



Policy Author	Risk Management
Origination Date	10/88
Current Review Date(s)	12/01, 4/10
Current Revision Date(s)	5/14, 4/21, 1/24

**MARINHEALTH MEDICAL CENTER  
HOUSEWIDE ADMINISTRATIVE MANUAL  
SAFETY EVENT REPORTING (SER)**

**I. POLICY**

- A. Any MarinHealth employee or provider may file a Safety Event Report (SER). It is the policy of MarinHealth to provide parameters for defining the safety events that must be reported. Note that any MarinHealth patient or visitor may tell staff or providers about safety issues or concerns they see. MarinHealth staff and providers are responsible for ensuring the SER is completed. Patient and/or visitor concerns about safety may also be submitted to MarinHealth via the external-facing MarinHealth website.
  
- B. It is also the policy of MarinHealth that SERs are not themselves to be utilized for disciplinary purposes. Any performance deficiency must be investigated separately. No copy of an event report may be made, and no quote from an event report may be utilized unless it was discovered separately from the Risk and Safety Investigation. All SERs are privileged under the Attorney Client Privilege, as any one of them can be utilized as Attorney work-product in MarinHealth defense litigation. Additionally, any supervisor who is investigating staff that may be compromised by this separate investigation must meet all of the Human Resource requirements. No printing of SERs should occur, except by authorized persons, in order to both protect the attorney-client privilege as well as to gain protection from the Patient Safety Organization (PSO) affiliated to MarinHealth from exposure and/or retaliation. The individual reporting has full rights to confidentiality when making a report.

**II. PURPOSE**

- A. The purpose of this policy is to clearly define the patient, staff, provider and visitor safety and risk events that must be reported, the reasons they should be reported, and MarinHealth Medical Center staff’s duty to report. In this way MarinHealth clearly communicates its value of a positive culture of patient, staff, provider and visitor safety. It is only through thorough, valid and reliable reporting that MarinHealth can evaluate the effectiveness of its Patient Safety Program.

**III. GENERAL INFORMATION**

**A. Background/ Scope**

- 1. A SER must be sent through the secure “**SAFETY EVENT REPORTING**” link on the MarinHealth intranet web portal. In the event of web portal

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unavailability, a “downtime” paper report form should be used. The SER reporting process and instructions are available on-line, on the Risk Management intranet web page.

**B. Definitions**

1. Patient Safety is defined as the avoidance and prevention of patient injuries or adverse outcomes resulting from undesirable variations in the process of health care delivery.
2. Levels of Severity classifications:
  - a. A. Unsafe Condition (Non Event)
  - b. B1. Near Miss- No Harm Didn’t Reach Patient Caught by Chance
  - c. B2. Near Miss- No Harm Didn’t Reach Patient Because of Active Recovery by Caregivers
  - d. C. No Harm- Reached Patient No Monitoring Required
  - e. D. No Harm- Reached Patient Monitoring Required
  - f. E. Harm- Temporary, Intervention Needed
  - g. F. Harm- Temporary, Hospitalization Needed
  - h. G. Harm- Permanent
  - i. H. Harm- Permanent, Intervention Required to Sustain Life
  - j. I. Death
3. Safety Story is a “great catch”.

**C. Application**

1. What to Report:
  - a. A "safety event" or “safety incident” is defined as any type of error, mistake, incident, accident, or deviation in the standard of care that either did result— or could reasonably have been expected to result—in patient harm, - regardless of whether or not it actually impacted the patient.
  - b. Under this definition, a potentially serious safety event that was caught prior to reaching the patient (AKA “near miss”) must be reported, as well as any mishap that reaches the patient.
  - c. All Safety events are given risk identifiers labeled as “Levels of Severity”.
  - d. Safety Hero nominations and Safety Stories.
2. Who Should Report:
  - a. All staff and providers are mandated to report events and potential events (“near misses”).
  - b. Although all SERs can be made anonymously, it is the preference of MarinHealth that individuals will identify themselves so both questions and recommendations for solutions can be referred to the reporting parties. Commendations and recognition for reporting can also be made when staff



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and providers include their names in the report.

3. When to Report:

- a. Events should be reported promptly and should be entered prior to the end of their shift. If an event is discovered after it occurs, then it should be entered into the system as soon as realized or reported.

**IV. PROCEDURE**

**A. Key Steps**

1. MHMC Leadership- Management of Assigned SER Worklist:

- a. Review your SERs daily.
- b. Events must be acknowledged within 5 business days.
- c. Event investigations must be completed within 10 business days.
- d. All Patient Safety/ Risk/ Quality Assurance investigation communications must take place in the event, in the RL Datix application.
- e. The Patient Safety team will refer the SER back to leadership if there are follow-up questions or if more investigation is needed.

2. MHMC Leadership- Completing a SER:

- a. If there is no response from leadership within 10 business days of receipt of event, the event will be closed. It is not ideal to close an event without follow up, thus every effort should be made to complete the investigations within the appropriate time frame to promote patient safety.
  - 1) Events will be closed after 21 days, with the exception of events that are significance level “F” or above. Those events rated “F” or above (or select lower-level events deemed a high significance per the discretion of the Patient Safety team) will be escalated up the chain of command should there be no response in 21 days.

**B. Required Data Documentation**

N/A

**C. Patient Education**

N/A

**V. AGE SPECIFIC CONSIDERATIONS**

N/A

**VI. EQUIPMENT**

N/A



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**VII. APPENDICES AND ATTACHMENTS**

N/A

**VIII. AUTHORITY, REFERENCES, APPROVAL**

**A. Replaces:** Safety Incident Reporting (SIR)

**New Title:** Safety Event Reporting (SER)

**B. Authority/ References:** N/A

**C. Originators and Authors**

Department or Function	Name	Title	Date
Originating Departments Risk Management	Unknown	Risk Manager	10/1988
Latest Authors Patient Safety	Colette Hall, RN	Patient Safety Coordinator	01/17/2024

**D. Reviewed or Revised By**

Department, Committee or Function	Subject Matter Experts Name	Title	Date
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Risk Management	Karen Chapman	Risk Manager	

**E. Approved By**

Department, Committee or Function	Name	Title	Date
Performance Improvement Committee	Unknown	Unknown	08/05/2021
Nursing Directors	Unknown	Unknown	07/30/2021
Policy & Procedure Committee	Unknown	Unknown	08/19/2021
Medical Executive Committee	Unknown	Unknown	09/20/2021
Quality & Patient Safety Committee	Unknown	Unknown	09/28/2021
Hospital Board of Directors	Unknown	Unknown	11/02/2021



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**MARINHEALTH MEDICAL CENTER  
HOUSEWIDE ADMINISTRATIVE MANUAL  
PATIENT RIGHTS AND RESPONSIBILITIES**

**I. POLICY**

- A. Every person entering MarinHealth Medical Center for care has rights and responsibilities. Patient rights and responsibilities are documented, posted on signage, and distributed to patients, families and their agents on admission. Patients are entitled to exercise these rights while hospitalized. Patients, their families and their agents are responsible for understanding and upholding hospital rules, including the expectation of reasonable, respectful and responsible behavior and conduct while in the hospital.

**II. PURPOSE**

- A. To document patient rights and responsibilities, and provide clear guidance for patient notification of rights, including posting and distribution.

**III. GENERAL INFORMATION**

- A. Patient rights and responsibilities are adapted from the California Code of Regulations - Title 22, Centers for Medicare and Medicaid, and The Joint Commission.
  - 1. Specific patient rights and responsibilities are fully documented in the attached Patient Rights Publication (Attachment A – English; Attachment A-1 – Spanish) and Patient Responsibilities (Attachment C - English; Attachment C-1 – Spanish).
  - 2. The hospital and medical staffs ensure that patient rights are fully documented in policy, posted in both English and Spanish in appropriate places within the hospital in patients' view, and available in the nursing units.

**IV. PROCEDURE**

**A. Key Steps**

- 1. The document outlining patient rights and responsibilities will be given to the patient, family and/or agents at the time of admission (See Attachment A, Patient Rights and Responsibilities).
- 2. Patient rights signs are posted in patient contact locations throughout the facility, including, but not limited to, Main Entrances, Admitting, Emergency Department, Outpatient Department, Psychiatric Emergency Services, Laboratory, Radiology and the Pharmacy.



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3. Each department/ nursing unit will have the Patient Rights at a Glance and Patient Responsibilities posted and the full document available (See attachment B).
4. Along with rights and responsibilities, phone numbers will be provided for patients, family/agents to ask for assistance in resolution of conflicts.

**B. Required Data Documentation NA**

**C. Patient Education NA**

**V. AGE SPECIFIC CONSIDERATIONS NA**

**VI. EQUIPMENT NA**

**VII. APPENDICES AND ATTACHMENTS**

Appendices and Attachments	Title
Attachment A	Patient Rights Publication (English)
Attachment A-1	Patient Rights Publication (Spanish)
Attachment B	Patient Rights At A Glance (English)
Attachment B-1	Patient Rights At A Glance (Spanish)
Attachment C	Patient Responsibilities (English)
Attachment C-1	Patient Responsibilities (Spanish)

**VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION**

**A. Replaces:** Patient Rights and Responsibilities #1107.15.4

**New Title:** Patient Rights and Responsibilities #1107.15.5

**B. Authority/ References**

1. [CHA Consent Manual, 2021 Edition](#)
2. Joint Commission Hospital Accreditation Manual, Rights and Responsibilities of the Individual (RI) chapter effective 02/19/2023
3. California Department of Public Health - [Title 22, § 70707. Patients' Rights](#)
4. Housewide Administrative Manual Related Policies:
  - a. [Patient Compliments, Complaints & Grievances 1107.13.6](#)
  - b. [Management of Lost Belongings 1106.20.2](#)
  - c. [Interpreting, Translation and Language Access Service 1107.8.4.](#)



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5. Notice of Privacy Practices. [Patient Rights under HIPAA to receive Notice of Privacy Practices](#) (1117.09)
6. Privacy Policies Under HIPAA – [Administrative Housewide Manual, section 14](#)

**C. Originators and Authors**

Department or Function	Name	Title	Date
Originating Departments Quality Management	NA	NA	11/30/2018
Latest Authors Patient Safety	Colette Hall, RN	Patient Safety Coordinator	04/18/2023
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**D. Reviewed or Revised By**

Department, Committee or Function	Subject Matter Experts Name	Title	Date
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Risk Management	Karen Chapman	Risk Manager	06/13/2023
Compliance & Privacy	John Wood	Compliance Officer	06/13/2023
CDM Revenue Integrity and Patient Revenue Integrity	Lynelle Takigawa	Director	06/13/2023

**E. Approved By**

Department, Committee or Function	Name	Title	Date
Nursing Directors	NA		
Pharmacy and Therapeutics Committee	NA		
Policy & Procedure Committee	Lillian Chan, FACHE	Chair, Policy & Procedure Committee	06/15/2023
Medical Executive Committee	K. Jennifer Voss, MD	Chair, Medical Executive Committee	08/21/2023
Quality & Patient Safety Committee	Adam Nevitt, MD	Chair, Quality & Patient Safety Committee	08/29/2023
Hospital Board of Directors	Andrea Schultz	Chair, Hospital Board of Directors	10/03/2023

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**MARINHEALTH MEDICAL CENTER**  
HOUSEWIDE ADMINISTRATIVE MANUAL  
**SENTINEL EVENTS**

**I. POLICY**

Sentinel events shall be reported to Risk Management immediately upon identification. Any sentinel event requires immediate action to determine why the incident occurred and how to reduce the likelihood of recurrence.

**II. PURPOSE**

The purpose of this policy is to improve patient care as well as to define the processes required for reporting and investigation of sentinel events at MarinHealth Medical Center.

**III. GENERAL INFORMATION**

A. Definitions

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe temporary harm or severe permanent harm. Sentinel events potentially involve a continuing threat to patient care or safety, have significant potential for being reflective of serious underlying systems problems within an organization, and can potentially undermine public confidence in the organization.

B. Sentinel Event Criteria (as defined by The Joint Commission)

The following is an established list of sentinel events related to this policy. It is understood that all high-risk events are reviewed by the administrative team, and at the direction of the administrative team, a root cause analysis may be requested for events that do not fall under the sentinel event criteria.

1. An event that has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition; death, permanent harm, severe temporary harm.
2. An event is also considered sentinel if it is one of the following:
  - a. Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge, including from a hospital's Emergency Department
  - b. Unanticipated death of full-term infant
  - c. Infant discharge to the wrong family
  - d. Abduction of any patient receiving care/services

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- e. Any elopement of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- f. Sexual abuse/assault of any patient while receiving care, treatment, and services while on site at the facility or while under supervision/care of the facility
- g. Sexual abuse/assault of a staff member, licensed independent practitioner (LIP), visitor, or vendor while at the facility or while providing care/supervision to patients/clients
- h. Physical assault of any patient (leading to death, permanent harm, or severe temporary harm) while receiving care, treatment, and services while on site at the facility or while under the supervision/care of the facility
- i. Physical assault (leading to death, permanent harm, or severe temporary harm) of a staff member, LIP, visitor, or vendor while on site at the facility or while providing care/supervision to patients
- j. Homicide of any patient while receiving care, treatment, and services while on site at the facility or while under the supervision/care of the facility
- k. Homicide of a staff member, LIP, visitor, or vendor while on site at the facility or while providing care/supervision to patients
- l. Administration of blood or blood products having unintended ABO and non-ABO incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm or permanent harm, or death
- m. Surgery or invasive procedure performed on the on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- n. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- o. Severe neonatal hyperbilirubinemia; bilirubin that is greater than 30 milligrams per deciliter
- p. Prolonged fluoroscopy with cumulative dose greater than 1,500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
- q. Fire, flame, or unanticipated smoke, heat, or flashes occurring during a direct patient care caused by equipment operated and used by the facility. To be

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considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.

- r. Any intrapartum (related to the birth process) maternal death
- s. Severe maternal morbidity when it reaches the patient and results in permanent harm or severe temporary harm
- t. Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; or a patient with coagulopathy who receives blood products as a result of the fall; death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

C. Application/Procedure

1. Upon notification of a sentinel event, MarinHealth Medical Center shall immediately conduct an analysis of all factors involved with the event, to determine why the incident occurred. This analysis is defined as a “Root Cause Analysis”, because the objective of the analysis is to determine the basic, causative factor(s) that led to the event.
2. Sentinel events shall be reviewed by the administrative team and the Risk Manager within 24 hours of incident identification.
3. The licensed independent practitioner responsible for managing the patient’s care, treatment and services, or other designee, shall inform the patient about unanticipated outcomes of care, treatment and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.
4. Support systems shall be available to staff who have been involved in an adverse or sentinel event.
5. If the Joint Commission (TJC) is alerted to a sentinel event by another regulatory body, a patient/family complaint, or the media, a root cause analysis will be conducted and submitted to TJC.

**IV. AGE SPECIFIC CONSIDERATIONS**

N/A

**V. EQUIPMENT**

N/A

**VI. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION**

**Policy/Procedure  
#1113.14.5**

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WRITTEN BY: Risk Manager and Quality Manager

Date: 1/91

**RELATED POLICIES:**

Root Cause Analysis (Policy #1113.26)

Safety Incident Reporting (Policy #1106.11.5)

**REFERENCES:**

The Joint Commission: Sentinel Event Framework Tool for SE, RCA and Action Plan

[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC)

**REVISED BY:**

Performance Improvement Coordinator

Date: 5/12/2021

**APPROVED BY:**

Director of Quality Management

Date: 5/12/2021

Performance Improvement Committee

Date: 8/5/2021

Nursing Directors

Date: 7/30/2021

Policy & Procedure Committee

Date: 8/19/2021

Medical Executive Committee

Date: 9/20/2021

Quality and Patient Safety Committee

Date: 9/28/2021

Board of Directors

Date: 11/2/2021



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**MARINHEALTH MEDICAL CENTER**  
**HOUSEWIDE ADMINISTRATIVE MANUAL**  
**DEFECTIVE EQUIPMENT AND DEVICES REPORTING**

## **I. POLICY**

- A.** Any equipment or evidence contributing to an event or potential event should be promptly secured in a powered state, left untouched and sequestered following an incident that results in harm or potential harm to a patient, employee or visitor.
- B.** MarinHealth Medical Center personnel will activate the Chain of Command. The Director/ Manager/Administrative Supervisor will ensure that the equipment is properly sequestered once all data has been secured. The supervisory party responsible will identify, report, retain and sequester any equipment identified as defective, hazardous, malfunctioning or that fails in any way to perform as described.

## **II. PURPOSE**

- A.** To assure contributing evidence is collected and maintained, and to avoid unintentional destruction of evidence.

## **III. GENERAL INFORMATION**

### **A. Definitions**

1. Serious Illness or Injury:
  - a. Life threatening
  - b. Results in permanent impairment (non-reversible)
  - c. Necessitates immediate medical or surgical intervention to preclude impairment
2. Reportable Event:
  - a. An event where equipment or a device likely caused or contributed to a death, serious injury or serious illness.
3. Medical Device Review (MDR) Reportable Event
  - a. An event including the failure of a diagnostic device if information reasonably suggests a probability that a misdiagnosis or lack of diagnosis resulted from the failure and:
    - 1) Has caused or contributed to a death, serious injury, or serious illness, or,
    - 2) Would cause or contribute to a death, serious illness or serious injury, if it were to recur.



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- b. MDR Reportable Events also include events similar or identical to previously reported events, for example, if a reportable event occurs a second time with a device such as an infusion pump, the second event must be reported even though the first adverse event was reported in the past.
4. "Information that reasonably suggests that there is a probability that a device has caused or contributed to a death or serious injury or serious illness":
  - a. Information including professional, scientific, or medical facts, observations, or opinions, which would cause a reasonable person to believe that a device caused or contributed to a death, serious injury, or serious illness.
5. Probability:
  - a. A person would have reason to believe, based on an analysis of the event and device, that the device has caused or contributed to an adverse event. This term does not signify any particular degree of statistical probability and is interchangeable with "probable", or "probably".
6. Suggestion of Probability:
  - a. Professional, scientific, or medical facts, observations, or opinions, which would cause a reasonable person to believe that a device caused or contributed to a death, serious injury, or serious illness.
  - b. Probability determinations should follow a prescribed method or analysis and decision making developed by the facility or manufacturer.
7. Device:
  - a. The Food, Drug, and Cosmetic Act defines the term "device" as "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part or accessory," which is:
    - 1) Recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them.
    - 2) Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease in man or other animals, or
    - 3) Intended to affect the structure or any function of the body of man or other animals, and which does not achieve.

## **B. Medical Devices Equipment Failure with Harm to Patient**

1. When an injury or potential injury has occurred to the patient their provider shall be notified immediately. Staff will activate the Chain of Command



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(Director/ Manager/ Administrative Supervisor). Person in command will ensure the proper protocol.

2. A Safety Incident Report (SIR) should be completed describing the failure.
  - a. The equipment, serial number, manufacturer’s I.D., wrapper or packaging material should be recorded and saved when possible.
3. The equipment should be maintained in a powered state to enable data recovery, moved immediately to a safe area/sequestered, and the Biomedical Department notified to remove the equipment.
  - a. Sequester all equipment including all disposable parts to prevent unauthorized handling or future use of defective equipment.
4. Risk Management should be notified of all serious incidents involving adverse patient outcome.
  - a. The Biomedical Department will consult with the Risk Manager as necessary.
  - b. The Biomedical Department/Risk Manager shall decide whether to hold the equipment for evidence or repair it.
5. The Biomedical Department shall log the serial number, manufacturer’s I.D. and record in detail the nature and findings of their investigations.
  - a. This log shall be maintained in the Biomedical Department and retained indefinitely.
6. The Biomedical Department is responsible for the reporting of information to the Food and Drug Administration (FDA) if applicable.
  - a. The Biomedical Department reports any deaths or serious injuries associated with a medical device to the FDA. Injuries or potential injuries are reported to the manufacturer.
7. Specimens released to Pathology, i.e., retained products, shall be clearly identified. A description of the specimen characteristics, who removed it, and the anatomical site of its removal shall be documented in the medical record.
  - a. Specimens shall be retained in Pathology for at least six months. Thereafter, any specimen identified by Risk Management shall be maintained in a secure location until further notice.

**C. Medical Devices Equipment Failure with No Harm to Patient**

1. A SIR shall be completed by the employee or medical staff identifying the problem.
2. The equipment shall be removed from service to prevent unauthorized handling.
  - a. Forward the equipment to Biomedical Department for repair.
3. The Biomedical Department shall log the service number, etc. and determine appropriate steps to be taken regarding repair or removal from service.



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- a. Consideration should be given to warranty, need to recall items and the decision to repair versus replace.

**D. Non-Medical Devices**

- 1. Defective non-medical items will be forwarded to Engineering for repair.
  - a. An Engineering work order will be completed.
- 2. Any defect in non-medical items resulting in an injury will be reported by entering a SIR.
- 3. Non-medical equipment involved in an injury which may result in litigation shall be removed to a safe area, not repaired, and stored until released by the Director of Facilities Engineering and the Risk Manager.

**IV. PROCEDURE**

**A. Use of Appropriate Equipment and Devices – Staff Obligations**

- 1. Staff witnessing the use of or implementing the use of a medical device causing a serious illness or injury are responsible for reporting that device to their supervisor.
- 2. The responsible supervisory party will contact the appropriate vendor and hospital Chain of Command to ensure that there is immediate action taken to ensure problem solving and resolution.
- 3. Newly created prototype equipment and devices must be approved through the Operating Room (OR) Management Committee process.
- 4. Newly created prototype equipment and devices that are not approved through the OR Management Committee are not permitted.
- 5. Upon knowledge of the use of non-approved equipment:
  - a. The procedure will not proceed until the equipment is removed from the OR.
  - b. If the provider resists removal of the equipment from the OR, the Chain of Command will be put in place.
  - c. A SIR will be generated.
  - d. The Peer Review process will occur.
- 6. Reportable events caused by user errors or the failure to service or maintain devices must be sent to manufacturers or to the FDA, depending upon the event type.

**B. Required Documentation**

- 1. In addition to submitting a Safety Incident Report (SIR), a written report on a Medical Device Report Form describing the injury or illness and the event(s) that caused or contributed to same should be filled out immediately and given



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to the Biomedical Department. The information should be professional, including scientific or medical facts, observations, or opinions giving sufficient cause to support the belief that the device was involved.

2. A report is not required, if, within the allowable time period of 5 working days, the Medical Center (as represented by Patient Safety, Risk Management, Quality, or Accreditation, Regulations & Licensing) determines that a death, serious injury, or serious illness has not occurred or that the device did not contribute to the event.
3. Incident information will be reviewed and documented by end user leadership and Biomedical Department.
  - a. Department supervisor will review reportable and non-reportable events.
  - b. Department Supervisor will meet and discuss with employee and each new employee responsibilities of reporting.
4. All device malfunction meeting reporting criteria will be submitted to the FDA and manufacturers.
5. Documentation includes information that facilitates the submission of semiannual reports, and systems that ensure access to information that facilitates timely follow-up and inspection by the FDA.
  - a. The FDA is not interested in having information on a patient's identity submitted with a report. If the agency required any patient information, it will request it.
  - b. The FDA is not interested in the identity of facility staff members involved.

### C. Reporting

1. User facilities must report known medical device-related deaths directly to the FDA and to the manufacturer. Reports of serious illnesses and serious injuries that are device-related must be reported directly to the manufacturer. If the manufacturer is not known, the user facility must report directly to the FDA. The FDA expects user facilities to make a reasonable effort to identify the manufacturer if it is not immediately known.
2. User facilities must submit to the FDA, on a semiannual basis, a summary of all reports submitted to the manufacturers and to the FDA during that period.
3. Device user facilities that made no reports during a semiannual period are not required to submit a semiannual report for that period. All user facility reports should be sent to the FDA at the following address:

Food and Drug Administration  
Center for Devices and Radiological Health MDR User Report  
P.O. Box 3002  
Rockville, MD 20847-3002



Policy Author	Biomed/ Safety/ Risk Mgmt/ Quality Mgmt
Origination Date	4/98
Current Review Date(s)	7/08, 7/11, 8/14
Current Revision Date(s)	1/04, 6/21

- Information in the semiannual summary would include an identification of the device, the user facility, and the manufacturer, if known, and a brief description of the event. (See Section 803.24 of the proposed regulation for more information.)
- The FDA expects facilities to use the standard report form. Reporters will be requested to enter codes (provided in the instructions) to answer certain questions and to provide short answers in some sections. A copy of the form and instructions can be found on the FDA website.
- The user facility will provide a unique “user facility report number” on each form which will facilitate tracking and auditing by the FDA and the facilities. The number consists of the facility’s Centers for Medicare & Medicaid Services (CMS), six-, seven-, or ten-digit number (050360), the calendar year, and the consecutive four-digit number for each report filed that year by the facility, e.g., 050360-2021-0001. Only the seven- or ten-digit numbers are mentioned in the proposal, but the six-digit CMS number is also acceptable. The last four-digit sequence number will be assigned by the facility in order of occurrence of reportable events within that year. For example, the first reported event of the year would be 0001; the 23rd reported event of the year would be 0023.
- If the facility does not have a CMS number, the first report should be submitted with all zeros in the CMS space and the FDA will assign a number to be used on future reports.

**D. File Retention**

- User facilities are expected to establish and maintain reportable event or “incident” files under the proposed regulation. Incident files are those files containing documents or any other information, including medical files and patient records, which are related to adverse events that may have been caused by a device under the control of user facilities. User facilities must contain a file for each identified adverse event that may be device-related, regardless of whether the user facility ultimately determines the event is reportable. User facilities must keep the records for two years.

**V. AGE SPECIFIC CONSIDERATIONS N/A**

**VI. EQUIPMENT N/A**

**VII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION**

**A. Authority/ Reference**

- Safe Medical Devices Act of 1990 Public Law No 101-629
- FDA: Title 21 eCFR Part 803.18.



Policy Author	Biomed/ Safety/ Risk Mgmt/ Quality Mgmt
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3. CMS: Title 42 eCFR § 482.41 (d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
4. The Joint Commission (TJC) EC.02.04.01: The hospital manages medical equipment risks.

**A. Originators and Authors**


Department or Function	NDeame	Title	Date
Originating Departments			
<ul style="list-style-type: none"> <li>• Quality Management Services</li> </ul>			1978
<ul style="list-style-type: none"> <li>• Biomedical Engineering</li> </ul>			1978
<ul style="list-style-type: none"> <li>• Safety</li> </ul>			1978
<ul style="list-style-type: none"> <li>• Risk Management</li> </ul>			1978
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**C. Approved By**

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Pharmacy & Therapeutics Committee	NA		
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Medical Executive Committee		Chair, Medical Executive Committee	
Quality & Patient Safety Committee		Chair, Quality & Patient Safety Committee	
Hospital Board of Directors		Chair, Hospital Board of Directors	05/2013

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Manual Owner Name: Critical Care	Replaces Document Name (if applicable):		

## I. POLICY

- A. All cardiac deaths and imminent brain deaths must be reported to the Donor Network West (DNW).
- B. All deaths of patients, from newborn of gestational age of 20 weeks (including stillborn), must be reported to DNW at (800) 55-DONOR. This referral should be made at or near the time of cardiac death or imminent brain death. Any hospital representative that is familiar with the patient's care may make the referral call.
- C. Medical and hospital staff assist decision makers or patients who wish to authorize donation of anatomical gifts.
- D. DNW provides educational services and serves as a resource to medical and hospital staff.
- E. DNW coordinators will evaluate the potential organ/tissue donor to determine medical suitability.

## II. PURPOSE

- A. Patients or their surrogate decision-makers have the right to forego life-sustaining treatment. All patients or their authorized decision makers have the right to elect organ donation in the event of death.
  - 1. At all times the hospital staff will exercise discretion and sensitivity to the circumstances, beliefs, and desires of the decision makers of potential donors. Potential organ donors are to be identified as early as possible upon clinical cues.


## III. GENERAL INFORMATION

### A. Background/ Scope

- 1. MarinHealth Medical Center believes that it is ethically appropriate to consider organ donation following cardiac death. This policy includes organ donation after circulatory death (DCD). It is intended to provide an additional option of organ donation that complies with patient's or authorized decision maker's directive after a patient or authorized decision maker has chosen to withdraw life support.
  - i. Potential tissue donors are to be identified as near to time of cardiac death, and reported to DNW within 60 minutes of cardiac time of death.

### a. Definitions

- 1. **Imminent Death:** defined in the context of this policy as having any of the following clinical cues:
  - i. A ventilator dependent patient
  - ii. At the first indication that the patient has suffered a non-recoverable illness/injury
  - iii. Prior to plans for the first brain death evaluation

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- iv. Prior to plans for family discussions of DNR or withdraw from support
- 2. **Donation after Circulatory Death (DCD):** organ donation from a patient who is pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions.
- 3. **Designated Requestor:** trained DNW personnel who has completed a course offered, or approved by, the Organ Procurement Organization (OPO) and designed in conjunction with the tissue and eye bank in the methodology for approaching potential donor families and requesting organ and tissue donation.
- 4. **DNW:** Donation Network West
- 5. **Legal next-of-kin** (in the order of Durable Power of Attorney (DPOA)): spouse, adult children, parents, adult siblings, grandparents, guardian or conservator at time of death, any other person authorized or obligated to dispose of body.
- b. Patient Specific Considerations
  - i. All patients, regardless of age, are considered potential tissue and organ donors.
- c. Responsible Parties
  - 1. All staff involved in care including but not limited to RNs, MDs, LCSWs, RTs, DNW staff, transplant coordinator and DPOA or other designated decision maker for patient.

## j. PROCEDURE

### A. Key Steps


#### 1. Assessment

- a. Patient care providers or admitting representative will notify DNW of all patient deaths or imminent deaths who have potential for tissue and/or organ donation.
- b. At or near time of death, contact DNW at (800) 55-DONOR. DNW will determine eligibility of patient for donation.

#### 2. Potential Donor Evaluation

##### a. Organ Donation

- i. A DNW coordinator will do an on-site evaluation of the potential organ donor to determine medical suitability, when appropriate.
- ii. It is the responsibility of the physician(s) on record to inform the family of grave prognosis and imminent or actual brain death or cardiac death.
- iii. DNW is the designated requestor to discuss authorization for donation from deciding parties. Donation should not be brought up with families, except in collaboration with DNW.
- iv. Hospital staff will provide supportive medical management to potential organ donors to ensure suitability of the organs for transplantation. Medical management will continue while DNW determines medical suitability. DNW will provide the hospital with donor management

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guidelines as a resource.

b. Donation After Circulatory Death (DCD)

- i. On arrival, the Transplant Coordinator, with the knowledge of the attending physician, will conduct additional screening and assist in coordinating an appropriately timed discussion with the patient's authorized decision maker about the option of organ and tissue donation.
- ii. DNW will evaluate if patient meets the following criteria for DCD:
  - The patient has a non-recoverable illness or injury, though the patient does not meet the criteria for brain death, and/or the patient has other system failure resulting in ventilator dependency and/or meets the criteria for imminent death.
  - The patient shall meet the suitability criteria listed below:
    - A. No known medical condition that would exclude organ donation.
    - B. Known cause of injury/insult/injury
    - C. Approval by Medical Examiner/Coroner, if case falls under their jurisdiction.
    - D. Inadequate respiratory effort to maintain life when disconnected from the ventilator.
- iii. The patient and/or authorized decision maker, in conjunction with the medical staff, have decided to withdraw life support due to the non-recoverability of the ongoing medical care. This will be documented in the patient's medical record by the attending physician or designee.


c. Tissue Donation

- i. A tissue bank coordinator will do a telephone evaluation of the potential tissue donor to determine medical suitability.
- ii. The hospital will provide information including, but not limited to: cause of death, lab results, IV fluids/blood products received, past medical history, and authorizing decision maker's contact information.

3. **Authorization of Donation**


a. Organ Donation

- i. The DNW coordinator will assess the family's readiness to be offered the option of organ donation. The authorizing decision maker must be given time to accept the hopelessness of the situation and understand the concept of brain death before the donation option is presented. The DNW coordinator will also assess patient wishes. These may be expressed by: First Person Authorization, evidenced by either a pint dot on the patient's ID or drivers' license; or the patient's registration on the Donor Registry. DNW has access to the registry, and the responsibility to determine whether the patient is a registered donor. Under the Uniform Anatomical Gift Act (UAGA), a patient's registration on the Donor Network is legally binding, and cannot be revoked, except for the process outlined in the

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UAGA.

- Will
  - Durable Power of Attorney for Healthcare, Advanced Health Care Directive (AHCD)
- ii. The DNW coordinator will coordinate a collaborative approach process with the hospital staff and physicians.
  - iii. When appropriate, the legal next-of-kin of the potential donor shall be informed of the option to donate organ and/or tissues by the DNW representative or a “trained designated requester.” The authorizing decision maker’s response and the name of the person who made the request should be documented in the progress notes.
  - iv. If family requests support in making the decision, contact appropriate resource person(s); e.g., chaplain, social worker, DNW.
  - v. Authorization may be given by the authorizing decision maker. Comprehensive list of hierarchy is listed in the UAGA and should be consulted when in question.
  - vi. If the authorizing decision maker is not physically available to sign the authorization form:
    - They may give verbal permission via telephone and a waiver form is completed.
    - DNW obtains voice recording of permission to donate tissue/organs.
    - A copy of the consent form will be included in the patient’s medical record.
- b. Donation after Circulatory Death
    - i. Authorized decision makers need to be fully informed regarding donation options and organ recovery procedures. A DNW coordinator will present donation options to the authorized decision maker following their decision to withdraw life support.
    - ii. If the authorized decision maker elects to donate, a DNW authorization form and a DCD Disclosure form will be completed.
    - iii. The authorized decision maker shall be informed of the administration of heparin immediately prior to death, and any other medications and procedures that may be necessary.
    - iv. Authorized decision makers should be offered the opportunity to attend the withdrawal of life support and death of their loved one.
  - c. Tissue Donation
    - i. The tissue coordinator will assess the authorizing decision maker’s readiness to be offered the option of tissue donation. The family must be given time to accept finality of the loss of their loved one before the donation option is presented.


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- ii. When and if appropriate, DNW will contact the authorizing decision maker, conduct a medical/social history and record the authorization for donation.
- iii. A transcribed copy of the authorization will be faxed to the hospital for inclusion in the patient's medical record.
- iv. The hospital will provide DNW a copy of the patient's medical record when requested.


#### 4. **Actual Donation Process**

##### a. Organ Donation

- i. Organ donation may take place when brain death has been established, and ventilator and cardiovascular support has been maintained, or with DCD, after cardiac death when a patient has been pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions. Organs considered for donation include: heart, lung(s), liver, pancreas, kidney(s), and small bowel.
  - Brain Death: Two licensed physicians must examine the patient and declare brain death. Both physicians must document in the medical record that the patient is brain dead. These notes must state, unequivocally, that the patient is brain dead and must include the date and time of declaration. Neither physician may assist in the recovery or transplantation of the donated organs. (Refer to [1106.08](#))
  - Donor Maintenance: Ventilatory and cardiovascular systems must be maintained until the organs are recovered by the transplant team in the operating room to maximize organ function. The DNW Transplant Coordinator will coordinate the medical management of the donor under the supervision of the DNW Medical Director. This includes writing all orders when a potential donor is declared legally dead, the physician caring for the patient can transfer care to DNW.
    - A. The hospital will provide a trained ICU RN alongside DNW's Transplant Coordinator, to continue to provide care to the donor patient throughout the ICU stay.
    - B. The hospital/physicians will provide consultations necessary to ensure suitability of the organs. These may include, but may not be limited to, bronchoscopy, echocardiograms, cardiac catheterization, and chest x-rays.
    - C. The hospital laboratory will provide DNW with STAT lab results for those test that can be completed in the hospital.
    - D. For lab tests not available at the hospital, DNW will provide outside lab services.

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- E. The DNW coordinator will continue to provide support and communication to the donor family throughout the donation process.
  - F. The DNW coordinator will facilitate communication with all involved parties, including but not limited to, appropriate hospital staff, the coroner, internal DNW personnel.
  - G. If the authorizing decision maker refuses authorization for donation, the primary physician will assume care.
- ii. Donation after Circulatory Death (DCD)
    - Patient Management
      - A. To facilitate optimal organ recovery, the hospital care team will continue to care for the patient, maintain the patient on a ventilator, hemodynamically support for organ perfusion and is responsible for the withdrawal of life support. In addition, Heparin (300µ/kg) will be administered prior to withdrawal of life support per the attending physician or physician designee order.
      - B. DNW staff and any physician affiliated with a transplant center will not write or give any verbal orders for patient management.
  - iii. Withdrawal of Life Support
    - The patient care team, in conjunction with DNW, will identify an appropriate location for the withdrawal of life support, which allows for a respectful end of life process and is in close proximity to the operating room (i.e., PACU).
    - Care and comfort measures will be carried out by the attending physician or designee and in accordance with standard hospital practice/policy. The attending physician/designee will monitor the patient until death has been declared or until a determination has been made that the patient is no longer a candidate for donation.
    - Following the pronouncement of cardiac death by the attending physician or physician designee, the patient will be transferred immediately to the operating room for the surgical recovery of organs.
    - If the patient does not arrest within the designated time frame determined by DNW on a case-by-case basis, the patient will be returned to a pre-determined room where comfort care measures will be maintained.
  - iv. Pronouncement of Death
    - Death will be pronounced by the attending physician or physician designee who shall be present and available throughout the withdrawal of life support process. The physician or designee

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certifying death may not be involved as part of a transplant or organ recovery team.


- When circulation and respirations have ceased, the physician or physician designee shall indicate the start of the observation period to the DNW representative and the criteria for death must be observed for five minutes. At the end of the five-minute observation period, the patient can be declared cardiac dead. The physician will record the date and time of death in the patient's medical record and, if applicable, complete the death certificate.
- The following may be used by a physician or physician designee declaring death to confirm the absence of circulation:
  - a. Non-pulsatile arterial catheter tracing
  - b. Absent Doppler signal
  - c. Pulseless electrical activity.

b. Tissue Donation

- i. Tissue donation should be considered on all deaths and donor referrals will be made at or near the time of death, but at least within 60 minutes of Cardiac Time of Death.
- ii. Tissues considered for donation include: eyes/corneas, middle ear bones, connective tissue, bone, skin, veins, fascia lata, heart valves, and pericardium.
  - Tissue Recovery
    - A. The tissue bank coordinator will schedule a time with the hospital OR staff if tissues are to be recovered in the OR.
    - B. The tissue bank coordinator will contact the Administrative Nursing Supervisor (ANS) if the tissue recovery is to take place in the hospital morgue.
    - C. The tissue bank will provide all needed staff, instrumentation, and supplies used during the tissue recovery.
    - D. The tissue bank staff will provide post mortem care, ensure the appropriate disposition of the body, and clean the fecality when the tissue recovery is completed.
  - The tissue bank coordinator will assume responsibility for notifying all appropriate agencies regarding the donation (i.e., the recovery team, the funeral director, the coroner, if appropriate).
  - Hospital Reimbursement: a minimal fee for the use of the OR suite for tissue recovery may be billed to DNW.

5. **Organ/Tissue Recovery**

- a. The DNW coordinator will notify the OR, as soon as possible, after authorization of the potential organ recovery.
- b. The hospital will make an OR suite available for the organ/tissue recovery process. The hospital will also provide anesthesia support and coordinate with

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the Transplant Coordinator, whenever necessary, and one scrub tech/RN and one circulating tech/RN.

- c. The DNW coordinator will schedule the organ recovery with the OR staff.
- d. The DNW coordinator will coordinate with the outside transplant centers to ensure timely arrival of the recovery teams.
- e. The DNW coordinator will continue to facilitate the donation process throughout the organ recovery in the OR.
- f. The DNW tissue bank coordinator will assist with post mortem care at the end of the recovery and will ensure appropriate disposition of the body.

#### 6. **Billing Process/Hospital Reimbursement**


- a. DNW will be responsible for all costs related to the evaluation and recovery of organs and tissues for transplantation. If the organ donation process is terminated, charges will be reverted back to the original guarantor. The hospital is reimbursed for DCD cases per case rate methodology after the Authorization and DCD Disclosure forms have been signed, dated, and timed.
- b. On acceptance of patient as a donor by DNW, notify Admitting/Registration immediately by phone or computer. A new Account number will be established at time of second brain death note.
- c. All DNW directed charges incurred following the declaration of brain death shall be billed to the Donor Network West, 12667 Alcosta Blvd #500, San Ramon, CA 94583.
- d. Dispose of inpatient ID labels. Admitting will send outpatient face sheet and patient ID labels to unit.
- e. Place all further charges on new outpatient account. The DNW transplant coordinator will assume the responsibility for notifying all appropriate agencies regarding the donation, (i.e., the tissue/eye bank, the mortician, and the coroner, if appropriate).

#### 7. **Coroner Cases**

- a. The coroner shall be notified by the DNW/Tissue Bank Coordinator before the removal of any organs and/or tissues if the patient's case is considered a reportable coroner's case. Appropriate documentation will be prepared for the coroner which includes a copy of the chart and a copy of the donation consent form.

#### 8. **Final Disposition of Body**

- a. After the death and the organ and/or tissue recovery have been completed, the ANS shall be notified by DNW / Tissue Bank Coordinator, and may assist in facilitating the removal of the body.
- b. Following the organ recovery, the transplant coordinator will transition care of the body to the Tissue Services Coordinator if tissue donation was authorized. Either the Transplant Coordinator or Tissue Services Coordinator will assist the

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hospital with post- mortem care at the completion of the case. The Transplant Coordinator will notify the authorized decision maker of the donation outcome. The Transplant Coordinator will notify the coroner/medical examiner of completion of the organ recovery, if applicable.

d. Documentation

1. All steps regarding transplantation needs to be clearly documented.

e. Patient Education: Not applicable

**k. AUTHORITY STANDARDS and REFERENCES**


- A.** The Department of Health and Human Services 42 CFR part 482 - Conditions of Participations for Hospitals, the California Assembly Bill 631, Section 7184, and Public Law 99509, Section 9318; in order to provided organs and tissues for transplantation.
- B.** The Joint Commission, Hospital Accreditation Standards, Transplant Safety. TS.01.01.01, EP 1, 4

**I. APPENDICES AND ATTACHMENTS**

Appendices and Attachments	Document Title
Appendix 1	Tasks to be Completed

**m. Subject Matter Experts Reviewers**

Department, Committee or Function	Subject Matter Experts Name	Person's Title	Date
Nursing Directors		Nursing Director, Chair	05/01/2020
Director of Critical Care	Matthew Mullis, RN, MSN	Director of Critical Care	08/04/2025

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### Appendix 1: Tasks to be Completed

Task to be Completed	Person Responsible	Completed	
		Date	Time
ID ventilated patients in which MD and/or family considering DNR status, utilizing the following criteria: <ul style="list-style-type: none"> <li>GCS of 5 or less</li> <li>Brain injury (i.e., bleed/anoxia/trauma)</li> <li>Physician discussion of possible/imminent brain death</li> <li>Discussion w/ family about withdrawal of life support or possible DNR</li> </ul> Family has questions about donation	ICU RN		
Review patient's advance directives.	ICU RN		
Notify DNW of potential imminent death of vented patient that meets criteria.	ICU Charge RN		
Record the date/time DNW notified and the Donor Referral Case number in the nurses' notes. Give info to the House Supervisor.	ICU RN		
DNW will evaluate appropriateness of organ donation.	DNW Coordinator		
Pre-Donation Discussion Meeting with DNW coordinator; plan of care	Attending MD, RN, LCSW		
DNW Coordinator will approach the legal next of kin to discuss the option of organ/tissue donation.	DNW Coordinator		
The consent for organ donation must be obtained from the next of kin.	DNW Coordinator		
Ensure the Coroner is notified and release/authorization for donation is secured.	ANS		
The medical management of the patient pending organ donation will be by the	Attending MD		

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<p>patient's attending MD, not DNW. However, DNW may provide information on physiological goals pending potential donation.</p>			
<p>If invasive procedures or further diagnostic testing is necessary to determine appropriateness for donation, they are to be ordered and conducted by the MD's and consents, when appropriate, should be obtained from the next of kin.</p>	Attending MD		
<p>The attending MD/Designee must support the plan for DCD and be available to pronounce death following withdrawal of life support.</p>	Attending MD		
<p>OR DCD Meeting: Review DCD Process with OR Staff</p>	DNW/OR staff		
<p>The OR will be notified of potential organ recovery and DNW will work with OR staff to schedule an OR time. The OR time will also be coordinated with the Attending MD.</p>	DNW Coordinator		
<p>ICU DCD Meeting: Review DCD Process with IC Staff</p>	DNW Coordinator/ ICU RN		
<p>The House Supervisor will ensure the original ICU bed is held until after patient expires. A bed in a private room should also be designated in the event the patient requires ongoing comfort care measures.</p>	ANS		
<p>The OR will provide a scrub nurse and circulating nurse to assist recovery teams. An anesthesiologist will only be needed if requested (for lung recovery only).</p>	OR Staff		
<p>OR scrub gown, cap and booties will be provided to: ICU RN, RT, Attending MD and family if appropriate.</p>	OR Staff		
<p>The House Supervisor will arrange for separate private waiting areas close to the</p>	ANS		

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OR: 1 for the family and 1 for the transplant team.			
The <b>DNW</b> Family Resource Coordinator (FRC) will provide all support and information to the family.	<b>DNW</b> Coordinator		
Once the OR is ready and the recovery team is assembled, the patient will be transferred to the PACU/Recovery unit being mechanically ventilated and monitored by the IC RN and RT.	ICU RN/Respiratory Therapist (RT)		
OR Time Out: Verification of Patient   final reminders, instructions by CTDN coordinator	ICU RN/ <b>DNW</b> Coordinator		
Comfort care meds, the appropriate dosage of heparin and the chart will be taken to the OR with the patient	ICU RN		
Heparin needs to be administered 5 minutes prior to extubation as ordered by the patient's attending MD.	ICU RN		
Comfort care medications will be administered as needed by the ICU RN. Heparin needs to be administered 5 minutes prior to extubation as ordered by the patient's attending MD. Comfort care medications will be administered as needed by the ICU RN.	ICU RN		
The <b>DNW</b> organ recovery team will prepare and drape the pt. and assemble necessary equipment in the OR.	<b>DNW</b> Team		
Prior to extubation, a blood draw is necessary for tissue typing purposes. This can be done by Hospital staff or <b>DNW</b> staff.	ICU RN or <b>DNW</b> Staff		
The Transplant Team will wait in the designated waiting area (close to the OR) until the patient is pronounced. Once the patient is pronounced, the transplant team will enter the OR.	<b>DNW</b> Recovery Team		

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Replaces Document Name (if applicable):

<p>The <b>DNW</b> transplant coordinator will remain in the OR to document a running time of the withdrawal process and vital signs.</p>	<p><b>DNW</b> Coordinator</p>		
<p>The patient's family will be offered the opportunity to say their final goodbyes and be present during the withdrawal of life support. Once the patient is pronounced, the family will be escorted to a designated waiting area.</p>	<p><b>DNW</b> Family Coordinator</p>		
<p>The attending MD will verbally indicate when circulation and respirations have ceased and the 5-minute observation period begins at this point.</p>	<p>Attending MD</p>		
<p>The House Supervisor will be notified when patient expires so appropriate calls can be made to the coroner</p>	<p>OR Staff</p>		
<p>The ICU RN and RT may leave the OR and will document appropriately in the patient's medical record once <b>DNW</b> arrives to initiate organ recovery.</p>	<p>ICU RN and RT</p>		
<p>When the <b>DNW</b> team has completed recovery, the patient may be prepared for transfer to the morgue.</p>	<p>OR Staff</p>		
<p>If desired, the family may see the deceased following organ recovery. The OR staff will identify a location for the viewing.</p>	<p>OR Staff</p>		
<p>The ICU RN and RT may leave the OR and will document appropriately in the patient's medical record once <b>DNW</b> arrives to initiate organ recovery.</p>	<p>ICU RN and RT</p>		
<p>When the <b>DNW</b> team has completed recovery, the patient may be prepared for transfer to the morgue.</p>	<p>OR Staff</p>		
<p>If desired, the family may see the deceased following organ recovery. The OR staff will identify a location for the viewing.</p>	<p>OR Staff</p>		



Document Name: **Anatomical Donations for Transplantation**

Manual: (check box)     Med Ctr Administrative     Med Ctr Clinical     Med Ctr Department

Manual Owner Name: Critical Care    Replaces Document Name (if applicable):

Transport should be notified when the deceased is ready for transport to the morgue.	OR Staff		
The House Supervisor will be notified of when the deceased has been transported to the morgue.	OR Staff		
If the patient does not arrest within the designated time frame and the recovery effort is terminated, the House Supervisor will be notified.	OR Staff		
The House Supervisor will assign an appropriate bed for the patient to be transported to.	ANS		
The attending MD will write further care orders prior to pt. transfer.	Attending MD		
Report will be called to the receiving unit.	ICU RN		
The patient will be transported to the designated room.	Transporter/RN		

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<b>Originated By</b>	CSU
<b>Origination Date</b>	10/04
<b>Current Review Date(s)</b>	3/06,4/09, 8/11,9/14, 5/17, 4/19
<b>Current Revision Date(s)</b>	9/14 7/19

## **MARINHEALTH MEDICAL CENTER HOUSEWIDE CLINICAL MANUAL**

### **MEDICAL DEVICE ALARM SAFETY**

#### **I. Policy**

MarinHealth Medical Center provides safe care, treatment, and services for all patients. To improve the safety of clinical alarm systems and to promote a safe environment all hospital staff will assure that alarms are activated with appropriate settings and sufficiently audible with respect to distances and competing noise.

#### **II. Purpose**

The purpose of this policy is to ensure alarms on medical devices designed to alert staff and practitioners to an actual or potential life-threatening patient condition remain in the ON mode. This policy applies to all care settings and services for which medical devices utilized in the provision of patient care contain alarms.

#### **III. General Information**

##### **A. Definitions:**

**MEDICAL DEVICE:** A piece of equipment designated by the Food & Drug Administration as a medical device.

**CRITICAL ALARMS:** Alarms on medical equipment designed to alert staff to the presence of a life-threatening or potentially life threatening condition.

**NON-CRITICAL ALARMS:** Alarms on medical equipment designed to alert staff to the presence of a non-life threatening condition

##### **B. Critical Alarms**

###### **1. AUTHORITY TO SET ALARM PARAMETERS**

Unless otherwise specified of this policy, initial parameters for critical alarms will be consistent with default settings established by the device manufacturer or latest evidence based practice. Changes to the manufacturer default settings may only be made upon order of the patient's physician, or qualified designee, who is familiar with the patient's clinical condition.

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## 2. AUTHORITY TO CHANGE ALARM PARAMETERS

Unless otherwise specified in this policy, critical alarm parameters may only be changed upon order of the patient's physician, or qualified designee, who is familiar with the patient's clinical condition.

## 3. AUTHORITY TO SET ALARM PARAMETERS TO OFF

Critical alarms may not be disabled or placed permanently in the off position unless directly ordered by the patient's physician.

## 4. TEMPORARY SUSPENSION OF ALARM SIGNALS

Critical alarms may be suspended while the patient is off the equipment, or staff is working directly with the patient, but must be returned to the on position when the equipment is placed back on the patient or when care is completed. Staff is expected to verify that critical (life threatening) alarms are in the ON position

## 5. AUDIBILITY OF ALARM SIGNALS

Critical alarm volumes shall be set at a level so that staff can hear them. If there is competing noise in the area, or the patient is housed at some distance from staff, then the volume of alarms will be set high enough or augmented in a manner that allows staff to hear them.

## 6. MONITORING & RESPONDING TO ALARM SIGNALS

Staff shall monitor and respond to the activation of a critical alarm in a timely manner. Monitoring may be either direct or indirect depending on the patient's clinical condition, care setting, medical devices in use, and other pertinent factors.

## 7. VERIFYING ALARM FUNCTIONALITY & SETTINGS

Operational functionality of critical alarms will be checked in accordance with manufacturer instructions as part of the equipment(s) biomedical preventive maintenance and repair program. In addition, users of medical devices shall verify – as appropriate – that critical alarms are in the “on” position and sufficiently audible:

- Prior to using the device on a patient
- When assuming care of a patient (i.e. at the start of shift)
- Following removal and subsequent reapplication of the device on a patient due to patient care needs
- Prior to transferring a patient with the device to another care area.

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## 8. ANNUAL REVIEW

A four step annual review process for all critical alarms will be conducted.  
(Appendix A)

## C. Non-Critical Alarms

### 1. NON-CRITICAL ALARM SIGNALS

Non-critical alarm parameters shall be set either to the default settings established by the manufacturer or as clinically warranted based on the patient's condition.

Parameters may be set and/or adjusted by the patient's physician or by staff trained and qualified to operate the equipment and understand the clinical implications of such action. In general, non-critical alarms should not be turned off, but the volume may be set so that it is not disruptive to the therapeutic milieu or contributes to alarm fatigue.

It is recognized that medical devices contain alarm signals designed to alert staff to a wide variety of clinical presentations. In some instances, these presentations are reflective of a patient's "normal and expected" condition. Under these circumstances, it is permissible to suspend or turn off the alarm component(s) or parameter(s) designed to alert staff of a normal and expected clinical presentation.

## D. Staff Training

### 1. STAFF TRAINING

Staff will be educated about the purpose and proper operation of alarm systems for which they are responsible. Evidence that staff have been trained to the medical device itself shall be considered inclusive of training on attendant alarm systems. Training shall be provided as part of staff's initial assessment of competency upon hire, when new medical devices are introduced into the organization, and as necessary.

### References:

Joint Commission Sentinel Event Alert on Alarm Safety, May 2013  
National Patient Safety Goal on Alarm Management

<b>Reviewed By:</b>	Nursing Director of CSU	<b>Date:</b> 4/30/2019
	Nursing Director of Critical Care Services	<b>Date:</b> 4/30/2019
	CNS, Cardiovascular Service Line	<b>Date:</b> 4/30/2019

<b>Revised By:</b>	Director of Critical Care Services	<b>Date:</b> 7/24/2019
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**Approved By:**

Policy and Procedure Committee  
Nursing Leadership  
MEC

**Date: 7/20/2019**  
**Date: 6/26/2019**  
**Date: 10/15/201**

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## Appendix A: Ensuring the Effectiveness of Clinical Alarm Systems

**Requirements:** Ensure that critical alarms used in the clinical environment are tested on an ongoing, scheduled basis and they are sufficiently audible to staff with respect to distance and competing noise in the unit.

**Definition:** A critical clinical alarm is any audible or visual indication from a system or device, that when activated, may result in the injury or death of a patient unless immediate clinical intervention results.

**Process:** A four step process is used to ensure the effectiveness of critical alarm systems, as defined below:

**Step 1:** *Determine which audible and visual indicators are included in the list of critical clinical alarms.* The determination of whether an audible or visual indication is considered a “critical clinical alarm” is evaluated by using a risk assessment process that considers the severity and probability of an inappropriate staff response to an alarm. A numerical evaluation is assessed and documented using the following criteria:

### Severity Rating (likely result if the alarm is not attended to by staff on a timely basis)

5	Death
4	Serious injury, likely to be permanent
3	Major injury, possible long-term effects
2	Minor injury, not likely to have long-term effects
1	No injury

### Probability of an inappropriate staff response after the alarm has activated:

5	Almost certain to occur
4	Occurrence is probable
3	Possible
2	Very unlikely to occur
1	Will not occur

The assessment score (AS) is calculated by multiplying the Severity Rating (SR) by the Probability (P):  $AS = SR \times P$ . Alarms that result from systems or equipment with scores greater than or equal to 9 will be included in the “critical alarm” list. Refer to Table 1 for the summary of risk assessment scores.

**Step 2:** *Clearly define testing responsibilities.* A description of the responsibilities for testing the critical clinical alarms is defined in Table 2.

**Step 3:** *Determine critical alarm audibility.* Although there are many methods to determine the audibility of critical alarms by clinical staff, the use of a self-assessment form (refer to Table 3) is recommended.









# Environment of Care

- 
- ✓ *Emergency Management*
  - ✓ *Electrical Safety*
  - ✓ *Utilities*
  - ✓ *Fire Safety*
  - ✓ *Hazard Communication*
  - ✓ *Workplace Violence Prevention*



# Emergency Management

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# Emergency Management

MarinHealth Medical Center works closely with the Marin County Emergency Operations Center (EOC) to ensure a coordinated response with other local, state and federal emergency resources.

The **Hospital Incident Command System (HICS)** is used to direct emergency response.

It is expected that in a major disaster the Medical Center is prepared to withstand a period for at least **96 hours without outside assistance**.

For resiliency, the Medical Center must address all four phases of Emergency Management.

There are 15 standards and 60 elements of performance in The Joint Commission's Emergency Management chapter which are also tied to the Center for Medicare and Medicaid Services requirements for participation and reimbursement.



# Response: Emergency Codes

- Code **Blue** - Adult Medical Emergency
- Code **Gray** - Combative Person  
"Get out, Get Help", Team response
- Code **Green** - Patient Elopement  
Monitor assigned locations and report suspicious activity
- Code **Orange** - Hazardous Material Spill or Release  
"SIN" Safety, Isolate, Notify"
- Code **Pink** - Infant Abduction - 0 to 6 months
- Code **Purple** - Child Abduction - 6 months to 14 years  
Monitor assigned locations and report suspicious activity
- Code **Red** - Fire  
"RACE" Rescue, Alarm, Confine, Extinguish/Evacuate  
"PASS" Pull, Aim, Squeeze, Sweep
- Code **Silver** - Weapon or Hostage  
"Run, Hide, Fight"
- Code **White** - Pediatric Medical Emergency
- Code **Yellow** - Bomb Threat  
Remain in your department and report any suspicious activity
- Code **2000** - Psychiatric Emergency.  
Response includes psychiatric social worker

**Each code is associated with a detailed plan for timely and effective response by trained teams.**

# Preparedness: Hazard Vulnerability Analysis (HVA)



The Emergency Management Subcommittee completes an annual HVA of risks to the organization in order to prioritize preparedness activities. This exercise is integrated with the county's Healthcare Preparedness Program.

Hazard	Freq.	Impact
1. Biological Event >5 airborne, >25 droplet (2009, 2014, 2020, 2021, 2022)	High	Medium
2. Pandemic- Medium frequency, High impact	High	Med
3. Cyber Attack	High	Med
4. Wildland Fire: 2015, 2017, 2018, 2019, 2020, 2021, 2022	High	Med
5. Critical Medical Supply Shortage	High	High
6. Severe Weather (Rain, Cold, Drought, Extreme Heat > 3 days)	High	Low
7. Active Shooter/Weapon/Hostage Situation	Medium	High
8. Fire/Explosion (internal): 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022	Medium	High
9. Mass Casualty Incident > 11 patients requiring transport, or 6 Immediate (Level II)	Low	High
10. Utility Outage/Failure Internal or External (water, power, sewer, med gas, HVAC)	High	Medium
11. Labor Disruption	Medium	Low
12. Construction Incident/Structural Damage	Medium	Medium
13. Civil Unrest (2020, 2021)	Low	Medium
14. Communications/Computer Outage (Unplanned)	High	Medium
15. Flooding External (rain, tsunami): 1998, 2005/06, 2008, 2016/17, 2021, 2022	Medium	Medium
16. High-profile Patient (Concierge and Forensic)	Medium	Low
17. Major Earthquake: SF Bay Area 63% of >6.7 w/in next 30 years (highest probability for Hayward-Rodgers Creek Fault)	Low	High
18. Bomb Threat/ Suspicious Package	Low	High
19. HazMat Internal (large internal spill, medical waste incident)	Low	Medium

# Emergency Operations Plan (EOP) – Code Triage



## EOP Purpose

To provide guidelines for timely, integrated, and coordinated responses to the wide range of extraordinary emergency situations which could disrupt normal operations.



## Where to find the EOP

- MarinHealth Intranet > Policies & Procedures
- Binder located at each Medical Center department



## All-Hazard Disaster Response

- Section 1: Base Plan and Continuity of Operations
- Section 2: Emergency Response Plans
- Section 3: Incident Response Guides (HICS)

# Response: Code Triage

## Code Triage: Activating the Emergency Operations Plan (EOP)

If the answer is YES to any guideline CODE TRIAGE should be established to activate the EOP. The Administrative Nursing Supervisor (ANS) or highest ranking official on site can activate CODE TRIAGE and establish the Hospital Command Center, if needed.

Impact to Hospital	Scope of Event	Type of Event – See HVA
Has the hospital's infrastructure, communications or utilities been damaged?	Has the city/county EOC been activated?	Is terrorism suspected (radiation, chemical, or biological)?
Will hospital personnel be exposed to unusually hazardous or unknown conditions?	Has there been (or might be) mass casualties?	Does the event involve extreme, hostile or violent behaviors (i.e. hostage situation, riots, bombs)?
Is there potential for evacuation or sheltering-in-place of the hospital, care units?	Does it appear conditions of the event will worsen?	Does the event involve an epidemic that may affect large numbers of people (flu outbreak, etc.)?
Are service demands exceeding hospital capacity to respond?	Will the number of patients seeking medical care exceed the capabilities of the Emergency Room?	Does the event restrict movement or transportation in the community (earthquake, severe snowstorm, volcano eruption, etc.)?
Have major utility failures affected patient care or services?	Rapid influx of patients above and beyond the capacity of present staff to meet patient needs?	Have credible security threats or warnings been made against the facility or personnel?
Are there patient/staff safety concerns?	Are other medical facilities experiencing an emergency that affects us? (transfers, field triage with fire departments, etc.)	Loss of facility power, water, communications?

# Response: Hospital Command Center

## Initiating Code Triage:

The **Administrative Nursing Supervisor (ANS)** and/or the **highest-ranking Administrator on-site** have the authority to implement the Emergency Operations Plan and assume or assign the role of **Incident Commander**.

## The Hospital Command Center (HCC) activities:

- Central command during an emergency and/or disaster event
- Coordination and tracking of emergency response operations
- Provides a central area for gathering and dissemination of information, including coordination with outside resources
- Roles may be pre-assigned or designated at the time of the incident

# Response: Hospital Command Center (HCC)



The Incident Commander will determine the location and activation of the **Hospital Command Center (HCC)**. The primary location of the HCC is:

**Tamalpais Conference Room and/or the Inverness Conference Room  
(Oak Pavilion)**

A virtual component (Zoom, Teams, WebEx) may also be established.

All staff who do not have immediate patient care duties should report to the **Labor Pool, if activated**. Primary location of the Labor Pool is:

**Creekside Café/Cafeteria  
(Redwood Pavilion)**

# Preparedness: Exercises

It is critical to practice emergency response in order to be prepared to respond safely and effectively to an actual event.

The EOP must be activated or exercised at least 2x annually at MarinHealth Medical Center and at least 1x annually at all business locations. Exercises are often coordinated with partners from the Healthcare Preparedness Program.

Functional or table-top drills provide opportunities to practice and identify Improvements.

What you drill is what you do.



# Preparedness: Evacuation Devices

In the event of an evacuation, MarinHealth Medical Center can deploy Paraslyde evacuation sleds and the HoverJacks to move patients.



Vertical evacuation



Horizontal evacuation



# Evacuation Slides for Vertical Evacuation



x5 =



## Oak Pavilion

- 3500 Maternity Care
- 3600 PMCU
- 4500 Medical & Surgical
- 4600 Medical & Surgical

## Cedar Pavilion

- Level 3
- Level 4
- Level 5



## Oak Pavilion

- Lobby Level
- 4600
- 2024: Redwood-5

# Response: Staff Roles

## All staff have, at a minimum, the following responsibilities:

- Communicate situational needs, report operational status, and issues in a clear, concise, and timely manner. IF YOU SEE SOMETHING, SAY SOMETHING.
- Conserve resources and assets, and utilize said resources and assets appropriately.
- Be aware of, and maintain, the safety and security of themselves and the environment in which care, treatment, and service are rendered.
- Appropriately utilize and conserve utilities, and to report disruption or failure of utilities to the appropriate individual(s) or entity(s) in a timely manner.
- Assure that clinical activities are carried out in accordance with accepted standards of care, and in a safe and efficacious manner.



# Recovery

## Once the immediate emergency has resolved, there is still much to be done:

- A continual assessment of viability of essential functions is assigned by Incident Commander and completed by the Business Continuity Branch.
- Critical incident stress debriefing (CISD) for staff and responders may need to be initiated.
- Documentation of the incident is collected and an After Action Report (AAR) of the event is completed to capture lessons learned
- Operational systems will be redeployed systematically according to the priorities of the organization

# Electrical Safety



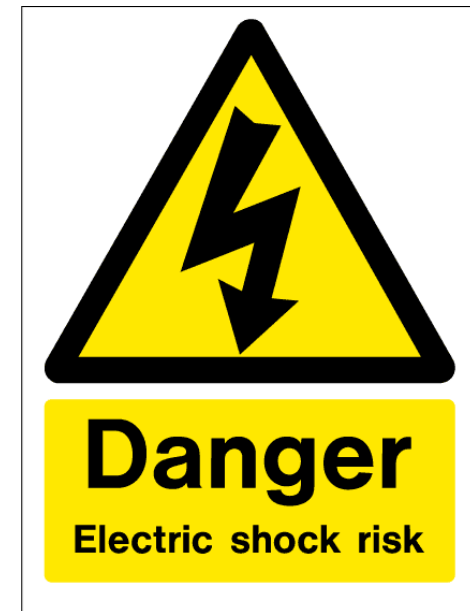
# Electric Safety – Shock Hazards

**Most equipment in the healthcare setting is electric.** From common equipment such as patient beds to monitors to complex procedural equipment the common energy source is, electricity.

Patients and staff are constantly in contact with these devices.

**Electric shock** can cause:

- Burns
- Muscle spasms
- Anormal heartbeats
- Stopping of breathing
- Electrocutation



# Electric Shock Hazards

## To protect patients:

- Place electric equipment at a distance from patients, whenever possible.
- Make sure the floors in patient areas stay dry.
- If possible, do not touch patients and electric equipment at the same time.
- Equipment brought in by patients must be authorized by Facilities Engineering prior to use
- Immediately remove damaged equipment from service. Clearly tag with the date and hazard. Notify Biomedical Engineering for patient care equipment; for other equipment, notify Facilities Engineering.

# Utilities



# Utilities - Power Cords and Outlets

Overloading circuits or outlets creates unacceptable risk of injury or fire

- Outlets that get too hot may not be wired safely. Unplug cords from the outlet. Report the problem to Facilities Engineering.
- Do not bend, stretch, or kink power cords.
- Use only power cords with three-prong plugs. Never use adapters, two-prong plugs, or broken three-prong plugs.
- Do not use outlets or cords with exposed wiring.
- **NEVER** connect a chain of plugs and surge protectors.
- Surge protectors must be approved and placed by the Biomedical department

If you have any questions or concerns about equipment usage, notify Biomedical and/or Facilities Engineering.

# Utilities – Emergency Power



- The emergency power system is robust in Medical Center buildings.
- In the Redwood and Cedar Pavilions, all outlets and switches as well as emergency lighting are tied into the emergency power system.
- In the Oak Pavilion all **RED** outlets and switches as well as emergency lighting are tied into the emergency power system.

# Preparedness: Equipment

**Code Triage** Emergency supplies boxes are located on patient care units.

They contain emergency lighting equipment for use during loss of power events. Emergency lighting equipment is also mounted throughout the building.

MarinHealth Medical Center is also equipped with back-up emergency generator power should there be an interruption of PG&E power.

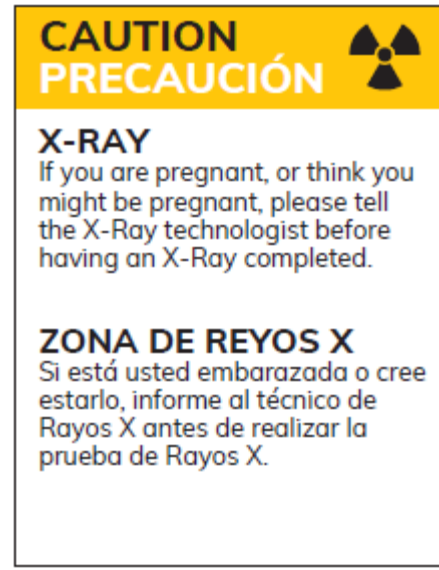
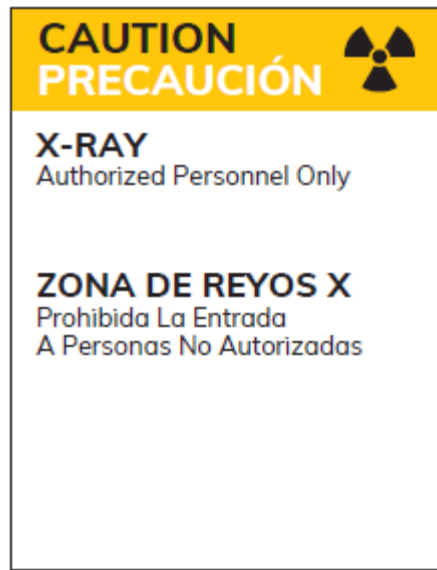


# Hazard signs - Imaging and Radiology

MRI, CT, Ultrasound and X-ray equipment is now located on the Lobby Level, 500 Block in the Oak Pavilion.

Hazard signage is in place for employee and patient safety.

Do not enter any room when the sign is illuminated.




# Hazard Signs – MRI Zones

The MRI magnet is live at all times.  
Observe and follow precautions in the safety zones!

MRI	
<b>MRI ZONE 1</b>	MRI Access General Public Area <b>Acceso a MRI</b> Área Pública General
WARNING ADVERTENCIA	
 <p><b>MAGNET IS ALWAYS ON</b> System Use And Scanning Room Access For MRI Authorized Personnel Only</p> <p><b>EL IMÁN SIEMPRE ESTÁ ENCENDIDO</b> Uso Del Sistema Y Acceso A La Sala De Escaneo Sólo Para Personal Autorizado De Mri</p>  <p>Only Screened And Approved Devices Allowed In Scanning Room</p> <p>Sólo Se Permiten Dispositivos Examinados Y Aprobados En La Sala De Escaneo</p>  <p>While Scanning, Rf Fields And Acoustic Noise Durante El Escaneo, Hay Campos De Rf Y Ruido Acústico</p>	

NOTICE AVISO	
<b>MRI ZONE 2</b>	Restricted Access MRI Patient Pre-Screening & Preparation <b>Acceso Restringido</b> Paciente De Mri Evaluación Preliminar Y Preparación
WARNING ADVERTENCIA	
 <p><b>MAGNET IS ALWAYS ON</b> System Use And Scanning Room Access For MRI Authorized Personnel Only</p> <p><b>EL IMÁN SIEMPRE ESTÁ ENCENDIDO</b> Uso Del Sistema Y Acceso A La Sala De Escaneo Sólo Para Personal Autorizado De Mri</p>  <p>Only Screened And Approved Devices Allowed In Scanning Room</p> <p>Sólo Se Permiten Dispositivos Examinados Y Aprobados En La Sala De Escaneo</p>  <p>While Scanning, Rf Fields And Acoustic Noise Durante El Escaneo, Hay Campos De Rf Y Ruido Acústico</p>	

CAUTION PRECAUCIÓN	
<b>MRI ZONE 3</b>	Restricted Access Screened MRI Patients & MRI Personnel Only <b>Acceso Restringido</b> Pacientes De MRI Evaluados Y Personal De MRI Solamente
WARNING ADVERTENCIA	
 <p><b>MAGNET IS ALWAYS ON</b> System Use And Scanning Room Access For MRI Authorized Personnel Only</p> <p><b>EL IMÁN SIEMPRE ESTÁ ENCENDIDO</b> Uso Del Sistema Y Acceso A La Sala De Escaneo Sólo Para Personal Autorizado De Mri</p>  <p>Only Screened And Approved Devices Allowed In Scanning Room</p> <p>Sólo Se Permiten Dispositivos Examinados Y Aprobados En La Sala De Escaneo</p>  <p>While Scanning, Rf Fields And Acoustic Noise Durante El Escaneo, Hay Campos De Rf Y Ruido Acústico</p>	

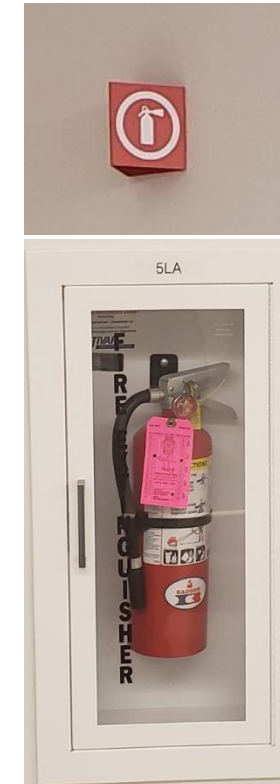
DANGER PELIGRO	
<b>MRI ZONE 4</b>	Restricted Access Screened MRI Patients Under Direct Supervision of Trained MRI Personnel Only <b>Acceso Restringido</b> Pacientes De MRI Evaluados Bajo La Supervisión Directa De Personal Capacitado De MRI Solamente
WARNING ADVERTENCIA	
 <p><b>MAGNET IS ALWAYS ON</b> System Use And Scanning Room Access For MRI Authorized Personnel Only</p> <p><b>EL IMÁN SIEMPRE ESTÁ ENCENDIDO</b> Uso Del Sistema Y Acceso A La Sala De Escaneo Sólo Para Personal Autorizado De Mri</p>  <p>Only Screened And Approved Devices Allowed In Scanning Room</p> <p>Sólo Se Permiten Dispositivos Examinados Y Aprobados En La Sala De Escaneo</p>  <p>While Scanning, Rf Fields And Acoustic Noise Durante El Escaneo, Hay Campos De Rf Y Ruido Acústico</p>	

# Fire Safety



# Code RED - Signage and Equipment

Identify locations of pull stations and extinguishers in your areas of work. Know your routes of egress.



➡ EXIT PATH

Follow arrows for exit

**A** FIRE ALARM

 EXTINGUISHER

# Fire – Code RED

**At the first sign of fire or smoke, don't hesitate, start R.A.C.E.**

**RESCUE** anyone who is in immediate danger

**ACTIVATE** fire alarm by pulling the nearest pull station

**CONFINE** the fire. Close all the doors in & around the fire area

**EXTINGUISH** the fire by using a fire extinguisher (if safe to do so)



Boston Globe 2023 -Brockton  
Hospital 10-Alarm Fire

# Fire Safety Features and Drills

MarinHealth Medical Center is equipped with, automatic fire doors and smoke partitions with multiple hour fire ratings.

Safety features separate the building into many zones:

- Fire and smoke in one zone should not spread easily to other zones
- Fires can be contained
- This means fewer patients and staff need to be evacuated

All staff are **required** to participate in fire drills occurring in their areas of work- **do not** call the PBX Hospital Operator to ask whether or not a Code Red announcement is a drill.

**Always** assume a Code Red is real!



ECRI Institute

# Code Red – Smoke Compartments



## *Oak Pavilion Retractable WON Doors*

- Doors will close if a smoke head on either side goes into alarm
- Doors can be opened if passage is required.
- Look through the small glass window for safety. Press green paddle

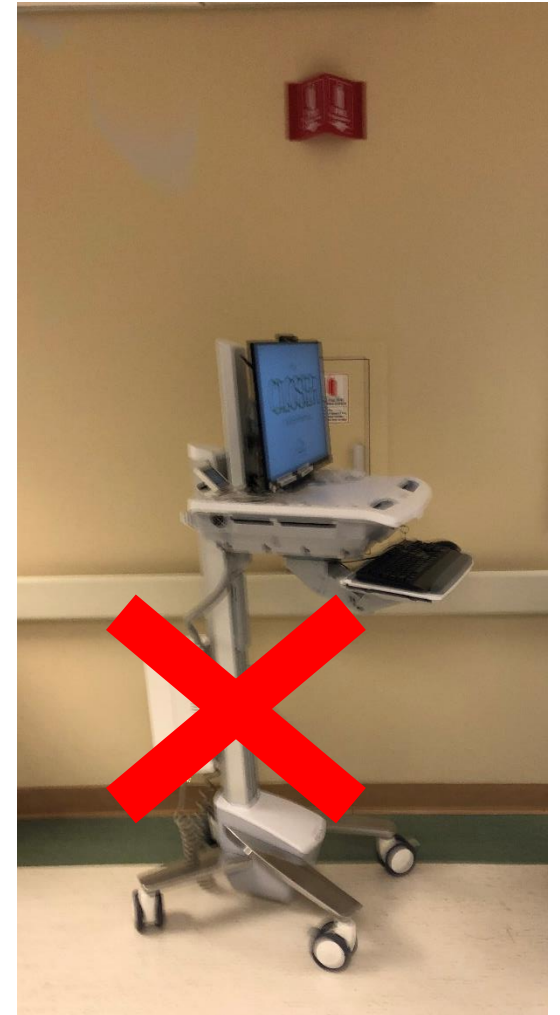
 SMOKE BARRIER



# Fire Safety Equipment

## YOUR ROLE:

1. R.A.C.E.
2. Make sure that automatic fire doors are not blocked, propped or wedged open.
3. All corridors are clear, equipment moved to one side.
4. Fire extinguishers and pull stations are not blocked.



# Hazard Communication

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# Hazard Communication - 29CFR 1910.1200

The Hazard Communication Standard (HCS) is based on a simple concept--that **employees have both a need and a right** to know the hazards and identities of the chemicals they are exposed to when working.

Employees also need to know what protective measures are available to prevent adverse effects from occurring.

## Key features of the Globally Harmonized System:

- Signal word
- Hazard and Precautionary Statements
- Chemical classification
- Additional hazards
- Routes of exposure
- Target organs
- Pictograms



# Detecting Hazardous Chemical Release

MarinHealth Medical Center strives to minimize the use of hazardous chemicals in our environment.

Environmental monitoring is completed per regulatory requirements. Reports are available from the Safety Officer, Charles Holloway, ext. 7976

Observations used to detect the presence or release of a hazardous chemical in the work area can include:


- Smell - Detection of an odor
- Sight - an overturned, or suspiciously empty container, a container absent the proper seal, soiled packaging labeled with HazMat shipping labels
- Physical reaction - eye irritation, respiratory issues

Any suspicious activity should be reported to supervisor immediately so that the hazard can be identified and mitigated for the safety of all staff, patients and visitors in the area.

# Label: Hazardous Chemicals

OSHA has requirements for labeling of hazardous chemicals under its Hazard Communication Standard (HCS). All labels are required to have pictograms, a signal word, hazard and precautionary statements, the product identifier, and supplier identification.

**SAMPLE LABEL**

CODE _____ Product Name _____	} <b>Product Identifier</b>	<b>Hazard Pictograms</b> 
Company Name _____ Street Address _____ City _____ State _____ Postal Code _____ Country _____ Emergency Phone Number _____	} <b>Supplier Identification</b>	
<b>Precautionary Statements</b> Keep container tightly closed. Store in a cool, well-ventilated place that is locked. Keep away from heat/sparks/open flame. No smoking. Only use non-sparking tools. Use explosion-proof electrical equipment. Take precautionary measures against static discharge. Ground and bond container and receiving equipment. Do not breathe vapors. Wear protective gloves. Do not eat, drink or smoke when using this product. Wash hands thoroughly after handling. Dispose of in accordance with local, regional, national, international regulations as specified.		<b>Signal Word</b> <b>Danger</b>
<b>Hazard Statements</b> Highly flammable liquid and vapor. May cause liver and kidney damage.		
<b>Supplemental Information</b> Directions for Use _____ _____ _____  Fill weight: _____ Lot Number: _____ Gross weight: _____ Fill Date: _____ Expiration Date: _____		
<b>First Aid</b> If exposed call Poison Center. If on skin (or hair): Take off immediately any contaminated clothing. Rinse skin with water.		

OSHA 3492-01R 2016

# Label: Hazard and Precautionary Statement

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

Example: Fatal if swallowed (Acute Oral Toxicity)

**Precautionary statement** is a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical, or improper storage or handling.

Example: Do not eat, drink, or smoke when using this product

Example: Keep container tightly closed

# Label: Signal Word and Pictograms

**Signal word** means a word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label

- **Danger** is used for the more severe hazard
- **Warning** is used for the less severe








**Pictogram** means a composition that may include a symbol plus other graphic elements, such as a border, background pattern, or color, that is intended to convey specific information about the hazards of a chemical

Nine pictograms are designated under this standard for application to a hazard category



# Pictograms and Hazards

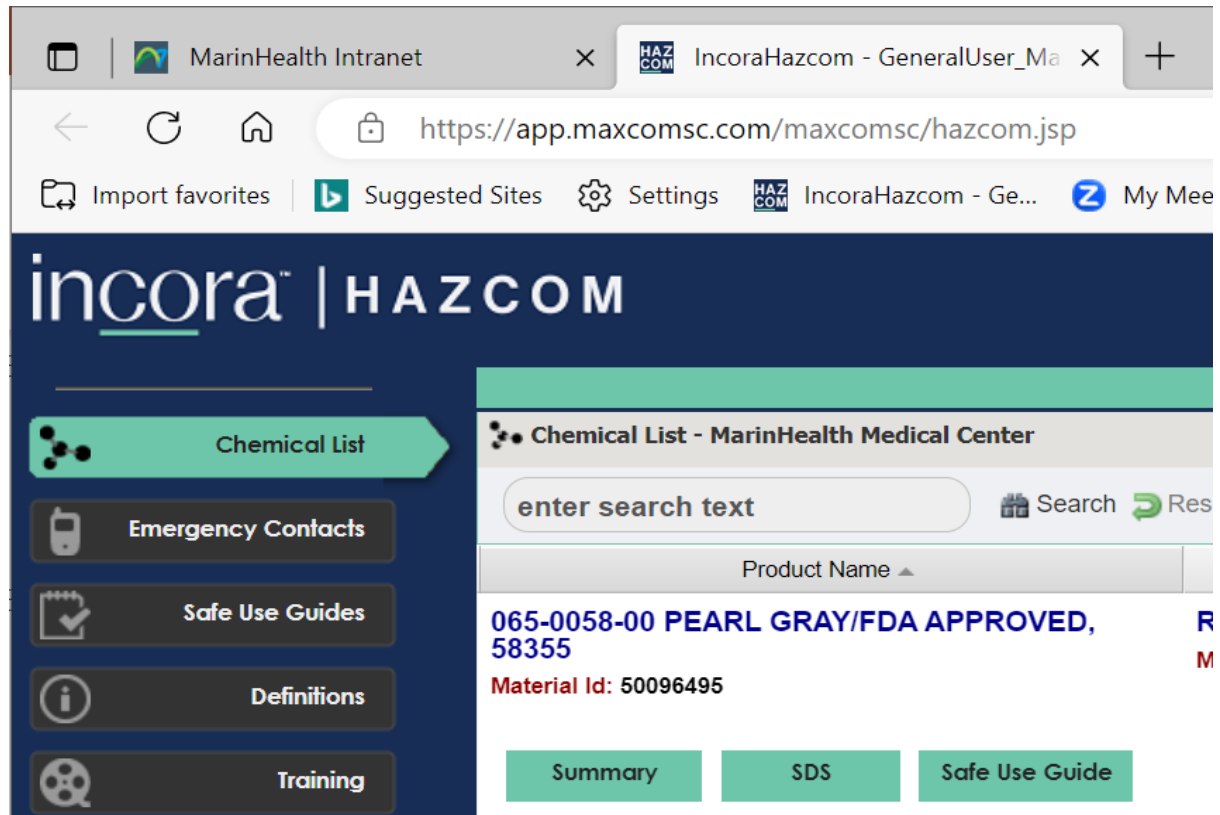
## HCS Pictograms and Hazards

<p><b>Health Hazard</b></p>  <ul style="list-style-type: none"><li>• Carcinogen</li><li>• Mutagenicity</li><li>• Reproductive Toxicity</li><li>• Respiratory Sensitizer</li><li>• Target Organ Toxicity</li><li>• Aspiration Toxicity</li></ul>	<p><b>Flame</b></p>  <ul style="list-style-type: none"><li>• Flammables</li><li>• Pyrophorics</li><li>• Self-Heating</li><li>• Emits Flammable Gas</li><li>• Self-Reactives</li><li>• Organic Peroxides</li></ul>	<p><b>Exclamation Mark</b></p>  <ul style="list-style-type: none"><li>• Irritant (skin and eye)</li><li>• Skin Sensitizer</li><li>• Acute Toxicity (harmful)</li><li>• Narcotic Effects</li><li>• Respiratory Tract Irritant</li><li>• Hazardous to Ozone Layer (Non-Mandatory)</li></ul>
<p><b>Gas Cylinder</b></p>  <ul style="list-style-type: none"><li>• Gases Under Pressure</li></ul>	<p><b>Corrosion</b></p>  <ul style="list-style-type: none"><li>• Skin Corrosion/ Burns</li><li>• Eye Damage</li><li>• Corrosive to Metals</li></ul>	<p><b>Exploding Bomb</b></p>  <ul style="list-style-type: none"><li>• Explosives</li><li>• Self-Reactives</li><li>• Organic Peroxides</li></ul>
<p><b>Flame Over Circle</b></p>  <ul style="list-style-type: none"><li>• Oxidizers</li></ul>	<p><b>Environment (Non-Mandatory)</b></p>  <ul style="list-style-type: none"><li>• Aquatic Toxicity</li></ul>	<p><b>Skull and Crossbones</b></p>  <ul style="list-style-type: none"><li>• Acute Toxicity (fatal or toxic)</li></ul>

# HazCom System: SDS + Safe Use Guides

Information is available 24/7 via the MarinHealth Intranet:

- IT Applications > Safety Data Sheets
- Departments & Programs > Safety > HazMat> Safety Data Sheets



The screenshot shows a web browser window with the following elements:

- Browser Tabs:** "MarinHealth Intranet" and "IncoRaHazcom - GeneralUser\_Ma".
- Address Bar:** "https://app.maxcomsc.com/maxcomsc/hazcom.jsp".
- Navigation Bar:** Includes "Import favorites", "Suggested Sites", "Settings", "IncoRaHazcom - Ge...", and "My Mee".
- Header:** "incora | HAZCOM".
- Left Sidebar:** Contains buttons for "Chemical List", "Emergency Contacts", "Safe Use Guides", "Definitions", and "Training".
- Main Content Area:**
  - Section: "Chemical List - MarinHealth Medical Center".
  - Search bar: "enter search text" with "Search" and "Res" buttons.
  - Dropdown menu: "Product Name".
  - Chemical entry: "065-0058-00 PEARL GRAY/FDA APPROVED, 58355" with a "Material Id: 50096495".
  - Buttons: "Summary", "SDS", and "Safe Use Guide".

# Safety Data Sheet (SDS)

A Safety Data Sheet (SDS) is the detailed source of information about the chemical.

SDS are organized using a specified order of information.

The required information will appear in the same sections of an SDS regardless of the supplier.

The most important information will be listed in the first sections of the SDS.

1. Identification
2. Hazard(s) identification
3. Composition/information on ingredients
4. First-aid measures
5. Fire-fighting measures
6. Accidental release measures
7. Handling and storage
8. Exposure control/personal protection
9. Physical and chemical properties
10. Stability and reactivity
11. Toxicological information
12. Ecological information
13. Disposal considerations
14. Transport information
15. Regulatory information
16. Other information

# Code Orange – Hazardous Chemical Spill

Hazardous chemicals exist in various Medical Center locations.

Proper PPE is essential for use in the presence of hazardous chemicals and hazardous pharmaceuticals.

If you encounter a potentially hazardous spill, follow the **S - I - N** protocol:

**Safety** – Maintain a safe distance, get to a well-ventilated area

**Isolate** – Keep the area clear

**Notify** – Alert staff and visitors, call the Operator at ext. 4444

Announce **Code Orange**

- Identify the location of the spill
- Identify the size of the spill.
- Include any other pertinent information that will assist responder in identifying the chemical.
- Locate the SDS for the chemical and follow instructions for First Aid and Accidental Release.

Departments with hazardous chemicals are equipped with spill kits for immediate containment of minor spills.

# Workplace Violence Prevention

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# Workplace Violence - Definition

Workplace violence is defined as any act of violence or threat of violence that occurs at the work site and includes:

The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.



## References:

Cal/OSHA Section 3342

The Joint Commission:

- 2022 Workplace Violence Prevention Standards, R3 Report, Issue 30, 6/18/21
- Sentinel Alert 59

# Workplace Violence - Profiles of Perpetrators



## No relationship with MarinHealth

The perpetrator has no legitimate business relationship to the organization and usually enters to commit a robbery or other criminal act.

## Current/Former client/patient/family member

Healthcare workers interact with patients and family members who often feel frustrated and vulnerable.

## Current or former employee

Stresses in the healthcare environment can trigger verbal or physical abuse from patients *and* staff.

## Associated with a current or former employee or patient

Domestic situations or criminal interactions can spill over into the workplace.

# Workplace Violence Prevention Plan

The MarinHealth Workplace Violence Prevention Plan defines workplace violence and identifies accountability for leaders and staff in mitigating risk.

- The plan is most successful when designed with input from all levels of the organization to effectively capture unique risks in different locations and departments.
- An annual risk assessment is completed and security incidents are tracked and trended at least weekly to identify patterns of risk and develop mitigation plans and procedures.
- The plan is reviewed annually by the Secure Environment Subcommittee and the Environment of Care Safety Committee.
- Unit Practice Councils have been a valuable resource to identify issues and develop solutions.

# Workplace Violence Prevention - Reducing Risk

MarinHealth has instituted physical and operational measures to address security risk in the environment:

- Integrative Agitation Management (IAM) classes
- Staff and visitor badging
- Campus lighting
- Access control and video surveillance systems
- Emergency call boxes at the staff parking garage
- Communication tools for emergency notification such as panic buttons, emergency code phone, radios
- Security rounding on campus and in patient units
- Posted alert at patient room door ("See RN Before Entering")
- Use of emergency codes and response plans
- Annual review of local crime statistics
- Coordination with law enforcement agencies

# Workplace Violence Prevention – Identifying Risk

There are many risk factors in the healthcare environment that may trigger threatening behaviors on a spectrum ranging from agitation to aggression. These factors impact all participants in the environment of care:

## Patient and Visitor Emotional Stressors

Depersonalization, frustration and upset related to feeling out of control of personal choice, long wait times, communication issues and misunderstandings, language barriers, loneliness, fear, pain, financial uncertainty, trauma.

## Environmental Factors

Open floor plans, cramped quarters, multiple access points into the facility.

## Care provision Factors

Patients' altered state due to physiologic or cognitive issues impact of time and resource pressure experienced by care team members.

## Care Provider Fatigue and Burnout

Chronic depletion experienced by care team members impacting high reliability.



# Workplace Violence Prevention – Avoiding Harm

Preparation, situational awareness and presence are critical tools to avoid harm.

## Before you enter a room:

- Did you receive an uplifting, detailed SBAR report on the individual's condition and risk factors for aggressive behavior?
- Be alert to notifications posted in APeX and outside the patient room.
- If risk factors are present use the buddy system to have others observe your interaction.
- Identify and create a clear exit route before you breach the individual's personal space.
- Be prepared to maintain a calm tone of voice and non-threatening body language.



# Workplace Violence Prevention - Avoiding Harm

## In the room or service area:

- Acknowledge the patient and family, introduce yourself, explain what you will be doing, and thank them (**AIDET**).
- Maintain visual contact at all times, do not turn your back
- **Personalize!** Allow time for the individual(s) to give permission or ask questions.
- If you notice resistance, threat or escalating behavior, STOP and re-establish a safe distance or agreed upon behaviors.
- If the behavior does not stop, leave the area, maintain visual contact and call for assistance from team members and/or Security. GET OUT, GET HELP.
- Be alert to individuals who are altered or have cognitive issues particularly during transitions such as sleep to wake or interruptions of activity.
- When there is known aggressive behavior, assemble a team with a leader and clear assignments to manage the care activity and maintain staff safety
- At all times identify a partner or team to safely manage limbs for kicking, striking or grabbing, spitting, biting, head butts.

# Workplace Violence Prevention: Self Regulation

## Restore your spirit throughout the day.

Prior to every encounter there can be an opportunity to restore personal harmony and wellbeing:

- Prior to entering a room, gel or wash your hands, **Ground**.
- As you enter, **Center** your mind in compassion for yourself and your patient.
- **Observe** the situation in with non-reactivity or judgment
- Entering an encounter with calm **Presence** is a very effective tool to create safety, reduce agitation and stress for all involved



**Mindfulness**  
Being aware of the physical,  
emotional, or mental pain  
of the moment.



**Self-kindness**  
Treating ourselves with  
kindness, considering  
our own needs.



**Common Humanity**  
Recognizing that these  
experiences are a normal  
part of being human.

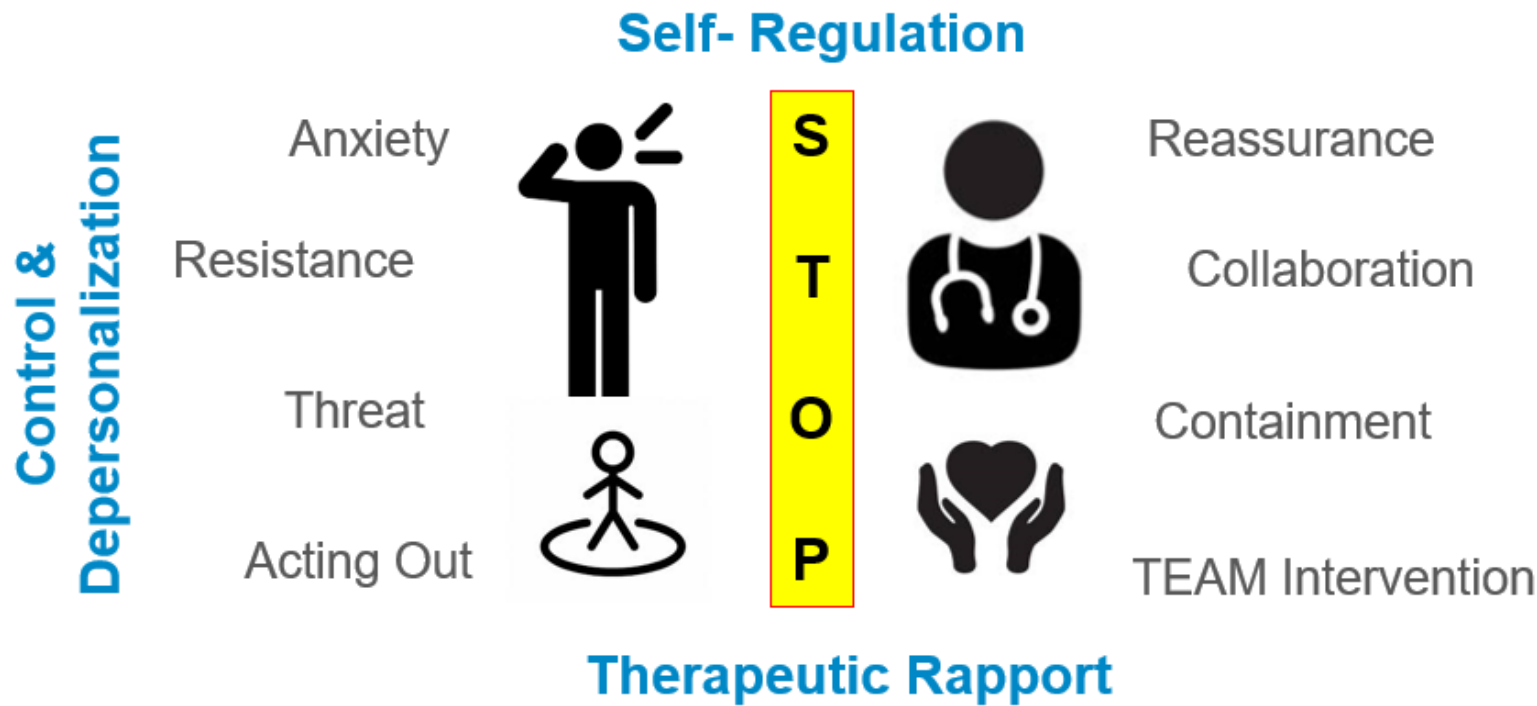
Mindful Self-Compassion  
Dr. Kristin Neff

# Self-preservation Cycle: STOP

Relationship-Based Care creates a shared experience and therapeutic rapport.



Relationship-Based Care



The patient is coping the best they know how.

You are doing your best to give safe, compassionate care.

# Workplace Violence - Reporting and Support

- All incidents of Workplace Violence must be reported to Security. The officer on duty will initiate a report with the impacted parties. The report will be reviewed by department leadership for submission to CalOSHA.
- Online injury/illness reports must be completed by the employee and manager. Safety and Human Resources review all reports.
- Security is available to assist if you chose to make a report to law enforcement. To reach Security, dial "0" for the Operator (4-4-4-4 in an emergency). It is your right to press charges if you have been the victim of an assault or battery.
- Anyone involved in or witnessing an incident may also wish to receive supportive resources from the Employee Assistance Program. These services may be obtained confidentially at [www.halyconeap.com](http://www.halyconeap.com). Use login ID: mhmc, or call 1-888-425-4800. Staff may also request an incident debrief from department management or through Security.

# Workplace Violence Prevention - Security's Role



The Security Department consists of a Director and Supervisor who oversee and manage the program. This includes continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and mitigate security risks, vulnerabilities and protect security sensitive areas and oversight of contracted Security staff.

## Security Officer scope and role:

- Officers work under the direction of clinical staff
- Respond to all calls for assistance
- Trained in de-escalation techniques as well as physical response
- Act as a liaison to all law enforcement operating in the Medical Center
- Enforce MarinHealth policies and behavior contracts
- Work with leaders to manage disruptive patients, family members, visitors, staff
- Coordinate with clinical leadership and staff to track and report individuals with history of disruptive behaviors
- Identify and manage security risks in real time

# Workplace Violence – Reporting a Code Silver



In extreme circumstances, you may encounter or have suspicion of the presence of a weapon.

- **DO NOT** make the person aware that you have knowledge of the weapon.
- Remove yourself from the area immediately.
- Calmly suggest that others such as patients and visitors follow you out of the area, if they are able. For example, you can suggest that they need to come with you for a medical reason.
- Contact the Medical Center Operator immediately by dialing the emergency number **4-4-4-4** and announce **Code Silver** and the location and description of suspect(s).
- Stay on the line (if able) to give additional details about the weapon(s).
- By using **Code Silver**, you will initiate an immediate Security and Law Enforcement response.
- If you are at an offsite location, call 9-1-1 to report the issue, then contact the Medical Center Operator to alert Security.

# Workplace Violence - Responding to Code Silver

## Active Attacker/Shooter

- If you hear shots, call for assistance immediately, dial 4-4-4-4 and/or call/text 9-1-1 (from Medical Center phones dial 9-9-1-1)
- Be aware that these are very dynamic situations requiring immediate recognition, action steps, and modification in plans based on changing circumstances.
- Decisions during active shooter events in medical facilities is further complicated by inability of patients to be safely evacuated.
- Due to effective training and response, most active shooter events are over within 15 minutes.
- Do not interrupt law enforcement response- they have trained to advance and take out the threat. Comply with law enforcement and keep your hands up.

# Workplace Violence - Responding to Code Silver



## RUN

Avoid the threat. Be aware of your surroundings at all times for unusual behavior and do not hesitate when you hear or suspect the sound of gunfire. Proceed to the closest safe exit (hands up so as not to be a threat to law enforcement).

## HIDE

Deny access and stay out of sight. Keep the attacker away from you by locking doors, turning lights off, and barricading. Have a back up plan if the area is breached.

## FIGHT

This may have to be your first response, depending on how much time you have to react. You have the right to defend yourself by any means. Do not fight fair, be aggressive- use objects in the vicinity as weapons. Self-preservation is the goal so that you can survive, help others, and return to your loved ones safely.

# Questions



If you have any comments, questions, concerns or feedback regarding the MarinHealth Workplace Violence Prevention Plan, TEAM Advanced Techniques for Effective Agitation Management, or the Security Management Program, please contact:

**Charles Holloway, Director of Safety and Security, Transportation and Safety Officer**

Office : 1-415-925-7976 [charles.holloway@mymarinhealth.org](mailto:charles.holloway@mymarinhealth.org)

If you would like to make a confidential report you may use the **Compliance & Ethics Hotline & Web Submission Portal**, MarinHealth contracts with a third party to manage the MarinHealth Hotline: (1-877-376-3852).

See the intranet to access the [web submission site](#).

# References and Resources

Sentinel Event Alert The Joint Commission Physical and verbal violence against healthcare workers; issue 59 April 17, 2018

Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers (OSHA, 3148-04R). Washington, DC: OSHA, 2015.

Crisis Prevention Institute Top 10 De-escalation tips

<https://www.crisisprevention.com/Blog/October-2017/CPI-s-Top-10-De-Escalation-Tips-Revisited>

Surviving an Active Shooter Event - Civilian Response to Active Shooter

<https://www.youtube.com/watch?v=j0lt68YxLQQ&feature=youtu.be>


Thank you for completing  
the module on the  
Environment of Care.

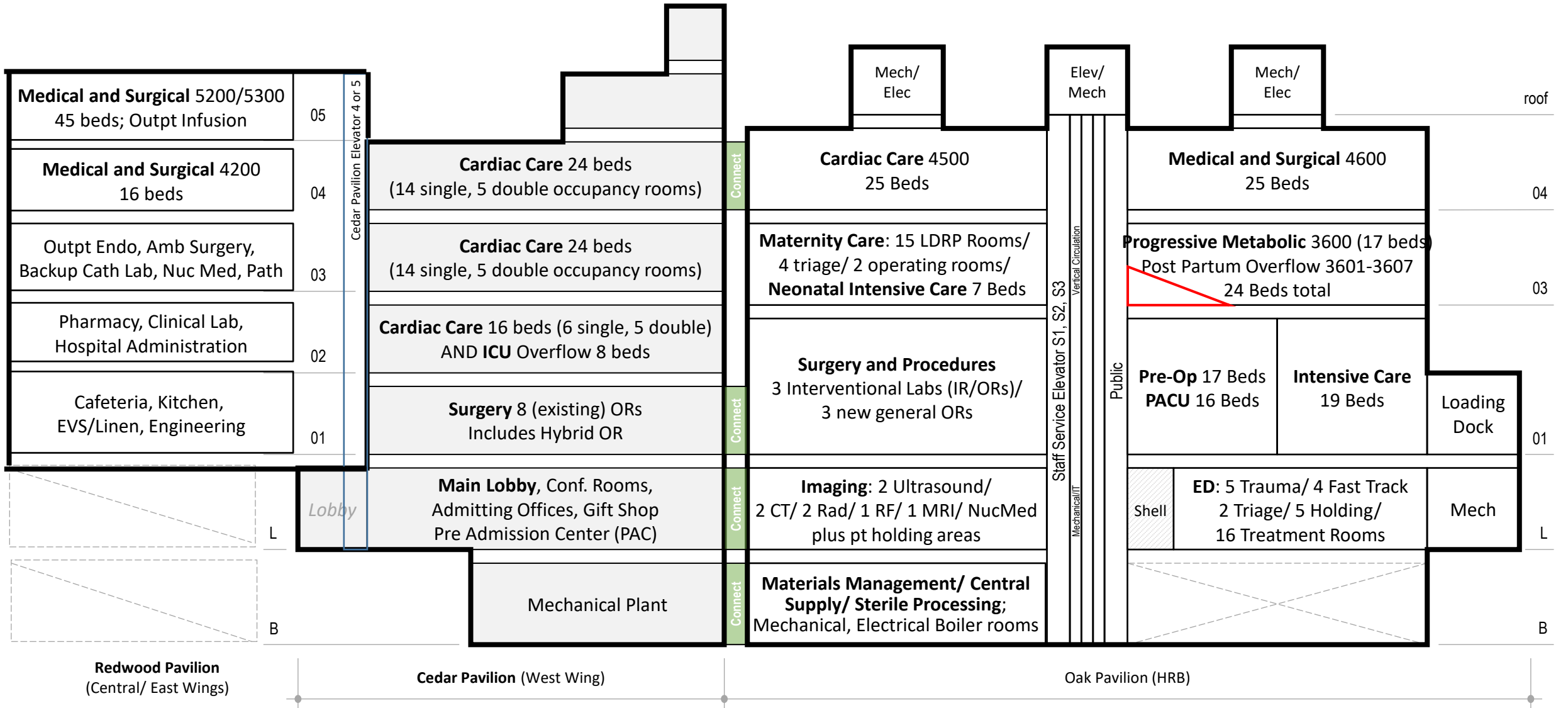
Please continue to the test.



# MarinHealth Medical Center Pavilions

## Stacked Diagram

 = rooms 3601-3607 used for post partum overflow





Document Name:

**Suspected Elder Spousal Partner Child Abuse**

Manual: (check box)

Med Ctr Administrative

Med Ctr Clinical

Med Ctr Department

Manual Owner Name: Emergency Department/PES

Replaces Document Name (if applicable):

**I. POLICY**

- A. All individuals seen or cared for in the in-patient or outpatient setting of MarinHealth Medical Center who have injuries indicative of intentional injury, neglect, or suspected abuse by use of force, violence, duress, menace, verbal abuse or fear of immediate and unlawful bodily injury or an individual who reports physical, emotional, or fiduciary abuse of another must be taken seriously and responded to in an empathic, nonjudgmental manner.
- B. It is the policy of the Medical Center that each employee is responsible for immediately reporting suspected abuse through the applicable Chain of Command. It is also the policy of the Medical Center that any employee or staff person from the registry or agency accused of patient abuse shall be placed on an immediate paid Administrative Leave of Absence or placed on hold. They may not return to duty until an appropriate investigation of the allegation(s) has been completed. Any employee found to have engaged in patient abuse as defined below, will be subject to immediate termination

**II. PURPOSE**

- A. To provide inpatients and outpatients of all ages with respectful and appropriate care of the patient who requires evaluation and treatment for suspected abuse; and to secure each patient the rights to access protective and advocacy services.

**III. GENERAL INFORMATION**

**A. Background/Scope**

1. All staff at the Medical Center have a responsibility to immediately report any incidents of suspected abuse involving patients, by contacting the appropriate Chain of Command who will assist in contacting Adult Protective Services (APS) or Child Protective Services (CPS), or the appropriate law enforcement agency.
2. State law requires that suspected abuses must be reported verbally, as soon the occurrence has been investigated. An investigation must start immediately upon discovery and a written report must be submitted within thirty-six (36) hours for children and forty-eight (48) hours after discovery for adults. Failure to comply is a misdemeanor. Those reporting are granted specific immunity against civil or criminal litigation.
  - a. Exception: Mandated reporters are required to report facts giving rise to the suspicion of elder or dependent adult abuse, and it is up



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to law enforcement to investigate and determine whether abuse occurred.

3. After contacting their immediate supervisor, staff should contact the Unit Social Worker or the Psychiatric Social Worker to assist with the investigation and contacting of the appropriate agency. The Director/Manager of the Unit or the Administrative Nursing Supervisor must be contacted with information regarding any suspected abuse occurring at the Medical Center (an Internal Event).
4. When a staff member, registry or agency personnel is accused or suspected of patient abuse, the Administrative Nursing Supervisor, or Unit/Department Manager or Director who is on duty at the time of reported abuse must immediately place the employee/agency/registry personnel accused/suspected of possible abuse on Paid Administrative Leave or hold, per the staffing office. The staff member will be allowed to participate in the investigation by giving a statement of the facts as known to them and providing the names of witnesses to the event(s) leading to the allegation. However, the staff member may not return-to-work until such time that the investigation is completed, and they have been absolved of any wrongdoing. Employees who are found to have engaged in any form of patient abuse are subject to immediate termination.
5. Upon receipt of a report of patient abuse, the Chain of Command member receiving the complaint must immediately report the suspected abuse to both the Director of Human Resources and the Risk Manager along with the Director/Manager of the responsible unit (refer to Appendix 1 and 2). These individuals will then be responsible for overseeing the required investigation of any patient abuse allegation.
6. When a positive sign of skin pressure is found during the admission skin assessment/evaluation for the presence of pressure sores, nursing staff must complete a Safety Event Report online and forward to Risk Management as part of the evaluation of possible neglect.

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7. The needs of patients for confidentiality, privacy and security will be respected to the extent necessary to comply with reporting suspected abuse. The disclosure of confidential information will be limited to the extent necessary to comply with the law.
8. This person can expect to be:
  - a. Interviewed and examined
  - b. Treated for their medical, psychosocial, pastoral, and spiritual needs
  - c. Provided with referrals to appropriate local community resources.
9. If the incident occurs during hospitalization, a Safety Event Report (SER) must be filled out and forwarded to Risk Management immediately after completion.
10. Victims of suspected abuse will receive an evaluation of and complete physical examination including neurologic exam; x-rays, if needed; assessment for suicidal ideation; examination of trauma related to sexual abuse/rape; risk of homicide; substance abuse.
11. Adults and children suspected of being victims of sexual assault within the past seventy-two (72) hours will have an examination and evidence collection as soon as possible. For purposes of sexual assault, the definition of a child victim is one less than twelve (12) years of age.
  - a. The examination will be conducted in accordance with the California Medical Protocol for Examinations of Sexual Assault and Child Sexual Abuse Victims. Please refer to Marin County SART Protocol for Sexual Abuse Response Team, located in the Emergency Department, for adults.
12. As part of the SART protocol, physicians and Sexual Abuse Nurse Examiners will offer victims of sexual abuse appropriate prescription preventions for sexually transmitted diseases and pregnancy.
13. A child whose suspected abuse has occurred prior to seventy-two (72) hours may be scheduled for examination at a different time and place

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**Suspected Elder Spousal Partner Child Abuse**

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Department

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Emergency Department/PES

Replaces Document Name (if applicable):

## B. Definitions

1. **Elder Abuse:** abuse or neglect involving individuals 65 years and over, or dependent adults. Dependent adults are patients between 18 and 65 who have physical or mental limitations that restrict their ability to engage in usual and customary adult decision making, protect their own rights, or carry out normal daily life.
2. **Dependent Adult:** a person between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital (refer to Appendix 3 – Elder Abuse Reporting Definitions.)
3. **Spousal or Partner Abuse:** abuse involving any person, or suspected person, who has been abused by his/her intimate partner or former intimate partner. An intimate partner is defined as a husband/wife, ex-husband/ex-wife, boyfriend/girlfriend, ex-boyfriend/girlfriend, lover, or ex-lover.
4. **Child Abuse/Sexual Assault:** any act of omission or commission that endangers or impairs the child's physical or emotional health and development. Child abuse includes physical assault, nutritional neglect, drug abuse (poisoning or drugging), medical care neglect, sexual exploitation, safety neglect, corporeal punishment, and emotional abuse.
5. **Verbal Abuse:** the following responses of victims of verbal abuse show the variety of negative communication that may occur between the patient and another person, including family members, caretakers, and health care staff.
  - a. These responses include being yelled at, nagged at, called stupid (name calling,) talked down to, having appearance ridiculed, embarrassed in public, called names, called racial slurs, told no one else wants me, had constant put-downs, being told that s/he was a bad sex partner, being threatened to be killed, being belittled about accomplishments.
  - b. Patients experiencing verbal abuse may experience withholding of information; jesting, being the recipient of joking or disparaging remarks; being trivialized-made to feel unimportant; being judged or criticized; having the abuser block or divert the patient's interpersonal communication.

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c. Threatening, denial, undermining and ordering. are other types of verbal abuse. The Abuse Counseling and Treatment, Inc. note on their website that all these abusive behaviors prohibit normal, healthy interaction between two adults as well as a lack of respect for individual thoughts, feelings perceptions and values.

6. **Suspected Abuse:** includes, but is not limited to, abuse that is physical, sexual, psychological, or fiduciary in nature, perpetrated by another or self-inflicted.

**C. Responsible Parties**

1. It is the responsibility of all staff members employed by the Medical Center to uphold this policy.

**IV. PROCEDURE**

**A. Key Steps**

1. Identification of Suspected Abuse

a. Be alert to the following ways in which suspected abuse might be identified:

- i. Verbal Report: any report must be taken with all due seriousness. When patient with dementia attest to abuse, it is important to verify by means of interviews with other available sources, such as family members other than the suspected abuser, home care personnel, or friends.
- ii. Physical Examination: patients who present with old fractures or injuries which are unexplained, physical trauma to the anal or genital area, infestations, urine burns, rope-like burns below the diaphragm or wrists, or poor hygiene should be evaluated for possible abuse.
- iii. Emotional Response: patients, who appear to be withdrawn or depressed, show delayed response to injury, state that they are 'accident prone,' and/or demonstrate an exaggerated startle response may well be victims of abuse. Families who minimize injuries, refuse to leave their family member alone with health care personnel, and bring their family member to a medical facility outside of their local community may be attempting to hide an abusive situation.

Document Name:

**Suspected Elder Spousal Partner Child Abuse**

Manual: (check box)

 Med Ctr  
Administrative Med Ctr Clinical Med Ctr  
DepartmentManual Owner Name:  
Emergency Department/PES

Replaces Document Name (if applicable):

- b. For children, be alert to situations surrounding a child, and injuries which arouse suspicion of neglect/abuse (refer to Appendix 4, Appendix 5).
  - c. For adults, be alert to potential criteria for identifying possible victims of domestic violence (refer to Appendix 5). Non-threatening direct questions to ask the patient will aid in identifying these individuals (refer to Appendix 6).
  - d. If patient, family, or staff complains that a staff member or any other person has been verbally, or physically abusive to the patient, this must rise to the level of suspected abuse, neglect, isolation, intentional physical or mental harm.
  - e. If an employee has been suspected of abuse, see:
    - a. "Additional reporting of suspected abuse, internal" (refer to section B, 5).
    - b. Refer to Appendix 1
2. Assessment of Situation
- a. Assess the immediate safety of the victim and/or other potential victims.
  - b. Ask non-judgmental, non-blaming questions (refer to Appendix 7).
  - c. Reinforce to the victim that he or she is not at fault and that no one deserves to be abused.
  - d. Explain to the victim that there is help available.
    - i. Refer patient to appropriate community resources for follow-up and support (refer to Appendix 11 and 12).
    - ii. Give patient Resource List of Community Agencies (refer to Appendix 11 and 12).
3. Reporting Structure:
- a. Internal Reporting Process
    - i. Report immediately to your supervisor all cases of abuse/neglect of patients who have been admitted to the Medical Center, inpatient or outpatient.
    - ii. Staff must contact the Unit Social Worker or the Psychiatric Social Worker assist with the completion of the investigation and forms.
    - iii. Notify the Administrative Nursing Supervisor along with the proper Chain of Command and follow as appropriate (refer to Appendix 1).
    - iv. Make a copy of External Agency Report for medical record.

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**b. External Agency Reports for:**

- i. Children: contact Child Protective Services (DHS agency) by phone number (415-473-7153) immediately and submit written report within 36 hours (refer to Appendix 10).
- ii. Elder and Dependent Adults; contact Adult Protective Services (DHS Agency) by phone number (415-473-2774) immediately and submit written report within 48 hours (refer to Appendix 13).
  - If immediate threat persists, also call local law enforcement agency.
- iii. Spousal and Partner/Domestic Abuse; contact the Marin County Sheriff's Office at phone number (415-479- 2311) immediately then complete and send form. Complete this form "Report of Injuries due to Violations of State Penal Code, Domestic Violence or Violent Action." (refer to Appendix 14).
- iv. Risk Management will report to the California Department of Public Health all cases of known or suspected abuse

**B. Documentation**

1. Document completely on the Abuse Notification form.
2. For suspected abuse occurring in the hospital, make copy of report; the original report goes with the medical record and the copy is sent to Risk Management immediately.
3. Document the suspected abuse/neglect in patient's medical record as appropriate.
  - a. If appropriate, record the law enforcement agency to which the incident was reported; name of person who took report; time report was given.
  - b. Record any referrals made for follow-up care and support
4. Referrals:
  - a. Refer patient to appropriate community resources for follow-up and support (refer to Appendix 11) and give her/him this list of resources.
  - b. Contact appropriate agency when patient consents.
5. Additional reporting for suspected abuse occurring in hospital.
  - a. If an employee is suspected perpetrating abuse on a patient in the hospital, the Department Director and appropriate Human Resources staff will begin the investigation immediately.
    - i. In instances where an employee has been accused of patient abuse, harassment, or other actions that indicate

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that patient safety and well-being may have been jeopardized, any employee accused of such acts will be placed on paid administrative leave during which time an investigation of the allegations, including an interview, will be conducted.

- ii. If following the investigation, the allegation(s) are substantiated, disciplinary action consistent with the facts of the allegation(s) and this policy will then be taken (refer to [EMPREL 5403.00 Disciplinary Procedures](#)).
- b. Physician suspected of perpetrating abuse
  - i. Immediately notify Director/ Admin. Supervisor/designee who will notify department chair and appropriate Chain of Command.
  - c. For any other suspected of perpetrating abuse while in hospital (visitors, other patients, registry employees, etc.) immediately notify Director/Administrative Supervisor/designee and appropriate Chain of Command.
  - d. Appropriate staff in the Chain of Command who will complete a SER and forward to Risk Management immediately, who will investigate all instances of suspected abuse.
  - e. If allegations are confirmed, follow external reporting process.
    - i. Exception: Suspected of known elder ore dependent adult abuse must be reported prior to the facility commencing an investigation
    - ii. Reinforce to the victim that he or she is not at fault and that no one deserves to be abused.
    - iii. Explain to the victim that there is help available

**V. AUTHORITY STANDARDS and REFERENCES**

- A. California Welfare and Institutions Code §15600-15675

**VI. APPENDICES AND ATTACHMENTS**

Appendices and Attachments	Document Title
Appendix 1	Event Notification Procedure for Abuse Policy Algorithm
Appendix 2	Elder Abuse Reporting Definitions
Appendix 3	Manifestations of Abuse - Physical
Appendix 4	Manifestations of Abuse - Physiological
Appendix 5	Indicators of Possible Financial Abuse

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Appendices and Attachments	Document Title
Appendix 6	Situations Surrounding a Child which Arouse Suspicion of Child Neglect/Abuse
Appendix 7	Injuries in Children which Arouse Suspicion of Child Neglect/Abuse
Appendix 8	Criteria to Aid in Identification of Victims of Possible Domestic Violence
Appendix 9	Interviewing Strategies for Patients who are Possible Victims of Domestic Violence
Appendix 10	Resource List of Community Agencies (English)
Appendix 11	Resource List of Community Agencies (Spanish)
Appendix 12	Reporting Requirements for Suspected Abuse, Assault, and Domestic Violence
Appendix 13	Suspected Dependent Adult/Elder Abuse Form
Appendix 14	Suspicious Injury Report Form/ Mandated Reporting Form
Appendix 15	Suspected Child Abuse Report Form

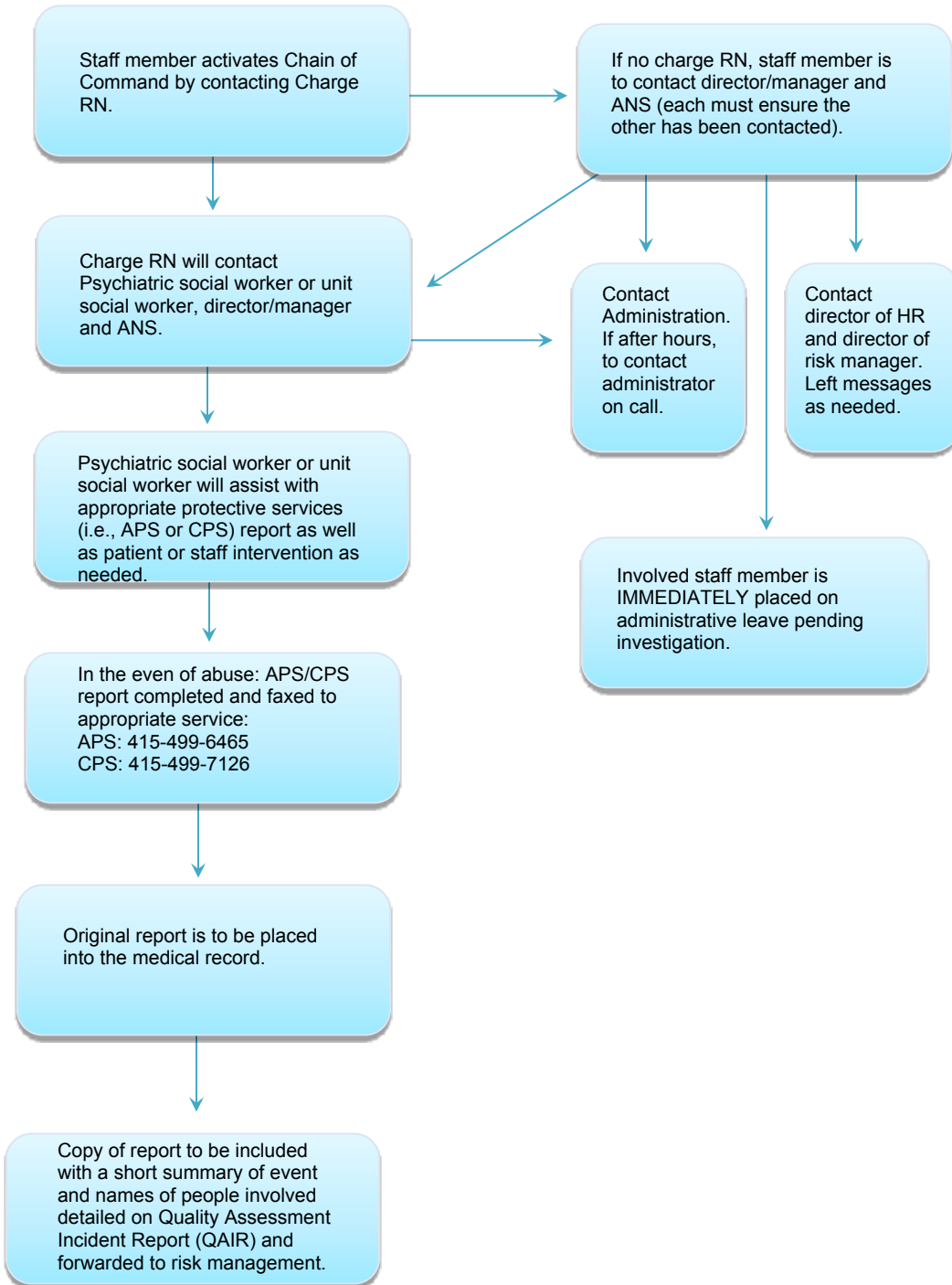
## VII. Subject Matter Experts Reviewers

Department, Committee or Function	Subject Matter Experts Name	Person's Title	Date
Nursing Department	Vicki White	Chief Nursing Officer	03/23/2001
		Medical Executive Committee	02/15/2003
Behavioral Health			04/15/2016
Nursing Directors		Director of Nursing	04/26/2019
Quality/Risk Management		Director Quality /Risk Management	06/05/2008
Emergency Department		Director of Emergency Department	01/28/2019
Behavioral Health	Rebecca Maxwell, LCSW	Director	06/15/2024
Nursing	Anna Rotter, MSN, RN	CN II	09/11/2025

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**Appendix 1: Event Notification Process for Abuse Policy Algorithm**

Please note: This algorithm only applies to suspected abuse within the Medical Center.



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**Appendix 2: Elder Abuse Reporting Definitions**

- A. **Elder:** a person 65 years of age or older.
- B. **Elder abuse:** any one or more of the following acts which are inflicted by other than accidental means on an elder, or on a dependent adult which includes a person between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital, by another person: physical abuse, fiduciary abuse, neglect, or abandonment.
- C. **Physical abuse:** a situation where any person who has the care or custody of, or who stands in a position of trust with, an elder, willfully inflicts upon that elder any cruel or inhuman corporal punishment or injury. Physical abuse includes, but is not limited to, direct beatings, sexual assault, unreasonable physical constraint, or prolonged deprivation of food or water.
- D. **Fiduciary abuse:** a situation where any person who stands in a position of trust with respect to an elder willfully steals the money or property of that elder, or secretes or appropriates the money or property of that elder, to any use or purpose not in the due and lawful execution of his or her trust.
- E. **Verbal Abuse:** negative communication between the patient and another person, including family members, friends, caretakers, and health care staff. It includes being talked down to, being yelled at, and being the recipient of disparaging remarks; being trivialized-made to feel unimportant; being judged or criticized; having the abuser block or divert the patient's interpersonal communication; Other behaviors toward the patient include being threatening, showing denial, undermining, ordering, and withholding information.
- F. **Neglect:** the negligent failure of any person having the care or custody of an elder to exercise that degree of care that a reasonable person in a like position would exercise. Neglect includes, but is not limited to:
1. Failure to assist in personal hygiene, or in the provision of food and clothing for an elder.
  2. Failure to provide the medical care for the physical and mental health needs of an elder. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
  3. Failure to protect an elder from health and safety hazards.
  4. Failure to prevent an elder from suffering malnutrition.
- G. **Abandonment:** the desertion or willful forsaking on an elder person by any person having the care or custody of that elder under circumstances in which a reasonable person would continue to provide care or custody.



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- H. **Isolation:** intentionally restricting communication via mail or phone, false imprisonment or physical restraint for the purpose of preventing the person from meeting with visitors.
- I. **Elder care custodian:** an administrator of a community care facility licensed to care for the elderly, a public assistance worker, a probation officer, a social worker, a licensed home aide, or an employee of an elder care institution including personnel of residential care facilities, skilled nursing facilities, and intermediate care facilities.
- J. **Medical practitioner:** a physician and surgeon, psychiatrist, psychologist, dentist, osteopath, podiatrist, chiropractor, resident, intern, nurse, pharmacist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
- K. **Non-medical practitioner:** a state or county public health employee who treats an elder for any condition, a paramedic, a coroner, a geriatric or family counselor, or a lawyer.
- L. **Elder protective agency:** the State Department of Social Services, a county probation department, a county welfare department, a police or sheriff's department, or a nursing home ombudsman.



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**Appendix 3: Manifestations of Abuse - Physical**

1. Injuries from attempted murder
2. Detached retina
3. Hematoma
4. Decubiti
5. Fractures
6. Choke marks
7. Dehydration
8. Contractures
9. Hypothermia
10. Death/murder
11. Paralysis
12. Dislocation
13. Welts
14. Pain on touching
15. Puncture marks
16. Bruises
17. Scalp injury
18. Gag marks
19. Cigarette burns
20. Rope burns
21. Scratches
22. Cuts
23. Pinch marks



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**Appendix 4: Manifestations of Abuse – Physiological**

1. Suicide
2. Nervous breakdown
3. Depression
4. Fearfulness
5. Anger
6. Confusion
7. Helplessness
8. Hopelessness
9. Severe anxiety
10. Agitation
11. Anger
12. Cowering
13. Isolation
14. Trembling
15. Passivity
16. Implausible stories
17. Denial
18. Responsiveness
19. Mild anxiety
20. Non-responsiveness
21. Ambivalence
22. Deference
23. Obsequiousness

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**Appendix 5:** Indicators of Possible Financial Abuse

1. Power of attorney given or will drawn up when the elder is unable to comprehend the financial situation and is legally incapable of giving a valid power of attorney or does not have testamentary capacity.
2. Unusual interest in the amount of money being expended for the care of the older person; concern that too much is being spent.
3. Refusal to spend money on the care of the elder. Numerous unpaid bills such as overdue rent, utilities, taxes, when someone is supposed to be paying the bills. Utilities are shut off.
4. Recent acquaintances expressing gushy, undying affection for a wealthy older person.
5. Recent change of title of house in favor of a "friend" when the older person is incapable of understanding the nature of the transaction.
6. Caretaker asks only financial questions of the worker, does not ask care questions.
7. Placement not commensurate with alleged size of the estate.
8. Lack of amenities; i.e., TV, personal grooming items; appropriate clothing when the estate can afford it.
9. Housekeeper tries to isolate older person from old friends and family; tells older person no one wants to see him/her; housekeeper gradually gains total control, tells older person, "What would you do without me, and then threatens to leave unless the will is changed in favor of the housekeeper.
10. Promises of life-long care in exchange for willing or deeding of all property/bank accounts to caretaker.
11. Signatures on checks, etc., that do not resemble older person's signature.
12. Checks and other documents signed when older person cannot write.
13. Client complains that used to have money and doesn't anymore.
14. Eviction notice arrives when person thought they owned the house.
15. Client says has been signing papers and doesn't know what they are.
16. Lack of solid arrangements for financial management.
17. Caretaker is evasive about financial arrangements.
18. Implausible stories about the finances of caretaker and/or elder.

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**Appendix 6: Situations Surrounding a Child which Arouse Suspicion of Child Neglect/Abuse**

- A. Circumstances Arousing Suspicion - Characteristic age under 3
1. Parents describe an accident that does not explain the injuries.
  2. Each parent has a different version of the accident.
  3. Parents are vague about the circumstances of the accident.
  4. Parents claim the infant (under 6 months of age) inflicted the injury upon himself.
  5. The parents blame the accident on baby sitter, neighbors, brothers, sisters. In this case, try to speak with this other person.
  6. Parent has waited a significant period of time before reporting the accident.
  7. There are repeated injuries or ingestion of toxins.
  8. Scattered history of many accidents, doctors, moves, or hospitals.
  9. Child appears scrawny, undernourished, dehydrated, severe diaper rash.
  10. Injuries on several surface areas.
  11. Imprint of object on skin, e.g., belt buckle, iron, electrical wire, spoon.
  12. Injuries mostly located on head or face.
  13. Injuries found on physical exam and x-ray, not reported by parents.
- B. Behavior of Child
1. Inappropriate behavior for age group.
  2. Child who is depressed, withdrawn or apathetic, frightened, or suspicious.
  3. Child generally fearful of adults, non-spontaneous, refuses to speak in front of parents.
  4. Dull, vacant stare.
- C. Behavior of Parent
1. When the baby cries, does the mother comfort it – or can she?
  2. If attention is focused on the child, is the parent pleased or uncomfortable?
  3. Are most of the things the parent says about the child negative?
  4. Parents bring child to medical facility for unneeded treatment.
  5. Verbal threats against life of the child made by parents.

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**Appendix 7: Injuries in Children which Arouse Suspicion of Child Neglect/Abuse**

- A.** Injuries to the head
1. Hair pulling
  2. Diagnosis of chronic or spontaneous subdural hematoma
  3. Periorbital ecchymoses
  4. Ruptured tympanic membranes
  5. Acute hyphemia
  6. Dislocated lens
  7. Loosened or missing teeth
- B.** Injuries to the soft tissues
1. Tears in mesentery or small intestine
  2. Bruises in the shape of a hand, finger and thumbprints
  3. Human bites
  4. Broken skin
- C.** Restraint injuries
1. Bruises around the mouth caused by gagging
  2. Blisters or bruises around the ankles or wrists caused by rope or wire
- D.** Burn injuries
1. Glove- or sock-like appearance (from emersion in hot liquid)
  2. Doughnut shape on buttocks (held down in hot liquid)
  3. Pointed or deeper in the middle (hot liquid poured on)
  4. Shape of object (poker, heater, grill, utensil)
  5. Circular lesions (cigarette burns)
- E.** Injuries due to sexual abuse
1. Recurrent vaginitis
  2. Recurrent vulvitis
  3. Anal fissures
  4. Venereal disease Perineal tears

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**F. Neglect**

1. Poor hygiene
2. Acute or chronic diaper rash
3. Pallor suggesting anemia
4. Dullness or height or weight well below normal for age

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**Appendix 8:** Criteria to Aid in Identification of Victims of Possible Domestic Violence

- A. Injuries to the face, neck, throat, chest, abdomen, or genitals.
- B. Evidence of sexual assault.
- C. Pregnant women.
- D. Multiple injuries of various states of healing.
- E. Injuries inconsistent with the patient's history.
- F. Repeated visits/admissions to the hospital, especially in cases of injuries with vague medical, psychosocial, or emotional complaints and unexplained perineal or pelvic pain.
- G. Evidence of alcohol or drug abuse.
- H. Suicidal ideations or gestures.
- I. Feelings of isolation or inability to cope.
- J. Patients accompanied by partners who insist on staying close and answering all suspected questions directed toward the patient.


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**Appendix 9:** Interviewing Strategies for Patients who are Possible Victims of Domestic Violence

Ask the patient direct, non-threatening questions in an empathetic manner. You may find it difficult to ask these questions. However, asking the questions and identifying the individual as battered is the first step toward appropriate treatment.

Examples:

- A. I noticed you have a number of bruises. Could you tell me how this happened? Did someone hit you?
- B. You seem frightened of your partner. Has your partner ever hurt you?
- C. Sometimes patients tell me someone close to them has hurt them. Could this be happening to you?
- D. You mention your partner loses his/her temper with the children. Does he/she lose his/her temper with you?
- E. Have there been times during your relationship when you have had physical fights?
- F. Do your verbal fights ever include physical contact?
- G. Have you ever been in a relationship where you have been hit, punched, kicked, or hurt in any way? Are you in such a relationship now?
- H. You mentioned your partner uses drugs/alcohol. How does your partner act when drinking or on drugs?
- I. Does your partner consistently control your actions or put you down?
- J. Sometimes when others are overprotective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- K. Your partner seems very concerned and anxious. Was he/she responsible for your injuries?

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## Appendix 10: Resource List of Community Agencies (English)


### Agencies for Batterers

Battered Women's Alternative Men's Program	510-676-2968
Community United Against Violence (Gay/Lesbian/Straight)	415-333-HELP (crisis)
Men Overcoming Violence	415-777-4496

### Agencies for Victims

Family Service Agency of Marin County	415-473-3696
Marin Abused Women's Services	415-924-1070
Marin County Adult Protective Services	415-473-2774
Marin County Child Protective Services	415-473-7153
Rape Crisis Center of Marin (24 hours a day)	415-924-2100 (hotline)
S.F. Network for Battered Lesbians & Bisexual Women (24 hours a day)	415-281-0276 415-864-4722 (hotline)
S.F. Woman Inc. (crisis counseling)	415-864-4722
Asian Women's Shelter, S.F. (crisis line)	415-751-7110
La Casa De Las Madres, S.F. (crisis line)	415-503-0500

National Domestic Violence Hotline	1-800-799-SAFE
District Attorney Victim Assistance	415-553-9044
CUAV (battered gay men)	415-777-5500
Immigrant Assistance Line	415-554-2444
Victim Witness	1-800-842-8467
Woman, Inc.	415-864-4722

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## Appendix 11: Resource List of Community Agencies (Spanish)


### Agencias para Abusadores

Programa Alternativo para Hombres de Mujeres Abusadas	510-676-2968
Comunidad Unida Contra la Violencia (Gays/Lesbianas/No Homosexual o Lesbiana)	415-333-HELP (crisis)
Hombres Sobresaliendo Violencia	415-777-4496

### Agencias para Victimas

Agencia de Servicios Familiares del Condado de Marin	415-473-3696
Servicios para Mujeres Abusadas de Marin	415-924-1070
Servicios Protectores para Adultos del Condado de Marin Servicios	415-473-2774
Proctectores para Niños del Condado de Marin	415-473-7153
Centro de Crisis de Violación de Marin (24 horas linea)	415-924-2100 (teléfono directo)
Red de San Francisco para Lesbianas y Mujeres Bisexuales Abusadas (24 horas linea)	415-281-0276 415-864-4722 (teléfono directo)
Incorporación Mujer de San Francisco (Consejeros de crisis)	415-864-4722
Amparo para Mujeres Asiaticas de San Francisco (linea de crisis)	415-751-7110
La Casa De Las Madres, S.F. (linea de crisis)	415-503-0500


Linea de Violación Domestica Nacional	1-800-799-SAFE
Proyecto de Asistencia para Victimas	415-553-9044
CUAV (hombres homosexuales abusados)	415-777-5500
Linea de Asistencia para Inmigrantes	415-554-2444
Testigo de Victima	1-800-842-8467
Incorporación Mujer	415-864-4722

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## Appendix 12: Reporting Requirements for Suspected Abuse, Assault, and Domestic Violence

Report to your immediate supervisor or case manager. This chart is for hospital personnel and medical staff.


Reporting Requirements	Trigger Incident	Report Content	Report to	Time Frame	Required Forms
<b>Abuse of Patients Received from a Licensed Health Facility</b>  Cal. Penal Code 11161.8	Patient received in hospital with physical injury or abuse or self-report.	<b>Describe injury and perpetrator</b> , if known.	Marin County Sheriff Department  <b>Phone:</b> 479-2311 or 499-7233  <u>and</u>  Long-term Care Ombudsman <b>Phone: 499-74461</b> ; Fax 499-6933	Immediate phone call <u>and</u> written report within 2 days.	Mandatory: "Suspected Dependent Adult/Elder Abuse" (form #SOC 341) - Appendix 13  Send to: Marin County Ombudsman 10 N. San Pedro Rd., Ste. 1024 San Rafael, CA 94903
<b>Abuse of Elders and Dependent Adults</b>  Cal. Welfare Institute (WIC) 1560015637	Elders of dependent adults with physical injury or self-report.	<b>Describe injury and perpetrator</b> , if known.	Adult Protective Social Services <b>Phone: 507-2774</b> (24 hrs); Fax 499-6465  If immediate threat persists, also call local law enforcement agency Marin County Sheriff Department  <b>Phone:</b> 479-2311 or 499-7233.	Immediate phone call <u>and</u> written report within 2 days.	Mandatory: "Suspected Dependent Adult/Elder Abuse" (form #SOC 341) - Appendix 13  Send to: Adult Protective Services 10 N. San Pedro Rd., Ste. 1007 San Rafael, CA 94903
<b>Child Abuse</b>  Cal. Penal Code 11164-11174.3	Newborns and children under 18 received with physical injury, <b>including sexual</b> or abuse or self-report	<b>Describe injury and perpetrator</b> , if known.	Marin County Child Protective Services  <b>Phone: 499-7153</b> ; Fax 499-7126  If under age 14 sexual assault exams are done at Children's Hospital in Oakland for acute cases (incident occurred <72 hours).	Immediate phone call to CPS <u>and</u> written report within 36 hrs.  Non-acute cases (>72 hrs.), call Dr. Michelle Perro to schedule an appointment.	Mandatory: "Suspected Child Abuse Report" (form #SS 8572) - Appendix 15  Send to: Child Protective Services 10 N. San Pedro Rd., Ste. 1002 San Rafael, CA 94903  "Medical Report – Suspected Child Sexual Abuse" (form #OCJP 925)

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<b>Adult Violent Injury or Domestic Violence</b>  Cal. Penal Code 11160-11163	Patient with wound or injury or self-report.	<b>Describe injury and perpetrator, if known.</b>	Marin County Sheriff Department  <b>Phone:</b> 479-2311 or 499-7233	Immediate phone call <u>and</u> written report within 2 days.	Report of Injuries Due to Violation of State Penal Code Domestic Violence or Violent Action form  Send to: Marin County Sheriff's Office Civic Center, Hall of Justice, Rm 167 San Rafael, CA 94903
<b>Employee Assault and Battery</b>  AB508/74X	Hospital personnel or medical staff assaulted or injured in hospital.	<b>Describe injury and perpetrator, if known</b>	Hospital Security and Marin County Sheriff Department  <b>Phone:</b> 479-2311 or 499-7233	Immediate notification hospital security and written report within 2 days.	

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Appendix 13: Suspected Dependent Adult/Elder Abuse Form

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California Health & Human Services Agency

California Department of Social Services

**REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE**

Date Completed
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**CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE**  
 TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE.  
 SEE GENERAL INSTRUCTIONS.

**A. VICTIM** -  Check box if victim consents to disclosure of information  
 (Ombudsman use only - WIC 15636(a))

Name (Last Name, First Name)		Age	Date of Birth	SSN
Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other/Nonbinary <input type="checkbox"/> Unknown/Not Provided		Sexual Orientation <input type="checkbox"/> Straight <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Unknown/Not Provided		Ethnicity
		Race		Language (Check one) <input type="checkbox"/> Non-Verbal <input type="checkbox"/> English <input type="checkbox"/> Other (Specify) _____
Address (If facility, include name and notify ombudsman)		City	Zip Code	Telephone
Present Location (If different from above)		City	Zip Code	Telephone
<input type="checkbox"/> Elderly (60+) <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Mentally Ill/Disabled <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Unknown/Other			<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others	


**B. SUSPECTED ABUSER** - Check if  Self-Neglect

Name of Suspected Abuser				
Address		City	Zip Code	Telephone
<input type="checkbox"/> Care Custodian (Type) _____		<input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other _____		
<input type="checkbox"/> Health Practitioner (Type) _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Other Relation _____		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity	Age	D.O.B	
Height	Weight	Eyes	Hair	

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Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		

**C. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.) or concerns about the client's mental health.**

CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

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Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		

California Health & Human Services Agency

California Department of Social Services

**D. REPORTING PARTY** - Check appropriate box if reporting party waives confidentiality to:

All  All but victim  All but perpetrator

Name	Signature	Occupation	Agency/Name of Business
Relation to Victim/How Abuse is Known:	Street	City	Zip Code
Telephone	E-mail Address		

**E. INCIDENT INFORMATION** - Address where incident occurred:

\_\_\_\_\_

Date/Time of Incident(s): \_\_\_\_\_

Place of Incident (Check One):

Own Home  Community Care Facility  Hospital/Acute Care Hospital  
 Home of Another  Nursing Facility/Swing Bed  Other (Specify) \_\_\_\_\_

**F. REPORTED TYPES OF ABUSE** (Check All that Apply):

1. Perpetrated by Others (WIC 15610.07 & 15610.63):
- |   |  |
|---|--|
| a. <input type="checkbox"/> Physical (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication) | e. <input type="checkbox"/> Abandonment          |
| b. <input type="checkbox"/> Sexual  | f. <input type="checkbox"/> Isolation            |
| c. <input type="checkbox"/> Financial   | g. <input type="checkbox"/> Abduction            |
| d. <input type="checkbox"/> Neglect (including Deprivation of Goods and Services by a Care Custodian)                             | h. <input type="checkbox"/> Psychological/Mental |
|   | i. <input type="checkbox"/> Other _____          |


2. Self-Neglect (WIC 15610.57 (b)(5)):
- |  |   |
|--|---|
| a. <input type="checkbox"/> Neglect of Physical Care (e.g. personal hygiene, food, clothing, malnutrition/dehydration) | c. <input type="checkbox"/> Financial Self-Neglect (e.g. inability to manage one's own personal finances) |
| b. <input type="checkbox"/> Self-Neglect of Residence (unsafe environment)   |   |

Abuse Resulted In (Check All that Apply):

No Physical Injury  Minor Medical Care  Hospitalization  Care Provider Required  
 Death  Mental Suffering  Serious Bodily Injury\*  Other (Specify) \_\_\_\_\_  
 Unknown  Health & Safety Endangered

**G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE**  
*(Family, significant others, neighbors, medical providers, agencies involved, etc.)*

Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone

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Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		

California Health & Human Services Agency

California Department of Social Services

**H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE**

(If known, list contact person) If Contact person check

Name		Relationship	
Address	City	Zip Code	Telephone

**I. TELEPHONE REPORT MADE TO**  APS  Law Enforcement  Local Ombudsman  
 Calif. Dept. of State Hospitals  Calif. Dept. of Developmental Services

Name of Official Contacted by Phone	Telephone	Date/Time
-------------------------------------	-----------	-----------

**J. WRITTEN REPORT** - Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury\*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

Agency Name	Address or Fax	<input type="checkbox"/> Date Mailed	<input type="checkbox"/> Date Faxed
Agency Name	Address or Fax	<input type="checkbox"/> Date Mailed	<input type="checkbox"/> Date Faxed
Agency Name	Address or Fax	<input type="checkbox"/> Date Mailed	<input type="checkbox"/> Date Faxed

**K. RECEIVING AGENCY USE ONLY**  Telephone Report  Written Report


1. Report Received By	Date/Time
-----------------------	-----------

2. Assigned  Immediate Response  Ten-Day Response  No Initial Response (NIR)  
 Not APS  Not Ombudsman  No Ten-Day (NTD)

Approved By	Assigned To (optional)
-------------	------------------------

3. Cross-Reported to:  CDPH-Licensing & Cert.;  CDSS-CCL;  Local Ombudsman;  
 Bureau of Medi-Cal Fraud & Elder Abuse;  
 Calif. Dept. of State Hospitals;  Law Enforcement;  
 Professional Licensing Board;  Calif. Dept. of Developmental Services;  
 APS;  Other (Specify) \_\_\_\_\_  
Date of Cross-Report \_\_\_\_\_

4. APS/Ombudsman/Law Enforcement Case File Number
---

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Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		

**REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE  
GENERAL INSTRUCTIONS**

**PURPOSE OF FORM**

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. For purposes of mandatory reporting, **elder** means any person residing in this state who is 60 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 59, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 59 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3). Adults age 60+, however, are eligible for Adult Protective Services (APS). APS can investigate allegations of abuse against them, and if confirmed, offer appropriate services.


**COMPLETION OF THE FORM**

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item D: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

**REPORTING RESPONSIBILITIES AND TIME FRAMES:**

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult immediately or as soon as practicably possible.

**\*Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

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**Reporting shall be completed as follows:**

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, the reporter shall submit a written report to both the LTCOP and the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- In all other instances of abuse that occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) a verbal report shall be made by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within twenty-four (24) hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse or neglect occurred in a state mental hospital or a state developmental center, mandated reporters shall report immediately, but no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency and the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency and to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or confidential Internet report shall be sent to adult protective services or law enforcement within two working days.

**REPORTING PARTY DEFINITIONS**

**Mandated Reporter** (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

**Care Custodian** (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders;

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(g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

**Health Practitioner** (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.


Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, "Report of Suspected Dependent Adult/Elder Financial Abuse".

### **MULTIPLE REPORTERS**

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

### **IDENTITY OF THE REPORTER**

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney

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General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

### FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder (age 65 or older) or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than \$1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder (age 65 or older) or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to \$5,000, or by both imprisonment and fine (WIC Section 15630(h)).

No one, including a supervisor, employer, or lawyer, can excuse a mandated reporter from his or her personal legal duty to report known or suspected abuse. Anyone who attempts to impede or inhibit a mandated reporter from reporting may be prosecuted for a misdemeanor punishable by a fine, imprisonment, or both. Mandated reporters are therefore expected to report any such efforts to law enforcement, as well as any other responsible agency (see Welfare and Institutions Code Section 15630(f) and (h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

### ADULT PROTECTIVE SERVICES ELIGIBILITY


For purposes of eligibility to receive services under the APS program, an elder is defined as anyone residing in this state 60 years of age or older. (WIC Section 15750(b)(2)). As of January 1, 2022, APS agencies can receive referrals and investigate allegations of abuse and provide intervention and case management to any elder 60 years of age or older, and to dependent adults between the ages of 18-59 (WIC Section 15750(b)(1)(A)). Statutes governing mandated reporting have not been affected; accordingly, mandatory reporting still only applies to elders age 65 years and older.

### DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under "Reporting Responsibilities and Time Frames"); and keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

**DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.**

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## Appendix 14: Suspicious Injury Report Form/Mandated Reporting Form

CALIFORNIA EMERGENCY MANAGEMENT AGENCY  
**SUSPICIOUS INJURY REPORT**  
 CalEMA 2-920 (4/1/09)



STATE OF CALIFORNIA

### INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

#### Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	4. SAFE PHONE NUMBER ( )
5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt. - NO P.O. Box)		City	State Zip
6. PATIENT SPEAKS ENGLISH <input type="checkbox"/> Y <input type="checkbox"/> N - Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: _____ Time: <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> Unknown		
8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE - Check here if unknown: <input type="checkbox"/>			
9. PATIENT'S COMMENTS ABOUT THE INCIDENT - Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident.			<input type="checkbox"/> ADDITIONAL PAGES ATTACHED


10. NAME OF SUSPECT - If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY
12. SUSPICIOUS INJURY DESCRIPTION - Include a brief description of physical findings and the final diagnosis.	
<input type="checkbox"/> ADDITIONAL PAGES ATTACHED	

#### Part B: REQUIRED - AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: _____ Time: <input type="checkbox"/> am <input type="checkbox"/> pm	
15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )
18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)		19. AGENCY INCIDENT NUMBER

#### Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )	
22. EMPLOYER'S ADDRESS (Number and Street)	City	State Zip
23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE	
25. HEALTH PRACTITIONER'S SIGNATURE:		26. DATE SIGNED:

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Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		



### Instructions To The Health Practitioner

Penal Code Section 11160 mandates the following regarding suspicious injuries:

- Internal procedures established to facilitate reporting and apprise supervisors and administrators of reports shall be consistent with the reporting requirements of PC Section 11160. The internal procedures shall not require any employee who must make a report to disclose his or her identity to the employer.
- Report suspicious injuries to your local law enforcement agency by telephone **immediately**, or as soon as practically possible.
- Submit the required completed written report to your local law enforcement agency *within two working days of discovering a suspicious injury, whether or not:*
  - The person has expired;
  - The injury was a factor contributing to the person's death; or
  - Evidence of the conduct of the perpetrator is discovered during an autopsy.
- Use this standard form or a form, developed and adopted by another state agency, that otherwise fulfills the requirements of this form, (see "Exceptions to using this form" below).
- Two or more health practitioners with knowledge of a suspicious injury may mutually select a team member to make the telephone report and one written report signed by the selected team member. A team member who knows that the selected team member has not made the telephone call or submitted the written report shall make the report(s).
- No supervisor or administrator shall impede or inhibit the required reporting duties, and no person making a report pursuant to this section shall be subject to any sanction for making the report.

### Exceptions To Using This Form

Other state reporting mandates pre-empt the use of this form to report suspicious injuries, as follows:

Incident	Form	Source of Form
Physical Child Abuse	SS 8572	Call California Department of Justice at (916) 227-3285.
Dependent Adult / Elder Abuse	SOC 341	Online: <a href="http://www.dss.cahwnet.gov/pdf/SOC341.pdf">http://www.dss.cahwnet.gov/pdf/SOC341.pdf</a> or contact your local County Adult Protective Services Dept.
Sexual Assault – Adult*	CalEMA 2-923*	Online: <a href="http://www.CalEMA.ca.gov">www.CalEMA.ca.gov</a> under Plans and Publications or call Cal EMA at (916) 324-9100.
Sexual Assault – Child*	CalEMA 2-925* CalEMA 2-930*	

\*Use these forms to conduct a forensic examination of the victim. Otherwise, use this Suspicious Injury Report form.

### Definitions

**Health Practitioner** – Provides medical services to a patient for a physical condition that he/she reasonably suspects is a suspicious injury as listed below, and is employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.


**Suspicious Injury** – Includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury is by means of a firearm, OR
- Is suspected to be the result of *assaultive or abusive conduct* inflicted upon the injured person.

**Injury** – Shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

**Assaultive / Abusive Conduct** – includes committing, or an attempt to commit, any of the following Penal Code violations:

- |   |   |  |   |
|---|---|--|---|
| <ul style="list-style-type: none"> <li>Abuse of spouse or cohabitant</li> <li>Aggravated mayhem</li> <li>Administering controlled substances or anesthetic to aid in the commission of a felony</li> <li>Assault with a stun gun or taser</li> <li>Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury</li> </ul> | <ul style="list-style-type: none"> <li>Assault with intent to commit mayhem, rape, sodomy, or oral copulation</li> <li>Battery</li> <li>Child abuse or endangerment (including Statutory Rape)</li> <li>Elder abuse</li> <li>Incest</li> <li>Lewd and lascivious acts with a child</li> </ul> | <ul style="list-style-type: none"> <li>Murder</li> <li>Manslaughter</li> <li>Mayhem</li> <li>Oral copulation</li> <li>Procuring any female to have sex with another man</li> <li>Rape</li> <li>Sexual battery</li> <li>Sexual penetration</li> </ul> | <ul style="list-style-type: none"> <li>Sodomy</li> <li>Spousal rape</li> <li>Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure</li> <li>Torture CAL</li> </ul> |
|---|---|--|---|

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Appendix 15: Suspected Child Abuse Report Form



STATE OF CALIFORNIA  
BCIA 8572  
(Rev. 04/2017)

DEPARTMENT OF JUSTICE  
Page 1 of 2

**SUSPECTED CHILD ABUSE REPORT**  
(Pursuant to Penal Code section 11166)

[Print Form](#) [Clear Form](#)


To Be Completed by Mandated Child Abuse Reporters  
PLEASE PRINT OR TYPE

CASE NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

A. REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY	
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS			Street	City	Zip
	REPORTER'S TELEPHONE (DAYTIME)		SIGNATURE		TODAY'S DATE	
B. REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT		<input type="checkbox"/> COUNTY PROBATION		AGENCY	
	<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)		ADDRESS		DATE/TIME OF PHONE CALL	
	OFFICIAL CONTACTED - NAME AND TITLE		TELEPHONE			
C. VICTIM One report per victim	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY	
	ADDRESS		Street	City	Zip	TELEPHONE
	PRESENT LOCATION OF VICTIM		SCHOOL		CLASS	GRADE
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:			TYPE OF ABUSE (CHECK ONE OR MORE):	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> DAY CARE	<input type="checkbox"/> CHILD CARE CENTER	<input type="checkbox"/> FOSTER FAMILY HOME	<input type="checkbox"/> PHYSICAL	<input type="checkbox"/> MENTAL
RELATIONSHIP TO SUSPECT		PHOTOS TAKEN?		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
D. INVOLVED PARTIES	VICTIM'S SIBLINGS		NAME		BIRTHDATE SEX ETHNICITY	
	1.		3.		4.	
	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS		Street	City	Zip	HOME PHONE BUSINESS PHONE
	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS		Street	City	Zip	HOME PHONE BUSINESS PHONE
SUSPECT	SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS		Street	City	Zip	TELEPHONE
	OTHER RELEVANT INFORMATION					
E. INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/> IF MULTIPLE VICTIMS, INDICATE NUMBER: _____					
	DATE/TIME OF INCIDENT		PLACE OF INCIDENT			
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incident's involving the victim(s) or suspect)					

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.

	MarinHealth Medical Center	Policy Number: 1106.01.7	Page 37 of 37
Document Name:	<b>Suspected Elder Spousal Partner Child Abuse</b>		
Manual: (check box)	<input checked="" type="checkbox"/> Med Ctr Administrative	<input type="checkbox"/> Med Ctr Clinical	<input type="checkbox"/> Med Ctr Department
Manual Owner Name: Emergency Department/PES	Replaces Document Name (if applicable):		



STATE OF CALIFORNIA  
BCIA 8572  
(Rev. 04/2017)

DEPARTMENT OF JUSTICE  
Page 2 of 2

## SUSPECTED CHILD ABUSE REPORT (Pursuant to Penal Code section 11166)

### DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8572

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: <http://leginfo.legislature.ca.gov/faces/codes.xhtml> (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).)

#### I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

#### II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

#### III. REPORTING RESPONSIBILITIES

Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof *within 36 hours* of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

#### IV. INSTRUCTIONS

**SECTION A – REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes/no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

#### IV. INSTRUCTIONS (continued)

**SECTION B – REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

**SECTION C – VICTIM (One Report per Victim):** Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

**SECTION D – INVOLVED PARTIES:** Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

**SECTION E – INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

#### V. DISTRIBUTION

**Reporting Party:** After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

**Designated Agency:** *Within 36 hours* of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

#### ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian



Policy Author	QM/ RM
Origination Date	1991
Current Review Date(s)	9/07, 3/10, 3/17
Current Revision Date(s)	1/16, 7/21

**MARINHEALTH MEDICAL CENTER  
HOUSEWIDE ADMINISTRATIVE MANUAL  
ADVANCE HEALTH CARE DIRECTIVE (AHCD)**

**I. POLICY**

MarinHealth Medical Center respects the lawful rights and wishes of patients in their health care decisions. We encourage self-determination, recognizing that all adult (and emancipated minor) hospital inpatients have a right to make medical decisions. These decisions include the right to accept or refuse treatment, and those decisions relating to end of life care. MarinHealth Medical Center respects the needs of patients for confidentiality, privacy and security while addressing the wishes of the patient/agent.

Providers and hospital staff will involve patients/agents in decisions about planned care, treatment, and services while adhering to the terms described in the Advance Health Care Directive (AHCD) document within the limits of the law for both in-patients and out-patients. Unless the document states otherwise, a power of attorney for health care is of unlimited duration (Probate Code Section 4686).

**II. PURPOSE**

The purpose of this policy is:

- A. To acknowledge and further patient rights under the Patient Self-Determination Act (PSDA) (42 U.S.C. Sections 1395cc(f) and 1396 a (w));
- B. To inform patients about the process to submit an Advance Health Care Directive (AHCD) or to receive information about filling out an AHCD;
- C. To elicit patient’s wishes and desires about end-of-life care;
- D. To guide providers and hospital staff in efforts to discover and appropriately document patient’s wishes and desires for the patient’s care and treatment;
- E. To assist patients/agent/Power-of-Attorneys to make medical decisions.

**III. GENERAL INFORMATION**

**A. Background/ Scope**

- 1. Patients and their families can expect that their physicians and hospital staff will involve them in decisions about planned care, treatment, and services.
- 2. Unless the document states otherwise, a power of attorney for health care is of unlimited duration (Probate Code Section 4686).
- 3. The AHCD must pertain only to health care decisions (e.g., Explanation of Power of Attorney for Health Care (PAHC) which may not be combined with general power of attorney pertaining to financial or other matters.)



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4. In the absence of the actual Advance Directive, the patient’s provider and licensed care-givers will document the substance of the directive in the progress notes of the patient’s electronic medical record (EMR).
5. All patient care staff must follow up, to complete AHCD information that was not completed on admission.
6. If patients indicate a desire to appoint an agent, or to have a person make health care decisions on their behalf, the hospital may provide the patient with a copy of the AHCD. The document is available in English and Spanish. (Attachment A).
7. A patient may verbally designate an adult as an “agent” to make health care decisions, by personally notifying his/her primary provider (supervising health care provider).
8. An agent may make all health care decisions for the patient; to the same extent the patient could make such decisions if s/he had the capacity to do so.
9. Restrictions: An agent may not consent to any of the following:
  - a. Commitment to or placement in a mental health facility
  - b. Convulsive treatment
  - c. Psychosurgery
  - d. Sterilization (i.e., procedures performed for the primary purpose of rendering a person sterile)
  - e. Abortion
10. Capacity
  - a. The primary provider is responsible for determining the patient’s capacity, and documenting this in the Medical Record. Upon the patient’s mental incapacity, the AHCD will be reviewed by the patient’s provider, and the patient’s wishes will be incorporated into the patient’s medical treatment plan.
  - b. The supervising health care provider/primary provider shall, if at all possible, advise the patient of any health care decisions that have been made on the patient’s behalf, as well as the identity of the person making the decisions.
  - c. When questions arise regarding the validity of the agent’s directions, or when to invoke the agent, the Chain of Command should be implemented. Staff should contact the Director/Manager, Administrative Nursing Supervisor. The Risk Management or Quality Management Director may be contacted for consultation.
  - f. If the patient has limited English proficiency (LEP), s/he may need assistance to complete the AHCD. Forms are available in Spanish and English. Staff will offer the LEP patient assistance through the Language Line and document this in the EMR.



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- g. Controversial issues or conflicts of interest will be referred to the Bio-Ethics Committee or Legal Counsel for review.
  - h. For those patients who may require additional information about their medical status in order to complete the AHCD, attempts should be made by hospital staff to facilitate communication between the patient and his/her attending provider.
  - i. For patients requesting any additional information about AHCD, or who desire emotional support in dealing with these sensitive issues, a request for Social Worker, Chaplain or Palliative Care Team consultation may be appropriate.
  - j. For Patients who request additional information on making an Advance Directive, staff will provide a copy of “Your Right to Make Decisions About Medical Treatment” available in English or Spanish (Attachment C).
  - k. **Hospital Employees DO NOT witness this document.**
  - l. Notary Service is available 24 hours a day for a nominal fee; contact Spiritual Care for assistance .
11. Clarification: Patients who need further clarification regarding an AHCD should be directed to call their own attorney or, if they do not have one, they should be referred to the attorney referral service (California Bar Association, (866-442-2529).
12. Emergency Exception  
*(i) In an emergent clinical situation, MarinHealth Medical Center staff will provide necessary emergency care, treatment and services to patients who:*
- a. Are unable to give consent.
  - b. Do not have an AHCD copy in their medical record.
  - c. Whose health care agents are not documented or available.
  - d. Staff will make best efforts to contact the agent, document the above process in the medical record and include him/her in the patient’s continuing plan of care.
13. Obligations and Penalties  
 The AHCD shall not be construed to condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. It does not permit any affirmative or deliberate act of omission to end life other than withholding or withdrawing health care pursuant to an advance directive, by an agent, or as otherwise provided, so as to permit the natural process of dying.
14. Penalties may be assessed against an institution or individual provider for negligently violating the Health Care Decisions Law.

**B. Definitions**



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1. Advance Health Care Directive

- a. May authorize another person to make health care decisions for a patient when a patient is no longer able to make decisions for him or herself;
- b. May contain information about a patient’s desires concerning health care decisions, particularly decisions concerning end of life care;
- c. May also designate another person to make health care decisions even if the patient is still capable of making his or her own decisions.

2. Agent

An individual designated in a power of attorney for health care (which is usually a part of the Advance Directive form) to make health care decision for a patient. An agent may include a successor or alternate agent.

3. Capacity

Patient's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant risks, benefits, and alternatives, etc. A patient's capacity may be transient. Decisions made during periods when the patient has capacity remain in effect if the patient loses capacity at a later time.

4. Supervising Health Care Provider

The primary physician, or, if the patient has no primary physician or the primary physician is not reasonably available, the health care provider who has undertaken primary responsibility for the patient's health care.

5. For additional definitions, see Attachment B.

**C. Application**

1. **Patient Access Staff Process**

During the Admitting/Registration process, Staff will:

- a. Ask the patient or the patient’s representative if s/he has an AHCD, and request a copy to include in the patient’s medical record.
- b. Document on the patient’s COA signature page if s/he has an Advance Health Care Directive, the status of MarinHealth Medical Center’s possession of a copy of the patient’s AHCD and if information was provided to patients that do not have an AHCD.
- c. If the ACHD is provided, scan immediately to the EMR.
- d. Send the hardcopy to the HIM Department.
- e. Offer an AHCD form (Attachment A) to patients who are unable to provide a copy of an AHCD, and *Your Right Make Decisions About Medical Treatment* (Attachment C).

**IV. PROCEDURE**



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**A. Key Steps**

1. Unit Clerk Process

- a. Determine if a copy of the AHCD is present in patient’s medical record.
- b. If a copy is present, print a copy for the paper chart.

2. Health Information Management Process

- a. If the paper chart contains an AHCD verify that it is in the EMR.

3. Provider Responsibility

- a. When the provider interviews the patient, s/he will inquire about the presence of the AHCD. If a copy exists in the chart, s/he will write appropriate orders on the MD order sheet.
- b. If there is no AHCD present, the provider will ask the patient/representative’s wishes and desires regarding intensity of treatment. The provider will then complete the appropriate orders on the **‘Physician Order Sheet, Patient Code Status Form.’** (Attachment D).
- c. Should the patient suffer an acute episode of illness and/or require transfer to a more intensive level of care, the primary provider will review the patient’s current wishes and desires and document the discussion and outcome in the EMR on progress notes and on the Physician’s order sheet as appropriate.

4. Nursing/Clinical Care Staff Responsibilities

- a. The admitting/patient care RN and other licensed caregivers will show ongoing efforts to follow up and complete documentation of AHCD information in the Patient’s EMR. Any changes in a patient’s wishes or desires including change of agent will be communicated to the primary provider and other members of the patient care team (i.e., Case Managers, Social Workers, Physical Therapists and Respiratory Therapists) using the Intensity of Treatment Sticker (Attachment E).
- b. The Intensity of Treatment Physician Orders will be placed in the front of the patient’s charts as necessary.
- c. Patient care staff will document ongoing efforts to secure a copy of the patient’s AHCD for his/her Medical Record.
- d. The admitting nurse will use this information to interview the patient while completing the admission process.

**V. AGE SPECIFIC CONSIDERATIONS**

This policy applies to persons age 18 and older; as well as emancipated minors.

**VI. EQUIPMENT**

Not Applicable



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**VII. APPENDICES AND ATTACHMENTS**

Appendices and Attachments	Title
Attachment A	Definitions
Attachment D	Advance Health Care Directive- Spanish
Attachment E	Your Right to Make Decisions About Medical Treatment- English
Attachment F	Your Right to Make Decisions About Medical Treatment- Spanish

**VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION:**

REFERENCES:

Consent Manual 2015

ORIGINATORS AND AUTHORS:

Patient Access Department

Date: 1991

REVISED BY:

Patient Safety Coordinator

Date: 7/27/2021

APPROVED BY:

Director Quality Management	Date: 8/9/2021
Spiritual Care	Date: 8/24/2019
Nursing Directors	Date: NA
Pharmacy and Therapeutics Committee	Date: NA
Policy & Procedure Committee	Date: 09/16/2021
Medical Executive Committee	Date: 3/15/2004
Quality & Patient Safety Committee	Date:
Hospital Board of Directors	Date:



Policy Author	Quality Management
Origination Date	03/02
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Current Revision Date(s)	03/12, 03/16, 04/22

**MARINHEALTH MEDICAL CENTER  
HOUSEWIDE ADMINISTRATIVE MANUAL  
INTERPRETING, TRANSLATION AND LANGUAGE ACCESS SERVICES**

**I. POLICY**

- A. MarinHealth Medical Center will take reasonable steps to ensure that patients with Limited English Proficiency (LEP), deaf or hard of hearing patients, patients who are visually impaired, and patients with speech difficulty, have meaningful access and an equal opportunity to participate in the Medical Center services, activities, programs and other benefits. All interpreters, translators and other aids needed to comply with this policy will be provided without cost to the person being served.
  
- B. Language assistance will be provided through use of video interpretation services, telephonic interpretation services, competent bilingual staff, or staff interpreters. At minimum, Telephonic (and some video) language interpretation will be available 24-hour a day, along with video sign-language interpretation.
  
- C. The Medical Center will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures annually.

**II. PURPOSE**

- A. To ensure the provision of culturally appropriate care and equitable access to all services offered by the Medical Center to LEP patients, deaf or hard of hearing patients, patients who are visually impaired, and patients with speech difficulty.
  
- B. To meet State of California, Federal and accrediting agency requirements for the provision of language and/or communication assistance to all LEP and hearing- and vision-impaired persons as necessary for effective communication in connection with the health care plan and treatment rendered by the Medical Center.

**III. GENERAL INFORMATION**

**A. Background/ Scope**

- 1. Language and communication assistance will include:
  - a. Language interpretation services for LEP individuals;
  - b. Sign language interpretation services for hearing impaired individuals;

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- c. Written translation of standard treatment and consent information in Spanish and other languages as indicated;
- d. Patient room telephone equipment with flashing lights signifying ring, volume control, and large print number/letter pads for communication assistance for persons with vision impairment; and
- e. Telecommunications Device for the Deaf/TeleTYpe (TDD/TTY) equipment in designated areas and also available on request.

**B. Definitions**

1. Translation: Conversion of written text from one language to another.
2. Interpretation: Conversion of the spoken word from one language to another.
3. Limited English Proficient (LEP): Individuals whose preferred language of communication is not English, and who have limited ability to read, write, speak or understand English.
4. Language Barriers: Spoken language barriers experienced by individuals who are limited English-speaking or non-English speaking.
5. Communication Barriers: Impediments experienced by individuals who are deaf and whose primary language is sign language, or those persons with vision impairment.
6. Interpreter: An individual who mediates spoken or signed communication languages between people speaking different languages without omitting, adding, or distorting meaning or editorializing. **Employees and contract interpreters must be certified for Basic or Medical Interpretation to serve as interpreters for individuals.**
7. Certified Basic Interpreter: Staff member who speaks the language fluently, has some knowledge of basic medical terminology, and is certified via the Education Department. This staff member may be used for interpreting that does not include medical dialogue regarding health condition or symptoms, diagnosis, treatment, or discharge instructions.
8. Certified Medical Interpreter: Staff member who is able to speak the language fluently, has a command of medical terminology, reads and writes the language, and is certified via the Education Department. The Certified Medical Interpreter can interpret direct dialogue regarding health conditions or systems, treatment, diagnoses or discharge instructions, but cannot provide written translation.
9. Preferred Language: The language that an LEP individual identifies as the language they use to communicate effectively and would prefer to use to for discussing healthcare.

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## IV. PROCEDURE

### A. Key Steps

1. Identifying LEP Individuals and Language Assistance Needs
  - a. Registration staff will document the preferred language of every patient in the Electronic Medical Record (EMR).
  - b. Nursing will document the presence of hearing or vision impairment during their initial assessment (and update as needed).
  - c. It is the responsibility of the individual/department scheduling the patient to determine if and when an interpreter is needed or required, and to provide access to a Certified Medical Interpreter in the most appropriate manner.
  - d. Patients are encouraged to not utilize their relatives to serve as medical interpreters.
2. Utilizing Language Assistance Measures
  - a. Obtaining a Qualified Interpreter
    - i. If an interpreter is requested, MarinHealth Medical Center staff should utilize a certified interpreter in the needed language.
    - ii. Qualified Telephone Interpreters are available through an approved vendor service. Call PBX (dial 0) to request an interpreter.
    - iii. Video Interpreters (iPad) are available in all clinical units, providing qualified interpretation in multiple languages including Spanish and American Sign Language. Use is recommended in situations where a headset or speaker is not ideal. If a speakerphone is to be used, special precautions should be taken to ensure the patient's privacy and confidentiality of medical information are upheld.
    - iv. In-person interpreter services for LEP persons are available through certified, volunteer employees on an as-needed basis, as employees are available and willing to serve. A list of MarinHealth Basic and Medical Certified Employee Interpreters is available on the MarinHealth Intranet, maintained by the Education Department. The list includes the name, certified language, phone number, and hours of availability of bilingual staff.
    - v. Communication regarding basic instructions in activities of daily living (ADLs) or demographic data can be provided by non-certified bilingual employees. Non-certified employees will not be utilized as interpreters for health care/medical interpretation unless a clinical emergency arises and certified interpreter services are not immediately available.
    - vi. Family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an



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interpreter at no charge has been made by the facility. Such an offer and the response will be documented in the person’s EMR.

- vii. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.
- viii. Minors (children under 16 years of age) will not be utilized as interpreters by MarinHealth Medical Center, consistent with state law, in order to ensure confidentiality of information and accurate communication.
- b. Refusal of Offered Interpreter Services
  - i. Any refusal of the offered interpreter services will be documented in the medical record. Such documentation will include the name of the person serving as an interpreter at the patient/family/representative’s request, and their relationship to the patient or patient’s representative.
  - ii. In the event of disagreement between staff/provider(s) and the patient/family/representative regarding use of designated translator, the MarinHealth language interpretation services will be utilized.
- c. Translation of Written Materials
  - i. MarinHealth will provide written patient education information for common procedures in several languages.
  - ii. When pre-approved translated materials are not available, oral interpretation of vital documents is the preferred first response. Staff should not provide materials sourced through the internet that have not been validated for accuracy.
    - 1) If oral interpretation of written materials is provided, the staff member attending the patient will note the following in the EMR: “[In-Person Interpreter name or language interpretation services identification number] has read the foregoing document to [insert patient’s or patient’s representative’s name] in [identify language]. [Patient or patient’s representative] has acknowledged their agreement of the contents of the document by signing the document in my presence”
    - 2) The statement should then be signed and dated by the staff member.



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- d. Communication Assistance and Interpreter Services for the Hearing Impaired
  - i. Spanish and American Sign Language contractors are available through Video Interpreters (iPad), available in all clinical units, 24 hours a day, 7 days a week.
  - ii. Non-certified employees with sign language capabilities may only be utilized to communicate basic instructions or obtain demographic data in ADLs.
  - iii. In-person sign-language interpretation:
    - 1) In-person sign-language interpretation from a contracted service may be provided in specific pre-approved cases, where video interpreters do not meet the specific needs of a patient. In this situation, the contracted interpreter will be provided and paid for by MarinHealth. This should be requested at least 24 hours in advance, whenever practical, in order to ensure MarinHealth can procure an interpreter.
    - 2) Individuals may request to use their own sign language interpreter. The Medical Center will determine if the patient-designated interpreter is willing and able to provide effective communication, and if use of that interpreter is appropriate to the situation. Minors under 16 years of age will not be utilized as interpreters by MarinHealth Medical Center.
    - 3) Staff is encouraged to identify the questions and information required to communicate with the patient and/or representative prior to the arrival of the interpreter to ensure effective and efficient utilization of interpreter services.
    - 4) Staff will record the name of the interpreter and source / interpreter number in the patient's EMR.
  - iv. MarinHealth Medical Center IT Telecommunications maintains TDD or TTY units, and will use its best efforts to make available, upon request, a TDD or TTY telephone for individuals who are hearing impaired. TTY units allow a written message over the telephone. Information regarding the services available for the hearing impaired, including how to access the nearest TDD or TTY services, will be given to patients who are hearing impaired upon registration/admission and upon request.
  - v. Phones with flashing handsets and volume control dials are available from IT Telecommunications. Phones with large print key/number pads are available on request from IT.
  - vi. Televisions located in the main Hospital are equipped with Closed Caption features. This feature can be activated by contacting the on-



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duty Engineer, who can program specific televisions into the Closed Caption mode.

- e. Assistance for the Visually Impaired
  - i. Verbal health care plan and treatment instructions will be provided by staff or through audio instructions when appropriate. Patient/family/representative will be provided with written documentation.
  - ii. Consents, forms, and other information will be read to the patient or their representative, as appropriate. The patient/family/representative should sign the selected form if they agree to the terms and conditions that the staff member verbally stated.
    - 1) The staff will document this has been done. Such as the following: “I have accurately and completely read the foregoing document to (insert patient’s or patient’s representative’s name). They orally stated that they understood all of the terms and conditions and acknowledged their agreement by signing the document in my presence.”
  - iii. If appropriate, staff may enlarge written materials for the visually impaired patient/family/representative using an onsite copy machine.
- f. Discharge Materials
  - i. All pre-printed/written discharge instructions and medication instructions will be provided and reviewed with the patient/family/representative by the nurse in the patient’s preferred language using the appropriate language assistance tools. Discharge Instructions will include name, location, appointment date, time, and phone number of the referral provider for follow-up care. Documentation that the LEP patient received instructions in their preferred language will occur in the EMR.
  - ii. If the paper Downtime Language Log was utilized, the RN/staff will retain the original Language Log in the paper chart and forward the yellow copy of it to the Quality Management Services Department. Unit Managers/Directors, Case Managers and Administrative Supervisors will assist the Charge RN/Patient Care RN with this process if needed.
- g. Patient Surveys
  - i. MarinHealth utilizes a 3<sup>rd</sup> party vendor to facilitate patient feedback consistent with CMS standards for publicly reported patient survey data (i.e. HCAHPS and OAS CAHPS), as well as outpatient areas. The 3<sup>rd</sup> party vendor provides patient surveys in both English and Spanish.

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- h. Documentation Requirements
  - i. The patient’s or patient representative’s communication needs will be recorded in the EMR, including preferred language for healthcare discussion. Staff should refer to this data source and review communication preferences with the patient to ensure appropriate provision of language services.
  - ii. Interpreter information will be documented in the EMR each time an interpreter is used, except for ADLs and demographic collection. Document the interpreter’s name/relationship/phone number or the language interpretation services operator’s name/certification number, date and time of use in the EMR.
  - iii. All conversations regarding consent, teaching, diagnoses, medications, procedures, options and discharge instructions should be interpreted in the individual’s preferred language and documented completely in the EMR.
  - iv. Any verbal translations of consents, forms, and other information for the visually impaired will be documented with the following language in the EMR, such as:
 

“I have accurately and completely read the foregoing document to *(insert patient’s or patient’s representative’s name)*. They orally stated that they understood all of the terms and conditions and acknowledged their agreement by signing the document in my presence.”
  - v. Any refusal of the offered interpreter services will be documented in the medical record. Such documentation will include the name of the person serving as an interpreter at the patient/family/representative’s request, and their relationship to the patient or patient’s representative.
  - vi. Receipt of discharge instructions in LEP patient’s primary (non-Spanish) language will be documented in the EMR.
- 3. Providing Notice to LEP Persons
  - a. The Medical Center will inform LEP persons of the availability of language assistance, free of charge. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, ambulance bay, admitting/registration area, hospital main entrance, and outpatient areas.
- 4. Monitoring Language Needs and Implementation
  - a. On an ongoing basis, the Medical Center will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, the Medical Center will regularly assess the efficacy of these procedures, including

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but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, and feedback from patients.

5. Training of Staff
  - a. All new employees of MarinHealth Medical Center will be provided in-service training on the Interpreter Services, and the procedures to be utilized when providing language assistance.
  - b. Annual training will be provided to all MarinHealth Medical Center employees as necessary to ensure adherence to the policy, including appropriate documentation.
  - c. MarinHealth Medical Center will take appropriate action if there is observed failure of any of its personnel to follow HHS/OCR Guidelines and adhere to this policy.
  
6. Resolution of Patient Complaints
  - a. Patients have the right to file a complaint regarding the provision of language assistance services. Notices posted in the Emergency Room, the Admitting Areas, the Main Entrance and in outpatient areas will inform patients of MarinHealth Medical Center’s internal complaint resolution procedure. The notices will also advise persons that complaints regarding interpreter services may be directed to the California Department of Public Health (CDPH) and will include the department’s address and telephone number, including its TDD number for the hearing impaired.
  - b. MarinHealth Medical Center will ensure that its patient grievance procedure includes the right to be heard and not denied access to any care or services (See Policies # 1107.15 Patients’ Rights and Responsibilities, # 1107.13 Patient Compliments Complaints and Grievances.) The notices will also advise patients of how to file a complaint with the appropriate government agency regarding the provision of language assistance services to LEP persons or communication assistance to persons who are hearing or visually impaired.
  
7. Monitoring of Language Assistance Policy
  - a. This policy will be reviewed every three years, at a minimum and updated as necessary.
  - b. The Quality Management Services Department will review completed interpreter services surveys on a periodic basis to assess the adequacy of interpreter services and related user satisfaction.
  - c. Quality Management Services may also review medical record Language Log documentation on a periodic basis to assess the adequacy of documentation.



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- d. Revisions will be made to the Policy as necessary to ensure that LEP persons with hearing and visual impairments have meaningful access to services provided by MarinHealth Medical Center.

**V. AGE SPECIFIC CONSIDERATIONS NA**

**VI. EQUIPMENT**

- A. Interpreter on Wheels (iPad)

**VII. APPENDICES AND ATTACHMENTS NA**

**VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION**

**A. Authority/ Reference**

1. Title VI of the Civil Rights Act of 1964
2. California Hospital Association Consent Manual, 2023
3. Health and Safety code, Section 1259
4. Health and Human Services/Office of Minority Health, Cultural and Language Access Service (CLAS) standards, 2022
5. Office of Civil Rights Policy Guidance December 5, 2001
6. Federal Register Volume 68 No. 153/August 8, 2003

**B. Originators and Authors**

Department or Function	Name	Title	Date
Originating Departments Quality Management Services	Unknown	Unknown	03/2002
Latest Authors Patient Experience	Anna Sellenriek, MBA	Exec Dir Patient Exp.	04/25/2024

**C. Reviewed or Revised By**

Department, Committee or Function	Subject Matter Experts Name	Title	Date
Education Patient Relations	Danielle Shockey, MSN, RN Joanie Bettencourt	Educator Supervisor, Patient Relations	01/2022 5/13/2024
Quality, Population Health, Complex Care	Leigh Burns, RDN, CDCES	Manager, QIP Programs and Complex Care	4/2022
Patient Safety	Colette Hall, BSN, RN	Patient Safety Coordinator	05/14/2024



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**D. Approved By**

Department, Committee or Function	Name	Title	Date
Pharmacy & Therapeutics Committee	NA		NA
Nursing Directors	NA		NA
Policy & Procedure Committee	Lillian Chan, FACHE	Chair, Polices & Procedures Committee	05/16/2024
Medical Executive Committee	Kirsten Jennifer Voss, MD, Chief of Staff	Chair, Medical Executive Committee	06/20/2022
Quality & Patient Safety Committee	Adam Nevitt, MD	Chair, Quality & Patient Safety Committee	06/28/2022
Hospital Board of Directors	Andrea Schultz	Chair, Hospital Board of Directors	08/02/2022



<b>Originated By</b>	Behavioral Health/ Risk Management
<b>Origination Date</b>	10/02
<b>Current Review Date(s)</b>	3/03, 1/05, 4/10,
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**MARINHEALTH MEDICAL CENTER**  
**HOUSEWIDE ADMINISTRATIVE MANUAL**  
**PATIENT CONFIDENTIALITY AND COMMUNICATIONS WITH LAW**  
**ENFORCEMENT**

**I. POLICY**

MarinHealth Medical Center, in order to comply with the Health Insurance Portability and Accountability Act ("HIPAA) (45 C.F.R. Part 160 et seq.), and other state and local laws, is required to ensure that patient privacy, confidentiality and security are maintained and patient rights are ensured.

**II. PURPOSE**

To communicate MarinHealth Medical Center’s policy regarding patient confidentiality and communications with law enforcement.

**III. GENERAL INFORMATION**

**A. Background/ Scope**

When patients are admitted to the Hospital for medical clearance, services or diagnosis prior to being arrested and/or placed in custody, it is the policy of MarinHealth Medical Center that patient information will not be released or disclosed in writing or orally without expressed patient consent.

**B. Definitions**

1. Patient Information Includes

- a. The status or condition of the patient
- b. Medical record information regarding the services provided to the patient
- c. Patient welfare
- d. Protected health information, which includes identifying patient health information as defined in HIPAA
- e. Medical diagnosis
- f. Discharge date and/or time

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#### IV. PROCEDURE

- A. If a patient is brought to MarinHealth Medical Center and law enforcement states that the patient is in custody, law enforcement must assume responsibility for that patient by providing appropriate personnel to guard the patient.
- B. If law enforcement arrives at MarinHealth Medical Center with the intent to arrest an in-patient, staff may request legal documentation. In all cases, police may complete searches only if the warrant states finding a probable cause and specifically describes the person and the procedure to be performed. Proper documentation in the form of an arrest warrant or documentation from the court must be provided prior to law enforcement taking the patient into their custody.
- C. MarinHealth Medical Center may only provide patient information to law enforcement when a patient is admitted under law enforcement physical custody and remains in that custody until discharge.
- D. The Allowable HIPAA Disclosures to Police Enforcement Are:
  - 1. Information that is needed to determine if the law was violated by someone other than the victim, including crimes committed on the premises.
  - 2. Disclosure that will ensure immediate enforcement of the law.
  - 3. The physician determines the disclosure is in the best interests of the patient
  - 4. The disclosure is limited to that which is necessary for the investigation.
- E. Patient identity and location may be disclosed to law enforcement when the patient has been identified as the victim of crime and with expressed consent, when responsive, and/or the patient requests to speak to law enforcement.
- F. Certain circumstances allow disclosure when the patient has been identified as the perpetrator. One must always keep in mind to use their professional judgment and to give only the "minimum necessary" information.
- G. If law enforcement releases the patient from physical custody during the patient's stay in the Hospital, it is the policy of MarinHealth Medical Center not to provide law enforcement with patient information without the patient's consent.
- H. In the Special Circumstances of 5150 Holds:
  - 1. At the time of discharge, the licensed caregiver providing care during the 72-hour evaluation and treatment, or his or her designee, shall notify the designated law enforcement agency as specified on the 5150 form, see 'Notifications To Be Provided To Law Enforcement Agency' on 'Application for 72 Hour Detention for Evaluation and Treatment' Form.
- I. MarinHealth Medical Center staff may share relevant treatment information for patients participating in other mental health programs who sign the 'Participation Agreement and Release of Information' Form.

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**V. AGE SPECIFIC CONSIDERATIONS NA**

**VI. EQUIPMENT NA**

**VII. APPENDICES AND ATTACHMENTS**

Appendices and Attachments	Title
Attachment A	Application for up to 72 Hour Assessment, Evaluation, Crisis Intervention or Placement for Evaluation and Treatment DHCS 1801

**VIII. AUTHORITY, REFERENCES, RELATED POLICIES, AND APPROVAL:**

**A. Replaces:** NA

**New Title:** NA

**B. Authority/ Reference**

1. HIPAA 45 C.F.R. Part 160 et seq.
2. W & I Code Sections 5152.1 and 5152.2
3. W & I Code Section 8102
4. California Hospital Consent Manual, 2021 edition

**C. Originators and Authors**

Department or Function	Name	Title	Date
Originating Departments			
<ul style="list-style-type: none"> <li>• Risk Management</li> <li>• Behavioral Health</li> </ul>	NA	<ul style="list-style-type: none"> <li>• Director Risk Management</li> <li>• Director</li> </ul>	<ul style="list-style-type: none"> <li>• 01/2003</li> <li>• 9/29/2003</li> </ul>
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**D. Reviewed or Revised By**

Department, Committee or Function	Subject Matter Experts Name	Title	Date
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<b>Originated By</b>	Behavioral Health/ Risk Management
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Department, Committee or Function	Subject Matter Experts Name	Title	Date
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Risk Management	Joan McCready, RN	Interim Risk Manager	7/19/2021

**E. Approved By**

Department, Committee or Function	Name	Title	Date
Nursing Directors	NA		
Pharmacy and Therapeutics Committee	NA		
Policy & Procedure Committee	Lillian Chan, FACHE	Chair, Policy & Procedure Committee	5/19/2022
Medical Executive Committee	Kirsten Jennifer Voss, MD	Chair, Medical Executive Committee	06/20/2022
Quality & Patient Safety Committee	Adam Nevitt, MD	Chair, Quality & Patient Safety Committee	06/28/2022
Hospital Board of Directors	Andrea Shultz	Chair, Hospital Board of Directors	08/02/2022