CHLA IS A MAGNET HOSPITAL

- Magnet Status is the highest level of recognition that the American Nurses Credentialing Center can accord to organized nursing services in health care organizations.
<table>
<thead>
<tr>
<th>New CHLA Codes</th>
<th>Code Description</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Red</strong></td>
<td>Fire</td>
<td>Dial “33” or pull closest fire alarm</td>
</tr>
<tr>
<td><strong>Code Blue</strong></td>
<td>Medical Emergency</td>
<td>“33”</td>
</tr>
<tr>
<td><strong>Code Orange</strong></td>
<td>Hazardous Material Spill</td>
<td>“33”</td>
</tr>
<tr>
<td><strong>Code Pink</strong></td>
<td>Infant abduction</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Purple</strong></td>
<td>Child abduction (toddlers and above)</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Yellow</strong></td>
<td>Bomb threat</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Gray</strong></td>
<td>Combative person</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Silver</strong></td>
<td>Person with weapon and/or active shooter and/or hostage situation</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Triage Internal</strong></td>
<td>Activate emergency operations plan for internal incident</td>
<td>“33” for any concern House Supervisor (Incident Commander) – activates</td>
</tr>
<tr>
<td><strong>Code Triage External</strong></td>
<td>Activate emergency operations plan for external incident</td>
<td></td>
</tr>
<tr>
<td>Fire and Evacuation Response Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Closest manual alarm pull station:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting a fire</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The two closest evacuation routes are:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>My department assembly area is:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fire alarm code</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fire response procedure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>To use a fire extinguisher</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evacuation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient evacuation priorities</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Closest manual alarm pull station:**
Dial 33

**Reporting a fire**

**The two closest evacuation routes are:**
1. 
2. 

**My department assembly area is:**

**Fire alarm code**
Code Red

**Fire response procedure**
- Safety of Life. Remove occupants if safe to do so. Close the door
- Notify / activate the manual pull station. Dial 33. Give your location, name, and extension
- Return to use fire extinguisher if safe to do so
- Remove occupants from the adjoining area if danger of fire spreading

**To use a fire extinguisher**
PASS
- Pull the pin
- Aim the hose / extinguisher
- Squeeze the handle
- Sweep from side to side

**Evacuation**
- Move horizontally beyond next fire/smoke door
- Move vertically, two floors minimum or unit capable of receiving patient type
- Meet at designated assembly area
- Account for all staff and patients
- Notify emergency operations center extension 12342 of status / missing persons

**Patient evacuation priorities**
- Those closest to danger
- Ambulatory patients
- Those you can evacuate yourself
- Those you need help to evacuate
- Medical records if safe to do so
<table>
<thead>
<tr>
<th>AGE</th>
<th>PSYCHOLOGICAL ISSUES</th>
<th>CONCEPTS OF ILLNESS</th>
<th>REACTION TO HOSPITALIZATION</th>
<th>PERCEPTION OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANCY</td>
<td>• Importance of parent-child bonding</td>
<td>• Generalized perception of discomfort and pain</td>
<td>• Need to have parents close by</td>
<td>• Fear of separation</td>
</tr>
<tr>
<td></td>
<td>• Need to be as close physically as is feasible</td>
<td>• Perceptions modulated by response of environment</td>
<td>• Parent’s absence and reactions provide best support in handling fear, pain and separation</td>
<td></td>
</tr>
<tr>
<td>PRE-SCHOOL</td>
<td>• Need to boost sense of mastery</td>
<td>• Illness/injury seen as a punishment for bad behavior</td>
<td>• Presence of parents is of primary importance</td>
<td>• Death may be personified</td>
</tr>
<tr>
<td></td>
<td>• Need to prepare for medical procedures, separation, etc.</td>
<td>• Magical view, fullness</td>
<td>• Hospitalization perceived as rejection or punishment</td>
<td>• Often sees as violent</td>
</tr>
<tr>
<td></td>
<td>• Possibility of regressions and fears</td>
<td>• Adults seen as omnipotent with power to magically cure the illness/injury if they wanted to</td>
<td>• Fear of mutilation arises</td>
<td>• Don't always see death as permanent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Feelings of inadequacy arise</td>
<td>• Treatment may be seen as punishment</td>
<td>• Death is a punishment for being bad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Concerns about body penetrations by surgery or injections</td>
<td>• Concerns about body penetrations by surgery or injections</td>
<td>• Dead people continue to live</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Simple explanations useful for maintaining trust</td>
<td>• Simple explanations useful for maintaining trust</td>
<td>• Death is confused with separation and sleep</td>
</tr>
<tr>
<td>SCHOOL-AGE</td>
<td>• Need to be productive and learn</td>
<td>• Cause of illness/injury is from disobedient behavior but takes longer to express</td>
<td>• Primary concern is lack of body control and mastery</td>
<td>• Begin to understand the finality of death</td>
</tr>
<tr>
<td></td>
<td>• Begin to use knowledge and understanding of the body, cause of illness and the process of treatment</td>
<td></td>
<td>• Feelings of inadequacy arise</td>
<td>• Death becomes more real, final, universal and inevitable</td>
</tr>
<tr>
<td>AGE</td>
<td>PSYCHOLOGICAL ISSUES</td>
<td>CONCEPTS OF ILLNESS</td>
<td>REACTION TO HOSPITALIZATION</td>
<td>PERCEPTION OF DEATH</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>SCHOOL-AGE CONTINUED</td>
<td>• Needs honest explanations</td>
<td>• Can begin to understand body processes and functions</td>
<td>• May become demanding or rebellious to maintain semblance of control</td>
<td>• Differentiation of living and non-living</td>
</tr>
<tr>
<td></td>
<td>• Fear of loss of control and sense of body integrity</td>
<td>• Conceptualization characterized by internalization and contamination</td>
<td>• Knowledge about illness or injury effective in handling anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Separation from family and peers may interfere with developmental task mastery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADOLESCENCE</td>
<td>• Begins to deal with issues of illness/injury as an individual</td>
<td>• Focus on discrete symptom rather than overall impact of illness/injury</td>
<td>• Seen as threat to independence</td>
<td>• Able to acknowledge the fragility of life</td>
</tr>
<tr>
<td></td>
<td>• Relies less of family support</td>
<td>• Ability to intellectually question and deal with information about illness/injury</td>
<td>• Conflicts over control issues may become a focal concern</td>
<td>• Death may be viewed as philosophical problem in life or challenged and denial by risk-taking</td>
</tr>
<tr>
<td></td>
<td>• Difficulty with compliance of medical regimes proposed by adults (rebellion that jeopardizes death)</td>
<td>• May use denial of illness/injury or over compensation in areas not affected</td>
<td>• Concern about status in peer group after hospitalization</td>
<td>• Idea that death is not permanent may recur (suicide seen as retaliation but reversible</td>
</tr>
<tr>
<td></td>
<td>• Intense preoccupation with body changes and sexuality</td>
<td>• Conceptualization is characterized by physiological and psychophysiological causes of illness/injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Concerns about being &quot;different&quot; heightened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Illness/injury may impair ability to plan for future</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
# N-PASS

## Neonatal Pain, Agitation, & Sedation Scale

Hummel & Puchalski, 2000

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Sedation</th>
<th>Normal</th>
<th>Pain / Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-2</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>Crying Irritability</td>
<td>No cry with deep painful stimuli</td>
<td>Moans or cries briefly with painful stimuli</td>
<td>Little crying Not irritable</td>
</tr>
<tr>
<td>Behavior State</td>
<td>No arousal to any stimuli No spontaneous movement</td>
<td>Aroused briefly to stimuli Little spontaneous movement</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td>Facial Expression</td>
<td>Mouth is lax No expression</td>
<td>Minimal expression with stimuli</td>
<td>Relaxed</td>
</tr>
<tr>
<td>Extremities Tone</td>
<td>Weak grasp reflex Flaccid tone</td>
<td>Weak grasp reflex</td>
<td>Relaxed hands and feet Normal tone</td>
</tr>
<tr>
<td>Vital Signs HR, BP, RR, O₂ Sats</td>
<td>No variability with stimuli Hypoventilation or apnea</td>
<td>&lt; 10% variability from baseline with stimuli</td>
<td>Within baseline or normal for gestational age</td>
</tr>
<tr>
<td></td>
<td>↑ &gt; 20% above baseline SaO₂ ≤ 75% with stimulation - slow ↑ Out of sync with vent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Premature Pain Assessment:
- + 3 if < 28 weeks gestation / corrected age
- + 2 if 28-31 weeks gestation / corrected age
- + 1 if 32-35 weeks gestation / corrected age

@ Hummel & Puchalski, Loyola University Health System, Loyola University Chicago, 2000

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Wong-Baker FACES® Pain Rating Scale

0  2  4  6  8  10
No Hurt Hurts Little Bit Hurts Little More Hurts Even More Hurts Whole Lot Hurts Worst

This tool was originally created with children for children to help them communicate about their pain. Now the scale is used around the world with people ages 3 and older, facilitating communication and improving assessment so pain management can be addressed.
# Quick Reference to Providing Age Specific Care

<table>
<thead>
<tr>
<th>Age</th>
<th>Nursing Care</th>
</tr>
</thead>
</table>
| **Neonates** | 1. Foster attachment to parents  
2. Meet needs promptly and gently  
3. Recognize avoidance behaviors: yawning, averting eyes, frowning, arching, gagging or regurgitation and finger splaying  
4. Recognize approach behaviors: sucking, hand to mouth, cooing and hand clasping  
5. Include parents as partners in care |
| **Infant** | 1. Allow parents to remain with child  
2. Recognize fear of separation from parents  
3. Be aware of fear of strangers  
4. Console through rocking, holding, swaddling, touch and oral stimulation  
5. Know developmental milestones which are rapidly changing  
6. Maintain parents participation in care  
7. Maintain a safe environment: keep side rails up; never leave unattended in a highchair or wagon |
| **Toddler** | 1. Establish honest communication in child’s own language  
2. Promote independence and encourage exploration through movement  
3. Recognize signs of separation anxiety: protest, despair and detachment  
4. Maintain daily rituals and routines and encourage parents to bring in familiar objects from home  
5. Keep teaching brief with emphasis on what child hears, sees, tastes and feels  
6. Maintain a safe environment: keep side rails up; avoid foods that are easily aspirated; supervise activities |
| **Preschooler** | 1. Encourage exploration  
2. Recognize tendency to use imagination in play and expanding on fears  
3. Maintain daily routines and rituals  
4. Encourage play; supervise activities  
5. Prepare for procedures with brief and simple explanations |
| **School Age** | 1. Allow responsibility for simple tasks  
2. Give detailed explanations and obtain their consent for all procedures and tests  
3. Set limits for behavior  
4. Maintain privacy  
5. Maintain contact with parents, siblings and peers  
6. Encourage play |
| **Adolescents** | 1. Recognize possible concerns about body image due to rapid physical and sexual changes  
2. Foster independence  
3. Recognize parental conflict may occur as adolescent and parents learn new roles  
4. Encourage contact with peers  
5. Recognize risk taking and negative peer group behaviors and set limits as necessary  
6. Maintain privacy  
7. Provide opportunity to express feelings  
8. Give detailed explanations and obtain their consent for all procedures and tests |
| **Adult** | 1. Foster independence  
2. Provide detailed information on all aspects of care and allow patient to direct medical decisions  
3. Encourage participation in normal adult roles  
4. Recognize need to feel productive  
5. Maintain privacy  
6. Provide opportunity to express feelings |
The Key Elements of Family-Centered Care

- Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service systems and support personnel within those systems fluctuate.

- Facilitating parent/professional collaboration at all levels of hospital, home, and community care:
  - Care of an individual child;
  - Program development, implementation, evaluation, and evolution; and
  - Policy formation.

- Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.

- Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.

- Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports to meet the diverse needs of families.

- Encouraging and facilitating family-to-family support and networking.

- Ensuring that hospital, home, and community service and support systems for children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.

- Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

PURPOSE:
Family-Centered Care is a philosophy that incorporates patient and family involvement in both the care provided by the hospital and the aspects of hospital operations that impact patients and families. As defined in this policy, Family-Centered Care is designed to strengthen a family’s ability to serve as a child’s primary advocate in the health care process. It is the policy of Children’s Hospital Los Angeles that each staff member provides health care services that are aligned with the principles of Patient and Family-Centered Care within the scope of their job description and professional expectations.

DEFINITION
Family-Centered Care is a model of care in which health care provider’s partner with families and age appropriate patients to make all health care decisions. Family-Centered Care is grounded in the belief that mutually beneficial partnerships between patients, families, and health care professionals lead to the best health outcomes, positively impacting both quality and safety. Families are recognized as the ones who know their child the best, are the constant in their child’s life and are essential members of a complete health care team. When Family-Centered Care is successfully implemented, a family can overcome feelings of helplessness and become empowered to actively participate in their child’s care.

PRINCIPLES
CHLA adopts and subscribes to the core principles of family-centered care as defined by the Institute for Patient- and Family-Centered Care as follows:

- **Dignity and Respect**: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing**: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation**: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration**: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in facility design; and in professional education, as well as in the delivery of care. (Institute for Patient- and Family-Centered Care, 2006)
PROCEDURES:

A. Implementation of Family-Centered Care

Family-Centered Care cannot be operationalized in a complete and definitive list of behaviors and tasks, there are some basic guidelines to foster successful implementation. While individual units and locations in the hospital are encouraged to develop practices specific to their work area, the following minimum expectations must be met across the institution.

1. Ensuring Family Presence
   a. Parents are not visitors and should not be labeled or referred to as such.
   b. Encourage and empower families to stay with their child at all times in the inpatient setting and ensure that structures and processes are in place to support continuous family presence in all hospital units.
   c. Educate families about sleep options within close proximity to patient. Orient parents/families to outpatient and inpatient settings (use the CHLA Welcome Book for inpatient admissions and the Partners in Care patient safety brochure for outpatients). Inform parents/families of food available to them at CHLA (cafeteria, vending machines and “room service” for inpatients).
   d. Consult with services such as Clinical Social Work, Spiritual Care, Child Life and Diversity Services to maximize support for family.

2. Partnering with Parents/Guardians/Families for Effective Care
   a. As appropriate for age, include the patient as full members of the Health Care Team, incorporating their knowledge of their child and/or themselves.
   b. Partner on all decisions regarding their child.
   c. Utilize the information parents and families share about their child.
   d. Link parents/families with hospital and community resources including and child-to-child and family-to-family supports. Consult with Clinical Social Work for assistance.
   e. Empower parents/guardians/families to actively participate in their child’s care through education, support and encouragement. Coach families to ask questions and participate in their child’s care plan.
   f. Prepare to positively participate during procedures. Give clear descriptions prior to the procedure, and give parents/guardians/families the option to remain with their child. Consult with Child Life for assistance.
   g. Whenever possible, schedule tests/procedures at times that are optimal for family participation/presence.
   h. Educate parents/guardians/families about the medications their child is receiving, and show them each dose of medication before their child receives it.
   i. Effectively educate patients/guardians/families about CHLA’s rapid response team, “Team Help,” and ensure that families understand its function and purpose.
j. Inform parents/families about hand hygiene procedures and encourage them to feel free to remind others.

3. Provide Timely and Unbiased Information
   a. Integrate families in patient care rounds, including staff change of shift or “hand off” rounds.
   b. Provide families with results of tests/labs as soon as quickly as possible.
   c. Schedule frequent update meetings with all treating services and provide adequate supports for family to participate in a meaningful way (Clinical Social Work, Spiritual Care, etc.).

4. Honor the Individuality of Families:
   a. Speak respectfully to and about all family members and patients.
   b. Speak to families in their preferred language. Utilize interpreters and/or Qualified Bilingual Employees to ensure that communication is accurate and effective.
   c. Provide care and resources that support the families’ religious beliefs. Consult with Spiritual Care Services to ensure maximum support.
   d. Provide education through methods preferred by family as noted in the care plan.
   e. Respect families’ care decisions without judgment.
   f. Elicit information regarding cultural practices that could be observed during the hospital stay or possibly incorporated into the patient’s care.

5. Collaborate with Families for Quality Improvement
   a. Work areas are encouraged to identify potential family advisors from their specific populations who are passionate about improving the patient/family experience.
   b. Thoughtfully utilize data from patient satisfaction surveys to inform policy and process changes that affect patients and families.
   c. Include parents/families as members in key hospital committees subject to parent availability.
   d. Include patient and family experiences/feedback and patient satisfaction data on agendas for senior leadership and board meetings.

B. Oversight and Accountability

The successful implementation of Family-Centered Care requires fundamental culture change and can therefore not rest under the sole oversight of one person or governing body. It is the responsibility of each hospital staff member to ensure that the core principles are incorporated into his or her practice.

In order to monitor the hospital’s success/progress, the following entities have been developed:

- Family Advisory Council (FAC): The FAC is primarily comprised of parents and caregivers of current or former CHLA patients. The Council provides family feedback and the perspective of patients on issues of importance, particularly those around patient care and families’ access to
hospital services. The Council meets monthly and is co-chaired by a parent and a hospital staff member.

- **Family Advisors as members of hospital Committees/Councils**: Family Advisors serving as members of a committee or council provide the perspective of patients/families on issues of clinical and patient and family experience excellence. These Family Advisor entities will provide summaries of issues that impact patients and families and recommendations to hospital leadership through the Clinical Services Director over Family Centered Care and the Chief Clinical Officer.

### REFERENCES:


### POLICY OWNER:
Administrator, Patient Family Education Resources

### CONTRIBUTORS:

Alex Field  
Manager, Expressive Arts & Therapies

Lori Marshall, RN, MSN, PHD  
Administrator, Patient Family Education Resources

Sharon Chinn  
Director, Family Centered Care Support Services  
Family Advisory Council

Diversity and Equity Council
PURPOSE:
To ensure that hand-off communications between caregivers provides a comprehensive and succinct overview of the patient’s current situation and needs as well as relevant background information. Consistent hand-off communication content and format increases the quantity of information staff members accurately transmit, prevents the omission of information, and improves patient care.

PROCEDURES:
I. Circumstances for Patient Hand-Off Communications
1. Hand-Off Communications for patients can occur during shift changes, temporary or permanent relief coverage, admission from the Emergency Department (ED), various transfers of information or transitions in physical setting in the inpatient and outpatient settings across the continuum.

2. For information regarding patient transfers to different hospitals, long-term care facilities, and home and community health services, refer to CHLA Policy CC – 012.0 Transportation to Another Hospital. Greater detail on patient transport within the hospital can be found in CHLA Policy CC – 088.0 Transport of Patient, Attachment C CC – 088.1 Transport Pyramid, and Attachment B CC – 088.2 Ticket To Ride Form.

II. Hand-Off Communications Requirements
The following attributes of effective hand-off communications must be followed:
1. Information Verification: Hand-offs must include a method to verify the received information. For example, repeat-back or read-back techniques allow for the opportunity for clarification between the giver and receiver of patient information.

2. Up-to-Date Information: Hand-offs must include up-to-date information regarding the patient’s condition, care, treatment, medications, services and any recent or anticipated changes.

3. Standardization: The use of standardized templates or prompting tools is encouraged to prevent omission of important information. A standardized approach to hand-off communication does not mean the same process must be used for all types of hand-off situations. Rather, each type of hand-off communication should follow a process that is standardized for that particular hand-off situation. Each patient care unit/discipline/clinic should modify/supplement their template to fit the specific needs of the patient population.

4. Review of Information: Hand-offs must include an opportunity for the receiver to review relevant patient historical data, which may include previous care, treatment and services. The medical record, whether paper or electronic, should be available to the receiver of the information during the hand off.

5. Limited Interruptions: Interruptions during hand-offs must be limited to minimize the possibility that information would be omitted or forgotten.

6. Communication Prior to Transfer of Care: Hand-off communications must occur prior to
transfer of care. In particularly emergent situations, such as transfers to ICU, the initial hand-off communication may be limited to information focused on the patient’s decompensation; however, complete hand-off communication must occur soon after the patient is transported. Any change in the patient’s care, treatment and services, and/or condition that has occurred between the time of the last hand-off communication and the physical transfer of the patient must be communicated prior to the transfer of care, meeting the other requirements of this policy.

II. Methods for Hand-Off Communications
   1. **Verbal**: Face-to-face or via phone communication.
   2. **Bedside**
   3. **Written Only**: This method is discouraged. If utilized, this method should include a way for the receiver to clarify information.

III. Format for Hand-Off Communications
Hand-Off communication between caregivers should utilize the Situation-Background-Assessment-Recommendation-Questions (SBARQ) format detailed below. The elements listed below for each category should be utilized, as appropriate, for the given Hand-Off Communication situation. The elements for each category should be addressed only as they pertain to the current situation.

1. **Situation (S)**
   A. Patient’s name/age/current location/Patient ID band check
   B. Patient diagnosis
   C. AND/DNR status
   D. Reason for Hand-Off Communication

2. **Background (B)**
   A. Significant medical history: focused to discipline/system involved
   B. Current medications
   C. Psycho/Social issues for patient and/or family
   D. Primary language for patient/family
   E. Allergies
   F. Isolation status and precautions

3. **Assessment (A)**
   A. Most recent set of VS/parameters
   B. Systems head-to-toe, which may include but is not limited to:
      i. Airway/breathing status or issues
      ii. Current pain scale rating
      iii. Nutrition status, e.g., NPO
iv. Invasive lines/tubes  
v. Surgical sites/wounds/fractures  
vi. Skin integrity  
C. Falls risk  
D. Mobility limitations and precautions  
E. Equipment/monitors  
F. Recent Codes, RRTs or Situational Awareness status  
G. Any pending tests, procedures, etc.  
H. Any fluids or medications currently infusing

4. **Recommendation (R)**  
   A. Recommended interventions  
   B. Discharge planning needs and/or additions/alterations to MPC or patient treatment goals; and  
   C. Other pertinent information to facilitate that the care of the patient is not interrupted and important issues are attended.  

5. **Questions (Q)**  
   A. Receiver of information should utilize repeat-back or read-back techniques for anything needing clarification, and be given the opportunity to ask for additional information.  

**REFERENCES:**  
2. [CC – 012.0 Transportation to Another Hospital](#)  
3. [CC – 088.0 Transport of Patient](#)  
   a. [CC – 088.1 Attachment A Transport Pyramid](#)  
   b. [CC – 088.2 Attachment B Ticket To Ride Form](#)

**REVIEWED BY/AUTHOR:**  
David Davis, MN, RN  
CS Clinical Practice Council
First thing’s first...

- **Safety of Life** - Remove Occupants IF safe to do so. Close the door.
- **Activate** - the alarm/ manual pull station. **Dial 33.** Give your location, name, and extension.
- **Fight the fire** - if safe to do so. Use fire extinguisher
- **Evacuate** - Remove occupants from the adjoining area if fire is spreading

**The Fire Extinguisher:**

- **P** - Pull the pin
- **A** - Aim the hose/ extinguisher
- **S** - Squeeze the handle
- **S** - Sweep from side to side

**Let’s go, Let’s go!**

- Move horizontally beyond next fire/ smoke door
- Move vertically, two floors minimum or unit capable of receiving patient type
- Meet at designated assembly area
- Account for all staff and patients
- Notify emergency operations center extension 12342 of status/ missing persons

**Who to evacuate first? (In order of priority)**

- Those closest to danger
- Ambulatory patients
- Those you can evacuate yourself
- Those you need help to evacuate
- Medical Records if safe to do so
1. Introduce the scale to the parent (if possible) before the painful event occurs. Explain that this scale will be used, with their input, to assess the child's level of pain and response to intervention.

2. Look for pain behaviors in each of the five identified categories. If available, seek parent's opinion.

3. Score pain behaviors in each category on a scale ranging from 0-2. This will result in a total score between zero and ten.

4. Refer to Pediatric Pain Management Guideline (appendix 1) for suggested intervention for mild (1-3); moderate (4-7); or severe (8-10) pain.

5. Within an hour of intervention, re-assess the patient. A decrease in pain behaviors suggests successful intervention. No change or increase in pain cues signifies need for further intervention.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td><strong>Face</strong></td>
<td>No particular expression, smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant frown, clenched jaw, quivering chin</td>
</tr>
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</tr>
<tr>
<td><strong>Legs</strong></td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Lying quietly, normal positions, moves easily</td>
<td>Squirming, shifting back/forth, tense</td>
<td>Arched, rigid, or jerking</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Cry</strong></td>
<td>No cry (awake or asleep)</td>
<td>Moans, whimpers, occasional complaint</td>
<td>Crying steadily, screams, or sobs; frequent complaints</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or talking to, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

For example: Your assessment is as follows: face: grimacing occasionally when you touch him tummy (1), his legs a little tense (1), but you can move him easily (0). He occasionally whimpers (1) and he usually stops when mom carries him (1). His pain = 4/10.
Infection Prevention and Control Program
The CHLA Infection Prevention and Control Program is designed to strategically prevent and control hospital-acquired infections among patients, families, employees, medical staff, volunteers and visitors. It is an essential component of effective clinical programs integrating evidence-based practices designed to reduce the frequency of adverse events such as infection or injury.

Infection Prevention and Control (IPC) Staff:
Office Phone: 323-361-5510

Medical Director of Infection Prevention & Control:
Jeffrey M. Bender MD
Pediatric Infectious Diseases
Hospital Epidemiologist
Phone: 323-361-2509

Director of Infection Prevention & Control:
Marisa Pinchas, MPH, CIC
Phone: 323-361-3356

Infection Preventionists:

- Ivan Sumulong, CIC
  Phone: 323-361-5157

- Catherine Ngo, MPH, CIC
  Phone: 323-361-2206

- Elisa Kim, MHA
  Phone: 323-361-2595

- Linda Samano
  Phone: 323-361-3381

Infection Prevention and Control Education

Orientation and In-services
The Infection Prevention and Control Program will provide orientation and in-services upon request. Requests can be made by calling 323-361-5510 or emailing us at InfectionPreventionAndControl@chla.usc.edu

For reference, the Infection Prevention policy & procedure manual can be found at: https://sharepoint.chla.usc.edu/Docs/Infection%20Control/Forms/AllItems.aspx
Preventing Transmission of Communicable Diseases

Hand Hygiene

Performing proper hand hygiene is one of the most important infection control measures for preventing healthcare associated infections. Hands can become contaminated when touching body secretions, wounds and non-intact skin. However, they can also become contaminated when touching surfaces in the immediate vicinity of patients.

Hands should be cleaned according to recommendations outlined by the World Health Organization (WHO). They are as follows:

Washing hands with antimicrobial soap and water (30 seconds):
- When hands are visibly soiled or contaminated
- Before eating
- After using the restroom
- When you start and end your shift
- After sneezing or coughing
- After caring for patients with Clostridium difficile or Norovirus disease

If hands are not visibly soiled, use an alcohol based hand rub (20 seconds) for routinely decontaminating hands in the following situations. CHLA follows the WHO 5 Moments of Hand Hygiene.

- Before patient contact
- Before clean/aseptic procedure
- After body fluid exposure
- After patient contact
- After contact with a patient environment

Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions may contain transmissible infectious agents. Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. Standard Precautions should be used in ALL healthcare settings, inpatient and outpatient.

- Standard Precautions include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Each will be discussed later in this document.
- Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, contain heavily soiled equipment)

Transmission-Based Precautions

In addition to Standard Precautions, we add additional precautions as needed based on the symptoms or diagnosis of the patient.

- Contact Precautions:
  - For diseases that are spread by direct physical contact.
    - Examples: MRSA, diarrhea, lice, scabies
  - PPE required
    - Hand hygiene, donning gloves and gown are required for every room entry.
• **Contact + Precautions:**
  o For *Clostridium difficile* disease and Norovirus (when patient has diarrhea only)
  o PPE required
    ▪ Hand hygiene with soap and water required (these pathogens are resistant to hand sanitizer)
    ▪ Donning gloves and gown are required for *every* room entry.
    ▪ Only bleach wipes should be used to clean these rooms.

• **Combined-Droplet Precautions:**
  o For respiratory infections transmitted through large respiratory droplets
    ▪ Examples: common cold, influenza, pertussis, RSV
  o PPE required
    ▪ Hand hygiene, donning gloves, gown, and surgical masks are required for *every* room entry.

• **Combined-Droplet + Precautions:**
  o For patients with Norovirus infection who are vomiting or for patients with *C. difficile*
    who also have respiratory infections
  o PPE required
    ▪ Hand hygiene with soap and water required (these pathogens are resistant to hand sanitizer)
    ▪ Donning gloves and gown and surgical masks are required for *every* room entry.
    ▪ Only bleach wipes should be used to clean these rooms.

• **Combined-Airborne Precautions:**
  o For respiratory infections that remain infectious over long distances when spread through the air
    ▪ Examples: Tuberculosis, Chickenpox, Measles
  o PPE required
    ▪ Patients are placed into negative pressure rooms.
    ▪ Hand hygiene, donning gloves, gowns and N95 respirator masks are required for *every* room entry. Note, if you are not fit tested for an N95 mask, you must wear a Powered Air Purifying Respirator (PAPR) instead.

• **Mask and Protective Precautions**
  o Reverse isolation to protect highly vulnerable patients
  o Mask isolation: pre-op Heart transplant patients
    ▪ All visitors and staff must wear masks when entering room
  o Protective isolation: SCIDS patients
    ▪ All visitors and staff must wear gowns, gloves, and masks when entering room

**Donning and Doffing (Removal) of Personal Protective Equipment (PPE)**
The following images can be found online at [www.cdc.gov](http://www.cdc.gov)
SEQUENCE FOR PUTTING ON
PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN
   • Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   • Fasten in back of neck and waist

2. MASK OR RESPIRATOR
   • Secure ties or elastic bands at middle of head and neck
   • Fit flexible band to nose bridge
   • Fit snug to face and below chin
   • Fit-check respirator

3. GOGGLES OR FACE SHIELD
   • Place over face and eyes and adjust to fit

4. GLOVES
   • Extend to cover wrist of isolation gown
CHLA-specific PPE reminders:

1. Always remember to tie your isolation gowns in the back.
2. Remember to remove PPE after you leave one patient room and put on new PPE when you enter the next room. Never wear the same PPE into multiple patient rooms.
3. If you are wearing gloves, remember to wash your hands before and after gloving.
Respiratory Hygiene/Cough Etiquette

Serious respiratory illnesses like influenza, respiratory syncytial virus (RSV), whooping cough, and severe acute respiratory syndrome (SARS) are spread by:
- Coughing or sneezing
- Unclean hands

To prevent the spread of illnesses to others, respiratory hygiene should be followed:
- Cover your mouth and nose with a tissue when you cough or sneeze.
- Put used tissue in the wastebasket.
- If a tissue is unavailable, cough or sneeze into your upper sleeve or elbow, not your hands.
- Perform hand hygiene after coughing or sneezing

Cleaning and Disinfection

Microorganisms can survive on surfaces in the healthcare environment for long periods of time and the physical environment of the hospital is an important reservoir of infections from one patient to another. Cleaning and disinfection is an extremely important infection prevention strategy to prevent this transmission.

Any item that is shared or used on multiple patients must be disinfected in between use. In addition, cleaning and disinfection of the patient room must occur on a regular basis, especially in high touch surfaces like the doorknob, light switch, bedside table, bed rails, computer and keyboard.

CHLA uses two primary disinfectant wipes:

- PDI Super Sani-Cloth Wipes
  - Must stay wet for **two minutes** to be effective
  - For use on most hard surfaces

- Dispatch Bleach Wipes
  - Must stay wet for **three minutes** to be effective
  - For patients with C. difficile or Norovirus

Respiratory Protection and Aerosol Transmissible Disease Exposure Plan

All healthcare personnel who potentially interact with patients who have droplet or airborne transmissible respiratory diseases must participate in the facility respiratory protection program.

CHLA provides annual Fit Testing and Respiratory Protection Clinic in September every year. Appointments are required. The following is reviewed at the clinic:
- N95 Fit Testing is conducted
- Powered Air Purifying Respirator (PAPR) training is provided
- Proper PPE for care of patients with droplet and airborne transmissible infections is reviewed

Refer to IC 800: Aerosol Transmissible Disease Exposure Control Plan for further information.

Multi-Drug Resistant Organisms
Multi-Drug Resistant Organisms (MDROs) such as Methicillin Resistant Staphylococcus aureus (MRSA), Vancomycin Resistant Enterococcus (VRE) and *Clostridium difficile* (C.diff) have important infection control implications. This is because these organisms are highly resistant to one or more classes of antibiotics used against them.

Options for treating patients who are diagnosed with an MDRO are limited. Patients with MDROs have longer hospital stays, increased costs and increased risk for mortality.

Prevention of MDROs:
- **Isolation**
  - Most MDROs require Contact Precautions (C. difficile requires Contact + Precautions).
  - Resistant organisms are noted in the blue banner bar for all patients in KIDS.
- **Antimicrobial Stewardship Program (ASP)**
  - Interdisciplinary program focused on reducing unnecessary and inappropriate antibiotic use.
- **Cleaning and Disinfection, Hand Hygiene, PPE**
- **Patients isolated with an MDRO should have dedicated equipment or single use disposable non-critical equipment, instruments and devices.**

**MRSA**

MRSA is a type of skin bacteria that is resistant to methicillin. *The main mode of transmission of MRSA is by direct or indirect contact with infected or colonized patients and by contact with the patient’s environment.*

All patients admitted to Children’s Hospital Los Angeles are screened for MRSA on the day of admission.
  - California State Law SB 1058 requires that patients be notified of MRSA positive results.
  - At CHLA patient notification and education is the responsibility of the physician caring for the patient. Educational materials from CDC are available in multiple languages for the physician to provide to the patient and family.
  - Patients at high risk for acquisition of MRSA during their stay at CHLA are screened at discharge for MRSA. High risk populations are identified by the Infection Control Committee annually in the IC Risk Assessment and Plan.
  - Please reference CHLA IC Policy 318: MRSA Screening for further details.

**Clostridium difficile or C. Difficile**

*Clostridium difficile* is a bacterium which causes diarrhea and is primarily associated with healthcare settings. The main way *C. difficile* is spread by direct contact with the patient and/or the patient’s stools and by contact with the patient’s environment.

**Bloodborne Pathogen Exposure**

The following body fluids, tissues and substances are potential sources of bloodborne pathogens (BBP), particularly HIV, Hepatitis B and Hepatitis C, and should be taken into consideration in the post-exposure assessment:
- blood or blood containing body fluids, tissues or substances visibly contaminated with blood;
- amniotic, cerebrospinal, pericardial, peritoneal, pleural or synovial fluids;
- inflammatory exudates;
- semen and vaginal secretions;
- human milk (at CHLA);
• Viral cultures, regardless of the age of the specimen.

Principal Routes. The principal routes of exposure to substances that carry a potential risk of BBP transmission are:
• Percutaneous injuries (i.e.: skin puncture from contaminated needle or laceration from contaminated sharp objects);
• Exposure of mucous membranes;
• Exposure of non-intact skin.

All bloodborne pathogen exposures must be reported and exposed staff must be offered medical evaluation. Reference IC 601 for the most up-to-date BBP exposure protocol.

Strategies to prevent bloodborne pathogen exposures include:
1. Avoid recapping needles.
2. Plan for safe handling and proper disposal of all sharps in appropriate sharps containers.
3. Use devices with safety features when possible.
4. Wear proper PPE, including face shields, when there is a risk of bloodborne pathogen exposure.

**Safe Injection Practices**

Another important Infection Prevention strategy at CHLA is the adoption of safe injection practices which include:

1. Never reuse a syringe for more than one patient after only changing the needle
2. Never use single-dose/single-use vials for multiple patients
3. Never use the same syringe to re-enter a multiple-dose vial more than once.
4. Never bring a multiple-dose vial to the bedside for use with the patient
5. Never use a common bag or bottle of IV solution as a source of flushes and drug diluents for multiple patients

Author: Marisa Pinchas MPH, CIC  
Director of Infection Prevention and Control
Related Policies for Review:

IC 212: Hand Hygiene
IC 220: Standard Precautions
IC 301: Transmission Based Precautions
IC 317: Clostridium Difficile- Preventing Transmission
IC 318: MRSA Screening and Surveillance
IC 716: Cleaning and Disinfection
IC 601: Management of Blood Borne Pathogen Exposure
IC 602: Employee Exposures
IC 800: Aerosol Transmissible Disease Exposure Control Plan
IC 825: Multidrug Resistant Organisms (MDRO) Preventing Transmission (MRSA, VRE, ESBL, GNB)
HR 62.0: Influenza Vaccination

References:

PURPOSE:

1) To protect patients, staff, employees, family members, and the community from seasonal influenza infection through annual immunization of all personnel subject to this policy and through infection control precautions for influenza.

2) To comply with California Department of Public Health mandates and the LA County Department of Public Health Officer Order mandating influenza vaccination.

PROCEDURE:

Immunization

1. This policy applies to the following personnel (regardless of their employer) who work for any portion of a day at any location in which CHLA is responsible for the care of and provides services to patients including, but not limited to hospitals, outpatient clinics, home health, student and employee health centers, dental clinics, and pharmacies:

   - All faculty, CHLA employees, volunteers, licensed health care professionals, medical staff members, residents, fellows, researchers, medical students, nursing students, nurse practitioner/physician assistant students, pharmacy students, respiratory therapy students, radiation technology students, all other students receiving training at a CHLA health care facility, contractors, vendors, representatives or distributors of a manufacturer or company who visit for the purpose of soliciting, marketing, or distributing products or information regarding the use of medications, products, equipment and/or services.

2. All individuals covered by this policy must be vaccinated or granted an exception by November 1st each year. Dates of the influenza vaccination program will be announced by CHLA Employee Health Services acting with the advice of Infection Prevention and Control and the Division of Infectious Diseases.

3. If there is a shortage of vaccine, the Medical Director of Infection Prevention and Control, Infection Prevention and Control, Employee Health Services, and Pharmacy staff will establish a prioritization schedule for personnel. Individuals not applying for an exception who have not received a vaccination because of the shortage will be given a reprieve from disciplinary action for so long as the shortage exists.

4. Influenza vaccine is available free of charge to all personnel identified in Item (1.) above.

5. Any person vaccinated through services other than CHLA Employee Health (for example, by a private
physician, public clinic, or pharmacy) must provide adequate proof of immunization to Employee Health.

6. Failure to comply with this immunization policy will result in a written warning. If an individual is not vaccinated or granted an exception within five business days of the warning, they will be subject to further disciplinary action up to and including termination of employment.

7. Influenza vaccination rates are reported to the California Department of Public Health on an annual basis. CHLA uses the Center for Disease Control and Prevention’s definitions to calculate influenza vaccination rates, which include the following categories of healthcare worker:
   - Employees (staff on facility payroll)
   - Licensed independent practitioners: Physicians, advanced practice nurses, and physician assistants
   - Adult students/trainees and volunteers
   - Other contract personnel

Vaccination Exceptions

1. Exceptions to immunization may be granted by CHLA for medical reasons or religious beliefs. Individuals requesting exemption due to medical reasons must provide a Physician Letter completed by a California licensed physician who has examined them. Medical reasons will be evaluated individually based upon recommendations from the Centers for Disease Control and Prevention. Acceptable medical reasons would include documented adverse reaction to influenza vaccine or documented allergy to a vaccine component. Pregnancy will not be accepted as a medical contraindication. Individuals requesting a religious accommodation must provide a letter from clergy supporting the exception and the request must be consistent with prior vaccination history.

2. Exceptions to immunization on other grounds will be evaluated individually by Employee Health.

3. No exception will be granted unless the individual completes a declination form provided by CHLA. If an exception is granted, it is granted for one year only. The individual must reapply each flu season.

4. An exception will only be granted under the condition that the individual sign a declination and wear a surgical mask throughout the influenza season. Mask use is required for all unvaccinated health care personnel to maintain compliance with the Health Officer order issued by Los Angeles County Department of Public Health (LACDPH) in October 2013. Influenza season is defined in the LACDPH Health Officer order as November 1st through March 31st.

5. For those who decline the vaccination, a hospital-approved surgical mask must be worn at all times in
any geographic location where there might be contact with CHLA patients, families, or other CHLA personnel, which includes entrances, elevators, meeting rooms, bathrooms, cafeterias, and waiting rooms. The surgical mask must cover the mouth and nose at all times.

The masking policy will be enforced at all CHLA main campus buildings, in CHLA shuttles and parking lots, and at CHLA off-site facilities including all off-site patient care facilities, Virgil Place, and the Brand building in Glendale. This is in addition to strictly adhering to all other respiratory, hand, and other hygiene practices and isolation precautions applicable to CHLA personnel generally.

6. If an unvaccinated individual with an exception fails to comply with the masking policy following a written warning, they are subject to further disciplinary action up to and including termination of employment.

7. In addition to wearing a surgical mask the person’s CHLA identification badge will be marked to allow supervisors and other staff to validate who should be wearing a mask.

**Infection Prevention precautions for influenza**

Influenza is spread by droplets that are coughed or sneezed. Patients with suspected or confirmed influenza are placed in Combined-Droplet isolation precautions, per [IC 301 Isolation Precautions](#).

Staff, families, and visitors should practice respiratory hygiene and cough etiquette to prevent the spread of influenza, which includes covering cough and sneezes and performing hand hygiene after contact with respiratory secretions (See [HR 62.1 Cover your Cough](#) for educational materials about respiratory hygiene and cough etiquette). Parents and visitors should not visit CHLA while displaying symptoms of influenza; additional visitation restrictions will be implemented during viral respiratory season on an annual basis (see [EOC 40.0 Visitation](#)).

CHLA staff should not come to work when they have signs or symptoms or recent exposure to communicable disease, including but not limited to fever, cough, vomiting, diarrhea. See [IC 602 Employee Exposures](#) for more information.

CHLA reserves the right to institute other measures in order to prevent or control the spread of influenza.

**ATTACHMENTS:**

1. [HR – 62.1 Cover your Cough Poster](#)

**REFERENCES:**

1. California Health and Safety Code Section 1288.7

3. CHLA Policy: **IC 602 Employee Exposures**

4. CHLA Policy: **EOC 40.0 Visitation**

5. CHLA Policy: **IC 301 Isolation Precautions**

**POLICY OWNER:**
Chief People Officer
*Mamoon Syed*

**POLICY CONTRIBUTORS:**
Quality and Patient Safety

Human Resources Leadership Team

Infection Control and Prevention
PURPOSE:
To develop user awareness of linen as a supply cost and focus on appropriate utilization in order to decrease linen expense for the organization while promoting patient safety and comfort.

PROCEDURE:
A. Bed linen will be straightened and refreshed daily and as needed. Bed linen changes will occur by item when soiled or a patient and/or family member requests an entire change. Patient and Parent Linen is the BMT unit is changed daily.

The following are examples of recommended linen usage.
1. Standard bed composition
   a. 1 fitted sheet
   b. 1 flat sheet
   c. 1 pillow
   d. 1 pillowcase
   e. 1 thermal spread
2. Pediatric crib composition
   a. 1 fitted sheet
3. Incontinent bed composition
   a. 1 fitted sheet
   b. 1 flat sheet
   c. 1 pillow
   d. 1 pillowcase
   e. 1 thermal spread
   f. 1 incontinent underpad
B. Additional linen will be available as required
1. Pillow and pillowcase
2. Bath blanket
3. Gown/pajamas
4. Wash cloth
5. Bath towel
C. Do not layer linen under the patient.

D. Limit excess linen taken into patient rooms. Linen taken into patient rooms is limited to the amount needed for patient care provided in that day only.

1. Clean linen is not to be stored in bed stands or closets for “just in case”.
2. Once linen is in the patient room, it cannot be used on another patient and is considered contaminated.

3. When transferring patients to another unit, send all pillows and blankets and any clean linen in the room with the patient instead of putting it in the soiled hamper.

E. Bed should not be changed for patients who are anticipating discharge.

F. If needed, a sheet or bath blanket can be placed on top of the thermal blanket to create the needed insulation. This should be at the request of a patient or his/her family.

G. Isolation Gowns (Yellow Gowns) should be used according to the Infection Control Manual isolation Precautions Policy 304. The following are inappropriate uses for yellow gowns:
1. As a warm up jacket.
2. Outside the patient room. Isolation gowns should be removed before leaving the patient room and placed in the contaminated linen bag after a SINGLE use.
3. For airborne precautions unless splattering is expected or holding a child.

H. All unusable torn and stained clean linen is to be placed in the reject linen hamper to be recycled for other uses. Reject linen hampers (yellow bags) are located next to the laundry cart in each unit.

I. Do not throw any linen in the trash. It is a valuable hospital asset, is costly to replace and can be recycled for other uses.

J. Do not use tape on linen for any purpose. Linen with tape on it gets destroyed in the laundry processes and becomes non-reusable.

K. Soiled linen is to be placed into an appropriate covered hamper and standard precautions are to be maintained.

L. Upon patient discharge or transfer to another facility: No hospital linen (including pajamas) is to go with the patient.

M. A bath blanket may be used when bathing a patient. Please do not use bath blankets as a bottom sheet or as a lift sheet.

N. Pillows, not blankets, should be used to position patients (excluding infants). The individual units will determine storage areas for pillows. Additional pillows can be obtained by contacting the laundry department. Soiled pillows are not to be placed in the linen hampers. Pillows are cleaned by EVS with a
 disinfectant in the same manner as the mattress so they should remain on the bed when a patient is discharged. Bed rails should not be padded with linen or pillows.

O. Reusable incontinent underpads should only be added upon assessment of patient need. They should be used for incontinence or containment of body fluids only.

P. Parent Linen is available upon request by contacting ext. 12236. Please remind parents to reuse the linen that is issued to them. Do not allow parents access to linen carts and cabinets. There is a limited PAR level of Parent Linen Packets available in the linen carts.

Q. Linen is not for employee personal use. Hospital personnel should provide their own attire for warmth and not use hospital linens.

R. The Linen Committee and Vice President Patient Care Services (CNO) at CHLA must approve any hospital/facility specific changes to this linen policy.

REVIEWED BY/AUTHOR:
Linen Committee
<table>
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<td>EOC – 74.0</td>
<td>ENVIRONMENT OF CARE</td>
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<tr>
<td>APPROVED BY:</td>
<td>Rod Hanners COO</td>
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PURPOSE:
This policy and procedure will provide an overview of immediate steps to be taken when a suspicion arises that a patient and/or patient family member is the victim of child, dependent adult, or elder abuse. Detailed social work and medical response is provided in The Audrey Hepburn CARES Team (The CARES Team, CARES Team) Guidelines.

DEFINITIONS:
It is the policy of Children’s Hospital Los Angeles to report all known or suspected cases of child abuse, the abuse of dependent adults or the elderly.

1. Child Abuse Definitions
   A. **Abuse of a child**: acts that result in the physical or emotional harm such as inflicted trauma, failure to thrive by reason of neglect/deprivation, child endangering, abandonment, sexual molestation, mental suffering.
   B. **Child**: a person under the age of 18 years (as defined in California Penal Code 11164).
   C. **Reporting Requirements**: Such reporting is mandatory in accordance with Section 11166 et al. of the California Penal Code. Telephone reporting to a Law Enforcement Agency or Child Protective Services agency must be done immediately (or as soon as practically possible) when "reasonable suspicion" of abuse arises. A written report must be forwarded within 36 hours of receiving the information regarding the incident (PC11166a).

2. Elder or Dependent Adult Abuse Definitions
   A. **Abuse of an elder or a dependent adult** means any of the following:
      i. Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering;
      ii. The deprivation by a care custodian of goods or services that is necessary to avoid physical harm or mental suffering;
      iii. Financial abuse.
   B. **Dependent adult**: any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or mental abilities have diminished because of age. This includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility.
   C. **Elder adult**: any person residing in this state, 65 years of age or older (W&I code 15610).
   D. **Reporting Requirements**: Such reporting is mandatory in accordance with Section 15630 of the Welfare and Institutions Code. Telephone reporting to a Law Enforcement Agency or Adult Protective Services agency must be done immediately (or as soon as practically possible) when "reasonable suspicion" of abuse arises. A written report must be forwarded
within two business days of receiving the information regarding the incident (WIC 15630b)

3. Hospital Responsibilities and Roles
   A. Mandated Reporters: Medical and non-medical practitioners (e.g. physicians, nurses, other health professionals) are mandated reporters under the law, and are required to identify and report any known or suspicion of child, adult or dependent adult abuse. Employees hired after January 1, 1985 are asked to sign a statement to the effect that they have been informed of this requirement.

   B. Designated Reporter System: CHLA utilizes a “DESIGNATED REPORTER SYSTEM” to report suspicion for child, adult or dependent adult abuse, or neglect. A "DESIGNATED REPORTER SYSTEM" is utilized when more than one mandated reporter has knowledge about suspected child, adult or dependent adult abuse. At CHLA the assigned social worker to the unit or service from the Division of Family-Centered Care Support Services is the "designated reporter" for most of CHLA’s inpatient services and clinics.

   C. The Clinical Social Work Department has responsibility, in collaboration with other health providers, in situations of suspected abuse/neglect, to ensure the safety and protection of children. This is done in accordance with applicable state, county & local regulations.

PROCEDURE:
1. Under the law, any mandated reporter has the obligation to report. However, for purposes of coordination, it is recommended that reporting of suspected child, adult or dependent adult abuse cases be managed by the Clinical Social Work staff. Social workers may become involved through case finding efforts.

2. If suspicions of abuse or neglect arise, the hospital staff is to immediately contact the social worker, if available, for evaluation and non-medical management of suspected child, adult or dependent adult abuse or neglect. In most instances, the primary social worker assigned to the patient’s unit or medical service should be contacted. If the primary social worker is not available, please page the duty social worker at 61-1101.
   a. When no social worker is available (usually from 0200-0800 daily) and a question regarding a case of suspected child abuse arises, the Nursing Supervisor should be notified as soon as possible to contact the After-Hours On-Call social worker. During this time (0200-0800) the Designated Reporter is the attending physician.

3. The CARES Team Guidelines provide details for medical and psychosocial management of cases involving suspected child abuse. As a reference regarding Red Flags and signs of abuse, refer to appendix CC - 35.1 CARES Team Guidelines.
4. Hospital and Community Resources
   a. CHLA Clinical Social Work Office: Extension 12485
   b. CARES Team: Extension 14977 and Pager (213) 209-1118
   c. County of Los Angeles Department of Children & Family Services Child Protection Hotline: (800)540-4000
   d. Los Angeles Police Department Dispatch: (877) 275-5273

ATTACHMENTS:
1. CC - 35.1 CARES Team Guidelines

REFERENCES:
1. Child Abuse and Neglect Reporting Act, California Penal Code § 11164 - 11174.3
2. Elder Abuse and Dependent Adult Civil Protection Act, California Welfare and Institutions Code § 15610 – 15632
3. CARES Team Policy and Procedure Manual

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