

Injury and Illness Prevention Program

ATASCADERO



SAFETY HANDBOOK

Revised 05/05/15

**DEPARTMENT OF STATE HOSPITALS - ATASCADERO
INJURY AND ILLNESS PREVENTION PROGRAM**

RESPONSIBLE PERSONS

Signature indicates that a copy of the program has been provided and responsibility to implement the program is understood.



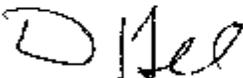
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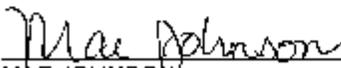
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I. INTRODUCTION

The Injury and Illness Prevention Program (IIPP) contains the safety policies and procedures for managers, supervisors, and rank-and-file staff with the California Department of State Hospitals (DSH). It is established according to the IIPP regulations set forth in the California Code of Regulations Title 8, Section 3203; Welfare and Institutions Code 4141; and Labor Code Section 6401.7. It is the responsibility of employees to understand and adhere to the standards contained herein.

The IIPP recognizes that Department of State Hospitals – (DSH-A) is a high hazard environment due to the forensic patient population we serve and their propensity for violence against staff and other patients. While DSH-A cannot eliminate all risk of violence, safety of our staff is our number one priority. The policies and procedures contained within are designed to prevent injuries and illnesses and guide employee response when injuries and illnesses occur.

A. SAFETY PROGRAM GOALS

The department's Injury and Illness Prevention Program is designed to:

1. Protect the life and physical well-being of staff;
2. Provide a safe and healthy work environment for staff;
3. Provide a safe and healthy environment conducive to the provision of care and treatment of our patients;
4. Identify potential work hazards and initiate reasonable actions to eliminate or control them before they contribute to violence, accidents, injury, or illness;
5. Respond to employee reports of unsafe practices in a timely and effective manner;
6. Make safety a normal part of work practices and procedures;
7. Develop safe employee attitudes and behavior;
8. Investigate work related violence, accidents, injuries, and illnesses promptly and implement improved prevention methods;
9. Maintain employee well-being and minimize the loss of productivity due to injury;
10. Reduce the frequency and severity of occupational violence, accidents, injuries, and illnesses;
11. Reduce the monetary cost of accidents;
12. Comply with applicable safety-related laws, regulations, and policies, such as state safety orders published in the California Code of Regulations (CCR), Title 8.

B. SAFETY PROGRAM EFFECTIVENESS

The primary purpose for review of occupational injuries and illnesses is to determine the cause and contributory factors so that appropriate prevention measures can be taken to reduce the frequency and severity of work related violence, accidents, injuries, illnesses, and exposures in the future. The success of the department's safety program depends upon the following:

1. Accurate assessment of needs in order to best direct safety efforts.

2. Integration of injury and illness prevention efforts into ongoing operations of the department.
3. Action by supervisors and managers to implement and enforce various safety guidelines, policies, and procedures of the department.
4. The accountability of managers and supervisors for implementation and enforcement of safety regulations, policies, procedures, and protocols.
5. Action to set and adjust standards and procedures, train staff, provide safety equipment, identify and correct unsafe practices, and use corrective measures to enforce safety regulations, policies, procedures, and protocols.

There must be a high level of management concern for and involvement in safety. A safety program cannot be successful without management commitment. Managers must have a personal involvement in the safety program on a continuing basis. First line supervisors are a focal point for work site safety, and their involvement is critical to an effective program. The visible interest by managers and supervisors in the safety program provides a positive example to all employees.

Employee participation at all levels is equally important for a successful safety program. The chances for a successful program increase as employee support is solicited and encouraged. If employees have a genuine part in the program, they are more likely to be committed to its success.

II. SAFETY PROGRAM RESPONSIBILITY

The IIPP/Safety Program Administrator for DSH-A is ultimately the Executive Director. The Health and Safety Officer has the responsibility for implementing the provisions of this plan for DSH-A. The Health and Safety Officer can be reached at (805) 468-2013.

Program Location: The IIPP can be found on the hospital intranet under the Health and Safety Department. In areas where employees do not have computer access, a hard copy will be kept.

A. RESPONSIBILITY OF EMPLOYEES

DSH-A staff are responsible to act safely and to promptly report work related violence, accidents, injuries, illnesses, and exposures to a supervisor. Staff will adhere to the DSH Code of Safe Practices which identifies conduct expected of staff that is designed to ensure a safe work environment. See Appendix D. Employee Code of Safe Practices.

Employees must report unsafe conditions, practices, procedures and equipment so that they may be corrected before an accident occurs. Staff is obligated to protect themselves, their co-workers and patients by immediately correcting or communicating safety concerns and reporting safety hazards to their supervisor or other appropriate parties.

To maintain a safe work environment, all staff is required to:

1. Conduct work with safety as a primary concern.
2. Follow rules, regulations, and laws pertaining to safety.
3. Be attentive.
4. Avoid taking unnecessary risks that could cause injury.
5. Be proactive and initiate the removal, repair, or reporting of the following to their immediate supervisors:
 - a) Potential hazards
 - b) On-the-job injuries or job-related illnesses
 - c) Injury incidents involving patients or visitors
 - d) Anything having the potential for dangerous or disastrous consequences involving staff, visitors, or patients.
 - e) Operate equipment correctly and only after training is completed.
 - f) Wear required personal protective equipment (PPE).
 - g) Become knowledgeable about patients, their behaviors, triggers and precursors and take appropriate action at signs of change;
 - h) Near misses

B. RESPONSIBILITY OF SUPERVISORS/ MANAGERS

Each Program Director/Department Head has authority and total responsibility for maintaining safe and healthful working conditions within their jurisdiction. Although employee exposure to hazards varies widely in the work activities, it is expected that an unrelenting effort will be directed toward training, injury control, and prevention of collisions, liabilities, and wasted materials.

All Supervisors have the responsibility to monitor the safe actions of staff and the safe performance of machines and equipment within the operating area. The Supervisor has full authority to enforce the provisions of the safety policy to keep losses at an absolute minimum. Supervisors must assess work practices and conditions continuously; based on these assessments, direct staff so that they know specifically what is required of them, the hazards/risks involved, and the safety precautions to be followed to prevent accidents and injuries/illnesses including environmental factors and patient aggression.

To maintain a safe work environment, supervisors/managers shall:

1. Teach staff to work in a safe manner and comply with policies/procedures to maintain a safe work environment.
2. Set a good example by your own safety actions.
3. Conduct frequent and thorough reviews of work areas to maintain employee safety;
4. Encourage and reward safe practices exhibited by staff.
5. Immediately correct safety issues when made aware.
6. Report issues that cannot be immediately corrected to the Health and Safety Office.
7. Ensure staff is current in required safety training.
8. Follow Hospital Health and Safety Program procedures, especially as applies to Supervisors/Managers and Area Specific Safety processes. For further information see [AD 909 Hospital Health and Safety Program](#).
9. Take disciplinary action as necessary when unsafe work practices are discovered.
10. Ensure that injured workers receive necessary medical care.
11. Make every effort to ensure that any cause of the injury or illness is no longer a danger.
12. Conduct a thorough review of the circumstances to determine the root cause and document the event in writing.
13. Make a report using: MH Form 5420, (Supervisor's First Report of Injury). This form will be sent to Human Resources (Return-To-Work) and Health & Safety Department as quickly as possible no longer than 36 hours after the injury/incident.
14. In the case of death or serious injury, the supervisor must **IMMEDIATELY - dial 2911** which notifies the Department of Police Services (DPS), Nursing Office of the Day (NOD), Urgent Care Room and Fire Department at once. NOD is responsible to notify the Health and Safety Department. During normal business hours Health and Safety office will be responsible for notifying Cal/OSHA at the Bakersfield District Office at (661) 588-6400 and/or fax (661) 588-6428. During evening hours, weekends and holiday's the NOD will be responsible for notifying Cal/OSHA by fax. Health and Safety office will follow up with Cal/OSHA on the next business day if necessary.

C. RESPONSIBILITY OF HEALTH AND SAFETY OFFICER

The Health and Safety Officer shall be responsible for the overall coordination of all phases of the Safety Program and the Health and Safety Office (H&SO). The H&SO acts in an advisory capacity on all matters pertaining to safety. Through the cooperation of all treatment, support services, and management staff, unsafe work practices and

conditions shall be identified and corrected. The H&SO works collaboratively with Managers, and Supervisors to assist in eliminating, minimizing and/or mitigating hazards within the work environment by:

1. Intervening, by authority of the Executive Director, whenever conditions exist which:
 - a) Pose an immediate threat to life or health
 - b) Pose a threat of damage to equipment or building
2. Maintaining compliance with applicable laws, rules, regulations (Title 22 & Title 8), The Joint Commission Standards, and Environmental Health recommendations through on-going implementation and corrective activities.
3. Acting as a liaison to: Administration, Managers, Supervisors, Staff, and the DSH Enterprise Risk Management Branch - Sacramento.
4. Participating in the development and evaluation of departmental and hospital-wide safety and violence reduction policies and procedures.
5. Managing the hospital-wide process to collect and evaluate information used to identify safety issues. This includes hazards, safety practices, and the evaluation of injuries. These are addressed through recommendations to the following: Quality Council, Environment of Care Process Management Team (EC PMT), Hospital-wide Area Specific Safety Coordinators Committee, Area Specific Health and Safety Committees, The Executive Director's Inspection Team (EDIT), and Managers/Supervisors when performance improvement or corrective action is necessary.
6. Leading EC PMT and coordinating with the Area Specific Safety Coordinators to facilitate and implement safety recommendations and monitoring the effectiveness of the changes.
7. Being responsible for environmental safety surveillance of the facility and ensuring checklists and techniques for safety compliance are current.
8. Assuring hospital-wide Health and Safety training is in place and current for New Employee Orientation, annual training, area specific training and SB 409 for Supervisors.
9. Quarterly review of safety management issues and annual evaluation of the Safety Program with recommendations for appropriate revisions of the objectives, scope, organization, and effectiveness of the safety management program. This includes performance improvement and actions taken as the result of safety program activity.
10. Assuring that the Cal OSHA "Serious Illness/Injury Reporting Procedure" is in place and proper notification is made to Cal OSHA in the event of an injury that meets the reporting requirements of Title 8 Section 342.
11. Maintain liaison and cooperate with public agencies in matters of safety, including inspections.
12. Establish an injury reporting system that includes a mechanism for investigating and evaluating all employee injury and illnesses and for documenting the review of all such reports and actions taken. Investigate and analyze injury reports to seek causes, establish trends and determine whether appropriate corrective action has been taken.

D. RESPONSIBILITY OF EXECUTIVE TEAM

The Executive Team is responsible for policy formation, decision making, and enforcement of rules and regulations at DSH-A. The Executive Team shall provide management, communication, and administrative services in a manner that ensures an effective operational environment conducive to the health, safety, and security of employees and patients. The current members of the Executive Team (consist of the Executive Director, Medical Director, Clinical Administrator and Hospital Administrator) and can be found on the signature page of the IIPP.

III. SAFETY COMPLIANCE PROGRAM

California Department of State Hospitals (DSH) will provide every employee with a safe, healthy, and secure work environment and to fully comply with Labor Code Section 6401.7 (SB198) and General Industry Safety Orders Section 3203.

It is DSH-A's policy that intimidation, threats, assaults and acts of violence in the workplace, affecting employee health and safety and/or impacting hospital operations will not be tolerated. This zero tolerance policy applies equally to the conduct of staff, patients, non-staff conducting business on DSH property, visitors, and guests.

Any employee, who intimidates, threatens, or takes violent actions against others will be subject to adverse action up to, and including, termination. If necessary, the Department will refer additional action to internal, local or state law enforcement agencies.

To maintain a safe work environment, DSH-A ensures that staff complies with the policies and procedures designed to promote safety, as described in this document. Enforcement of safe work practices plays a vital role in prevention of work related injuries/illnesses. Corrective action of unsafe acts is necessary and may involve progressive disciplinary action.

A. CODE OF SAFE PRACTICES

The following Code of Safe Practices is a list of expectations for each employee at the DSH-A, to provide for a safe working environment for staff. For a role-based checklist for departmental staff see Appendix D. Employee Code of Safe Practices. For further information see [AD 103 Administrative Rules](#)

1. A healthy and safe work environment is the responsibility of every employee. Employees will be aware of the hospital's Health and Safety Program. For further information see [AD 909 Hospital Health and Safety Program](#)
2. Employees shall follow these safe practice rules, render every possible aid to safe operations, correct and / or report unsafe conditions or practices to their supervisor.
3. Supervisor's and or manager's shall insist on staff observing and obeying rules, regulations, and orders as is necessary to the safe conduct of the work, and take such action as is necessary to obtain observance.
4. Employees shall be given accident prevention instructions.
5. Work shall be well planned and supervised to prevent injuries in the handling of materials, patients and in working together with equipment and /or patients.
6. No one shall knowingly be permitted or required to work while the employee's ability or alertness is so impaired by fatigue, illness, or other causes that it might unnecessarily expose the employee or others to injury.
7. Staff shall be instructed to ensure that guards and other personal protective equipment (PPE) or devices are in proper places and adjusted, and shall report any deficiencies or missing equipment promptly to their supervisor.
8. Employees shall not handle or tamper with any equipment or machinery not within the scope of their duties, unless they have received instructions and proper training from their supervisor.
9. Injuries shall be reported promptly to the supervisor and appropriate arrangements will be made for medical or first aid treatment.

10. When lifting heavy objects, the large muscles of the leg instead of the smaller muscles of the back should be used.
11. Inappropriate footwear or shoes with thin or badly worn soles should not be worn.
12. Do not throw objects.
13. Position electrical cords and cables under desks or along walls to prevent slip/trip/fall hazards.
14. Use step stools or ladders for objects that are out of reach.
15. Read the Safety Data Sheet (SDS) and product label before handling any chemicals.
16. Employees will practice good housekeeping in their work areas.

B. WORKPLACE SECURITY POLICY

The DSH - A is committed to providing a safe and secure work environment for employees and visitors. Violence, harassment, or intimidation in any form including but not limited to direct or indirect threats, regardless of intent, made against the life, health, family, property, or physical or emotional well-being of any employee or visitor, is unacceptable and will not be tolerated.

Any employee, including managerial and supervisory personnel, engaging in any type of threat, harassment, intimidation, or violent activity in the workplace will be subject to adverse action up to and including termination.

DSH-A is committed to the prevention of and appropriate response to incidents involving a violent or criminal act by a current or former employee, by anyone who has an employment-related involvement with DSH-A, by a recipient of a service provided by DSH-A, or by a person with no legitimate relationship to the workplace.

Definitions

Threat: is a verbal or written statement or physical action which is intended to intimidate by expressing the intent to harass, hurt, take the life of another person or damage or destroy property. This includes threats made in jest but which others could reasonably perceive as serious.

Harassment: is the creation of a hostile work environment through unwelcome words, actions or physical contact not resulting in physical harm. This includes disparaging or derogatory comments or slurs, unreasonable or excessive criticism or name-calling.

Intimidation: is to frighten, alarm, annoy or scare someone or to force someone into, or deter from, some action by inducing fear by threats.

Act of violence: is an attempt to use, or the actual use of, force with the intent to threaten, harass, intimidate, commit a violent act that results in injury or damage or destroy property.

State workplace: is anywhere a state employee is conducting authorized state business, or is en route to and from (excluding normal commute) a location where state business is, will be, or has been conducted.

Abuse/Abusive Behavior: Verbal, written or physical expression that can result in physical or psychological harm, e.g., physical violence, threats/threatening behavior, intimidation, and any type of slurs.

Assault/Assaultive Behavior: Violent physical, written or verbal expression that represents an unlawful threat or unsuccessful attempt to do physical harm, and/or can result in the fear of potential or immediate harm.

Employees

Employees are expected to act professionally, courteously and responsibly.

Employees will:

- 1) Be responsible and accountable for your own behavior.
- 2) Wear identification badges in plain view at all times.
- 3) Be fully aware of and follow DSH-A workplace security policies and procedures.
- 4) Participate in training related to DSH-A workplace security.
- 5) Report to their supervisor's knowledge of any potentially threatening situation in the workplace, such as harassment, name calling, gesturing, or slurs as well as veiled or actual threats, violent acts, harassment, or any other behavior whether from co-workers or visitor's, which causes concern.
- 6) Cooperate with management and DPS in reporting and investigating workplace security issues.

In an emergency or life-threatening situation, **CALL 2-9-1-1**. Dispatch will respond and notify DPS, Fire, NOD & Unit 1. Notify your supervisor as quickly thereafter as is possible.

Any person who retaliates against any employee for reporting or cooperating in an investigation of workplace security will be subject to adverse action up to and including termination.

Supervisors and Managers

Supervisors and managers are responsible for demonstrating and practicing a high level of commitment to workplace safety and security.

As a result, supervisors and managers will:

- 1) Participate in workplace security training for managers and supervisors.
- 2) Implement and maintain safety and security procedures in their work areas.
- 3) Utilize a management style that minimizes conflicts in the workplace.
- 4) Immediately report incidents of threat, violence, harassment or intimidation by any person of which they have knowledge to management and to a member of DPS.
- 5) Respond promptly to and take appropriate action in reported incidents of actual or potential violence or threats.
- 6) Implement disciplinary actions, reached in concert with Human Resources, for employees involved in incidents of workplace threat or violence.
- 7) Recognize employees who practice and promote security in the workplace.

Incident Management Review Committee

To ensure that programmatic and systemic issues are identified and recommendations for corrective/preventative measures are presented to the appropriate departments for follow through. The Incident Management Review Committee (IMRC) will be responsible for tracking programmatic and administrative recommendations and effective implementation of recommendations. The committee will identify opportunities for performance improvement and track identified action items.

The IMRC will:

- 1) Review Special Incident Reports, DPS Reports, and Special Investigations. In reviewing the reports, the committee will identify opportunities for improvement and ways to prevent like incidents from occurring in the future. In reviewing investigations, the committee will determine if they were conducted according to the Special Investigations manual guidelines and that actions were taken appropriate to investigation findings.
- 2) Review Headquarters Special Incident Briefs.
- 3) Identify and track corrective measures to ensure that they have been effectively implemented in a timely manner.
- 4) Review and revise Incident Management Policy and Procedures annually.
- 5) Provide a working link between Special Incident Reports, Office of Special Investigations (OSI) and DPS reports.
- 6) Sustain a system that ensures incident notifications are routed to the appropriate department in a timely manner.
- 7) Review aggregate data for patterns and trends.
- 8) Recommend and/or implement actions to improve the performance of staff and systems.

C. HEALTH AND SAFETY POLICY

There shall be an effective safety management program that is designed to provide a physical environment free of hazards and manage activities to reduce the risk of human injury and illness to employees, patients, and visitors at DSH-A. Hospital staff, patients, and visitors are responsible to actively participate in all aspects of the hospital's Health and Safety Program.

The hospital's Health and Safety program is a comprehensive safety management process with ongoing monitoring to assure compliance. Mandated areas of concentration include Injury and Illness Prevention, Risk Assessment and Safety Surveillance, Hazardous Materials Management, Waste Disposal and Hazard Communication Programs, Ergonomics, Hearing Conservation, Heat Illness Prevention Plan, Vector Control, Defensive Driving, Respiratory Protection Program and Safety Training. For further information see [AD 909 Hospital Health and Safety Program](#)

The IIPP is a written workplace safety program. Title 8 of the California Code of Regulations (T8CCR) section 3203 requires every employer to develop and implement an effective IIPP. An effective IIPP improves the safety and health in your workplace and reduces costs by good management and employee involvement.

D. SAFETY COMMITTEE

Safety committees are established to assist staff, supervisors and managers in meeting the objectives of the safety program. Regular committee meetings encourage discussion about safety at all levels. These committees are responsible for consistently and regularly improving and updating safety standards.

The following identifies safety committees at DSH-A:

Area Specific Safety Committee:

Each Department/Program has an Area Specific Safety Committee which meets monthly and allows the Area Specific Safety Coordinators to share information with co-workers. Items for both staff and patients of that specific area are discussed such as identified hazards/risks, injuries & prevention and resolutions of safety issues. This committee can also recommend identified hazards/risks be taken forward to Area Specific Safety Coordinator's Committee for further assessment. The Area Specific Safety Committee meeting minutes for the last three (3) months are posted on the employee bulletin boards for information and review.

Area Specific Safety Coordinator's Committee:

Monthly meetings are held allowing Area Specific Safety Coordinators (designated safety representatives from each Department/Program) to bring forward any identified hazards/risks from staff or patients and discuss resolutions. This committee can also recommend identified hazards/risks be taken forward to Environment of Care Committee for further assessment. The Area Specific Safety Coordinator's Committee meeting minutes for the last three (3) months are posted on the employee bulletin boards for information and review.

Environment of Care Process Management Team (EC PMT):

Composed of representatives from various Programs/Departments, this group meets monthly to review and analyze identified safety management issues and to develop recommendations to resolve such issues. EC PMT may take safety recommendations, safety policy approval to Quality Council for review and approval.

Quality Council:

The Quality Council maintains support for the safety management program by giving direction or approval of general safety policies, reporting mechanisms, and leadership. Communication to the Quality Council can begin at the Area Specific Safety Committee level, through Area Specific Safety Coordinators Committee and to EC PMT for resolution of health and safety issues. Key incidents, trends, and efforts for problem resolution, monitoring, and evaluation, are documented quarterly and made available to DSH-A staff.



Executive Director's Inspection Team (EDIT):

The Executive Director's Inspection Team (EDIT) is the basis for the safety surveillance program at the DSH-A through regularly scheduled facility inspections. For further information see [AD 909.3 Executive Director's Inspection Team](#)

It is during these inspections that compliance with safety rules and regulations will be monitored or audited. Any deficiencies will be noted on the inspection report that is sent to the Area Supervisor or Department Head with a copy to the Executive Team. The area/department has 30 days to complete the plan of correction. If the item identified is an immediate threat to staff or patients it will be addressed at the time of the inspection with the Manager or Supervisor present. The Health and Safety Department will monitor the item until it is corrected. The inspection team consists of Fire Department, DPS, General Services, Plant Operations, Public Health Nurse, Nursing Coordinator, and a Unit Supervisor. The team leader is Health and Safety staff member. These inspections are in compliance with Title 8 Section 3203 (4), Joint Commission Accreditation Standards, and Licensing.

The areas to be inspected are not announced in advance. Inspections shall be conducted twice a year in all areas occupied by patients and annually in all other areas in order to:

1. Meet and maintain compliance with laws, regulations and standards.
2. Recognize and commend positive practices.
3. Identify deficiencies and recommend correction.
4. Provide immediate and on-site training and instruction in injury/illness prevention strategies.

A quarterly summary of the major findings of the EDIT shall be provided in the Environment of Care PMT Quarterly Report, which is forwarded to the Governing Body-Department of State Hospitals. For further information see [AD 102 Governing Body-Department of State Hospitals](#)

Statewide Safety Committee:

The Statewide Safety Committee is designed to improve effectiveness of communication between all DSH locations in regards to health and safety standards and policies. The

committee meets monthly, at a minimum and will include Health and Safety representatives from each DSH location. The Enterprise Risk Management Branch in Sacramento is responsible for the organization and coordination of this committee's schedule and agenda. The Statewide Safety Committee helps provide consistency throughout the DSH system.

Joint Labor Management/Health and Safety Committee:

The purpose of the Joint Labor Management/Health and Safety Committee is to facilitate communications between labor and management and to promote a climate conducive to constructive employee relations. The subjects discussed at the labor management meeting must relate to individual contract items, hospital policies or procedures, or health and safety issues per individual Bargaining Unit Agreement.

The committee will meet at least four times per year and is responsible to report safety recommendations to the Executive Director. For further information see [AD 222.39 Joint Labor Management/Health and Safety Committee](#)

IV. SAFETY COMMUNICATION PROGRAM

The purpose of this section is to identify DSH-A's channels of communication for disseminating safety information to staff. DSH-A's system of communication includes:

- 1) Safety Committee Meetings
- 2) Staff Meetings
- 3) DSH-A Intranet
- 4) Safety Tailgate/Safety Briefings
- 5) Required Postings
- 6) Safety Bulletins
- 7) Posters, Inserts, Letters and Mailings

Employees are encouraged to submit ideas for improving safety in the workplace. Staff may submit observations and ideas through the following communication channels:

- 1) Their immediate supervisor/manager;
- 2) Employee Safety Information Request (MH 3358) form
- 3) Safety Committees
- 4) Health and Safety Department
- 5) Employee Suggestion Box (these may be anonymous)
- 6) Union Stewards
- 7) Joint-Labor Management Meeting
- 8) DSH-A Intranet Suggestion Box

A. SAFETY NOTICES

The purpose of this section is to provide timely distribution of Safety information that can potentially reduce the number and severity of work related violence, accidents, injuries, illnesses, and exposures.

These notices will be generated from several sources such as but not limited to: Cal/OSHA, The Joint Commission (TJC), Cal-Office of Emergency Services (Cal OES), California Department of Public Health (CDPH), State Fire Marshal, and Hospital Safety Committees. Ideas and recommendations for advisories, bulletins, and suggestions should be submitted to the Health and Safety Officer. Safety information at DSH-A can be distributed through the following:

All Staff Email Notification – Issued through the Executive Director's Office, Medical Director's Office, Clinical Administrator's Office or Hospital Administrator's Office. All staff notifications are a way DSH-A distributes important information such as but not limited to any infrastructure maintenance that may impact staff/patients or any quarantined units.

Public Address (PA) System – The PA System is a tool used to announce information that needs immediate attention or action. The DPS Dispatch center does all PA announcements which can include but is not limited to red light alarm locations, recalling patients back to their units for an all patient count or to announce a facility wide lock down.

Marquee Board – There is a scrolling Marquee Board located in the main sally port that DPS uses to display information that may impact staff such as but not limited to wild animal sightings on grounds or severe weather warnings.

Safety Notice – The Health and Safety Department may produce suggested safety information that impacts employees. This may include personal safety tips, holiday information, daylight savings, general safety tips and local safety information. Format used can include email, paper posting, paper distribution, or a combination.

B. REQUIRED POSTINGS

1. Cal/OSHA Injury/Illness Summary – Form 300 logs:
Copies of the Cal/OSHA Injury/Illness Log Summary prepared by Return-to-Work Coordinator (RTWC), and posted on the bulletin board outside of Personnel building during the months of February, March, and April each year.
2. Safety Posters:
Cal/OSHA required posters are displayed on the bulletin board outside of the Human Resources building and/or at the main sally port.
3. Cal-OSHA citations will be posted on the bulletin board at the main sally port.

Asbestos Notification Program:

The asbestos notification is required by law, upon receiving notification of asbestos containing material being present at identified locations throughout the facility. In addition, new employees will be notified of the identified locations of asbestos at the time of hire. Employees will receive asbestos notifications on an annual basis.

When any construction, maintenance, or remodeling is conducted in an area of a building where there is the potential for persons to come into contact with, or to release or disturb any asbestos containing material, a warning notice shall be posted in that area, and evacuation of that area may be required.

Employees exposed to asbestos shall be provided, at no cost to the employee, a comprehensive medical examination. The Asbestos medical screening includes chest x-rays and pulmonary function studies.

The buildings of this facility have been surveyed for asbestos containing materials and results of the survey will be kept on file in Plant Operations and will be made available for review upon the employee's request. Upon receiving such notification, this facility shall comply with Legislation (AB3713) as stated above. Further information on asbestos notification, procedures, screening, etc., may be obtained from Plant Operations.

C. SAFETY TAILGATE/BRIEFINGS

These short and informal meetings are designed to improve local communication about safety. Supervisors and Managers are encouraged to conduct safety briefing meetings as a part of or separate from normal staff meetings. Topics should include items discussed in recent safety committee meetings, safety notices from Health and Safety department, those suggested by staff, and any risks or hazards observed since the previous meeting. These informal discussions will assist to encourage positive accident and injury prevention communication and present an opportunity for staff to report

unsafe conditions. Employee Safety Information Request forms (MH 3358) are designed to report non-urgent, non-life-threatening safety issues and is located in the facilities intranet. For copy of MH3358 see [Hospital Forms](#).

D. SAFETY ACTION REQUESTS

DSH-A uses Employee Safety Information Request form (MH 3358) as the safety action requests that can submitted by employees and are designed to report non-urgent, non-life-threatening safety issues.

Employees will immediately report safety problems or concerns to their supervisor as soon as they are observed or discovered. Unsafe conditions, work practices and procedures will be documented by the employee on MH 3358 form. Employees will submit this form to their supervisor for corrective action. Supervisors will take necessary action to correct the hazard.

If the hazard is not within the supervisor's immediate control to correct, they will take necessary action such as but not limited to submitting a work order or forward the issue to the appropriate place or person. The Supervisor will respond to the reporting employee within 3 business days, identifying the corrective action that has or will be taken. The Supervisor is responsible to verify the hazard has been corrected. Employee Safety Information Request forms will be kept on file in the reporting unit's safety file. If forwarded to the HSO, in addition the HSO will maintain a safety file to monitor safety performance and corrective actions.

V. RISK ASSESSMENT AND SAFETY INSPECTION PROGRAM

It is the policy of the DSH-A to conduct pro-active safety inspections/hazard assessments of the work environment on at least an annual basis. This includes buildings, grounds, equipment and people. Inspections and assessments are used to evaluate the impact of the environment on safety.

Hazard assessments are conducted when an actual hazard is identified. Hazards can be identified through a variety of sources such as safety meetings, supervisors, shift change, Employee Safety Information Request (MH3358), etc. Depending on the nature of the hazard, appropriate staff will assess and correct immediately or forward to the appropriate source for correction.

Periodic scheduled and un-scheduled safety inspections/hazard assessments are required as well as setting deadlines and priorities for the correction of deficiencies. Reports of findings are given to Supervisors, Managers and Executive Staff. Supervisors must respond with written plans of correction to Health and Safety within 30 days.

A. HAZARD AND RISK ASSESSMENTS

Safety inspections are proactive reviews to identify potential issues and to evaluate the impact on health and safety in order to reduce or eliminate risks of injury or illness. Inspections are also used to educate staff on safety processes and to identify the need for performance and/or process improvements.

ENVIRONMENT OF CARE (EC) INSPECTIONS

The Executive Director's Inspection Team (EDIT) is the basis for the safety surveillance program at the DSH-A through regularly scheduled facility inspections. Risk assessment proactively evaluates the impact of the physical plant, equipment, occupants and internal physical systems on staff, patients and the public.

Inspections are unannounced. The EDIT team is made up of representatives from eight disciplines: Fire Department, General Services, Health and Safety, Nursing Coordinator, Plant Operations, DPS, Public Health and Unit Supervisor. Attendance is mandatory for team members.

A report of all non-compliant items is completed and sent to the area supervisors and the executive team. Plans of Correction on items must be submitted by the area supervisor to the Health and Safety Department no later than one month after receipt of the inspection report. The Plan of Correction must include what was done to correct the deficiency including what the area will do to prevent it from happening again in the future. Plans of Correction also include the date it was corrected and if a work order has to be submitted, the work order number and date it was submitted. If the work order is not completed by the time the Plans of Correction are due, the area supervisor will follow up with Health and Safety office with the completion date.

During the inspections, the team members have a list of deficiencies from the previous inspection of the areas. This allows them to check if corrective actions took place. If an item is continuously deficient a letter will be sent to the area supervisor with a copy to

management letting them know they are out of compliance and corrective action needs to be taken.

A quarterly summary of the major findings of the EDIT shall be provided to the Environment of Care Process Management Team Quarterly Report, which is forwarded to the Governing Body. For further information see [AD 909.3 Executive Directors Inspection Team](#)

WORKPLACE VIOLENCE HAZARD INSPECTION POLICY

It is DSH-A's policy that intimidation, threats, assaults and acts of violence in the workplace, affecting employee health and safety and/or impacting hospital operations will not be tolerated. This zero tolerance policy applies equally to the conduct of staff, patients, non-staff conducting business on DSH property, visitors, and guests.

Any employee, who intimidates, threatens, or takes violent actions against others will be subject to adverse action up to, and including, termination. If necessary, the Department will refer additional action to internal, local or state law enforcement agencies.

Staff must be trained on workplace security policies and procedures. The supervisor is responsible for informing staff of policy updates and assuring necessary training is completed. Staff will be trained on the use and known deficiencies of current alarm systems.

The Workplace Hazard Violence Inspection is part of the Environment of Care Inspections (EDIT) as outlined in Section V., A., 1 and AD 909.3. During these inspections items that could be potentially used in a violent incident such as furniture, cords, sharp objects, etc. may be identified. The Health & Safety Department ensures the compliance of the inspections and monitors the plans of corrections. All inspection results are sent to the Executive Team and area supervisor's for review.

In addition to the weekly EDIT Inspections, each unit will perform a daily inspection of all areas of the unit. The Unit Supervisor is responsible for designating assignments by shift and ensuring compliance. Staff authorized by the Unit Supervisor (or designee) shall conduct the random inspection. A completed Security Inspection Sheet (AT 2379) shall be retained by the Unit Supervisor for one (1) year.

THERAPEUTIC STRATEGIES AND INTERVENTIONS (TSI)

The protection of staff and the patients at DSH – A is of the highest priority. Employees share in the responsibility of providing a safe work environment and therapeutic milieu. Therapeutic Strategies and Interventions (TSI) are instituted to prevent, suspend, and mitigate conditions and circumstances that may lead to an assaultive act by a patient for the purpose of preventing or limiting injury to those involved.

Appropriate TSI measures support the provision of effective treatment and care. They promote channeling of aggressive behavior in a socially acceptable fashion. They provide therapeutic interventions to prevent aggressive behavior and avoid provocation of harmful aggressive behavior. Every effort shall be made to resolve problems before they result in assaultive behavior.

Appropriate TSI and staff training are essential job functions for certain classifications as described in the employee's duty statement. The extent to which physically aggressive

behavior is prevented or effectively managed depends upon the treatment team's abilities to maintain a calm, understanding, accepting approach to the patient and to find constructive outlets for the patient's feelings and energy. For further information see [AD 519 Therapeutic Strategies and Interventions \(TSI\) Training](#)

B. VIOLENCE RISK ASSESSMENTS

The Risk Management Program at DSH-A seeks to prevent harm before it occurs by a systematic review of risk and protective factors. Representatives from various departments and disciplines participate in risk reduction activities that begin with preventative measures and include clinical and administrative oversight, data collection and analysis, intensive case analysis, thorough documentation of activities, and follow through on recommendations and action items. It is the responsibility of every employee at DSH-A to recognize, report, monitor, and work collaboratively in efforts to reduce risk.

The mission of the Risk Management Program is to identify and facilitate implementation of actions and interventions to prevent or minimize harm to patients and staff; identify emergency high-risk situations, specify systemic problems and corrective actions to mitigate risks; and oversee data tracking, trending, and analysis using a performance improvement methodology.

Components of the program include:

1. Reducing risks through pro-active risk mitigation programs.
2. Systematic identification of potential risk and implementation of appropriate treatment, milieu and environmental interventions.
3. Hierarchy of review commensurate of the identified risk or incident. Controlling the severity of adverse outcomes and their impact on patients and staff when serious incidents occur.
4. Data collection for monitoring outcomes and effectiveness of actions taken.
5. Identification and management of long-term trends and patterns.
6. An oversight mechanism that ensures data is tracked, trended, and analyzed using performance improvement methodology in an effort to provide ongoing oversight and monitoring of the effectiveness of each state hospital's Risk Management Program.
7. Establishing priorities for addressing identified risks to ensure effective utilization of available resources.

Violence against DSH-A staff is addressed by a multi-layered approach involving proactive and preventative measures, incident management, risk mitigation strategies, documentation and reporting systems. Proactive measures include:

1. Regular staff communication about risk;
2. Education and training regarding warning signs, triggers, de-escalation and containment techniques, and
3. Risk assessment and treatment individualization.

Communication at the unit level starts with change of shift meetings. The Change of Shift Report/Hand-off Communication shall begin and end as scheduled, and occur

at 0645, 1445, and 2300 on a daily basis. Through the exchange of relevant information between the off-going and on-coming shifts, the communication shall support continuity of care for patient, as well as a safe, secure, and therapeutic treatment environment. Oral reports shall be presented in a clear, concise, professional manner, and include summaries of information documented on the Change of Shift Report Worksheet. For further information see [AD 537 Change of Shift Report Hand-Off Communication](#).

Trigger Reporting is a mechanism DSH-A utilizes for the proper and timely identification of high-risk situations and to ensure timely interventions and other corrective actions by treatment teams, disciplines and administration to prevent or minimize risk of harm of patients; utilizing aggregate data to identify systemic trends and patterns for corrective actions and best practices. For further information see [AD 418 Key Indicator/Trigger Reporting](#)

Assessment of risk occurs upon patient admission and as clinically indicated by each discipline (Psychiatry, Psychology, Social Work, Rehabilitation Therapy, and Nursing). Focused assessments which measure patients' level of risk for violence are used at regular intervals. For further information see [AD 414 Treatment Planning](#)

Special Incident Reports (SIRs) are completed to report and document events that have an adverse effect on the safety, care, treatment, and rehabilitation of the patients served; to monitor the appropriateness and effectiveness of follow-up actions; to provide data for analysis for performance improvement and risk management activities. For further information see [AD 809 Special Incident Reports](#)

Incident Management at DSH-A involves a systematic approach to identifying factors which may have contributed to violence against staff, developing corrective actions to prevent future occurrence, and documentation and reporting thereof. The Incident Management System is a multi-layered process that deals with events which have an adverse effect on safety and patient care. The Incident Management Review Committee ensures follow through and completion of issues and implementation of recommendations. When an employee is the victim of an assault which results in death, serious physical or psychological injury, or risk thereof, a root cause analysis is conducted that identifies the strategies the hospital intends to implement to reduce the risk of similar events occurring in the future. Plans of correction are developed and implemented and monitored by Quality Council.

Patient transfers provide an avenue for patients that may be utilized in response to a violent incident, and include:

1. Transfer within the facility for patients who have engaged in institutional violence,
2. Transfer to other State Hospitals when identified risks cannot be adequately addressed within the facility; and
3. Referrals for transfer to the California Department of Corrections and Rehabilitation when identified risks cannot be adequately addressed with the State Hospital System

The Enhanced Treatment Unit (ETU) treats patients who pose extraordinary risk of harm to others. The most effective treatment to reduce aggression is determined through diagnostic clarification, stabilization and assessment/evaluation. The goal of the ETU is to return patients to mainstream treatment with supports in place to ensure safety for all.

VI. SAFETY HAZARD REPORTING

A. VIOLENCE REPORTING

In addition to the MH 5420 report, DSH-A utilizes the Special Incident Report (SIR) Packet as a procedure to document reports of patient assaults on staff and to assist the hospital in identifying risks. These packets can be obtained by your supervisor.

The violence incident reporting procedure is designed to provide hospital management with immediate notification of reported incidents which allows for timely and efficient responses and investigations. Aggregate data from this incident reporting procedure is analyzed by both Health and Safety and Standards Compliance to identify trends and to help reduce violence.

1. PATIENT ON STAFF VIOLENCE

Any employee who becomes aware of a serious injury or threat of physical violence by a patient against a staff member must report it to his or her supervisor as soon as practical. The supervisor will then advise the person at risk as well as their supervisor and report it to the DPS Watch Commander. If an employee is personally threatened with serious physical violence by a patient they must notify the DPS Watch Commander as soon as possible. For further information see [AD 906 Duty to Warn, Inform and Report Serious Threats](#)

All assaultive incidents require an investigation by DPS. When an assaultive incident occurs, staff will request a DPS officer by calling dispatch at extension 2366.

2. STAFF ON STAFF VIOLENCE

Staff shall report any injury, reasonably perceived threat, or incident of violence to their supervisor:

- a) If the anticipated or actual incident involves the employee's supervisor or manager, the report may be made to the next highest level in the chain of command;
- b) Reporting of incidents may be made anonymously. However, anonymity cannot be guaranteed in a case requiring legal or administrative action. The extent to which anonymity can be preserved must be explained to the employee upon such reporting.
- c) The investigation into the incident or perceived threat will be handled according to DPS and Human Resource policy.

B. UNSAFE WORK PRACTICES REPORTING

Employees must report unsafe work practices/conditions to their immediate supervisors. Supervisors will ensure that the hazard is immediately reviewed to determine what next steps should be taken. If the unsafe work practice is due to employee behavior, it will be the responsibility of the supervisor to discuss with the employee to correct the action. If necessary, progressive disciplinary procedures should be followed to ensure that the employee maintains corrective action ongoing. If the unsafe work practice is due to any

facility repair, the supervisor will complete a Work Order and ensure to follow up with Plant Operations for completion of Work Order. If employees have any further questions regarding possible unsafe work practices, they may contact the Health and Safety office (805) 468-2013 or write an anonymous memo and submit it to the Employee Suggestion box located in the lobby.

C. ACCIDENT/INCIDENT REPORTING

1. All First Aid injuries are to be recorded in the Unit/Department First Aid Log and signed by a supervisor with the exception of Body Substance Exposure (BSE) injuries. First Aid Injuries are defined as any injury requiring one time treatment of minor scratches, cuts, burns, splinters, bruises or sprains that don't require further medical care.
2. Staff will report any accident, injury (including psychological), illness or exposure to their Supervisor. After receiving a report the supervisor, or designee of the affected employee will:
 - a) If the employee suffers an injury/illness that is beyond first aid, accompany them to the Urgent Care Room (UCR) if necessary.
 - b) Conduct a thorough investigation of the circumstances and gather information using: Occupational Injury and Illness Report (MH 5420) & the Staff Injury Worksheet (AT 2990). This review will be completed immediately, or as soon as is safe to do so; but within 48 hours of an incident occurring.
 - c) Maintain communication and remain aware of the employee's status.
 - d) Determine the cause and contributory factors related to the injury or illness.
 - e) Forward the MH 5420 to Human Resources Return to Work and Health & Safety Department.
 - f) Route AT 2990 to Health and Safety.

D. SUPERVISOR'S INITIAL REPORT

See above section C and follow steps 2. b) through f).

E. DEATH AND SERIOUS INJURY REPORTING

Serious injuries are; (a) require in-patient hospitalization for a period in excess of 24 hours for other than medical observation, (b) dismemberment or serious permanent disfigurement. When serious injury or death occurs, the Health and Safety Office will be notified immediately by the Nursing Officer of the Day (NOD).

Per Title 8, Section 342, all serious injuries, illnesses or deaths will be reported to the Cal/OSHA District Office within 8 hours. Contact Cal/OSHA at the Bakersfield District Office at (661) 588-6400 and/or fax (661) 588-6428. If the injury occurs during business hours (8 AM – 4:30 PM M-F) the notification from DSH – A will be made to Cal OSHA by the Health and Safety Office. If the injury occurs during any other off hour times, (4:30 PM – 8 AM, weekends and holidays) the notification to Cal/OSHA will be done by the NOD and a copy of the notification will be sent immediately to the Health and Safety Office.

VII. EMERGENCY RESPONSE AND ACTION PLAN

Employees are responsible for being aware of the various procedures to call for aid from emergency personnel responders and other staff dependent upon the type of emergency. Each area will have an Area Specific Safety Plan that will be located as the last section of the IPPP. It is important that supervisors and managers ensure that new employees and employees new to their area/unit/program are trained on the Area Specific Safety plan for their specific area. Area Specific Safety plans are reviewed and updated each fiscal year in each area.

A. EMERGENCY RESPONSE TEAM

1. INSIDE SECURITY

- a) Activate personal alarm
- b) If emergency involves an injured/ill person quickly assess them
- c) If emergency necessitates the need, **Dial 2911** which notifies emergency responders and give them a brief description of the status of the injured (bleeding, breathing, conscious)
- d) Secure the area if it may be a crime scene
- e) All personal injuries are to be reported to the Supervisor, regardless of how minor the injury might be. The supervisor records it in the First Aid Log or on the Occupational Injury or Illness Form (MH 5420)

2. OUTSIDE SECURITY

- a) Using a personal cell phone dial 468-2911 or if from work phone you may dial 2911 which notifies the Fire Department and DPS
- b) Give a brief description of injured/ill and the scene to Dispatch
- c) Fire Department will provide medical attention and if needed, request outside assistance

B. PERSONAL DURESS ALARM RESPONSE

Personal Duress Alarms Systems (PDAS) initiate prompt action in emergency situations for those in need of immediate help. In all cases, alarms have priority over routine duties and shall be answered by those immediately responsible without delay. The response shall be with sufficient personnel to deal effectively with the emergency, whether it be fire, major or minor patient disturbance, patient escape, or serious illness or injury.

Employees working in the secured treatment area of the hospital shall obtain a scan transmitter prior to entering the main sally-port being sure to test the scan transmitter to ensure it is functioning properly. To test the white transmitter, remove it from the black case and observe the sensor upon entrance into the facility utilizing the test sensors that are located above the door to the Barber shop. If the red light comes on, the transmitter is working. If the transmitter is not functioning properly the employee will place it in the black box labeled "Broken Alarms" in the main sally-port.

The transmitter will be carried by each employee on their person at all times while in the secured area. To initiate an alarm, remove the white transmitter from the black case. Sensors are located throughout the facility and the signal will be picked up by the sensor

and relayed to Dispatch who will immediately put forth an announcement over the PA system stating the location of the alarm. Employees are expected to respond to red light alerts according to their level of training, unless their immediate task or physical condition precludes response. Additionally, employees in the immediate vicinity of a red light occurring in the main hallway are to assist, together with the staff assigned to respond based on the Red Light Zone Response system.

Unit alarm sensors will be tested weekly by the appropriate NOC shift personnel, after coordination with the Dispatch Center. Testing off-unit alarm sensors will be conducted at night by DPS on a weekly basis. Any off-unit area that prefers to be tested at a different time may do so by a request through the Watch Commander.

For further information and map of Red Light Response Zones see [AD 345 Alarm System](#).

C. FIRE ALARM RESPONSE

There are various types of fire reporting systems in the hospital that initiate an alarm. These systems include the fire emergency phone number 2911, 7 - telephone alarm, fire alarm pull boxes, fire alarm key operated boxes, visual alarms (flashing light or strobe light), and other fire detection devices. Staff has the responsibility of placing an emergency call to extension 2911 when they are aware of the sounding of an alarm. This will assure immediate emergency services response. Alarms are tested weekly throughout the facility and in outside areas by Fire Department personnel.

A Fire Plan Booklet is issued to each unit and support area and is also on the intranet. The plan contains a minimum of a fire evacuation route map, including firefighting equipment in the area, exits, fire doors, emergency fire phone number, fire alarm boxes, and evacuation routes. Other information is also provided in the booklet on the use of fire extinguishers, inspection guidelines, furnishings information, and special area fire information pertinent to the area, and personnel roles and procedures in a fire emergency. Staff is responsible to be familiar with the informational Fire Plan Booklet. Employees shall receive a minimum of one hour annual Fire and Life Safety training through the Fire Department. Specific employee work location orientation in fire safety measures is the responsibility of the area supervisor. The Fire Plan Booklet provides help to the supervisor. For further information see [AD 343.1 Fire Plan - Procedures in Case of Fire, Explosion or Rescue](#)

In response to a fire emergency, employees can implement the basic procedure of R.A.C.E. (Rescue-Alarm-Contain-Extinguish)

1. **R** - Rescue patients, staff, or visitors directly involved and evacuate the area.
2. **A** - Sound the alarm. (Call 2911 and pull the fire alarm pull box.)
3. **C** - Contain the fire. (Confine the fire and smoke by closing doors.)
4. **E** - Extinguish the fire, if safe to do so, and get help.

Other specific duties required in the rescue and evacuation phase include:

1. Systematically checking each room, under each bed, and securing the room by closing the door. The checking of all rooms, bathrooms, including all offices, program offices, and annexes.
2. Removing the logbook, count board, and other applicable items to safety.
3. Evacuating the area in an orderly manner to one of several pre-designated sites (gymnasium, auditorium, courtyard, or adjacent unit.)
4. Immediately hold a roll call.

*NOTE: Disabled Staff and Patients Notification and Evacuation: Staff shall be attentive to the special needs of disabled staff and patients. The immediate area supervisor shall take responsibility for the notification and evacuation of the disabled. Consideration of using a handheld placard stating "FIRE" may be of benefit in areas with hearing-impaired staff and patients.

D. MEDICAL EMERGENCY RESPONSE

1. INSIDE SECURITY

- a) Activate personal alarm;
- b) Quickly assess injured/ill
- c) **Dial 2911** which notifies emergency responders and give them a brief description of the status of the injured
- d) Secure the area if it may be a crime scene
- e) All personal injuries are to be reported to the Supervisor, regardless of how minor the injury might be. The supervisor records it in the First Aid Log or on the Occupational Injury or Illness Form (MH 5420)

2. OUTSIDE SECURITY

- a) Using a personal cell phone dial 468-2911 or if from work phone you may dial 2911 which notifies the Fire Department and DPS
- b) Give a brief description of injured/ill and the scene to Dispatch
- c) Fire Department will provide medical attention and if needed, request outside assistance

E. DISASTER RESPONSE

Disaster is defined as an earthquake, flood, electrical outage, etc. DSH-A's policy is to immediately activate the Incident Command Post and follow National Incident Management System (NIMS) protocol. The DSH-A Emergency Preparedness Manual provides specific information on policies and procedures relating to Emergency Management and preparedness drills. For further information see [AD 348 Emergency Services Plan - Life Threatening Emergency Attention to Patients](#) and [Emergency Preparedness Manual](#)

VIII. INVESTIGATIONS

Investigations are an essential element of the Injury and Illness Prevention Program. The purpose of investigation is to determine the contributing factors and root cause of workplace accidents, injuries, illnesses, and violence related incidents; and making necessary changes to policies, procedures, and protocols to prevent reoccurrence. Situations where there is a credible reason to believe threats or acts of violence have occurred, or are likely to occur, will be investigated by DPS Office of Special Investigations and may be subject to criminal proceedings. This includes threats or violence between employees.

It is essential that incidents be investigated as soon as possible while facts are still clear and more details can be remembered. Each accident/incident will be investigated according to the following:

- 1) Reviewing previous accidents/incidents, including any previous reports of inappropriate behavior by the perpetrator, if a violent incident has occurred;
- 2) Visiting the scene of the incident as soon as possible but no more than 24 hours after an incident occurs;
- 3) Interviewing complainant(s), witnesses, and if possible the respondent;
- 4) Examining risk factors associated with the accident/incident;
- 5) Determining the cause of the incident;
- 6) Writing a detailed report conveying details;
- 7) Taking corrective action to prevent the incident from reoccurring; and,
- 8) Recording the findings and corrective actions taken.

Minor incidents, “near misses”, and unsafe work practices, should be investigated since they are usually a warning of potential hazards that could result in serious injuries or illnesses to staff.

Documentation of corrective and/or preventative action taken will be documented in writing and forwarded to the Executive Director or designee.

A. WORKPLACE VIOLENCE INVESTIGATIONS

DSH-A works to foster an environment free of violence. DSH-A is committed to the prevention of and appropriate response to incidents involving a violent or criminal act by a current or former employee, by anyone who has an employment-related involvement with DSH-A, by a recipient of a service provided by DSH-A, or by a person with no legitimate relationship to the workplace.

Threatening behavior includes any behavior that is harassing, bullying, provoking or unsafe, which could be interpreted by a reasonable person as intent to cause physical harm to another individual. Threatening behavior may, or may not, include the act of physical force, with or without a weapon, toward another individual. Any employee who is personally threatened with serious physical violence shall notify the DPS Watch Commander as soon as possible.

Each supervisor is responsible for assuring a safe work environment by investigating and correcting safety concerns identified by themselves or their staff, including incidents that involve patients, personnel, or visitor injuries, occupational illnesses, or property damage.

Training

Employees shall receive training to promote awareness of workplace security. The focus of such training will be to recognize and respond appropriately to threats and acts of violence. Training will occur at new hire orientation, annually, and as necessary.

Where a Threat of Violence Has Occurred

1. The employee will inform their immediate supervisor of the incident.
2. The supervisor will address the immediate safety needs of that employee and others affected.
3. The supervisor will communicate information regarding the incident of threat to his/her supervisor and/or management for further investigation and action.
4. If the anticipated or actual incident involves the employee's supervisor or manager, the report may be made to the next highest level in the chain of command or to the Health & Safety Office or DPS.
5. Reporting of incidents may be made anonymously. However, anonymity cannot be guaranteed in a case requiring legal or administrative action. The extent to which anonymity can be preserved must be explained to the employee upon such reporting.

Where a Violent Act Has Occurred

1. Staff shall immediately Dial 2911, activate their alarm (PDAS). If staff calls dispatch, they must report what has occurred and where.
2. DPS will immediately respond and assess the situation to determine what resources are needed to contain the crisis.
3. Occupational Injury/Illness Report by Supervisor (MH 5420) and Worksheet (AT 2990), is completed by supervisors for staff injuries.
4. The Staff Injury Worksheet (AT 2990) is forwarded to the Area Specific Safety Coordinator and the Health and Safety Department for review and to assist in identifying root causes of injuries and development of plans of correction.
5. The Form 5420 is completed by the supervisor and sent to Claims Management and Health and Safety office.
6. Any investigation of staff on staff violence will be conducted by Special Investigations, EEO and/or an outside agency, depending on the nature of the event. Upon completion of the investigation, the report will be given to the Human Resource Department who will determine what, if any, further actions is necessary.

B. CRIMINAL INVESTIGATIONS

DPS shall be responsible for completing criminal investigations. The Office of Special Investigations (OSI) shall follow up with an internal administrative investigation of administrative violations when appropriate. If necessary, any findings may be required to be reported to outside agencies or law enforcement.

C. ADMINISTRATIVE INVESTIGATIONS

The Office of Special Investigations is responsible for conducting administrative investigations of policy and procedure that are not normally criminal in nature. Administrative investigations are reported to the Executive Team and may result in adverse action, civil sanctions, and/or fines.

D. ACCIDENT/INJURY/ILLNESS/EXPOSURE INVESTIGATIONS

Depending upon the nature of the accident/injury/illness/exposure, investigations may be conducted by (but not limited to) a Supervisor, Manager, Health and Safety Office, Standards Compliance Department, Equal Employment Office and DPS

Incidents involving employee's accident/injury/illness/exposure shall be reported to the Health and Safety department to ensure appropriate corrective actions are implemented as necessary. It is important for all staff to maintain open communication with Health and Safety staff throughout the investigation process.

Each supervisor is responsible for assuring a safe work environment in accordance with [AD 909 - Hospital Health and Safety Program](#). Supervisors are responsible for accurately completing Occupational Injury and Illness form (MH 5420) for all staff injuries and illnesses. It is essential that these forms are submitted within **48 hours** to the Return to Work office and Health and Safety department. Health and Safety staff will review incidents reported on the form MH 5420 to determine if corrective actions can be implemented to prevent future incidents from occurring.

Supervisors are to complete the Staff Injury Worksheet (AT2990) and forward to the Health and Safety department (fax # 3086) and a copy given to their Area Specific Safety Coordinator as soon as possible. All reports of staff injuries will be reviewed by Health and Safety to determine if a hazard correction plan can be made to prevent further incidents from occurring.

If assistance is required with developing or implementing a hazard correction plan, supervisors may contact Health and Safety staff at X2013. Failure to perform hazard corrections without sufficient cause will be reported to management for further action.

IX. POST INCIDENT RESPONSE

A. INJURED/ILL EMPLOYEE MEDICAL TREATMENT

1. All First Aid injuries are to be recorded in the Unit/Department First Aid Log and signed by a supervisor with the exception of Body Substance Exposure (BSE) injuries or any confidential injury (psych). First Aid Injuries are defined as any injury requiring one time treatment of minor scratches, cuts, burns, splinters, bruises or sprains that don't require further medical care.
2. Staff will report any accident, injury (including psychological), illness or exposure to their Supervisor. After receiving a report the supervisor of the affected employee will:
 - a) If the employee suffers an injury/illness that is beyond first aid, accompany them to the Urgent Care Room (UCR) if necessary.
 - b) Conduct a thorough investigation of the circumstances and gather information using: Occupational Injury and Illness Report (MH 5420), and the Staff Injury Worksheet (AT 2990). This review will be completed immediately, or as soon as is safe to do so; but within 48 hours of an incident occurring.
 - c) Determine the cause and contributory factors related to the injury or illness.
 - d) Forward the MH 5420 to Human Resources Return to Work
 - e) Route AT 2990 to Health and Safety.

B. CRITICAL INCIDENT STRESS DEBRIEFING

DSH-A recognizes that the health of our staff is as important as the health of the patients. As part of our commitment to provide a supportive and safe work environment, DSH-A offers a Critical Incident Stress Debriefing (CISD) program for helping staff cope with the psychological sequel of critical incidents related to employment. The CISD program is an adjunct to, not a replacement for, the Employee Assistance Program (EAP).

ACCESSING CISD SERVICES

Following a critical incident, a supervisor will offer CISD services to his/her employee or the employee may request CISD services through his/her supervisor. Authorization for CISD services will be made by the program/department manager.

Face-to-face and telephonic CISD services are coordinated by the Employee Assistance Program (EAP) Coordinator in the Human Resources (HR) Department. CISD services are conducted as soon after the event as is practically feasible and clinically appropriate. These services will be provided outside the secure treatment area of the hospital.

C. EMPLOYEE ASSISTANCE PROGRAM

As a State of California Employee, you and your eligible dependents have access to an Employee Assistance Program (EAP).

The EAP program is provided by the State of California as part of the State's commitment to promoting employee health and wellbeing. It is offered at no charge to the employee and provides a valuable resource for support and information during

difficult times, as well as consultation on day-to-day concerns. For further information see [AD 907 Critical Incident Stress Debriefing for Staff Following Critical Incidents](#)

EAP is an assessment, short-term counseling and referral service designed to provide you and your family with assistance in managing everyday concerns. EAP offers confidential clinical help 24 hours a day, seven days a week to all staff. For further information see [AD 909.1 Employee Assistance Program](#)

For more information on EAP, please contact your location's Employee Assistance Coordinator at 805-468-3402 or visit [Employee Assistance Program Website](#)

X. RISK MITIGATION AND HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures will be corrected in a timely manner based on severity when they are first observed or discovered.

At DSH-A the patient population can be the greatest hazard. Due to their unpredictable behavior, various psychiatric diagnosis and history of violent and aggressive behavior, the patients can be the cause of various hazardous situations. The purpose of this section is to identify expectations related to risk mitigation and hazard correction and identify what resources are available to staff during hazardous situations.

A. RISK MITIGATION

1. Violence Prevention Committee

Due to the various incidents that have occurred related to the violent and aggressive acts of the patients at DSH-A, the Violence Prevention Committee was created. The purpose of the committee is to:

- a. review incidents that occur in the hospital
- b. investigate measures that could prevent future reoccurrences of those incidents
- c. collect, review and provide feedback of suggestions from hospital suggestion box related to violence
- d. develop education and training for staff when hospital wide trends are observed
- e. create a repository of standard violence interventions and identify best practices

2. Therapeutic Strategies and Interventions (TSI)

TSI is instituted to prevent suspend and mitigate conditions and circumstances that may lead to an assaultive act by a patient for the purpose of preventing or limiting injury to those involved. TSI may be used to prevent aggressive behavior and avoid provocation of harmful aggressive behavior. Staff shall be given initial TSI training upon start of DSH employment and in accordance with training standards thereafter. For further information see [AD 519 Therapeutic Strategies and Interventions \(TSI\) Training](#)

3. Clinical Record

DSH-A maintains a clinical record for each patient. The clinical record is a legal document that serves a variety of purposes, including documentation of the patient's treatment plan, care, treatment, services and outcome. The clinical record promotes continuity of care among providers and contains unique identifying data, demographic information as well as the necessary information to support the patient's diagnosis and condition. Staff members who have access to the clinical record must maintain the confidentiality of the clinical record. The clinical record may never leave the hospital unless traveling to another facility within Department of State Hospitals.

Clinical records are easily accessible to clinical and level of care staff and may be found on the patient units or HIMD. For further information see AD 506 Clinical Record

4. Patient Kardex

The Patient Kardex contains basic information to identify the patient, assist in determining priorities for nursing care, and support consistent implementation of the treatment plan. Staff may use the Kardex as a source of information to identify:

a patient's internal or external triggers

- a. behavioral precursors
- b. mental and or medical diagnosis
- c. behavioral alerts
- d. physical alerts
- e. preference interventions
- f. current behavioral plan
- g. current medications
- h. team members involved in patient care

Staff may also access patient's criminal history and identify if patient has been psychologically, sexually or physically abused. Staff shall have access to Patient Kardex information via the DSH-A intranet. For further information see [AD 538 Kardex](#)

5. Search and Shakedown Policy and Procedures

During a hazardous situation the systematic identification and removal of potentially dangerous items and contraband material through standardized search and shakedown procedures is utilized to support a safe, secure environment for patients and staff. For further information see [AD 520 Search and Shakedown Policy and Procedures](#)

6. Facility Repairs

Repairs of the physical plant and equipment must be performed within a timely manner through the submission of work orders. Contact Plant Operations (PLOPS) for repairs of the physical plant

7. Equipment Repairs

Dysfunctional equipment must be repaired and safety hazards corrected immediately, or as soon as possible.

- a) Contact Plant Operations (PLOPS) for repairs of the physical plant
- b) Contact Technology Services for technical repairs

8. Administrative Directives (AD)

Staff is to be kept up to date on AD and changes that can affect hazard response and communication. Staff may refer to DSH-A intranet for a list and link to updated AD's. For further information see [AD Index](#)

9. Emergency Preparedness Manual (EPM)

The EPM is required to be on all units and in all departments so it is easily accessible to staff. The EPM includes instruction on what to do in response of natural disaster, bomb threat, security breach, terrorist attack and medical equipment and/or utility disruption.

A current copy of the Emergency Preparedness Manual can be easily accessed on the local DSH-A intranet. For further information see [Emergency Preparedness Manual](#)

10. Infection Control Manual

The Infection Control Manual shall be easily accessible to staff. The infection control manual addresses and defines the Infection Control Program which includes but not limited to:

- a) general infection control policies and practices
- b) infection control of the hospital environment
- c) protocols for the diagnosis and treatment of patients with infectious diseases or conditions including aerosol transmissible diseases
- d) employee infection control program
- e) Infection Control Program for support services
- f) performance improvement activities and findings related to infection control and related engineering controls.
- g) Blood borne pathogens

A current copy of the Infection Control Manual can be easily accessed on the local DSH-A intranet. For further information see [Infection Control Manual](#)

11. Nursing Procedures Manual

The Nursing Procedure Manual shall be easily accessible to nursing staff. Nursing staff may use the Nursing Procedures manual as a guide of how to handle specific nursing situations such as, but is not limited to:

- a) cardiac emergencies,
- b) burn care,
- c) head injuries,
- d) emergency oxygen administration,
- e) airway obstruction/choking episode,
- f) ingestion of poisonous substances, etc.

The Nursing Procedures Manual describes and guides nursing care. A current copy of the Nursing Procedures Manual can be easily accessed on the local DSH-A intranet. For further information see [Nursing Procedures Manual](#)

12. Pharmacy Manual

The Pharmacy Manual shall be easily accessible to all staff. The Pharmacy Manual informs staff of:

- a) pharmacy hours
- b) the hospital formulary system
- c) on-call pharmacists
- d) medication not requiring an MD order
- e) how to obtain medication if the pharmacy is closed
- f) "How to obtain an Emergency Drug Kit"

A current copy of the Pharmacy Manual can be easily accessed on the local DSH-A intranet. For further information see [Pharmacy Manual](#)

B. HEAT ILLNESS PREVENTION PLAN

The DSH-A Heat Illness Prevention Plan is in place for when environmental conditions reach high temperatures. High temperatures can place both employees and patients at

risk for heat illnesses and complications. This plan outlines precautions to minimize those risks. It is enforced by the Heat Illness Prevention Standard, Title 8 CCR, Section 3395.

There are four environmental factors that can cause heat stress in a hot work area. These are (1) temperature; (2) radiant heat from the sun or other sources; (3) humidity and (4) air velocity. The level of heat stress a person encounters is influenced by age, weight, level of fitness, medical condition and acclimatization to heat. Medications and work load can also be contributing factors.

PROCEDURE

DSH-A will initiate an annual seasonal reminder in the late spring or when a heat alert is received through the National Weather Service. The seasonal reminder will consist of an educational flyer titled "Extreme Heat Information". The flyer is distributed to employees and patients by the Health and Safety Department in collaboration with Public Health through email and supervisory staff.

From July through October, temperatures are monitored daily by staff either manually or electronically in all indoor areas occupied by employees and patients. A heat alert during other months of the year will also trigger the same monitoring process.

When temperatures outside are either predicted to be in the triple digits or actually reach 95 degrees and above, a facility wide "Heat Alert" will be initiated by either DPS, by direction of the Medical Director's Office or Health and Safety. During heat alerts, the following are critical:

Access to potable drinking water will be made available to employees and patients. The consumption of up to 4 cups per hour in small quantities will be encouraged, except where contraindicated due to medical reasons.

Acclimatization allows the body to adjust to work in high heat. People need several days to adjust when working conditions are significantly hotter than they are used to. Gradually increasing the work load or modifying work hours are examples.

Access to shade while outside shall be permitted at all times. Employees suffering from heat illness or believing a preventive recovery period is needed shall be provided access to an area with shade that is either open to the air or provided with ventilation or cooling for a period of no less than five minutes.

SIGNS AND SYMPTOMS

Signs and symptoms of heat illness include headache, muscle cramps, rash and unusual fatigue. Progression to more serious illness such as heat cramps, exhaustion and stroke, can be rapid and can include unusual behavior, nausea/vomiting, weakness, rapid pulse, excessive sweating or hot dry skin, seizures and fainting or loss of consciousness. Immediate medical attention is essential. Supervisors will continuously check employees who are at high risk for heat exposure and stay alert to the presence of heat-related symptoms. Staff will do the same for patients. Supervisors and staff are encouraged never to discount any signs or symptoms they see or experience and to report them immediately to their supervisor/manager.

EMERGENCY PROCEDURES

If a patient or employee begins to feel or show signs or symptoms of heat illness the supervisor should be notified immediately and if necessary 2911 should be called. Calls will be responded to:

Within the facility by the Nursing Officer of the Day (NOD) and DPS with the emergency cart. The injured will be taken to the Urgent Care Room (UCR) where they will be examined and treatment will be started if indicated. In the case of non-stabilization, 911 will be called immediately for ambulance transport to a local community hospital emergency room. For further information see [AD 348 Emergency Services Plan - Life-Threatening Emergency Attention to Patients](#) and [AD 351 Medical Attention for Non-Patients](#)

Outside the facility by the Fire Department and DPS. In the case of non-stabilization, 911 will be called immediately for ambulance transport to a local community hospital emergency room. [AD 351 Medical Attention for Non-Patients](#)

TRAINING

Heat Illness training will be provided to employees and supervisors pertaining to the environmental and personal risk factors of heat illness as outlined in Title 8 Section 3395. Training will also be provided on the different types of heat illness and their common signs and the importance of the employee reporting symptoms to their supervisors or co-workers for the possible contact of Emergency Medical Services.

In addition, prior to supervising employees performing work that could possibly result in exposure to the risk of heat illness, effective training will be provided to the supervisors. Supervisors will be trained on how to implement the provisions of this heat illness prevention program, the procedures the supervisor is to follow when an employee exhibits signs or symptoms of possible heat illness, including emergency response procedures and how they will monitor and respond to hot weather reports/advisories.

AREAS/PEOPLE MOST SUSCEPTIBLE TO HEAT

Three areas inside the facility, the Main Kitchen, Gym and Chapel are not serviced by the cooling system and are at higher risk for heat related illnesses. Thermometers are posted in these areas and in the event temperatures reach 90 degrees, precautions must to be started immediately to ensure the safety of employees and patients.

Employees who work outside during heat alerts, such as but not limited to Plant Operations, DPS and General Services staff are at a higher risk for heat related illnesses.

Patients on courtyard breaks who are on medication that may be affected by sun exposure are also in need of close supervision. In the event of an extended power outage, patients at risk in elevated temperatures should be moved to the 258 bed addition of the hospital.

Nutrition Services

If an indoor temperature reaches 80 degrees, Nutrition Services workers will be reminded to remain adequately hydrated. When drinking liquid for hydration, employees and patient workers are to step away from serving lines and direct production areas and keep their personal water well separated from the food service food/supplies. Employees and vocational workers may utilize drinking fountains whenever needed. Those in the hottest/most humid areas of the department, i.e., the ware wash rooms, are rotated out of the area upon request or when observed as necessary by supervisors.

Gym and Chapel

At 90 degrees the gym and chapel will be closed and patients sent back to their units. Employees may remain in the gym office to work as long as they continue to hydrate and utilize the buddy system to monitor each other. In the event the office reaches 95 degrees employees should notify their supervisor and relocate to a cool area.

DPS Observation Centers

Both Observation Centers are staffed 24/7. Each is self-contained with its own air-conditioning system. Officers in these posts are required to monitor the internal temperatures to ensure that the cooling units are working properly. Each tower has a small refrigerator to maintain the officers' food, ice and cold drinks. Each tower is equipped with a telephone, computer and police radio which allows for alternate means of communications in the event of a power failure. Outside patrol officers also maintain regular communications with the Observation Centers.

Gate Kiosk

The Gate Kiosk is also equipped with a cooling system and small refrigerator like the Observation Centers. Officers working in the kiosk have radios for communication with Dispatch as well as cell phones. The Kiosk officer is in regular communications with Dispatch throughout their shifts.

Police Academy Cadets

Cadets attending Police Academy on-grounds receive Close Order Drill instruction 3 to 4 days each week. These drills are conducted in the early morning hours, usually between 0700 and 0800 hours before temperatures become elevated. Physical training is conducted in the evenings when the weather is cooler or, in extreme temperature conditions, inside the training building that is equipped with air conditioning. Academy Instructors ensure the cadets are properly hydrated and continually monitor cadets for signs of distress. The instructors also remind cadets to immediately report if they are feeling ill.

Plant Operations

Plant Operations employees may work in hot conditions both outside and inside such as tunnels. When working in these conditions, employees are reminded of precautions to take to prevent heat illness by their supervisors and through health and safety bulletins and shop safety meetings. During heat alerts, employees are encouraged to finish outside work by noon. Heavy work activities should be completed during the cooler (early morning) part of the day and slower paced, less physically demanding work, shall be scheduled during the hotter parts of the day. When a modified work schedule is not possible more water and rest breaks will be provided. Co-workers will utilize the buddy-system to watch each other closely for signs of discomfort or symptoms of heat illness. Supervisory staff will carry cell phones or other means of communication to ensure that

emergency services can be called in the event of a heat-related illness. Cell phones will be checked at the beginning of shift to make sure they work.

Outside Work Assignments

Employees working outside will use the buddy system. If two employees are not available at the given location, the job should be postponed or a phone call must be made to the lone staff member every half-hour to check on water supply and health. Drinking water must be adequate for the amount of time required by the job. As confusion is a symptom of heat illness, questions must be asked to verify alertness. If an employee feels dizzy or light-headed they should stop working, sit in a shaded area and slowly drink water. The supervisor shall be notified immediately.

Courtyards

By order of the Medical Director, when the outside temperature reaches 100 degrees, DPS will close the Main Courtyard, as noted in AD 808. Program courtyards will remain open at the discretion of each Director. The Program Director will consider available shade in the courtyard, humidity and susceptibility to heat conditions due to medication. Employees will make certain an igloo filled with water and ice is in the courtyard during breaks with cups for patients and employees to drink from. Employees will watch patients with risk factors, as noted in Nursing Procedure Manual (NP) section 314.2, and encourage them to drink water often. During the hotter days, when courtyard breaks are over, employees will continue to observe at-risk patients and each other as delayed symptoms can result. Water must continue to be provided, showers should be allowed for patients and breaks allowed for employees if requested or needed. For further information see [AD 808 Courtyard Coverage](#)

Energy Conservation Measures

Energy conservation measures will be implemented by Plant Operations or Administration as related to non-safety/security adjustments to lights, fans, computers, and other appliances.

Incident Command System

In an excessive heat emergency, the facility Incident Command System may be implemented and will determine necessary action and what resources are needed. When local resources are inadequate to meet the need, requests are made to the next highest emergency response level utilizing the National Incident Management System (NIMS).

C. CONFINED SPACE PLAN

Per Title 8, Sections 5156 – 5158, DSH- maintains and adheres to a Confined Space Plan for all applicable areas within the facility grounds. The Confined Space Entry Program is developed and established to identify, evaluate, and control such spaces, and more important, to detail procedures and responsibilities for entering and working within confined spaces.

Confined spaces can be very dangerous due to a limited amount of space or the lack of oxygen or both and additional safety measures must be taken. Adherence to the policies and directives contained in this program is mandatory for supervisors and staff. Anyone failing to follow this program is subject to disciplinary action and/or dismissal.

As all confined spaces at DSH-A are in the Plant Operations Department, the plan is located there and can be reviewed in its entirety upon request.

D. VECTOR CONTROL POLICY

DSH-A has a responsibility to identify and eradicate insects, rodents and other pests in order to maintain a sanitary environment.

Staff is responsible for maintaining a clean and sanitary physical environment, which is non-conducive to the harboring or proliferation of insects and rodents.

Pest control services are coordinated through the Health and Safety Department. Minor problems are addressed by facility staff and a vendor is contracted to provide preventative and services as needed. Should any areas of the facility have issues with vectors, contact Health and Safety at (805) 468-2013. For further information see [AD 706 Vector Control](#)

E. HAZARD CORRECTION

Action to correct and resources available shall include but are not limited to:

1. Notify immediate Supervisor of hazard
 - a) Examples of hazards include but are not limited to: patients, broken equipment, fires, earthquakes, bomb threats, patient or staff medical emergencies, active shooters, terrorist attacks, etc.
2. When a hazard has occurred/is in progress, staff is to activate the hospital alarm system. Staff can access the alarm system in the following ways
 - a) **Activate personal alarm.** This will activate a red light alarm in the designated zone that will immediately notify dispatch, hospital DPS officers and staff where the location of the hazard is so they can respond.
 - b) **Dial 2911.** This will notify emergency personnel (Unit 1, DPS, Fire & NOD) of the hazard and they will respond.
 - c) **Elevator alarm button.** This will notify DPS of the hazard and they will respond along with staff that is within the designated response zone.
 - d) **Telephone alarm.** Telephone alarm is activated by dialing “7” after hearing a dial tone, then leaving the phone off the hook so the extension can be locked in at DPS dispatch center where it is received.
 - e) **Courtyard cordless telephones.** The phone can be located in the unit’s assigned courtyard and must be carried with staff while in the courtyard. To talk, the phone must be switched from “stand by” to “talk”. The same procedure is followed using the cordless phone as the regular telephone when activating the alarm to notify DPS. (see d. ‘telephone alarm’)

XI. SAFETY EDUCATION AND TRAINING

Employees including managers and supervisors shall have training and instruction on general and job-specific workplace safety and security practices. This training is mandatory for all new employees, and for staff given new job assignments for which training has not previously been provided.

Responsibility for formal safety training is assigned to the Health and Safety Officer and is coordinated through DSH-A's Training Department. Supervisors are responsible to ensure their staff attends all required training and that site specific training is provided as necessary.

A. NEW EMPLOYEE ORIENTATION (NEO)

New hospital staff will not be allowed to participate in any level of care, patient contact, or emergency response activities until they have successfully met the safety training requirements for their respective civil service classification and current licensure. NEO includes:

- 1) General Safety
- 2) Fire/Life Safety
- 3) Hazard Communication Overview
- 4) Therapeutic Strategies and Interventions
- 5) Security/Contraband
- 6) Infection Control
- 7) Area Specific Safety Training
- 8) Disaster Training

Requirements for other safety-related training, including CPR/First Aid vary according to the job classification of the employee.

Annual training is dependent upon classification and includes but is not limited to:

- 1) General Safety
- 2) Fire/Life Safety
- 3) Therapeutic Strategies and Interventions
- 4) Security/Contraband

Requirements for the other safety-related training including Infection Control and CPR/First Aid vary according to the job classification of the employee

B. WORKPLACE SECURITY

Staff must be trained on workplace security policies and procedures. The supervisor is responsible for informing staff of policy updates and assuring necessary training is completed. Staff will be trained on the use and known deficiencies of current alarm systems.

C. THERAPEUTIC STRATEGIES AND INTERVENTIONS (TSI)

Assaults by patients upon staff are a frequent cause of workplace injuries within the Department of State Hospitals system. In order to provide guidance on how to avoid and minimize assault risks, help reduce injuries, and provide protection to our staff and patients, TSI training is provided to all staff.

There are two levels of TSI, and staff are mandated to attend one or both levels annually or bi-annually based on their classification. Managers and supervisors are responsible to ensure their staff receives the appropriate level of TSI training.

TRAINING REQUIREMENTS

The hospital shall designate and define TSI training requirements for all employee classifications in the hospital training standards.

Managers and supervisors shall ensure employees receive the appropriate level of TSI training.

The Training Department shall establish a process for certifying competence in applying learned skills.

Required Training: Level I:

Level I include employees and non-employees (i.e., contractors) whose duties routinely place them in physical proximity for the delivery of treatment services to patients, either on residential or off-unit treatment sites. Level I include all managers and supervisors who are responsible for the clinical oversight of level-of-care staff, and the Office of Special Investigations (OSI). Level I employees must successfully complete the following training:

New hires shall attend training in all sections of TSI Module I (approximately 16 hours).

TSI Supervisors (Shift Leads, Unit Supervisors, Supervising RNs, Health Services Specialists, and Assistant Coordinator of Nursing Services), clinical managers, supervisors, and Executive staff. OSI, DPS Chief and Supervisors, shall attend 8-16 hours of enhanced TSI training for supervisors (TSI Modules I and II) within one (1) year of appointment date. This training will provide supervisory level skills and knowledge necessary to promote a therapeutic milieu and assure consistent assignment of TSI responsibilities.

Thereafter, employees whose duties include participation in the development or delivery of treatment services to patients shall attend a minimum of six (6) hours of TSI review annually (TSI Module 1), and shall participate in training with their unit team whenever possible. The annual review may be tailored to the expressed needs of a unit team. The TSI portion of the review shall include non-physical verbal interventions. Clinical managers, supervisors, and OSI shall attend a minimum of six (6) hours of TSI review annually (TSI Module 1).

Clinical managers, supervisors, Executive staff, OSI, DPS Chief and supervisors shall attend 8-16 hours of TSI leadership training (TSI Modules IV, V, and VI) at least once within one (1) year of their appointment date. This training will enhance skills and knowledge for effective leadership of the TSI program.

Required Training: Level II:

Level II includes those persons whose duties may periodically place them in close proximity to patients. All Level II employees must successfully complete the following training:

New hires shall take a basic TSI course comprised of Module I training and which may include non-physical verbal interventions, walk-through performance of TSI self-protection, awareness of unacceptable physical interventions, and familiarity with facility alarm protocol and crowd control duties (up to eight (8) hours).

D. ON-THE-JOB ORIENTATION

All new employees shall participate in general facility orientation and also receive on-the-job orientation; the orientation will include the use of the Worksite Orientation Checklist. When a new employee is about to start work, the supervisor orients each person to the job.

The supervisor will:

- 1) Orient the employee to the work place. Any special plans or procedures will be discussed with an emphasis on safety;
- 2) Show the employee the work area and discuss what the employee will be doing and what the hazards involved are;
- 3) Discuss the Safety Program and any safety and performance expectations with the employee;
- 4) Provide the employee with necessary Personal Protective Equipment;
- 5) Familiarize the employee with the Injury Illness Prevention Program Safety Manual, Area Specific Safety Plan, Program/Department Procedural Manual, and all other manuals as needed;
- 6) Whenever any new equipment is brought into the work area or processes or procedures change, training must be given. The supervisor is responsible for assuring staff is trained.

E. ADDITIONAL

Further safety related training that takes place includes:

- 1) Safety Briefings
- 2) Training on site specific job duties. This is provided prior to performance of job duties.
- 3) SB409 is required for all new supervisors and new supervisors are required to attend at least eight hours of safety-related training.
- 4) Defensive Driver Course for all staff who drive on official state business.
- 5) Back Fitness is available through a "Back Care" video located on the DSH-A Intranet under the training tab.

XII. HAZARDOUS MATERIALS COMMUNICATION PROGRAM

The California Code of Regulations, Title 8, Section 5194 states that employers shall provide information to their staff about the hazardous substances to which they may be exposed, by means of a hazard communication program.

The Hazard Communication Coordinator for DSH-A is the Assistant Health & Safety Officer at (805) 468-2013.

A. HAZARDOUS MATERIALS HANDLING POLICY

The policy of DSH-A is to protect the welfare of staff, patients, visitors, volunteers, and the community environment through the proper handling, labeling, storing, using, and disposing of hazardous materials and wastes. DSH-A is committed to operating in accordance with hazardous waste source reduction approaches. Implementation of this policy is the joint responsibility of staff, supervisors, managers, and the hospital. For further information see [AD 350 Hazard Communication Program](#).

B. SAFETY DATA SHEETS (SDS)

Hazardous materials in the hospital shall have a current, legible, and complete SDS readily accessible during each work shift for staff when they are in their work area(s). Area supervisors and managers are responsible for ensuring the accessibility of SDS and that staff know the location of the SDS binder. No hazardous material will be accepted in any area without the SDS.

SDS shall be no older than three (3) years, unless verified as current with a notation on the top right hand corner of SDS. The most common products SDS in the hospital can be obtain from the Health and Safety departments intranet website, otherwise it is the responsibility of each department to obtain the most current SDS from the manufacturer. If further assistance is needed to obtain an SDS, contact Health and Safety office at X2013.

C. COMMUNICATION

1. Definition of a Potentially Hazardous Material

A hazardous material is any material that, because of its quantity, concentration, or physical or chemical characteristics (ignitable, reactive, corrosive or toxic), poses a significant presence or potential hazard to human health and safety or to the environment.

2. Hazardous Material Inventory

The Hazard Communication Coordinator will assist each program /department in developing an inventory of hazardous materials that workers may be exposed to during normal work procedures or in the case of emergencies such as exposure, leaks, and spills. Supervisors are responsible for maintaining an accurate alphabetical inventory of hazardous materials used in their work area(s) and for ensuring the appropriateness of products used and quantities in inventory.

This inventory must be updated twice a year or whenever a product is added or deleted. A copy of the current inventory is retained in the SDS Binder. In most cases, the manufacturer or supplier of the chemical will do hazard evaluation. This hazard information is then required to appear on the label of each container. The supervisor is responsible for making sure that each chemical container is checked for hazard information.

The Health and Safety Department shall spot check SDS binders during EDIT inspections. Programs and Departments may contact the Health and Safety Department for further review and guidance as needed.

D. ACCUMULATION AND DISPOSAL OF HAZARDOUS WASTES

While accumulated at the satellite location, the hazardous waste is labeled as follows:

1. Initial date of waste accumulation.
2. The words "Hazardous Waste" or "Universal Waste," whichever is applicable.
3. The composition and physical state as indicated on the label.
4. A statement of hazardous properties (e.g. flammable, reactive) as indicated on the label.
5. The name and address of the generator.

All hazardous waste will be sent to the Corporation Yard for appropriate disposal through a contracted hazardous materials waste hauler. The waste will be disposed at least every 90 days or more frequently if needed.

E. LABELING

Labeling Requirements for all chemicals:

Each container shall be labeled with product identity, manufacturer, and a hazard warning statement. When filling a secondary container a label will be placed on the secondary container, and will include product identification and hazard warnings.

All hazardous materials and wastes used in the hospital shall be kept in proper containers designed for that purpose and shall be labeled. Labels on hazardous materials will contain information regarding the identity of the hazardous materials, hazard warnings, and the name and address of the manufacturer (per A.D. No. 350, Hazard Communication Program). Labels on hazardous wastes shall contain the legally required information specified in AD 350.1, Section VII, subsections A and B. For further information see [AD 350.1 Hazardous Materials and Waste Management Program](#) and [AD 350 Hazard Communication Program](#).

Storage:

1. Hazardous materials shall be stored in an upright position with the lids securely closed and at or below eye level in approved containers with proper labeling. Hazardous wastes shall be stored on the ground in approved containers with proper labeling as specified in AD 350.1, Section VII, Subsections A and B. For further information see AD 350.1 Hazardous Materials and Waste Management Program.

2. Incompatible chemicals shall be separated with trays and, if indicated by the SDS, by space or other physical barriers. Trays are labeled “ACIDS”, “ALKALINES” and “NEUTRALS.” The most current Chemical Storage PH Scale is available on the hospital intranet under Health and Safety department.
3. Only the absolute minimum required for the work area’s immediate needs shall be ordered.

Hazards and Protective Measures:

Program or Department Head representatives will ensure materials are properly stored to prevent accidental exposure. Pesticides will be stored separately from other incompatible chemicals, and all chemicals should be stored below eye level.

F. HAZARDOUS MATERIALS HANDLING

Each employee is responsible for being knowledgeable regarding the product label and SDS for each hazardous material used in their work area(s). Each employee is responsible for understanding and following every section of the SDS. The SDS provides important information regarding product handling, including product composition, potential health effects/routes of entry, required personal protective equipment (PPE), engineering controls/ventilation requirements, and chemical incompatibilities.

Every attempt to substitute a less hazardous material for the one being used shall be made. The Health and Safety Department must approve hazardous materials that meet one or more of the following conditions for use prior to the hazardous material being purchased/allowed on hospital grounds.

- a) The quantity of the hazardous material is equal to or greater than 55 gallons of liquid, 500 pounds of a solid, and/or 200 cubic feet (at standard pressure and temperature) of compressed gas.
- b) The hazardous material has a hazard rating of three or higher.
- c) The hazardous material will be used on multiple program units.

Concentrated cleaning materials will never be allowed in a patient’s possession. Never mix any chemicals or any cleaning compounds with any other chemicals or cleaning compounds.

G. PERSONAL PROTECTIVE EQUIPMENT FOR HAZARDOUS MATERIALS

Each employee will use required PPE specified in the SDS and labels. PPE includes eye protection (type of goggles required), skin protection (type of gloves, protective footwear/boots, and protective clothing required), and respiratory protection (type of mask/respirator required). If such equipment is not available, staff will notify their supervisor and defer use of the product until specified equipment is available.

H. TRAINING

The Health and Safety Department provides new employee overview orientation and an annual refresher course that addresses:

1. Cal/OSHA (state) and OSHA (federal) Hazard Communication regulations
2. The requirements of the Hazard Communication Standard and the employee's right to information on chemical hazards they face on the job.
3. The hospital's program to comply with the standard, sources of the standard, the written Hazard Communication Program and the availability SDS.
4. Identification of hazardous materials in the work area by using the SDS and product labels.
5. Use of SDS and labels to recognize potential health and environmental hazards, identify proper handling and storage techniques, personal protective equipment and other protective measures and procedures in the event of spills or exposures.
6. How to use and interpret labels and hazard warnings on containers of hazardous materials. Area supervisors are responsible for assuring that staff is trained in the proper handling, labeling, storage, use, and disposal of hazardous materials in their work area(s), and evacuation procedures. Supervisors are also responsible for training staff whenever a new chemical is introduced into the workplace.
7. The location of the SDS binder. The standardized location is in the Custodian's closet on all Units, in the immediate work area in other areas or Departments.
8. Location of DSH-A written The Hazard Communication Program. For further information see [AD 350 - Hazard Communication Program](#)
9. Location of DSH-A written Hazardous Materials and Waste Management Program For further information see [AD 350.1 - Hazardous Materials and Waste Management Program](#)
10. Site specific training for hazardous materials unique to each area is conducted by the area supervisor.
11. Employees who work with hazardous waste are to receive appropriate training in the safe handling and disposal of the specific waste with which they are assigned.

Outside contractors employed by DSH-A shall be:

- a) Informed of the Right to know law;
- b) Provide the facility with a SDS on any hazardous materials being used while on hospital grounds;
- c) Comply with Cal/OSHA code for safe handling;
- d) Wear personal protective equipment as required per the SDS.

I. EMERGENCIES AND SPILL PROCEDURES

Any employee who discovers a hazardous material or waste spill is responsible for beginning the following steps. They may enlist the assistance of other employees in the immediate area and of the custodian, if available.

1. Isolate spilled material. If the spill can be minimized or contained without exposing patients, employees, visitors, or volunteers to risk, it is appropriate to do so by placing barriers or placing the container upright.
2. Spills shall be cleaned according to the procedures provided on the SDS.

3. If the spill is beyond the abilities/training of staff at the site, or poses an immediate threat to life or health, or a threat of damage to equipment, building, or environment, the employee discovering the release or threatened release shall immediately call DSH-A's emergency number, 2911. The Fire Department and the Health and Safety Department will be notified. These departments shall enact the Facility Hazardous Materials Emergency Response Team in accordance with DSH-A's Emergency Response Plan. The facility participates in the San Luis Obispo County Regional Hazardous Materials Cooperative Agreement and has access to the County's Assessment Teams and Hazardous Incident Response Team.

J. BUSINESS PLAN FOR DISCLOSURE OF HAZARDOUS MATERIALS AND WASTES

DSH-A is required to submit an annual Business Plan (Emergency Response Plan, Employee Training Program, and Hazardous Waste Contingency Plan), which includes an inventory of all hazardous materials above threshold quantities and wastes to the County of San Luis Obispo. The Business Plan and/or inventory must be amended whenever there is a change in operations or in hazardous materials and wastes kept on hospital grounds.

The Business Plan and inventory shall be the responsibility of the Health and Safety Department, and copies shall be distributed to Plant Operations, DPS, the Fire Department, Incident Command Post, and/or Emergency Operations Centers.

XIII. ERGONOMICS PROGRAM

Title 8, Section 5110 requires worksite evaluations to be conducted on jobs, processes or operations with the potential for Repetitive Motion Injuries (RMI). As the most frequent RMI is computer use, DSH-A Ergonomics Program focuses on this aspect with an evaluation of each computer user's workstation.

Process:

1. The supervisor will be responsible for orienting each new employee to their workstation
2. Using the computer user's guide to an ergonomic workstation, the supervisor will go through the ergonomic checklist with each new employee to ensure their workstation is tailored to their height, reach requirement, distance to screen, etc.
3. Supervisor will complete ergonomic checklist with the employee, both will sign and file in supervisors employee's personnel file.
4. If an issue comes up that cannot be addressed by the ergonomic checklist, the supervisor will contact the ergonomic program coordinator in Health and Safety at 468-2013 and ask for a further assessment of the employees workstation.
5. The supervisor must submit an explanation to Health and Safety justifying the need for an assessment beyond the initial ergonomic checklist.
6. The ergonomic program coordinator will come out to the area and perform an assessment and will help to determine if adjustments can be made to the current workstation or if special equipment is necessary.
7. If the need is greater than the second assessment by the Health and Safety ergonomic coordinator, then an outside Ergonomist (consultant) will be called to provide a solution.
8. In addition to or beyond the outside Ergonomist's recommendation, a doctor's note may be required for additional ergonomic equipment to be ordered for employee's workstation.

A. ERGONOMIC HANDBOOK

"The Computer User's Guide to an Ergonomic Workstation" put out by The Department of Personnel Administration is used to provide staff with information on how to prevent RMIs and other injuries. This Guide can be obtained from the Health and Safety Office along with a memo with instructions on how to complete. Using the Ergonomics Workstation Checklist that is attached to the memo, the supervisor will conduct a workstation evaluation on each employee that uses a computer. This evaluation will take place with new staff and when the workstation has changed (moved or new equipment is used).

The checklist identifies any changes that may need to be made to the workstation and the supervisor is responsible to ensure that these changes are made. Once the process is completed, the checklist is sent to the Health and Safety Office for review. Problems that cannot be resolved are forwarded to the Health and Safety Office for further assessment.

B. ERGONOMIC TRAINING POWERPOINT

DSH-A does not have a training PowerPoint at this time. Refer to “The Computer User’s Guide to an Ergonomics Workstation” located with your immediate supervisor or a copy can be obtained from the Health and Safety office.

C. ERGONOMIC EVALUATION REQUEST FORM

After your supervisor has completed the workstation evaluation using the Ergonomics Workstation Checklist and changes to your workstation do not resolve your ergonomic issues, your supervisor may contact Health and Safety office at (805) 468-2013 for additional assistance and guidance.

XIV. RETURN-TO-WORK PROGRAM

The Return-to-Work (RTW) program is responsible for the following:

1. Workers' Compensation Administration
2. Pre-Employment and Annual Health Examinations
3. Limited Duty Assignments
4. Return to Work Evaluations

The RTW programs purpose is to return injured or ill employees to their jobs as soon as medically feasible. Limited medical treatment and care within the capacity of DSH-A is provided to employees who sustain occupational injuries or illnesses. Employees that become ill on duty may be assessed, upon the supervisor's referral, to determine the ability to continue their assigned duties. Any referral to outside sources of care will be coordinated through the RTW office. The RTW office is responsible for the maintenance and posting of the Cal/OSHA Log 300 and will post on the bulletin board outside of Personnel the report during the months of February, March, and April each year. For further information see [AD 915 Return to Work Office/ Employee Health Nurse](#)

A. PROCEDURES FOR NON-OCCUPATIONAL INJURY OR ILLNESS

Any employee who has been off duty for an extended period of time due to a non-occupational injury or illness is required to contact the RTW office at 468-2584 to determine what is needed for an employee to return to their duties. It may be necessary to obtain a physician's note stating that the employee is allowed to return to full duty with or without restrictions. An injured employee who is physically able to return to work, but who is not yet able to resume the full duties of their job classification may request a Limited Duty assignment. It is the Return-to-Work Coordinator's (RTWC) and supervisor's responsibility to work with the employee who wishes to request a limited duty assignment. For further information see [AD 909.2 Limited Duty Assignments](#)

B. WORKERS' COMPENSATION - OCCUPATIONAL INJURY OR ILLNESS

Minor injuries that require first aid shall be documented in the work location's first aid log and initialed by the area supervisor. Limited care and treatment of employee injuries and illness is permitted. In this case, the medical staff, equipment, materials, and hospital services may be used. The illness or injury must be reported to arise out of and occur during the course of State employment. They also must be within the scope of the State's liability as defined by Workers' Compensation and Safety Laws. The following services are approved:

1. First aid treatment.
2. Arrangement for further treatment.
3. Evaluation of the physical ability of an injured employee to return to work for the duration of the shift.
4. Pre-employment and periodic physical exams for fitness and ability to safely perform arduous and hazardous tasks.
5. Preventive measures, such as chest x-rays, lab tests, immunizations, and other measures that will minimize hazards of exposure to contagious diseases while at work.

The Return to Work office is not equipped to treat emergency situations. Employees behind security with initial occupational injuries and illnesses are directed to the Urgent Care Room (UCR) for evaluation, stabilization, and first aid. (Initial injury/illness is defined as occurring during the work shift). Occupational injuries and illnesses occurring during regular work hours shall be referred to Claims Management immediately. Occupational injuries and illnesses of a non-urgent nature (having occurred on a previous shift) shall be referred to Claims Management on the first business day following the event.

The employee will need to complete the following forms to initiate a Workers' Compensation Claim:

1. WC Claim Form 3301/DWC 1 Form: Employee completes top section. Once RTW Coordinator completes bottom section a copy is mailed to the employee within three (3) business days.
2. WC Claim Form 3301 Notice of Potential Eligibility. This completes the 3301 form and is given to the employee when the claim is filed on the same day the employee completes top section of Form 3301.
3. Employee is given the Authorization for the Use and Disclosure of all Medical Information form. All four pages are completed by the employee when they file a claim and a copy is mailed with the 3301 form within three (3) business days.
4. State Fund Medical Provider Network (MPN) information is given to the employee at the time the claim is filed.
5. MPN Implementation Notice, Receipt. This form is signed by the employee at the time they file a claim and confirms they received the State Fund Medical Provider Network (MPN) information.

In the event that the employee is seen for a work related injury in the UCR the following steps are used to complete the WC process:

1. WC Claim Form 3301/DWC 1 Form: Employee completes top section. Once RTW Coordinator completes bottom section a copy is mailed to the employee within three (3) business days.
2. WC Claim Form 3301 Notice of Potential Eligibility. This completes the 3301 form and is given to the employee when the claim is filed on the same day the employee completes top section of Form 3301.
3. UCR information form is given to the employee while in the UCR. This notice informs the employee on who to contact in RTW and gives them information on the State Compensation Insurance Fund (SCIF) MPN's.
4. Authorization for the Use and Disclosure of all Medical Information. The UCR DOES NOT have the employee complete this form; the RTW Coordinator follows up with the employee and completes the form after the initial claim.
5. The State Fund Medical Provider Network (MPN) and MPN Implementation Notice Receipt, IS NOT given in the UCR, the RTW Coordinator follows up with the employee and completes after the initial claim is filed.

C. PRE-EMPLOYMENT, ANNUAL AND EVALUATION OF FITNESS TO PERFORM DUTIES

Pre-employment physicals and annual health reviews are used to determine that each employee is able to perform his/her essential job functions without increased risk of injury or illness to the employee or others.

Annual health reviews are required to ascertain that the employee is free from symptoms indicating the presence of infection and are able to safely perform their job duties. It is the employee's responsibility to obtain an annual health review during the month of their birth date unless a pre-employment examination was completed within the past six (6) months. Employee's will be notified by the RTW office and may be seen in the office by appointments on Monday 1300-1600; Tuesday and Friday: NOC Shift 0700-0800 and All Shifts 0800-1100 and 1300-1500.

Case conferences may be initiated by Human Resources, Claims Management, and/or the appropriate manager or supervisor for circumstances in which an employee is having a continuing medical problem which may impact his/her ability to safely perform essential functions of the employee's position. For further information see [AD 916 Pre-Employment and Annual Health Examinations](#)

D. RETURN TO WORK EVALUATIONS

Each employee will be evaluated prior to returning to work after an occupational injury or a serious non-occupational injury, prolonged illness, or extended absence. The employee's supervisor must make the return to work evaluation appointment with the Return to Work office using Form AT 2062, "Supervisor's Referral for Return to Work Clearance." Employees scheduled for a return to work evaluation will be seen during normal business hours by the Return to Work office prior to the first return shift when the return shift is on the night shift, a weekend, or holiday. Exceptions can be authorized by the Human Resources Director.

XV. INFECTION CONTROL PROGRAM

According to the California Code of Regulations, Title 22, Section 71537, psychiatric hospitals are required to maintain a written Infection Control Program and Infection Control Committee.

DSH- A maintains and supports a collaborative and coordinated hospital-wide process to identify and reduce the risks of endemic and epidemic healthcare associated infections to patients, staff, contracted service workers, students, visitors, and the community at large. Surveillance systems are utilized to identify the influx of potential infections internally, locally, statewide, and nationwide to plan accordingly.

The Infection Control Committee oversees DSH-A's Infection Control Program. The Infection Control Committee is a multidisciplinary committee, chaired by an active member of the medical staff and meets at least monthly. The Infection Control Manual is available to staff in its entirety on DSH-A's Intranet. For further information see [Infection Control Manual](#)

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Personal Protective Equipment (PPE) is designed to protect workers from injuries or illnesses resulting from contact with chemical, physical, electrical, mechanical or other workplace hazards. PPE includes a variety of devices and garments such as but not limited to face shields, gloves, earplugs and respirators.

DSH-A is required by Title 8, Section 3380 to assess the workplace to determine if hazards are present, or is likely to be present, which necessitate the use of PPE. If hazards are present, or likely to be present, DSH-A shall:

- a) Select, and have each affected employee use, the type of PPE that will protect the affected employee from the hazards identified in the hazard assessment
- b) Communicate selection decisions to each affected employee
- c) Select PPE that properly fits each affected employee

Once PPE is selected DSH-A will provide training to each employee who is required to use the PPE. Each employee will be trained on the following:

- a) When to use the PPE
- b) What PPE to use
- c) How to properly don, doff, adjust and wear the PPE
- d) Any limitations of the PPE
- e) The proper care, maintenance, storage, life and proper disposal of the PPE

Training will take place anytime there is a change in the workplace that effects the current selection of PPE or its use, upon the hiring of a new employee or if new PPE is selected. DSH-A will verify that each affected employee has received and understood the required training through written certification reflecting the employee's name, dates they were trained and the PPE they were trained on that will remain in the employee's training file.

It is the employee's immediate supervisor who is responsible for making sure the proper PPE is available, in good condition and used in accordance with the manufacturer's instructions and training.

XVI. RESPIRATORY PROTECTION PROGRAM

DSH-A has a Respiratory Protection Program for employees who are required to wear a respirator as part of their duties. California Code of Regulations Title 8, Section 5144 Respiratory Protective Equipment and the Centers of Disease Control and Prevention (CDC) have issued regulations and guidelines for the use of respirators to provide filtering of potentially contaminated air when an employee may be exposed.

Whenever possible, engineering controls will be used to provide a safe working environment for staff. When engineering controls are not possible, respiratory protection programs will provide appropriate guidelines for respirator usage.

The different types of respirators are Powered Air Purifying Respirator (PAPR), full mask, half mask, N95 and Self Contained Breathing Apparatus (SCBA). The program is aimed at protecting employees by providing medical clearances, respiratory fit tests, safe equipment and safety education related to an employee's use of the various types of respirators.

The use of respiratory protection is mandatory if a respiratory hazard has been identified as part of an employee's job duties. Departments and areas that participate in DSH-A's Respiratory Protection Program are Plant Operations, Fire Department, DPS and identified medical staff. Training for respirator use is done initially upon hire and annually thereafter. Tight fitting face masks require a fit test initially and annually thereafter. PAPR users only get a onetime medical clearance and if necessary when there has been a medical change will an employee be required to obtain a new medical clearance.

It is your responsibility as an employee assigned to the use of a respirator to always have your personal respirator easily accessible for immediate use, to assess the function of the respirator each time of use, inform your supervisor of changes in your medical or physical status that would affect the performance of the respirator and perform fit checks when indicated.

The Respiratory Protection Program can be found on the Hospital Intranet under the Health and Safety Department Tab and in the areas that take part in the Program. The Program is monitored by The Health and Safety Department.

The following describes the processes for obtaining a respirator. DPS, Fire Department, Plant Operations, Central Medical Services and Unit 1 all participate in the Respiratory Protection Program. There are both medical and non-medical respirators.

1. Based on their job classification, staff will be identified as a participant in the Respiratory Protection Program.
2. Supervisor will schedule staff to be trained on respirator usage using Respiratory Protection Program training curriculum.
3. After staff has been trained, supervisor will issue staff his/her own respirator that meets National Institute for Occupational Safety and Health (NIOSH) requirements for job duties being performed
4. Following the completion of training, Health and Safety Dept. will be notified to set up an appointment with outside medical provider for staff to be fit tested and/or medically cleared to wear respirator
 - a. PAPRs do not need to be Fit tested, they only need a medical clearance

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5. Staff is not to use respirator until they have gone to and successfully passed/cleared their appointment with outside medical provider.
 6. Staff will take with them to their appointment a completed Respiratory Medical Questionnaire and the respirator issued to them during training.
 7. After staff attends their appointment, they are to provide documentation to their supervisor stating whether they passed or failed their Fit test and/or medical clearance.
 8. After the initial Fit test and/or medical clearance, staff is to be Fit tested annually thereafter if they wear a tightfitting face mask (N95, half mask, full mask, SCBA).
 - a. Staff who wears a PAPR will only need to be trained by their supervisor annually thereafter and do not need to be medically cleared by the outside medical provider again unless they have a change a significant change in their medical status.

XVII. HEARING CONSERVATION PROGRAM

The DSH-A Hearing Conservation program ensures staff is protected from permanent noise induced hearing loss. This program complies with Title 8, Sections 5095 – 5100. Each hospital area is tested for noise exposure levels. Staff exposed to noise levels at or above the action level of an 8-hour time weighted average (TWA) of 85 dBA or higher shall wear hearing protectors. Areas found to have action level dBA's 85 or greater; will be included in the program.

Staff working in the identified areas will receive hearing tests when hired to establish baseline hearing levels and annual tests thereafter to ensure they are being properly protected against workplace noise and to assess if a change in baseline has occurred.

Supervisors are responsible to ensure effective hearing protection is used in the Departments included in the Program.

To review the Hearing Conservation Program in its entirety please refer to the Health & Safety Department tab on DSH-A's Intranet.

Responsibility guidelines:

1. Health and Safety Department responsibility:
 - a. Test areas of the hospital for potentially harmful noise exposure levels.
 - b. Determine which areas meet or exceed a TWA of 85 dBA or higher and should be included in the Hearing Conservation Program.
 - c. Make appointments for employees with outside medical provider for initial and annual audiometric tests.
 - d. Oversee Hearing Conservation Program
2. Supervisor responsibility:
 - a. Report all new employees who will participate in the Hearing Conservation Program to Health and Safety
 - b. Conduct and keep track of annual hearing training for employees
 - c. Monitor employees use of hearing protection while on the job site, enforce proper use if employees are not in compliance and follow through with appropriate disciplinary action if necessary
 - d. Have sufficient amounts and variety of types of hearing protection available to employees at all times
 - e. Follow up with employees to ensure audiometric appointments have been attended and proper paperwork has been turned in
3. Employee responsibility:
 - a. Consistently wear hearing protection properly in all identified noise hazardous areas
 - b. Report to supervisor if they feel a new noise hazardous area has been established and report any unsafe conditions to their immediate supervisor
 - c. Inspect hearing protection daily before every use to ensure they will be fully protected
 - d. Report to all audiometric appointments as scheduled and complete any and all paperwork corresponding with audiometric appointments

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- e. Participate in annual training as required
- 4. Off-site Medical Provider responsibility:
 - a. Will provide DSH-A Health and Safety department with a copy of the employee's Audiogram and Audiometric History Form (baseline and annual)
 - b. Will provide DSH-A Health and Safety department annually a copy of the Ambient Noise Measurements of the Audiometric Test Room.
 - c. Will provide Health and Safety department a copy of the Certificate of Audiometer Calibration annually.
 - d. Will communicate immediately to Health and Safety any employees who have an abnormal or inconsistent test result, including recommendations made to employee.

Training

A training program will be provided annually for employees who are exposed to noise at or above the action level. The following topics will be addressed:

1. The Effects of Noise upon Hearing.
2. Hearing Protective Devices.
3. Audiometric Testing Program.

XVIII. VEHICLE SAFETY POLICY

Appropriate usage of state owned vehicles/electric carts is a major component of any safety plan. Vehicle accidents are costly, but more importantly, they may result in injury to you or others. It is the driver's responsibility to operate the vehicle/electric cart in a safe manner and to drive defensively to prevent injuries and property damage. DSH-A endorses all applicable state motor vehicle regulations relating to driver responsibility.

In accordance with the State Administrative Manual (SAM), (Sections 0750 – 0760, 2400 – 2462, 4102 & 4105 and Management Memo 13-05) DSH requires staff that will be driving on any official state business to complete an approved Defensive Driver Course. The defensive driving course is available online through the State Department of General Service's Office of Risk and Insurance Management (ORIM) and once completed will be verified that the employee's driving record meets standards for the DSH-A Accident Prevention Program for State and Private Vehicles, staff will be approved to drive state vehicles/electric carts. A review course must be taken at least every four (4) years or sooner in the event of traffic violations or accidents. For further information see [AD 908 Accident Prevention Program for State and Private Vehicles](#)

In addition to the Defensive Driver on-line course, DSH-A participates in the DMV Pull program. DSH-A Health and Safety office is notified, via secured file transfer from the DMV, when any staff member, who has been issued a Defensive Drivers Card, has action on their driving record such as tickets, moving violations, DUI arrests, probation, etc. At such time the employees driving record is again reviewed to ensure that they meet the criteria to have a Defensive Driving Card and to operate a vehicle on State business. If revocation of a Defensive Drivers Card is warranted, the staff member and appropriate supervisors are notified. For further information see [AD 909 Hospital Health and Safety Program](#) .

A. VEHICLE ACCIDENT REPORTING

The manager or supervisor of the electric/gasoline cart operator shall investigate accidents involving the electric/gasoline cart. This investigation shall be forwarded to the Health and Safety Officer for review. All accidents involving electric/gasoline carts are to be reported immediately to DPS.

Accidents involving State vehicles and private vehicles used on Official Business are reported using the following forms and procedures:

1. "Accident Identification Card," Form STD. 269, is to be used by the employee driver involved in an accident to summarize pertinent information at the scene of the accident and to establish contact information. A blank form is available in the glove compartment of all state vehicles. Drivers of private vehicles are to obtain a blank Form 269 from their supervisor or the Transportation Office before using their vehicle for Official State Business.
2. Within eight (8) hours of the accident, the employee must verbally report to the Program Director or Department Manager the details of the accident.
3. Injuries to non-state parties and significant property damage suffered by other parties must be reported immediately by telephone to the Office of Risk and Insurance Management at (916) 322-0459.

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4. The "Vehicle Accident Report" Form STD. 270 is to be completed and signed by the employee driver and submitted to the Program Director or Department Manager within 24 hours of the accident.
 5. The Program Director or Department Manager must investigate the accident in order to verify the information and sign the form. They will ensure that Form 270 is completed and signed by the employee. In situations where the employee is unable to complete the report, the supervisor will do so for the employee. Form 270 will be delivered to the Health and Safety Department within 36 hours of the accident.
 6. The Program Director or Department Manager will use all pertinent information, including California Highway Patrol or police reports, to complete Form STD. 274, "Review of State Driver Accident – Supervisors Review," and take any appropriate corrective action. This form will be submitted to the Health and Safety Department within four (4) days of the date of the accident.

XIX. RECORDKEEPING

Injury and illness reporting must consistently provide complete and accurate information to identify injury and illness trends, satisfy the reporting requirements of Cal/OSHA and other entities, and comply with state and federal regulations. DSH hospitals are in Category 1 on a designated Cal/OSHA “high hazard” industry list.

A. CAL/OSHA 300 LOGS

The Cal/OSHA Log 300 (Summary of Occupational Injuries and Illnesses) is maintained by the Claims Management Department based on the information available in the Supervisor’s Report of Occupational Injury or Illness (MH 5420). The MH 5420 also serves as the supplementary record of occupational injuries and illnesses on OSHA-recordable cases or workers’ compensation reports. These records are maintained by the Claims Management Department for at least five years.

Every year, the summary of the Cal/OSHA 300 form is posted on the bulletin board from February 1 thru April 30 outside Personnel’s Main Entrance.

B. CAL/OSHA COMPLIANCE

CAL/OSHA safety compliance engineers and industrial hygienists are responsible for enforcing compliance with CCR, Title 8 safety orders. They conduct inspections of employers’ safety programs, related records, and physical operations. The compliance engineer or industrial hygienist will meet initially with the Health and Safety Officer. CAL/OSHA considers that individual to be the department’s management representative.

The Health and Safety Officer will **immediately** send a copy of each special order, citation, study, or report received from a compliance safety engineer, industrial hygienist, or CAL/OSHA consultant to the Hospital Executive Team and Enterprise Risk Management Branch - Sacramento for referral to the DSH legal liaison, and if necessary, the Sacramento Executive Team.

The facility/department only has fifteen working days after receipt of the notice of citation or special order to file an appeal. The facility will consult with DSH Legal regarding filing of the appeal as failure to meet the deadline will eliminate the opportunity to appeal.

C. SERIOUS INJURY REPORTING

Serious injuries are; (a) require in-patient hospitalization for a period in excess of 24 hours for other than medical observation, (b) dismemberment or serious permanent disfigurement. When serious injury or death occurs, the Health and Safety Office will be notified immediately by the Nursing Officer of the Day (NOD).

Per Title 8, Section 342, all serious injuries, illnesses or deaths will be reported to the Cal/OSHA District Office within 8 hours. Contact Cal/OSHA at the Bakersfield District Office at (661) 588-6400 and/or fax (661) 588-6428. If the injury occurs during business hours (8 AM – 4:30 PM M-F) the notification from DSH – A will be made to Cal OSHA by the Health and Safety Office. If the injury occurs during any other off hour times, (4:30

PM – 8 AM, weekends and holidays) the notification to Cal/OSHA will be done by the NOD and a copy of the notification will be sent immediately to the Health and Safety Office.

In any case where an injury was a result of or a part of a possible criminal act, DPS shall also be contacted immediately to begin investigative and reporting procedures.

D. EXPOSURE RECORDS

Certain Cal/OSHA standards which deal with toxic substances and hazardous exposures require that records be maintained of employee exposure to these substances and sources, physical examination reports, employment records, etc. Employers using any of the regulated carcinogens have additional reporting and recordkeeping requirements. Staff exposure records are maintained by the Return to Work Office and investigation into the incident will be kept in the Health and Safety Department.

In the event of a Blood/Body Substance Exposure (BSE) the employee's exposure information will be kept with the Return to Work Office and the Infection Control Department. These exposures are also noted on the Cal/OSHA 300 log as a privacy case.

E. SAFETY INSPECTION RECORDS – EDIT REPORTS

The EDIT Safety inspection records are maintained in the Health and Safety Department for three years.

F. SAFETY TRAINING RECORDS

Safety training documentation is maintained in the Training Department/Supervisory File for three years per DSH-A policy. Employees are trained initially at new hire orientation and annually thereafter for yearly safety training.

XX. APPENDICES

A. GLOSSARY

Accident - An undesired event that results in personal injury or property damage.

Body Substance – Tissue, blood, urine, feces, wound drainage, oral and other secretions, vomitus and any other body fluid.

Code of Safe Practices – Framework of expectations for each employee to provide a safe working environment.

Confined Space – A space that is large enough that an employee can bodily enter and perform assigned work but has limited or restricted means for entry or exit or where oxygen can be depleted. Confined spaces are not designed for continuous employee occupancy (for example, tanks, vessels, silos, storage bins, hoppers, vaults, and pits are spaces that may have limited means of entry).

Employee - A person legally holding a position in the state civil service with the Department of State Hospitals. (Government Code Section 18526)

Employee Suggestion Box - Is available electronically, on the DSH intranet, or physically in designated locations at DSH facilities. It is intended for all DSH staff to provide suggestions, comments, and ideas about how to make DSH a better place to work; including those suggestions about safety and security. This feedback must have the option of being anonymous. (See Section on Safety Communication)

Exposure – The condition of being subject to some detrimental effect of harmful condition.

First Aid – Any one time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, bruises or sprains, or other minor industrial injury, which do not ordinarily require medical care.

Hazard Assessment – A written, formal appraisal of the safety risks that exist within a workplace.

Inappropriate Gesture - Any gesture that can reasonably be interpreted to be offensive, disruptive or threatening to an individual.

Incidents - Any event that results in an employee feeling threatened

Injury/Illness – For the purposes of this document, when referring to injury/illness it is work related injury/illness. An injury or illness is an abnormal condition or disorder. Injuries include cases such as, but not limited to, a cut, fracture, sprain, or amputation. Illness includes both acute and chronic illnesses, such as, but not limited to, a skin disease, respiratory disorder, or poisoning.

Manager/Supervisor - Any employee that has one or more staff directly reporting to them.

Minor Incident – An accident that may require first aid but no further medical attention.

Near Miss – Any accident that does not result in an injury or illness.

Patient - DSH patients are individuals who are civil or forensic commitments to the State Hospital system.

Personal Protective Equipment (PPE) – Engineering devices used to protect against various hazards.

Safety - “Safe,” “safety,” and “health” as applied to employment or a place of employment mean such freedom from danger to the life, safety, or health of staff as the nature of the employment reasonably permits. *(Labor Code 6306)*

Safety Device - Or “safeguard” includes any practicable method of mitigating or preventing a specific danger, including danger of exposure. This includes PPE, personal duress alarm activators, etc. *(Labor Code 6306)*

Safety Surveillance – Continuous observation for any unsafe work practices or conditions.

Safety Inspection - An evaluation of a work place or work situation to identify the potential for hazards that an employee may encounter while performing the job.

Safety Liaison - An employee, designated by their program director, who represents their unit and shift at safety committee meetings. Safety Liaisons will communicate safety information to their unit and are encouraged to discuss safety topics and goals at each shift pass-down meeting.

Secure Treatment Area - Zones within a State Hospital campus with increased security, including fences, Sally ports, DPS and alarm systems.

Site Specific - A designation of site specific indicates plans, policies and procedures designed for an individual DSH location rather than department wide.

Stalking - Stalking is a series of actions that puts a person in fear for his/her safety and is defined as any person who willfully, maliciously, and repeatedly follows or harasses another person and who makes a credible threat with the immediate intent to place that person in reasonable fear for his/her safety or the safety of his/her immediate family. Stalking also includes actions such as unauthorized surveillance.

Violence - Physical assault, threatening behavior, or verbal abuse.

B. INDEX OF FORMS

[AT 2062 Supervisors Referral For Return to Work Clearance](#)
[AT 2990 Staff Injury Worksheet](#)
[MH 3358 Employees Safety Information Request](#)
[MH 5420 Supervisors Occupational Injury and Illness Report](#)
[STD 269 Accident Investigations](#)
[STD 270 Vehicle Accident Report](#)
[STD 274 State Driver Accident Review](#)

C. REFERENCE MATERIALS

- 1) [AD 102.5.2 Performance Improvement Program - DSH -](#)
- 2) [AD 103 - Administrative Rules](#)
- 3) [AD 345 - Alarm System](#)
- 4) [AD 348 - Emergency Services Plan - Life Threatening Attention to Patients](#)
- 5) [AD 350 - Hazard Communication Program](#)
- 6) [AD 350.1 - Hazardous Materials and Waste Management Program](#)
- 7) [AD 351 - Emergency Medical Attention for Non-Patients](#)
- 8) [AD 414 - Treatment Planning](#)
- 9) [AD 418 - Key Indicator-Trigger Reporting](#)
- 10) [AD 421 - Risk Management](#)
- 11) [AD 503 - Infection Control Program](#)
- 12) [AD 506 - Clinical Record](#)
- 13) [AD 519 - Therapeutic Strategies and Interventions \(TSI\) Training](#)
- 14) [AD 520 - Search and Shakedown Policy and Procedures](#)
- 15) [AD 537 - Change of Shift Report/Hand-off Communication](#)
- 16) [AD 538 - Kardex](#)
- 17) [AD 706 - Vector Control](#)
- 18) [AD 802 - Facility Security - Staff Responsibility](#)
- 19) [AD 809 - Special Incident Reports](#)
- 20) [AD 906 - Duty to Warn, Inform and Report Serious Threats](#)
- 21) [AD 907 - Critical Incident Stress Debriefing for Staff Following Critical Incident](#)
- 22) [AD 908 - Accident Prevention Program for State and Private Vehicles](#)
- 23) [AD 909 - Health and Safety Program](#)
- 24) [AD 909.1 - Employee Assistance Program](#)
- 25) [AD 909.2 - Limited Duty Assignment](#)
- 26) [AD 909.3 - Executive Director's Inspection Team](#)
- 27) [AD 915 - Return to Work Office/Employee Health Nurse](#)
- 28) [AD 916 - Pre-Employment and Annual Health Exam](#)
- 29) [AL 2012-04 - Clinical Risk Management](#)
- 30) [Emergency Preparedness Plan \(EPM\)](#)
- 31) [Infection Control Manual](#)
- 32) [Nursing Procedures Manual](#)
- 33) [Pharmacy Manual](#)
- 34) [Senate Bill \(SB198\)](#)
- 35) [Senate Bill \(SB409\)](#)
- 36) [State Administrative Manual Sections \(SAM\):-0750-0760; 2400-2462; 4102 and 4105](#)
- 37) [Title 8, Section 3203 Injury, Illness Prevention Program](#)

38) [Welfare & Institution Code 4141](#)

39) [Welfare & Institution Code 4141; subsection \(b\) - Joint Labor Management](#)

D. CODE OF SAFE PRACTICES

[Click here](#) for Employee Code of Safe Practices:

