee will be given the name of the caller.

WHAT HAPPENS IF I REPORT SOMETHING?
As a university employee or student, you have a personal responsibility to report any activity that appears to violate the Code of Conduct or any applicable laws or regulations. In general, if you are aware of a compliance violation and fail to report it, you may be subject to corrective or disciplinary action.

The University takes all reporting activities very seriously. University Policy 380-17, Improper Governmental Activities/Whistleblower Protection says: “[t]he University is responsible for investigating alleged improper activities as defined in UC policies and the laws and regulations to which the University is subject, and correcting those activities through procedures defined by UC policies.” Given this, any suspicion of activities that may violate the Code of Conduct, applicable laws, or local policies and procedures must be investigated by the appropriate department.

In addition, UC policy and state law is committed to protecting any whistleblower employee or applicant for employment from retaliation having made a protected disclosure or whistleblower report. The UC Whistleblower Protection policy can be found at: [http://policy.ucop.edu/doc/1100563/WhistleblowerProtection](http://policy.ucop.edu/doc/1100563/WhistleblowerProtection).
Requirements for Employee Education about False Claims Recovery Under the Federal Deficit Reduction Act of 2005

What is the False Claims Act? The False Claims Act prohibits any person from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval of government funds. Under the federal False Claims Act, any person who knowingly submits a false or fraudulent claim to a Medicare, Medicaid or other federal healthcare program is liable to the federal government for three times the amount of the federal government’s damages plus penalties of $5,000 to $10,000 per false or fraudulent claim.

What are examples of a false claim? Under the federal False Claims Act (FCA), the federal government prosecutes, criminally or civilly, individuals or entities who submit or cause to be submitted, claims for payment by the government, when the claims are false. In the healthcare industry this includes Medicare, Medicaid and other federal healthcare programs. Examples that may create a false claim include but are not limited to: billing twice for the same service; billing for services not rendered; billing for medically unnecessary services or falsifying certificates of medical necessity; unbundling or billing separately for services that should be billed as one; creating false medical records or treatment plans to increase payments; failing to report and refund overpayments or credit balances; physician billing without personal involvement for services rendered by medical students, interns, residents or fellows in teaching hospitals; and giving and/or receiving unlawful inducements to healthcare providers for referrals for services.

What are the DRA Education Requirements? As a condition of receiving Medicaid payments, Qualifying Entities must establish written policies and procedures that provide detailed information to all employees, contractors, and agents regarding:

- The Federal False Claims Act;
- Administrative remedies for false claims and statements;
- Any state laws pertaining to civil or criminal penalties for false claims and statements; and
- The whistleblower protections under such laws.

How do University of California policies comply with the DRA education requirements? The University of California has a web-site dedicated to whistleblower procedures with information, frequently asked questions, resources and written policies which include specific details regarding policies and procedures for detecting and preventing fraud, waste, and abuse. The policies incorporate requirements under State of California laws. The UC “Standards of Business Conduct” (employee Code of Conduct) has been updated with DRA information and includes a section covering the laws described above, the rights of employees to be protected as whistleblowers, and UC policies and procedures for detecting fraud, waste, and abuse. For more information on the UC Whistleblower and Whistleblower Protection policies and additional information can be found online at: http://www.ucop.edu/uc-whistleblower/. University of California, Davis’s Whistleblower policy (Chapter 280- Section 17), can be found on line at: http://manuals.ucdavis.edu/PPM/380/380-17.pdf.
What and how do I report? If you suspect instances of fraud, submission of false medical billing claims or other non-compliance with federal, state, local laws, regulations UC or UCD policies, you should report it. Any activity by a UC or UCD employee that violates any state or federal law or regulation (e.g., corruption, malfeasance, bribery, theft or misuse of government property, fraud, coercion, or conversation); or wastes money, or involves gross misconduct, gross incompetence, or gross inefficiency can be reported.

Where to Report?

- Your supervisor (or other appropriate administrator within your unit), who will report it to the UCD Locally Designated Whistleblower Official, Human Resources, Academic Affairs, or Compliance Office
- Directly to any of the above offices
- University-wide Whistleblower Hotline: 1-800-403-4744 (the hotline is independently operated to help ensure confidentiality)
- In writing or orally, with as much specific factual information possible (report what you know, but don’t investigate – leave that to the experts!)
- Anonymously, if preferred

Confidentiality will be maintained, to the extent possible

What are examples of whistleblower protections? CA whistleblowers (or relators as they are referred to in the law) must be original sources of the allegations, thus they cannot use published accounts of fraud allegations or information that has already come to the attention of the government. FCA whistleblowers are protected by the law from retaliation in any form as the result of their whistle blowing. These protections include reinstatement without loss of seniority if fired, recovery of two times lost wages plus interest and recovery of attorney fees and other reasonable costs in connection with pursuing a retaliation claim.

For More Information: Contact your Human Resources or Academic Affairs office for information on the University’s Whistleblower and Whistleblower Protection policies and procedures or go to UCD’s web site at: http://ethics.ucdavis.edu/reporting-improper-activities.html.

The University’s Whistleblower and Whistleblower protection policies and additional information can be found online at http://www.ucop.edu/uc-whistleblower/.
PRIVACY IN HEALTHCARE

Maintaining the confidential nature of patient records is integral to practice of healthcare. In addition to the federal Health Insurance Portability and Accountability Act (HIPAA), which includes privacy regulations, California has several state laws governing health information privacy, such as the Confidentiality of Medical Information Act, California Patient Access to Health Records Act and the Lanterman-Petris-Short Act. All UCDHS employees receive privacy training at the time of hire and on an annual basis.

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rule is a federal regulation affecting Health Plans, Health Care Clearinghouses, and Health Care Providers who conduct certain financial or administrative transactions electronically. The HIPAA regulation has three main parts: Privacy, Security, and Electronic Transactions and Code Sets.

The Privacy Regulations address the rights and responsibilities of covered entities (Health Plans, Clearing Houses, and Health Care Providers) with respect to an individual’s Protected Health Information (PHI). PHI is virtually any information about the patient, whether it is written, spoken, or maintained electronically. In most situations when using or disclosing PHI, a covered entity must use or disclose only the minimum necessary to accomplish the required task. In addition, HIPAA requires that the covered entity provide the patient with a Notice of Privacy Practices that describes how the covered entity may use the patient’s PHI, as permitted by law. For uses of PHI not identified in the Notice of Privacy Practices, the covered entity must obtain the patient’s signed authorization prior to use or disclosure of the PHI.

In addition to HIPAA regulations, the State of California also has its own privacy and security laws. The state law further describes how patient information may be used, disclosed or accessed. The Health System has many policies that address compliance with the HIPAA regulations and state law which can be found is Sections 2300 and 2400 of the Hospital Policies and Procedures.

Both state and federal laws require entities such as UCDHS to proactively review the privacy practices within their organization and to investigate and report any activities that may violate state or federal privacy laws. At UCDHS, the Compliance Office is responsible for implementing the Privacy Program under the direction of the Privacy Official. UCDHS is required to review and report any improper use, access or disclosure of PHI to state and federal agencies. As such, any accidental, known or suspected misuse of PHI should be reported immediately to the employee’s supervisor and the Compliance Office by calling (916) 734-8808 or via email to hs-privacyprogram@ucdavis.edu.
PROMOTING HEALTHCARE EQUALITY

Traditionally sexual orientation and gender identity have not been talked about in the course of health care. The silence on that issue appears to have been important in masking serious health disparities experienced by those with minority sexual orientation (Lesbian, Gay and Bisexual people), those with minority gender identity (Transsexual and other identified people) as well as those with medical conditions making genitals ambiguous at birth or influencing sexual development at puberty (Intersex). Jointly these people constitute LGBTI populations. By including LGBTI information in the Electronic Health Record (self-disclose sexual orientation), our goal is to enhance the quality of care provided and to improve the atmosphere for LGBTI patients, learners, staff and faculty. These efforts stem from our commitment to fully implement and live by our Principles of Community.

UC Davis Principles of Community
UCDHS LGBT EMR Task Force: LGBTI Health Care Resources
https://myhs.ucdmc.ucdavis.edu/web/lgbti
ONLINE INCIDENT REPORTING

Incident Reporting system, RL Solutions is available for use by all UC Davis Health System employees. It may be accessed directly from any UC Davis Health System computer desktop. If the user types ‘incident” in the URL on the home page, it will take them directly to the login screen. The user ID and password correspond to the user’s Kerberos account.

Hospital Policy and Procedure #1466 - Confidential Incident Report, outlines how the IR system is to be used. Any event that is “…not consistent with the routine operation of UC Davis Health System and that potentially may, or actually did, result in injury, harm or loss to any patient, visitor, student, volunteer or employee of UCDHS” is to be reported. Essentially, anything that occurs outside the normal course of events should be reported. These would include adverse outcomes (e.g. pressure ulcers), procedural breakdowns (e.g. breach of confidentiality), and catastrophic events (e.g. wrong site surgery). Incident Reporting system, RL Solutions has 27 forms within which an IR can be submitted.

It is also important to report near misses. Review of near-miss activity may promote system changes that will prevent actual adverse outcomes for patients and staff.

Do not use Incident Reporting system, RL Solutions to report employee injuries (see Hospital Policy and Procedure 1881 – Workers’ Compensation Policy), or exposures to bloodborne pathogens or other employment related claims. Use the Workers’ Compensation system to report injuries and the online exposure reporting system for needlesticks and other bloodborne pathogen exposures. However you may use Incident Reporting system, RL Solutions to report the hazards that led to the injury or exposure. Make a note in the IR if a Workers’ Compensation claim or exposure report has been filed. Questions regarding Incident Reporting system, RL Solutions should be directed to Risk Management at 734-3883.
BLOOD PRODUCT ADMINISTRATION AND TRANSFUSION REACTION ANNUAL IN-SERVICE TRAINING

REFERENCES
Patient Care Standards XIII-12 Administration of Blood & Blood Components

PREPARING FOR BLOOD PRODUCT TRANSFUSION
− Verify MD order for transfusion and ascertain current availability of pool products.
− Ensure that there is a signed consent for blood.

CONSENT
− Administration of blood and components requires informed consent
− Inpatient areas, it is the physician’s responsibility to obtain the informed consent in non-emergent situations.
  − Informed consent for blood administration will be documented on a Consent to Operation, Procedures, Blood Transfusion and Anesthesia Administration form (#71431-854).
  − If this form is not used, informed consent must be documented in a Physician’s Progress Note.
  − Informed consent for blood administration covers all blood administration for a hospital admission.
− Outpatient infusion areas for adults and children, informed consent for blood administration is valid for one year with chronic conditions, and throughout the patient’s course of treatment for transient conditions lasting less than one year.

PATIENT EDUCATION
− Provide patient/family education related to transfusion of blood products.
  ▪ A physician, RN, CRNA or perfusionist must explain the procedure to the patient, patient’s family or to the patient’s lawfully authorized representative.
    − Explanation should include how the transfusion will be given, how long it will take, the expected outcome, the risks, benefits, alternatives, patient’s response and what symptoms to report.

OBTAINING SPECIMEN FOR TYPE & CROSS/TYPE & SCREEN
1. Two patient identification must be performed prior to any specimen collection, or transfusion
2. Ensure that the physician’s order is complete (should be on Physician Blood Order Form)
3. Assemble equipment needed to obtain and label the specimen:
  ▪ 4 ml purple top tube*
• EMR Lab label. Must have time, date, first initial and last name or of person drawing blood or block letter initials if two step collection is performed in order entry system.
• All specimens must be labeled at the bedside in the presence of the patient for Blood Bank testing.

4. PROCEED TO PATIENT’S BEDSIDE – all specimen labeling MUST be done at the patient’s bedside
5. Identify the patient by checking the hospital ID band for name and medical record number, and confirming the name and birth date with the patient (if the patient is alert)
6. Draw specimen
7. Place the completed EMR Lab label on the blood tube
8. Send the specimen to Transfusion Services each specimen should be in its own bag

SPECIMEN FOR ABO VERIFICATION
– If requested by the lab, draw a specimen for ABO verification. This specimen must be obtained by someone other than the person who drew the original blood specimen.

ADMINISTERING BLOOD PRODUCTS
– When blood product is “Ready” status in EMR, RN or designee will bring a demographic label or outpatient card to pick up blood product for the patient. The demographic label must have:
  ▪ Patient’s complete name, medical record number, and date of birth (Optional)
  ▪ Type of product and how many written on label.
  ▪ Full name of RN if a designee is sent to pick up blood product.
– Check blood product with another RN/LVN/MD, verifying identification data per policy
– Assemble necessary equipment and ensure patient has adequate IV access*
– Obtain baseline vital signs prior to infusion and initiate transfusion slowly (< 30 ml in the first 15 minutes). Remain with the patient for the first 5 minutes* after blood enters the vein.
– Monitor and document vital signs appropriately during the transfusion
– Continue to observe patient periodically and for up to 1 hour after transfusion
– Adjust rate of transfusion as prescribed, but not to exceed 4 hours
– At completion of transfusion, flush tubing with 0.9% NS.
– Document transfusion on the Transfusion Record.
– Used blood bags should be kept for 6 hours post transfusion.

RECOGNIZING TRANSFUSION REACTIONS
– Any change in a patient’s condition while blood is being administered should be considered a possible reaction to the transfusion
Acute reactions occur immediately, subacute reactions occur within 6 hours and delayed reactions occur up to several months after the completion of the transfusion.

- Used blood bags should be kept for 6 hours post transfusion in case a transfusion reaction is suspected, in which case the blood bags are then returned to Transfusion Services.

**SIGNS AND SYMPTOMS OF ACUTE REACTIONS INCLUDE:**
- Fevers (increased temperature of >1 degree C during or immediately following transfusion)
- Chills
- Mild itching or urticaria
- Pain
- Sudden onset of dyspnea or sensation /complaint of difficulty breathing
- Hypotension (sudden drop of blood pressure > 40 mm Hg)
- Hemoglobinuria
- Complaint of a sense of impending doom
- Sudden decrease in urine output
- Unexplained bleeding or oozing from puncture or incision sites
- Chest pain
- Pulmonary edema
- Shock

**SIGNS AND SYMPTOMS OF DELAYED REACTIONS INCLUDE:**
- Unexplained onset of jaundice
- Unexpected decrease or failed increase in hemoglobin occurring 5-13 days after transfusion
- Unexpected elevation in liver function tests
- Sudden and unexplained rash or diarrhea 6-10 days after transfusion

**AT FIRST SIGN OF AN ADVERSE REACTION:**
- Stop the transfusion immediately.
- Keep IV open with normal saline infusion. Use a new administration set.
- Check patient identification and donor unit match to confirm patient is receiving correct unit.
- Notify physician immediately.
- Notify Transfusion Service STAT and describe symptoms.
- At Transfusion Service’s request, send properly labeled samples ASAP.
- Send the remaining unit or empty blood bags, the Y-filter administration set and clamped IV fluids to Transfusion Service for follow-up as described in the policy for Administration of Blood and Blood components, PCS XIII-12.
- Physician or nurse to complete the Transfusion Reaction Investigation form and return to Transfusion Service ASAP. Do this STAT if patient requires additional transfusions.

*See policy for specific pediatric and neonatal requirements
EMERGENCY UNLOCKING OF PATIENT BATHROOMS
Staff may open locked patient bathrooms in an emergency. Here are examples from the main hospital of several handle configurations, and how to open them. (There may be other types in clinics). Submit a PO&M work order if you need extra blank keys.

**TYPE 1** Handle with a slot – the slot may be oblong or square. Use an oblong or square blank key, depending on the shape of the slot provided by PO&M. Put key in slot and turn. (Almost any key will fit in the oblong slot, and will work.)

**TYPE 2.** Handle with knob. Turn the knob with your fingers.

**TYPE 3.** Square slot hidden behind metal cap. Remove cap with fingers. Then use square blank key provided by PO&M. Put key in slot and turn.

cap  [image]
cap removed to reveal square slot  [image]
RESTRAINTS UPDATE

Purpose
Provide nursing care and documentation for patients requiring restraints according to the restraint policy and procedure.

Learning Objectives
1. Locate hospital policy on restraint.
2. Identify 3 specific risks associated with use of restraints.
3. List 4 alternatives to use of restraints.
4. Identify 2 nursing interventions to ensure patient safety in restraints.
5. Describe documentation standards for patient in restraints.
6. Identify frequency of required MD/DO/NP/PA order for continued use of restraints.

Staff are required to be familiar with current policy and to follow policy in providing patient care. Take this time to follow the links below and read through the current policy related to restraints.

1. UCDHS PCS IV-69 - Restraints
2. PCS IV-70 - Use of Restraints Protocol for Specific Patient Conditions

What is a restraint?
A physical 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; a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment dosage for the patient’s condition.

Four (4) Side Rails is considered a restraint when the intent of use is to restrict patient movement or immobilize or reduce the patient’s ability to move freely (e.g., If a patient is physically able to ambulate, even if it has been determined that they cannot safely ambulate and the 4 side rails prevent this, then the 4 side rails must be defined as a restraint). Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient’s freedom of movement. In this example, the use of all four side rails would not be considered restraint. (Other examples:

   a. When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.
b. When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.)

Exclusions:

1. Standard practices that include limitation of mobility or temporary immobilization for medical, dental, diagnostic, or surgical procedures, including post-procedure care. For example, the standards do not apply to surgical positioning, intravenous arm boards, radiotherapy procedures, or protection of surgical and treatment sites in pediatric patients.
2. Adaptive support used in response to a patient’s assessed need. For example, the standards do not apply to postural support, orthopedic appliances, or tabletop chairs.
3. Protective equipment, such as helmets.
4. Forensic restrictions and restrictions imposed by corrections and law enforcement authorities for security purposes.
5. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion.

Clinical justification for the use of restraints

1. Violent and self-destructive behavior, harmful to self, others, and the environment such as hitting, hair pulling, throwing objects, striking at or biting staff or others, and self-mutilation.
2. Behavior interfering with life-saving and/or necessary medical treatment such as pulling, tugging, grabbing at lines or tubes, picking at open wound, dressings, drains, and traction.
3. Behavior indicating patient is unable to follow directions to avoid self-injury, such as sitting at the edge of the bed, transferring in/out of bed, standing or ambulating, without the strength or cognition function of doing so safely.
4. The use of restraint is not based on a patient’s history of restraint or dangerous behavior.
5. A request from a family member for restraint, which they consider as beneficial, is not a sufficient basis for the use of restraints.
6. Use of alternative measures has proven ineffective.

Levels of restraints.

1. Treatment restraint is the use of soft restraints, Posey belts, bed enclosures, and other forms of restraints to protect a child or adult who is confused, disoriented, unable to call for assistance, or unable to follow instruction for his/her personal safety; or from dislodging a medical device; or from interfering with the integrity of a dressing or wound.
2. Behavioral Restraint is the use of a physical or mechanical device to involuntarily restrain the movement of all or a portion of a patient’s body as a means of controlling
violent or assaultive behavior with the intent to prevent patient from harming self or others.

**Restraint Orders/Nursing Care**

The healthcare team shall assess the need for use of restraints.

This assessment should include:

1. a physical assessment to identify medical problems that may be causing behavior changes, e.g., hypoxia, hypoglycemia, electrolyte imbalances, etc., and
2. alternative interventions that might prevent the need for restraints.

The RN may initiate the use of restraints upon receipt of a verbal, telephone or electronic restraint order from a MD/DO/NP/PA. If a MD/DO/NP/PA is not available to issue such an order, the RN initiates restraint use based on an appropriate assessment of the patient, notifies the MD/DO/NP/PA within 12 hours of the initiation of restraint and obtains an order.

The MD/DO/NP/PA must be notified immediately upon initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. PRN (as needed) orders are prohibited. MD/DO/NP/PA must provide an order for restraint within 12 hours of application of treatment restraints. This must be renewed every 24 hours after a face-to-face reassessment of the patient with determination of continued need. An exception to this is patients who meet criteria for protocols for specific conditions or certain specific clinical procedures.

<table>
<thead>
<tr>
<th>Type of Restraint Order</th>
<th>Order Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>May not exceed 24 hours.</td>
</tr>
<tr>
<td>Protocol for Use of Treatment Restraints for Specific Patient Conditions</td>
<td>Order expires when restraint removal criteria outlined in this protocol have been achieved.</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Behavioral restraint orders may not exceed:</td>
</tr>
<tr>
<td></td>
<td>4 hours for adults 18 years of age or older;</td>
</tr>
<tr>
<td></td>
<td>2 hours for children 9-17 years;</td>
</tr>
<tr>
<td></td>
<td>1 hour for children less than 9 years.</td>
</tr>
<tr>
<td></td>
<td>Orders may be renewed according to the time limits for a maximum of 24 hours.</td>
</tr>
<tr>
<td></td>
<td>After 24 hours, a new behavioral restraint order may be used after seeing and</td>
</tr>
<tr>
<td></td>
<td>assessing the adult or pediatric patient.</td>
</tr>
</tbody>
</table>
Protocol for Use of Treatment Restraints for Specific Patient Conditions

A MD/DO/NP/PA must issue a patient specific order authorizing the use of restraints. RN’s may apply restraints under a protocol with an MD/DO/NP/PA order for specific conditions or certain specific clinical procedures (e.g., post-traumatic brain injury, insertion of intra-aortic balloon pump) to prevent significant harm to the patient (see PCS IV-70 Protocol for Use of Treatment Restraints for Specific Patient Conditions). In this situation, RN’s maintain and terminate restraint in accordance with established criteria defined in the protocol.

Patient Safety in Restraints

The RN is responsible for using appropriate restraints, based on the MD/DO/NP/PA order, and for assessing, monitoring and re-evaluating the patient and restraints.

The Care Plan Problem:

In EMR, add Restraint (Adult, Ped) for Adult and Pediatric patients. For NICU patients add Restraints (NICU).

MONITORING AND ASSESSING PATIENTS IN RESTRAINTS

*The RN/MD/DO/NP/PA can monitor patients in restraint. PT, OT, Speech Therapist, Psycho-Social Vocational Services, and Radiology Technologists operate under the direction of the current order and continue to monitor and document when the patient is under their sole supervision.*

Assessment may include but is not limited to the following:

a. Type of restraint
b. Restraints appropriately applied, removed, or reapplied
c. Whether less restrictive methods are possible
d. Vital signs
e. Respiratory status
f. Circulation, movement, and sensation
g. Skin integrity
h. Mentation/Behavior/Cognitive Function/Level of distress and agitation
i. Bathroom needs
j. Fluids/Nourishment needs
k. Releasing the restraints to check for injury
l. Range of motion performed
m. Patient’s readiness for release from restraints
n. Call light within reach
o. Patient dignity and rights maintained
<table>
<thead>
<tr>
<th>Frequency assessment</th>
<th>Frequency documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least every 2 hours; observed as often as possible.</td>
<td>A minimum of every 2 hours</td>
<td>The selection of an intervention and determination of the necessary frequency of assessment and monitoring should be individualized according to patient needs and situational factors.</td>
</tr>
</tbody>
</table>

**Discontinuing Restraint Use**

1. The MD/DO/NP/PA/RN has the authority to discontinue the use of restraint.
2. Restraints will be discontinued as soon as is safely possible even if there is still time left on the order when:
   a. Improved mental status
   b. Patient’s agreement and compliance with instructions for safety
   c. Improved ability to sit at edge of bed, transfer or ambulate without risk or injury
   d. Less restrictive measures are effective
   e. Patient’s lines are discontinued or no longer required for medical treatment
   f. The need for restraints does not exist, such as discontinuation of medical treatments
   g. The order has expired
3. When restraints are terminated early and the patient subsequently exhibits the same behavior that initially required the restraints, a new order is required [CMS 482.13(e)(1)(i)(C) A-0161].

   Note: A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient’s need is not considered a discontinuation of the restraint. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

**Risks of Restraint Use**

Risks associated with restraint use should be taken into consideration when assessing the need for restraint and determining the monitoring and care needed while restraints are in place. These risks include:

- Patients with cognitive impairment may attempt self-removal, increasing risk of injury.
- Patients may not be able to communicate needs while in restraints.
- Patients in vest/belt restraints may be injured by falling through split side rails.
• Patients in vest/belt restraints may experience respiratory compromise.
• Patients in restraints may exhibit increased agitation.
• Patients may experience psychological distress due to restraints.
• Patients may experience circulatory compromise of restrained extremity.