

# Bartlett Regional Hospital

**BOARD OF DIRECTORS  
Agenda  
March 24, 2015  
Administration Boardroom**

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**Mission Statement**

**Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.**

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**I. ROLL CALL**

**II. PUBLIC PARTICIPATION**

**III. SPECIAL ORDER OF BUSINESS**

- Quality presentations (see handout)
- HQC Quarterly report (Pg. 3)

**IV. APPROVAL OF MINUTES from February 17, 2015 (Pg. 13)**

**V. OLD BUSINESS**

- CERNER update – Jane Sebens

**VI. NEW BUSINESS**

**VII. COMMITTEE REPORTS:**

**A. STANDING COMMITTEE REPORTS**

1. Executive Committee – Bob Storer (no meeting held)
2. Finance Committee – Linda Thomas (Pg. 18)
3. Hospital Quality Council – Mark Johnson
  - A. Process Improvement Plan (Pg. 20)
  - B. Medical Staff Process Improvement Plan (Pg. 43)
  - C. Risk Management Plan (Pg. 48)
  - D. Infection Control Plan (Pg. 54)
  - E. Utilization Review Plan (Pg. 61)
  - F. Environment of Care Plan (Pg. 67)
4. Planning Committee – Lauree Morton (no meeting held)
5. Bartlett Foundation – Bob Storer
6. Rainforest Recovery Center – Alex Malter (no meeting held)

**B. AD HOC COMMITTEE REPORTS**

- CAMHU update – Mark Johnson/Chuck Bill (informational)

**VIII. MANAGEMENT REPORTS**

- CEO – Mr. Bill (Pg. )

**IX. PRESIDENT’S REPORT**

**X. EXECUTIVE SESSION**

- A. Medical Staff report (Pg. 92)
- B. Rules & Regulation changes
  - Medical Records (Pg. 94) (approval required)
  - Medical Staff Committees (Pg. 95) (approval required)
- C. Union negotiation update – Ms. Cosgrove

**XIV. APRIL BOARD CALENDAR (Pg. 96)**

**XV. BOARD COMMENTS AND QUESTIONS**

**ADJOURNMENT**

# Hospital Quality Council

## Quarterly Report to the Board of Directors

Reporting on  
4<sup>th</sup> Quarter (Oct-Dec) 2014  
Activity

# Patient Satisfaction Update

- **Complaints**

- Trends:

- **Billing:** prices are too high
- **Pain Management:** ED physicians are unwilling to prescribe pain medication

- Noteworthy:

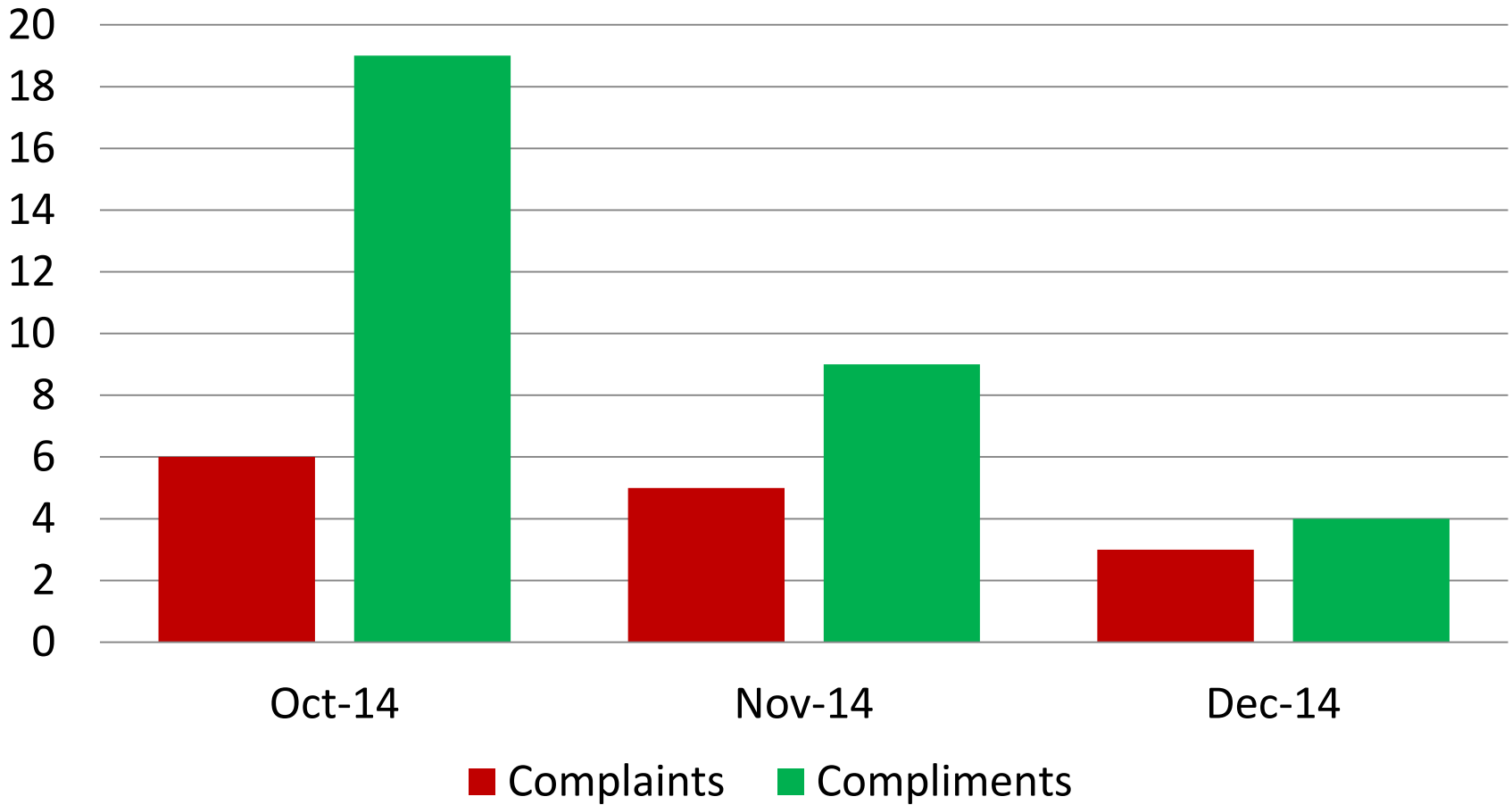
- **Communication of test results:** mammogram results mailed to patient prior to provider contacting patient

- **Compliments**

- Trends:

- Overall care
- Medical-Surgical Unit
- Medical Staff
- Mental Health / RRC
- Surgical Services

# Patient Satisfaction Update



# Patient Satisfaction Update

- Patient Surveys
  - **Trends:**
    - Outpatient areas: Arrival experience
    - Inpatient areas: Discharge experience
  - **Action:**
    - Identify PI teams to address patient Arrival and Discharge experiences
  - **Noteworthy:**
    - 4Q: 5 of 10 domains  $\geq 90^{\text{th}}$  percentile
    - “Responsiveness of Staff” (97<sup>th</sup> percentile)
    - “Communication with Doctors” (95<sup>th</sup> percentile)
    - “Rate the Hospital 0-10” (28<sup>th</sup> percentile)
    - “Recommend the Hospital” (23<sup>rd</sup> percentile)

# Quality Update

- Core Measures
  - 2015 changes to the IQR, HOQR and IPPS payment programs include:
    - **BRH 2015 Measure Sets:** STK, VTE, IMM, EED, OPT (7), HBIPS
      - **New:** HBIPS
      - **Retired:** AMI, SCIP, HF, PN
  - **Focus Area:** major improvement efforts for HBIPS Measures underway
  - **Upcoming:**
    - **Meditech 6.1:** hardwiring documentation of required elements
    - **e-Submission:** anticipating that this will be required soon for clinical quality measures

# Quality Update

- Multidisciplinary Process Improvement Efforts
  - **Ongoing:**
    - Hand Hygiene, Restraint Safety, Staff Flu Vaccination, Clinical Alarm Fatigue, RN-Managed SQ Insulin Protocol, Off-Hours IV Mixing, HBIPS Improvement, RN-Managed IV Sedation
  - **New:**
    - Patient Satisfaction (Arrival and Discharge)
  - **Resurrected:**
    - Falls Prevention
  - **Decommissioned:**
    - Ebola Preparedness



# Quality Update

- Medical Staff Process Improvement Efforts
  - **MSQIC:**
    - Building OPPE software for ongoing monitoring of physician quality metrics
  - **Credentials Committee:**
    - Initial FPPE (proctoring) for non-procedural privileges
  - **PHWC:**
    - Policy and procedure to address immediate concerns for physician impairment or substance abuse

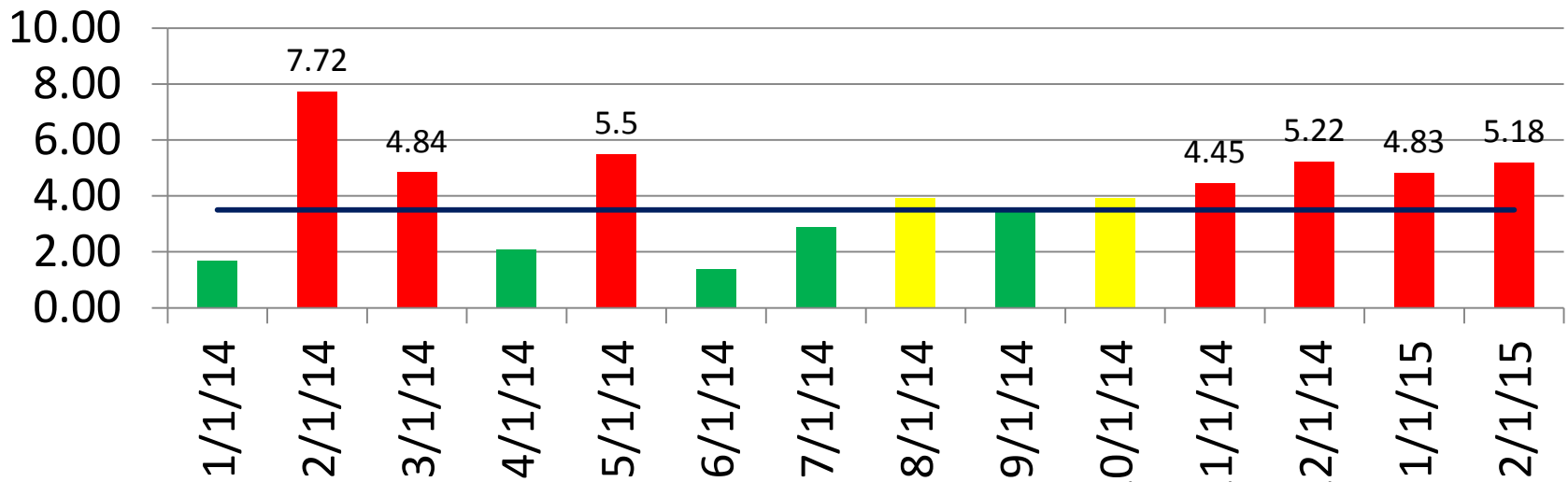
# Risk / Regulatory Update

- Joint Commission / CMS Readiness
  - Expect survey late-June or early-July 2015
    - 1-day survey
    - 4 surveyors
  - Preparation
    - Tracer activity (“mock surveys”) underway in high-risk areas
    - Leadership and staff education activities for interacting with surveyors and preparing their units for survey
    - Day-of-survey plans and documents

# Risk / Regulatory Update

- Occurrence Report Trends
  - Patient falls are steadily increasing
    - Falls *with injury* are not increasing
  - **Action: Resurrecting “Falls Prevention Team”**

**BRH Inpatient Falls per Patient Day**



# Risk / Regulatory Update

- Sentinel / Significant Events
  - **No Sentinel Events in 4Q 2014**
  - **Significant Events:**
    - Two MHU staff assaulted by a patient
      - Patient hit staff in the face with a coffee carafe
      - Injuries required medical care
      - **Action: evaluating opportunities to increase security in MHU**
    - Recently discharged patient started fire in BRH bathroom
      - Patient had to be removed from bathroom by staff
      - Significant water damage to building
      - No Security staff available due to being on patient watch in ED
      - **Action: ED staff to walk patients out of the building upon discharge; increasing Security staffing to accommodate needs for patient watches**
    - “Code Blue” alert system on extended down time
      - Interim procedures put in place
      - Part that failed had to be built from scratch
      - Occurred again in February, same problem
      - **Action: increase frequency of system tests; keep the back-up part in stock**

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900  
[www.bartletthospital.org](http://www.bartletthospital.org)

## Bartlett Regional Hospital Board of Directors Minutes February 17, 2015

**Called to order at 5:18 p.m. by Bob Storer**

### Roll call

#### Present

Bob Storer	Mary Borthwick
Linda Thomas	Lauree Morton
Mark Johnson	Alex Malter, MD

#### Absent

Kristen Bomengen, Past President	Nancy Davis, Vice President
Brenda Knapp	

#### Others present

Chuck Bill, CEO	Billy Gardner, CNO
Alan Ulrich, CFO	Mila Cosgrove, HR
Toni Petrie, Executive Assistant	Karen Crane, CBJ Liaison
Jane Sebens, CBJ Law	Kendri Cesar, Sonosky, Chambers
Bethany Rogers, Quality Director	Ursula Iha, Pharmacy Director
Dawn Bailey, OR Director	Jim Strader, Community Relations Director
Martha Palicka, IT Director	

**Public participation** – None

**Special order of business:** Ms. Rogers gave a powerful presentation on the importance of quality and went over what will be presented to the Board on a quarterly basis for what the hospital is doing to improve quality at Bartlett.

**APPROVAL OF THE MINUTES** – *Ms. Borthwick made a MOTION to approve the January 27, 2015 Board of Directors meeting. Mr. Johnson seconded and they were approved.*

## **OLD BUSINESS:**

Housing First – Mr. Storer asked the Board to share their thoughts on this project. Ms. Borthwick asked if the state grant doesn't come through, will the city still contribute the amount they agreed to, which was \$1.5 million dollars. Ms. Crane said not all of it and it will most likely delay the project if the grant doesn't get approved. Bartlett's donation will help strengthen the grant proposal. **Ms. Thomas made a MOTION to approve up to \$100,000 now, without the provision of the grant, and that any further funds would need to come before the Board with a lot more analysis. Mr. Johnson seconded.** Dr. Malter said he doesn't support the hospital being the main entity to fund this project. This motion supersedes the motion made in January. **The motion passed by five in favor and one against.**

CEO evaluation – Mr. Storer worked with Ms. Cosgrove on the goals for the CEO evaluation. She is proposing the Board approve the criteria tonight and hold a special board meeting to discuss the incentives and rate the CEO's performance to date. **Dr. Malter made a MOTION to approve the goals set for the CEO. Ms. Morton seconded and it was approved.**

CERNER update – Outside counsel has been engaged and documentation is being gathered. Ms. Sebens will provide an update at the next board meeting.

## **STANDING COMMITTEE REPORTS:**

Executive Committee – Mr. Storer reported the Committee met and discussed Housing First and the HR quarterly report. There was an update on Meditech and the Meaningful Use date possible moving. The hospital credit card was discussed. The RFP on the CAMHU is moving along. There was also a discussion getting packets out on time (3 days in advance prior to the committee meetings).

Finance Committee – Ms. Thomas gave a report on the Finance Committee meeting, which was held right before this meeting. There was a special meeting on February 5<sup>th</sup>, which was primarily educational and informational for the numbers on the various elements to the budget.

There was information provided on the Rural Community Hospital Demonstration Project. Payments have decreased as well as a cost of charge ratios because of the FY14 cost report. The decrease is about \$35,000 a month. The rest of the fiscal year, it will be approximately \$210,000 negative variance to the bottom line for this fiscal year.

Regarding the recoupment from Medicare on the \$1.9 million dollar over payment that was determined during 2014, we have been repaid \$1.6 million (approximately) year to date.

Mr. Ulrich put together an analysis of where he thought we might be by the end of the FY15 (draft). He will continue to refine it.

The Amex card that was in the prior CFO's name has been cancelled, one has been ordered in the CEO's name, and the credit limit adjusted to \$50,000. The Wells Fargo card will be canceled that was in the prior Compliance Officer's name for doing background checks.

The two GPO's Bartlett is working with are Provsorce and Amerinet. There was a lengthy discussion regarding the process and moving forward. **Ms. Thomas made a MOTION to approve Amerinet as the sole source GPO not to exceed one year and engage in an RFP process with other GPO providers. Mr. Johnson seconded and it was approved.**

A draft financial policy for collections was reviewed. Mr. Ulrich will send red lined copies to the committee members and bring it back before the Board in March.

Mr. Ulrich went over the January financials.

Three capital purchase items:

1. Alaska Surgical Services Lithotripsy agreement – Mr. Ulrich reported that we do lithotripsy procedures and the current equipment is very outdated. We have negotiated a contract with Alaska Surgical Services. **Ms. Thomas made the MOTION to approve the contract with Alaska Surgical Services for the cost of \$5,000 for three years not to exceed \$100,000. Dr. Malter seconded and it was approved by a roll call vote.**
2. Remote pharmacy services – Mr. Ulrich asked Ms. Iha to speak to this contract. Ms. Sebens is reviewing this contract. This contract will provide remote services when the pharmacy is closed. It will also help reduce the cost in travelers. The cost could be up to \$3,500 at the maximum for BRH. This will improve patient care. **Ms. Thomas made a MOTION to approve the Remote Pharmacy Services agreement on behalf of the Finance Committee subject to CBJ Legal approval. Mr. Johnson seconded and it was approved by a roll call vote.**
3. Intelligent Medical Objects - This contract has been reviewed by CBJ Law and Dick Monkman. The total cost is approximately \$25,000 annually and licensing is required for the Meditech implementation. **Ms. Thomas made a MOTION to move forward on the Intelligent Medical Objects licensing, not to exceed \$25,000 annually and subject to legal approval. Dr. Malter seconded and it was approved.**

There will be a dollar amount for salaries and wages for the Meditech project coming to the Board in March.

Break at 6:55 p.m.

Back in session 7:00 p.m.

Quality Committee – Mr. Johnson reported the Hospital Quality Committee will meet monthly and then provide a quarterly report to the Board.

BRH Foundation – Mr. Storer reported this is the time of year they have the Fahrenkamp golf putting tournament. There are teams and a silent auction. They continue to make progress on the Seafood Gala. The gift shop continues to lose money and they are working on ways to increase revenue.

CAMHU – Mr. Bill reported that we only received one response back and it was from the McDowell Group, but they requested more time. We agreed to give them an extra three weeks and they put together a proposal. The ad hoc committee will review the proposal and then we will be doing the gap needs analysis.

Governance Committee – Kristen will be calling a meeting soon.

CEO report – Mr. Bill reported that he sat in on a teleconference with Alaska hospitals CEO's and Senator Kelly regarding Medicaid expansion and reform. Senator Kelly was very candid and said this expansion is not going forward unless we have reform attached to it in some format. Mr. Bill said we will try to define what we want to identify as reform. We have to have the physicians on board for this to work. There's also talk about doing a provider sales tax. There currently isn't any in Alaska.

Senator Dan Sullivan will be here Thursday and he will come have lunch and a hospital tour. This will be a good opportunity to talk about the Rural Demonstration project.

President's report – Mr. Storer read a letter from the Medical Staff Quality Committee regarding medical marijuana. The committee recommends the hospital and CBJ work together on a policy for this since there currently isn't one.

Mr. Storer has been working with Mr. Bill, Ms. Cosgrove, and Ms. Sebens to try and fine tune the legal review process.

Mr. Bill is entitled to a certain amount of benefits per his contract and he hasn't used them, such as leasing a car. This is well within the scope of the contract.



The Assembly asked the Board to come before them and we need to schedule a date for that meeting.

***Mr. Johnson made a MOTION to go into executive session at 7:30 p.m., to discuss matters which are confidential by law (Medical Staff report) and matters which could have an adverse effect on the finances of the hospital. Ms. Borthwick seconded and it was approved.***

Out of executive session at 8:13 p.m.

The March calendar was reviewed.

**Adjourned at 8:15 p.m.**

DRAFT

# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900

[www.bartlethospital.org](http://www.bartlethospital.org)

Finance Committee

February 17, 2015

Minutes

**CALLED TO ORDER** at 4:00 p.m. by Linda Thomas, Chair

**ATTENDANCE:** Bob Storer, Mark Johnson, Chuck Bill, CEO, Billy Gardner, CNO, Alan Ulrich, CFO, Mila Cosgrove, HR, Karen Taug, Controller and Toni Petrie, Executive Assistant, Martha Palicka, IT Director

## **OLD BUSINESS:**

- A. Meditech update - Ms. Palicka gave an update on Meditech. The trainings will go into June by Meditech's recommendations. There have been good meetings held with the physician champions.

Mr. Ulrich said there was a meeting this afternoon with Santa Rosa to discuss moving the "Go Live" date and the financial impact on the hospital. The additional budget amount of \$300,000 was approved at the December board meeting, and the Santa Rosa contract amendment will go to CBJ Law for review.

Ms. Thomas would like to be apprised on the staff hours that were not budgeted for the implementation of Meditech. Mr. Ulrich will provide that information once he's obtained it. Mr. Bill stated that it could be a significant portion of the capital budget.

## **APPROVAL OF THE MINUTES:**

**Mr. Johnson made a MOTION to approve the minutes as amended. Mr. Storer seconded and they were approved.**

- B. Damaged computer hardware – Tabled since there was no further information on the insurance claim.
- C. CERNER update – A specialty attorney was engaged. Ms. Thomas would like to know if any of the legal fees will be covered under our contract with CBJ Law. Mr. Ulrich will follow up.
- D. Meaningful Use update – We have until April to file for the hardship exemption.
- E. Credit card update – Mr. Ulrich provided a list of the cardholders and the purchases that were made with each card included in the packet for review. Mr.

Ulrich said we have cancelled the American Express that was in the prior CFO's name. We have a new credit card in Chuck's name with a reduced credit limit of \$50,000. All credit card authorizations will go through the CFO for approval. There will be more discussion on this issue at the March Finance Committee meeting.

Ms. Thomas would like an update on the credit card policy and if it went before the Board for approval. Ms. Thomas would like to see the dates of the charges included on the spreadsheet information provided. The committee would like an executive summary of policy changes as they arise, and the opportunity to view/approve policies that should come before the Board. Mr. Ulrich is also cancelling the Wells Fargo credit card that we currently use in HR that was in the prior Compliance Officer's name. There was also discussion about the Costco credit card use as well as recording and safekeeping for the Gift Cards obtained via "points" from the American Express cards.

- F. Cost report consultant - Mr. Ulrich said he has been in touch with Susan Ruchin from Moss Adams. Mr. Ulrich is in the process of finalizing a request for proposal (RFP) for a consultant. Ms. Ruchin suggested we may need a legal consultant. March 20<sup>th</sup> is the deadline for request for bid, which is required for anything over \$5,000. We will have their responses to CMS and Noridian before that deadline.

#### **NEW BUSINESS:**

- A. GPO decision – We currently have two GPO's. Provsorce (Novation) and Amerinet. Mr. Ulrich and his staff are currently evaluating the purchases we have had with each group. They believe that we should stay with Amerinet. Our pricing advantage with Provsorce was discontinued late last year. Ms. Thomas asked to highlight the dollar amounts saved by each GPO. She has concerns about the prior history with the GPO's and the process used to evaluate the decision moving forward with Amerinet. Mr. Storer recommended developing an RFP and look for the best GPO. Mr. Ulrich will bring more information to the committee.
- B. BRH financial policies – There was a draft collections policy that was reviewed that combined three of our existing revised policies regarding patient financial responsibility. The recommendation is that the hospital develops a brochure for patients that define what our policies/expectations are for collecting money either on date of service or going forward.

***Mr. Johnson made a MOTION to go into executive session at 4:53 p.m., to discuss matters which could have an adverse effect on the finances of the hospital (GPO) and matters which are confidential by law (personnel matters). Mr. Storer seconded and it was approved.***

Back in session 5:02 p.m.

C. January 2015 financial statements – Will be presented at the Board meeting.

**CAPITAL PURCHASE ITEMS:**

- A. Alaska Surgical Services Lithotripsy agreement – *Mr. Johnson made a MOTION to move this to the Board for consideration. Mr. Storer seconded and it was approved.*
  
- B. Medication Review, Inc. – This is to provide an opportunity to have a remote pharmacist to provide services on off hours. This will help reduce the number of casuals and improve quality of care. *Mr. Johnson made a MOTION to move this to the Board for consideration. Mr. Storer seconded and it was approved.*

**Adjourned at 5:13 p.m.**

DRAFT

# **Executive Summary**

## **Substantive Changes to BRH CY15 Annual Plans**

(approved by Hospital Quality Council Jan. 2015)

### **Process Improvement Plan:**

- Added definitions for “Root Cause Analysis” and “Significant Event”
- Made wording less prescriptive for manner of communication from patients to Board
- Changed wording to align with changes to HQC charter
- Revised description of Failure Modes and Effects Analysis
- Made wording in Performance Measures section more specific, aligned with practice
- Added patient outcomes sentence, per CMS requirements
- Corrected “high volume” to read “low volume”

### **Medical Staff Process Improvement Plan:**

- Changed to reflect scope of Plan as it relates to new categories of the medical staff

### **Risk Management Plan:**

- Changed wording to align with changes to HQC charter
- Added goal to monitor risk association with implementation of new EHR
- Added “accrediting bodies” and “law enforcement agencies” as sources for identifying areas of risk

### **Infection Control Plan:**

- Described implementation of Infection Prevention Liaison program
- Added goal of 90% or greater staff influenza vaccination
- Changed CAUTI goal to focus on decreasing catheter utilization
- Eliminated pneumococcal vaccine from vaccination metric (focusing on influenza)

### **Utilization Review Plan:**

- Changed references to Quality Improvement Organization (QIO) vendor from Mountain-Pacific Health to Lavanta

### **Environment of Care Plans:**

- No substantive changes
- Plans include: Emergency Management, Hazardous Materials, Safety and Security, Utilities and Equipment, and Life Safety.

PATIENT SAFETY /  
QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT  
PLAN

CY ~~2014~~2015

Issued: August 2010  
Revised: ~~August-December~~ 2014  
Submitted by: Bethany Rogers, RN, CPHQ

## PURPOSE

The purpose of the Patient Safety / Quality Assessment / Performance Improvement Plan for Bartlett Regional Hospital (BRH) is to ensure that the governing body, medical staff, and professional service staff consistently endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal, controllable risk. The plan allows for a systematic, coordinated, continual data-driven approach to improving performance, focusing upon the processes and mechanisms that address these values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple hospital departments and disciplines in establishing plans, processes, and mechanisms that comprise performance improvement activities at BRH. The Plan is established by ~~the medical staff and h~~Hospital ~~and medical staff~~ ~~Quality Improvement leadership bodies~~Council (HQIC), and is supported and approved by the governing body, which has the responsibility of monitoring all aspects of patient care and services (including contracted services) from the time of the patient's initial participation with any of the services provided by BRH, including diagnosis, treatment, recovery and discharge activities. These activities are monitored in order to identify and resolve any breakdowns that may result in suboptimal patient care and safety, while striving to continually improve and facilitate positive patient outcomes.

This Plan describes key hospital and medical staff performance improvement activities and delineates the respective roles and responsibilities of the Board of Directors, the medical staff, and hospital leadership in developing, implementing, evaluating and coordinating a comprehensive plan. The Plan promotes high-quality patient care, the safety of patients, visitors, physicians, and employees, and aims to continually improve processes and services with the goal of improving patient outcomes.

## GOALS & OBJECTIVES

The primary goals of the Plan are to continually and systematically plan, design, measure, assess, and improve performance of critical focus areas, improve healthcare outcomes, and reduce and prevent medical / health care errors. To achieve these goals, the Plan strives to:

- Incorporate quality planning throughout the organization;
- Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their efforts toward performance improvement, providing feedback and learning throughout the organization;
- Provide for an organization-wide program that assures the organization designs processes well (with special emphasis on design of new, or revisions in established, services), and systematically measures, assesses,

and improves its performance to achieve optimal patient health outcomes using a collaborative, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others. Process design contains the following focus elements:

- Consistency with the organization's mission, vision, values, goals, objectives, and plans.
- Meets the needs of individuals served, staff and others.
- Use of clinically sound and current data sources (e.g. practice guidelines, relevant literature and clinical standards).
- Is based upon sound business practices.
- Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this institution.
- Utilizes the results of performance improvement, patient safety, and risk reduction activities.
- Assures that the improvement process is organization-wide monitoring, assessing, and evaluating the quality and appropriateness of patient care, patient safety practices, and clinical performance to resolve identified problems and improve performance.
- Appropriately reports information to the Governing Board, providing leaders with the information needed to ensure quality patient care and safety.
- Communicates necessary information among departments and services when problems or opportunities to improve patient care and patient safety practices involve multiple departments/services.
- Tracks identified problems and action plans to ensure improvement or problem resolution.
- Uses information from departments/services and the findings of discrete performance improvement activities and adverse patient events to detect trends, patterns of performance, or potential problems that affect multiple departments/services, and



- Annually evaluates the objectives, scope, and organization of the improvement program; evaluates mechanisms for reviewing the effectiveness of monitoring, assessment, and problem-solving activities in the performance improvement program; revises as necessary.

The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions or services.

## PATIENT SAFETY

We are focused on the dignity of persons we serve. The Patient Safety Program is designed to improve patient safety, reduce risk, and respect the dignity of those we serve by promoting a safe environment. We recognize that effective medical / health care error reduction requires an integrated and coordinated approach. Our plan relates specifically to a systematic hospital-wide program to minimize physical injury, accidents, and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering this environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical / health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about medical / health care errors;
- ~~Incorporate recognition~~ Recognize of patient safety as an integral job responsibility;
- Provide education on patient safety in job-specific competencies;
- Encourage recognition and reporting of medical / health care errors and risks to patient safety without judgment or placement of blame;
- Involve patients in decisions about their health care and promote open communication about medical errors ~~and their associated~~ consequences ~~which occur~~;
- Collect and analyze data, evaluate care processes for opportunities to reduce risk, and initiate actions;
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk: and

- Support knowledge transfer to effect behavioral changes within our facility by sharing of information.

The scope of patient safety includes adverse medical / health care events involving patient populations of all ages, visitors, hospital / medical staff, students and volunteers. Aggregate data from internal (IT data collection, occurrence reports, questionnaires / surveys, Core Measure reports, etc.) and external resources (Sentinel Event Alerts, evidence-based medicine, etc.) are used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories for medical / health care events include:

- No Harm – an act, either of omission or commission, either intended or unintended, or an act that does not adversely affect patients
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous (Latent) Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Root Cause Analysis or Focused Review- (Near Miss / Hit) – any process variation for which a recurrence carries a significant chance of a serious adverse outcome  
Structured and systematic process for evaluating the steps, systems, and processes that led up to a Significant or Sentinel event, with an eye toward identifying root and proximal causes that are within the organization's control operationally or financially
- Significant Event (Near Miss / Hit, Good Catch) – an unexpected occurrence of substantial adverse impact to patient safety or to organizational integrity that does not meet the definitions of "Sentinel Event" but that warrants intensive root cause analysis; any process variation for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of life, limb, or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome resulting in the former

The responsibilities of the Director of Quality include compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of this Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and timely response to reports concerning workplace conditions.

1. Discussion with the patient/family/caregivers regarding adverse outcomes:
  - a. Sentinel Events impacting the patient's clinical condition – The Director of Quality notifies the care-giving physician about informing the patient / family / caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient / family / caregivers, the Chief of Staff is notified by the Director of Quality. The patient / family / caregivers are not contacted without the notification of the care-giving physician involved.
  - b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Chief Nursing Officer determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.
  
2. Components of the organization are integrated through a collaborative effort of multiple disciplines. This is accomplished by:
  - a. Reporting of potential or actual occurrences through the Occurrence Reporting system by any employee in every department.
  - b. Communication between the Director of Quality and the Facility Safety Officer (FSO) to assure a comprehensive knowledge of not only clinical, but also environmental, factors involved in providing an overall safe environment.
  - c. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the Hospital Quality Improvement Committee-Council (HQIC).
  
3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (*Sentinel Event Policy, 9420-002* and *Occurrence Reporting Policy, 9420-008*). A root cause analysis of processes, conducted on either a Sentinel Event or Focus Review, are discussed with the Senior Leadership Team and the Medical Staff Quality Improvement Committee, as appropriate.
  
4. In support of our core values and belief in the concept that errors occur chiefly due to a breakdown in systems and processes, staff involved in an event with an adverse outcome are supported by:
  - a. A non-punitive approach and without fear of reprisal,
  - b. Voluntary participation in the root cause analysis for educational and improvement purposes and prevention of further occurrences.
  - c. Resources such as EAP, or Union representation, if the need to counsel the staff is required
  
5. Patient safety measures are a focus of our activities and may include review of adverse drug events, health care acquired infections, “never” events, CMS No Pay events, and other data and incidents. This may be based on

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information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient / family suggestions / expectations, or process outcomes.

6. Processes are assessed to determine the steps when there is or may be undesirable variation (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.
7. The procedures for immediate response to medical/health care error are as follows:
  - a. Staff obtain required orders to support the patient's clinical condition.
  - b. Significant or Sentinel adverse events:
    - i. Staff immediately report the event to the supervisor (either the nursing directors or the house supervisor if the event occurs during off-hours).
    - ii. The supervisor immediately communicates the event to the Director of Quality or the Regulatory Compliance / Risk Manager to initiate investigation and follow-up actions.
    - iii. Staff complete the Occurrence Report to preserve information.
    - iv. The FSO is notified by the Director of Quality of any situations of potential environmental risk to others.
    - v. The Director of Quality or Regulatory Compliance / Risk Manager follows usual protocols to investigate the error and coordinate the factual information / investigation for presentation, review and action by the RCA Team.
8. Solicitation of input and participation from patients and families in improving patient safety are accomplished by:
  - a. Conversations with patients and families from nursing director or administrative rounds
  - b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
  - c. Presentations Communication to the Board of Directors' Quality Committee by patients and/or families
  - d. Comments from patient Complaints or Grievances
9. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
  - a. Patient's Rights statements
  - b. Patient Responsibilities—A list of patient responsibilities are included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their

condition, asking questions, following instructions, accepting consequences, following facility rules, etc.

- c. Evaluating informational barriers to effective communication among caregivers.

10. Methods to assure in-services, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

- a. Providing information and reporting mechanisms to new staff in orientation training.
- b. Providing ongoing education, including reporting mechanisms.
- c. Evaluating staff's willingness to report medical errors.

11. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

a. Two representatives of the Board of Directors will be assigned as participants on the Hospital Quality Council.

b. Each department will report its progress on a Quality Assessment / Process Improvement project to the Board of Directors annually.

a.c. The minutes / reports of the HQIC are submitted to the Medical Staff Executive Committee and Director of Quality will provide a quarterly report of HQC activities to the Board of Directors, to include updates on multidisciplinary PI efforts, activities to sustain the organization's Bartlett Microsystems PI structure, updates on quality improvement activities of the medical staff, adverse event and patient complaint data and associated improvement activity, and updates on the organization's regulatory compliance activities.

~~b. These monthly reports will include ongoing activities including data collection presented in various ways, which may include statistical process control charts, analysis, actions taken, and monitoring for the effectiveness of actions.~~

~~c. Regular written / verbal report of significant HQIC activities to the Board Quality Committee.~~

12. External Reporting

~~a. A high-risk or error-prone process is selected for concentrated activity, ongoing measurement and periodic analysis via a Failure Mode Effects Analysis (FMEA) every 18 months.~~

b.a. External reporting is completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.

13. ~~The Director of Quality or Regulatory / Risk Manager submits reports to the HQIC and Board of Directors, which may include~~ Failure Modes and Effects Analysis (FMEA):

a. A high-risk or error-prone process is selected for concentrated activity, ongoing measurement and periodic analysis via a Failure Mode Effects Analysis (FMEA) at least every 18 months.

a-b. \_\_\_\_\_ Definition of the scope of occurrences including sentinel events, focused reviews and serious occurrences

b-c. \_\_\_\_\_ Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected

c-d. \_\_\_\_\_ Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.

## ACTIVITIES

The scope of the organizational plan includes an overall assessment of the efficacy of performance improvement activities, with a focus on continually improving care provided, and patient safety practices conducted, throughout the organization.

The program consists of these focus components:

- Performance improvement,
- Patient safety,
- Quality assessment and improvement,
- Quality control activities.

Collaborative and specific indicators of both processes and outcomes of care are designed, measured, and assessed by all appropriate departments / services and disciplines in an effort to improve patient safety and organizational performance. These indicators are objective, measurable, based on up-to-date knowledge and experience, and are structured to produce statistically valid, data-driven, performance measures of care or processes. This mechanism also provides for evaluation of improvements and the stability of these improvements over time.

- The scope of the organizational performance improvement program includes performance of the following medical staff and organizational functions:
  - The monitoring, assessment and evaluation of patient care and the clinical performance of all individuals with clinical privileges.
- At routine meetings of the medical staff or its various committees, these services will be reviewed, assessed and evaluated:
  - Operative / Invasive Procedure Monitoring
  - Medication Management
  - Information Management Function
  - Blood and Blood Product Use
  - Pharmacy and Therapeutics Function
  - Mortality Review
  - Risk Management
  - Infection Control

- o Utilization Management
- o Other processes as determined by the individual committee
- o Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
- o Assessment of the performance of the patient care and organizational functions are included.

- As necessary, rRelevant findings from performance improvement activities performed are considered part of:
  - o Reappraisal / reappointment of medical staff members, and
  - o The renewal or revision of the clinical privileges.

## ORGANIZATION

To achieve fulfillment of the objectives, goals and scope of the Organizational PI Plan, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment and evaluation of the care and services provided throughout the organization.

The Board of Directors is responsible for establishing, maintaining, and supporting an ongoing quality improvement program. This responsibility is carried out by the organization's administration, ~~the~~ medical staff, nursingclinical, and organizational support services. The organization's leaders set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's governance, management, clinical, and support processes. The organization's leaders include members of the Board of Directors, the Senior Leadership Team, and the Executive Committee of the Medical Staff.

With authority delegated by the Board of Directors, the medical staff and the organization's administration strives to improve and assure the provision of quality patient care through the monitoring, assessment and evaluation of performance measurements and outcomes.

The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important issues in patient care or safety are identified and resolved.

The Medical Staff Executive Committee and the HQ+C provide the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the organization.

The HQ+C's roles and responsibilities include ensuring that important processes and

activities are measured, assessed and improved systematically throughout the organization; determining the approach to Quality Assessment and Performance Improvement (QAPI); approving annual priorities and required resources to implement / support PI activities; reporting to Board of Directors; reviewing results of studies, teams, and ongoing measurement activity or additional actions required; approving communication processes to share outcomes of PI; approving changes and parameters for interdisciplinary teams; and reviewing the annual assessment of PI activities.

Medical Staff Service Line committees' roles and responsibilities as they relate to PI include: reviewing and analyzing data, making recommendations, taking actions where necessary, and reporting to the General Medical Staff through Committee chairs.

The HQ+C has designated responsibility to ensure patient safety. Patient safety is evaluated with a dedication to implementation and monitoring of the effectiveness of the patient safety activities. The scope of patient safety activities includes ongoing assessment and, using internal and external knowledge and experience, to prevent adverse event occurrence, and maintain and improve patient safety. RData reports of medication incidents are reviewed at the HQ+C. The HQ+C reviews at least one (1) high-risk safety process for proactive risk assessment (FMEA) every 18 months. Patient safety information reporting includes concurrent data / information related to ongoing patient safety and medical error issues, as well as information related to the proactive risk assessment and improvement endeavors.

## METHODOLOGY

The Bartlett Microsystems methodology is used to improve functions-systems and processes related to patient care and patient safety throughout the organization. An accelerated approach may be used for improvement that has been identified through data-driven reports such as patient satisfaction surveys, improvement that may not require a multi-disciplinary approach, single-process improvement issues or goals, or where sufficient information is available to identify the improvements needed.

Performance improvement data is collected, measured and assessed in a systematic and ongoing manner in order to assess variation and the need for improvement. Due to the differences in the types of data collected, assessment methodologies may vary. Individual case review data and peer review results are assessed and improved on a case-by-case basis and documented in committee minutes as appropriate. Whenever feasible, assessment and improvement methodologies include analysis of summary data, focus on the underlying process or system and on interdisciplinary collaboration.

The Bartlett Microsystems methodology is a structured and systematic improvement process that includes:

1. **See:** Identifying opportunities for improvement
2. **Source:** Finding root causes of variation
3. **Solve:** Using manageable steps to get improvement ideas



4. **Sample:** Developing and testing changes
5. **Sustain:** Monitoring changes so improvements stick

The following actions promote performance improvement:

- Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and determine how serious the possible effect is on the patient.
- For the most critical effects, conduct a root-cause analysis or use other quality management tools to determine why the undesirable variation leading to that effect may occur.
- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation.
- Test and implement the redesigned process.
- Identify and implement measures of the effectiveness of the redesigned process.
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events are routinely monitored. At a minimum, performance measured related to the following processes, as appropriate to care and services provided, are monitored ~~with approval of, and at the suggested frequency of, the HQIC:~~

- Management of hazardous conditions
- Medication management
- ~~Complications of o~~Operative and other invasive procedures
- Blood and blood product ~~use~~documentation
- Restraint use
- Outcomes related to resuscitation
- ~~Appropriateness of pain management~~
- ~~Care or services to high-risk populations~~
- National Patient Safety Goals
- Organ procurement effectiveness: conversion rate data is collected and analyzed and when reasonable, steps are taken to improve the rate.

## REPORTING FORMAT

The findings, conclusions, recommendations, and actions taken to improve performance and the results of actions taken are documented and reported through established channels.

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service line ~~or clinical~~ committees ~~and ancillary or nursing~~, ~~is-are~~ reported to the HQIC or

MSQIC on an annual or other basis as designated.

The HQIC, through its minutes, Medical Staff representative, or the Director of Quality, reports to the Medical Staff Executive Committee on a routine basis. The HQIC provides the Board of Directors with a report of ~~relevant findings from~~ performance improvement activities.

## ANNUAL EVALUATION AND APPROVAL

The organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary. This is to assure ~~that~~ the appropriate approach to planning processes of improvement, setting priorities for improvement, assessing performance systematically, implementing improvement activities on the basis of assessment, and maintaining achieved improvements, ~~the organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary.~~

## ACCOUNTABILITY

The Board of Directors of Bartlett Regional Hospital is ultimately responsible for the quality of care provided by the hospital. The Board of Directors shall provide that an ongoing, comprehensive and objective mechanism is in place to assess and improve the quality of patient care, to identify and resolve documented or potential problems and to identify further opportunities to improve patient care. The Board discharges this responsibility by establishing organizational priorities, allocating the necessary resources, appropriately delegating responsibility for the overall management of performance improvement activities and subsequently measuring the results of those activities. The Board reviews the quality of patient care services provided by medical, professional, and support staff.

The Board of Directors delegates operational authority and responsibility for performance improvement to the Chief Executive Officer and the Chief of the Medical Staff. Through coordination of activities between these two individuals, the hospital-wide approach to organizational performance improvement is developed and implemented.

The Chief Executive Officer and the Chief of the Medical Staff, acting through the HQIC and MSEC respectively, coordinate the program by assessing organizational needs, establishing priorities, providing necessary resources and measuring outcomes of all performance improvement activities using organizational goals, statutory and regulatory requirements, and other measurement standards.

The Medical Staff, through its ~~departments~~ service lines and committees, measures patient care processes, and assesses and evaluates quality and appropriateness, and is thus able to render judgments regarding the competence of individual practitioners.

Coordination of these activities occurs through the Medical Staff Executive Committee and the Chief of the Medical Staff.

## SCOPE

Organizational Performance Improvement is a hospital-wide activity. All Medical Staff departments and all hospital clinical and support services participate in planning, designing, measuring, analyzing and implementing opportunities to improve care and organizational performance.

Medical Staff functions are performed by the Medical Staff as described in the Medical Staff Bylaws and/or Rules and Regulations.

Administrative and other non-clinical functions are performed by individuals, hospital committees, departments, and-or through interdisciplinary team-based activities as approved by the HQIC.

Functions involving both the Medical Staff and the hospital are addressed through a joint effort directed and organized by the Medical Staff leadership and the HQIC.

**Safety activities** are addressed throughout the organization and reported through the HQIC, which then reports to the Board of Directors. These activities focus on patients, the hospital staff, and medical staff. The Director of Quality has primary oversight responsibility with regard to regulatory standards. Other individuals with key responsibilities are the Regulatory-Compliance / Risk Manager, and the Director of Facilities Services who functions as the Facilities Safety Officer. These individuals are active participants on the Environment of Care Committee, which meets regularly and facilitates timely corrective action as environmental safety issues are identified. The EOC Team routinely reviews activities related to all the seven-7 Management Plans for the Environment of Care.

The Director of Pharmacy and the Regulatory-Compliance / Risk Manager are primarily responsible for medication safety activities and risk reduction strategies related to medication error reduction.

## ORGANIZATION

### Board of Directors

The Hospital Board of Directors has the overall responsibility for the improvement of organizational performance and the quality of patient care as described above. The Chief Executive Officer, Chief Nursing Officer, the Chief of the Medical Staff, and the Director of Quality have operational responsibility for the development and

implementation of an integrated, coordinated, and interdisciplinary approach to performance improvement. An overview of the performance improvement activities is reviewed at least semi-annually at the Board of Directors ~~QA Committee~~ meeting.

### Medical Staff Executive Committee

The Medical Staff Executive Committee (MSEC) fulfills the overview capacity of the performance and quality improvement requirements by receiving and acting on outcomes data and recommending actions or further investigation. The Medical Staff is organized into service lines or committees as described in the Medical Staff Bylaws.

MSEC's responsibilities include:

- Analyzing reports and medical records referred for peer review according to the criteria established by the MSEC (delegated to the Medical Staff Quality Improvement Committee).
- Making recommendations for action and policy / procedure changes to the Hospital, Board of Directors, and Medical Staff regarding performance improvement.

### Medical Staff Committees

Medical Staff Committees are responsible for the tasks of reviewing the performance of practitioners granted privileges by the service line, as well as measuring and assessing the performance of important patient care processes. The chair of each Medical Staff Committee shall provide for an ongoing, systematic process for assessing and improving the quality of patient care provided.

The functions of the Medical Staff Committees include:

- Conducting a continuous and systematic review of the quality and appropriateness of care delivered by members of the service line, including (but not limited to) peer review of individual cases referred to the committee by members, other departments and committees, risk management, and cases which fail to meet departmental screening criteria.
- Coordinating with hospital staff and departments an interdisciplinary review of the following functions:
  - Surgical care and other operative invasive procedures
  - Medication and nutrition usage evaluation
  - Medical record review for clinical pertinence
  - Blood usage evaluation
  - Preoperative, postoperative, and pathological finding discrepancies
- Developing and reviewing interdisciplinary studies based on the service's scope of practice in order to improve the delivery of patient care.
- Recommending educational activities based on review findings, new standards or technology, identified need, or other sources of input to improve the quality and appropriateness of patient care.

- Develop~~ing~~ and implement~~ing~~ changes to correct identified problems or improve existing processes, and measur~~ing~~e and evaluat~~ing~~e the response to those changes in improving patient care.
- Us~~ing~~e findings of the performance improvement process in peer review and evaluation of the competence of individuals with clinical privileges when the findings of the performance improvement process~~es~~ are relevant to the performance of an individual.
- Report~~ing~~ to the Medical Staff Executive Committee as needed regarding:
  - Performance issues and problems that appear to involve multiple disciplines or services.
  - Improvements identified through performance and peer review activities.
  - Interventions taken to improve performance.
  - Results of the effectiveness of actions taken.

### Hospital Quality ~~Improvement~~ Council

The Hospital Quality ~~Improvement~~ Council (HQ~~I~~C) is an administrative committee responsible for identifying performance improvement issues that affect patient care and service ~~of at~~ Bartlett Regional Hospital.

The purpose of the HQ~~I~~C is to identify and prioritize performance improvement issues, encourage accountability, and review the effectiveness of activities through the systematic and continuous measurement of administrative and clinically directed processes and systems.

Goals of the HQ~~I~~C include:

- Provision for coordination and integration of performance improvement activities by maintaining a process through which performance improvement information is reviewed and appropriate follow-up recommendations are made.
- Communication of performance improvement activities and findings to all pertinent hospital staff, medical staff and the Board of Directors, and to provide for their active participation in the program.
- Identification of the continuing education needs of clinical, administrative and support personnel relative to the performance improvement process.
- Coordination of performance improvement activities and findings with those of the facility's utilization management, risk management, infection control, safety management, medical staff credentialing, and medical records functions.
- Addressing management and quality of service issues which arise as a direct or indirect result of performance improvement activities.
- ~~Maintain~~Maintenance of~~ing~~ a non-punitive environment in which healthcare errors are reported and reduced and the importance of patient safety is a priority.

- Review of management objectives on an annual basis and provision of continuity between management and performance improvement objectives.

Membership on the HQIC is composed of quality and safety leaders of the organization, as described in the Council's charter, including (but not limited to) the Chief Executive Officer, Chief Nursing Officer, and representation from the following stakeholders:

- ~~Board of Directors Representative~~
- ~~Quality Management~~
- ~~Risk Management~~
- ~~Labor Union~~
- ~~Medical Staff~~
- ~~Human Resources~~
- ~~Staff Development~~
- ~~Clinical Nursing Services~~
- ~~Pharmacy~~
- ~~Environment of Care Committee~~

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### Quality and Process Improvement Department

The Quality and Process Improvement (QPI) department of the hospital coordinates and manages the daily administrative activities of the Patient Safety Program, assists in the development of mechanisms for improving organizational performance, and assists departments and committees with performance improvement activities as requested.

The Quality Director:

- Provides support for data collection and analysis, including the ongoing, systematic review of data sources and aggregate reports.
- Assists in the dissemination of findings and reports.
- Assists hospital and Medical Staff ~~departments~~ service lines and committees in identifying important processes to measure, assess and improve.
- Develops data collection tools and reporting formats, as appropriate, to enhance uniformity and prevent duplication of effort.
- Attends meetings of Medical Staff service lines. Assists in preparation of reports to the Medical Staff Executive Committee and the Board of Directors as appropriate.
- Monitors pertinent state and federal regulations, standards and guidelines, as well as private initiatives in performance measurement and improvement.
- Assists in identification of continuing education needs and other corrective actions.
- Responds to identification of patient safety risks through patient, hospital staff, or medical staff complaints, analysis of occurrence reports, and active litigation.

## Hospital Departments

With assistance from the QPI Department, each department or service annually selects quality indicators with a focus on indicators which are high risk, high-low volume, and/or problem prone, important to customers, important to staff, or related to mission or strategic objectives, taking into account incidence, prevalence and/or severity.

Clinical departments identify and monitor indicators that measure patient outcomes.

Each department director provides for an ongoing and systematic process for measuring, assessing, and improving the quality of services, and patient satisfaction.

Each department or service is responsible for initiating and evaluating corrective action in response to findings, as well as those of accrediting agencies, other regulatory agencies and third-party payers.

Each hospital department collects regular (e.g. monthly, quarterly, annual) indicator data, monitors results, and reports to the HQ+C as requested. When monitored results do not meet expected goals, departments must provide an explanation and account of corrective actions being taken.

Each department or service ensures that identified problems and concerns are followed through to resolution.

Each department or service must select corrective actions most appropriate to the problems or concerns identified. These may include, but are not limited to: training or continuing education programs; new or revised policies; procedures or processes; individual counseling; proctoring; and sanctions or other disciplinary actions.

Each clinical department having an affiliation with a patient care contracted service may consider selecting a quality indicator for that service, and monitor, analyze, and report to the HQ+C.

## Collection and Analysis of Data

Data is collected and analyzed to ensure that actions taken are based on:

- Processes and outcomes, such as core measures, operative and invasive care, medication use and any medication use investigation studies.
- Comprehensive performance indicators, such as department-specific monitors.
- High risk, high-low volume, and problem-prone activities, such as review of complaints and occurrence reports, compliance with patient safety goals, and findings from Failure Mode Effects Analyses (FMEA).
- Significant risk events, such as conducting root-cause analyses.
- Individual performance and competence, such as compliance with policy and procedures.

## Sources of Data

Sources of data include (but are not limited to) the following:

- Indicators and screens including functions and services, which may be departmental, inter-departmental, Medical Staff related, or hospital-wide.
- Occurrence reports and risk management events
- Patient/customer complaint and grievance data
- Patient/customer, employee, and Medical Staff satisfaction data
- Resource utilization data
- National benchmark data

## ANNUAL EVALUATION

An annual assessment of the PI Plan including the results of PI activities is completed to ensure that improvement processes result in continuous and sustained improvement of patient care and services. The review specifically addresses the structure, process, and outcomes of improvement activities. The Board of Directors is included in the annual assessment process and the assessment of the effectiveness of the program in order to make evolutionary changes that keep BRH on the cutting edge of safe, effective, efficient, and appropriate patient care and services.

## CONFIDENTIALITY

All information related to performance improvement activities performed by the medical staff or hospital personnel in accordance with this Plan is confidential.

Confidential information may include (but is not limited to): the medical staff committee minutes, dashboards, hospital committee minutes, electronic data gathering and reporting, ~~untoward incident~~ occurrence reporting, and clinical profiling.

Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know basis" as approved by the Medical Staff Executive Committee, hospital administration and/or the Board of Directors.

## ACKNOWLEDGEMENT

The Performance Improvement Plan is approved by the Chief Executive Officer, Medical Staff Executive Committee, and The Board of Directors annually.

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Chief Executive Officer

Date

\_\_\_\_\_  
Chief of Medical Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
~~Quality Physician Advisor (MSQIC Chair)~~

\_\_\_\_\_  
~~Date~~

\_\_\_\_\_  
Board Chair

\_\_\_\_\_  
Date

## Stages of Development on the Pathway to High Reliability

(Consistency of Safety & Quality Performance Over Long Periods of Time)

	<b>Beginning</b>	<b>Refining</b>	<b>Maturing</b>	<b>Facility Assessment</b>
<b>Leadership</b>				
<b>Quality Activities</b>	Quality activities focused on regulatory requirements	Chief Executive officer leads proactive quality agenda	Organization commits to goal of high reliability for all clinical services	<b>Maturing</b>
<b>Quality Prioritized</b>	Strategic importance of quality improvement not recognized	Board reviews adverse events	Organization aims for near zero failure rates in some vital clinical processes	<b>Refining</b>
<b>Quality Rewarded</b>	Metrics for quality goals not part of strategic plan or incentive compensation	Organization sets a few measurable quality aims	Staff rewards system prominently reflects accomplishment of quality goals	<b>Refining / Maturing</b>
<b>Information Technology Support</b>	Information technology provides little support for quality improvement	Information technology supports some quality and safety initiatives	Information technology is integral to sustaining quality improvement	<b>Refining</b>
<b>Physician Engagement</b>	Physicians not actively engaged in quality improvement	Physician leaders champion quality goals in some areas	Physicians routinely lead quality efforts	<b>Refining</b>
<b>Safety Culture</b>				
<b>Safety Culture Program</b>	No specific program to assess safety culture	Establishing a safety culture is accorded high priority by leaders at all levels	Safety culture is well established	<b>Beginning / Refining</b>
<b>Safety Culture Implementation</b>	No assessment of trust or intimidating behavior	First measures of safety culture deployed	Measurement of safety culture is well established	<b>Maturing</b>
<b>Safety Culture Embedded</b>	Root cause analyses limited to most serious adverse events; close calls not recognized or evaluated	Beginning initiatives to encourage reporting and analysis of close calls	Regular reporting of close calls and unsafe conditions leads to early problem resolution	<b>Refining / Maturing</b>
<b>Process Improvement</b>				
<b>Use of PI Tools</b>	No formal quality management / improvement system	Organization commitment to strong quality improvement tools	Process improvement tools used throughout the organization	<b>Refining / Maturing</b>
<b>Organizational Engagement in PI</b>	External requirements are focus of improvement efforts	Training of selected staff in PI beginning	PI used throughout organization; patients also engaged in redesigning care processes	<b>Refining</b>
<b>Mandatory Implementation of PI</b>	No commitment to sustainable improvement	Improvement tools are used to achieve gains in quality and safety, in addition to routine business processes	Mandatory PI training of all staff; PI proficiency required for career advancement	<b>Refining</b>

## **Bartlett Regional Hospital**

Title: Medical Staff Process Improvement Plan

Department/s: Medical Staff

Original Date: 12/9/90

Author: MSQIC

### **PURPOSE:**

The purpose of the Medical Staff Process Improvement Plan is to identify a mechanism to monitor and evaluate the quality of patient care delivered by ~~active and associate~~ members of the medical staff, for whom clinical quality review in the context of hospital-based care is feasible and reasonable (refer to Medical Staff Bylaws, Article VIII, Categories of the Medical Staff). The plan focuses primarily on improving processes rather than looking for isolated incidents.

### **POLICY:**

- A. The Medical Staff Executive Committee (MSEC) has overall responsibility for the quality of the professional services provided by individuals with clinical privileges and for accounting to the governing board. The performance of this responsibility is delegated to the Medical Staff Quality Improvement Committee (MSQIC).
- B. The Medical Staff Quality Improvement Committee (MSQIC) will:
  - B.1. Adopt a specific Medical Staff Process Improvement Plan to identify and resolve problems that impact patient care in order to maintain the desired quality and effectiveness of care within the Hospital.
  - B.2. Coordinate multi-disciplinary studies and clinical service studies designed to identify and resolve clinical problems.
  - B.3. Follow the Medical Staff Process Improvement Plan when conducting reviews and making recommendations for practice changes.
  - B.4. Use non-physician review personnel when possible for those activities not requiring medical judgment.
  - B.5. Use a non-biased peer review process intended to measure, assess, and improve the quality of care provided at BRH.
- C. The MSQIC will work with the Medical Staff Committees, Risk Management and the Quality Director, Medical Directors, Committee Chairs, and Physician Liaison Officers as necessary to identify and correct problems affecting the quality of care delivered.
- D. The MSQIC is a review organization. As provided in Alaska State statutes, all activities of the MSQIC are considered protected, confidential and non-discoverable. Reports of the MSQIC activities will be forwarded to the MSEC and referred to the Credentials Committee as needed. A summary report of non-confidential information will be given at the general medical staff meeting as relevant information warrants.
- E. The results of MSQIC activities will be considered in the reappointment and privilege delineation process. The Quality Director maintains a confidential quality review file for licensed providers. Pertinent information in the file is reviewed by the Credentials Committee during the reappointment process.
- F. Committee membership on the MSQIC will include at least three active members of the Medical Staff. Other members of the committee will be the Quality Director and Risk Manager.
  - F.1. The President (Chief) of the Medical Staff shall appoint the MSQIC members for a term of one year.
  - F.2. The medical staff members are the only voting members of the committee.

- G. The work of the MSQIC is part of the hospital's performance and quality review program. This includes the monitoring and evaluation of the quality and appropriateness of patient care provided by all individuals with clinical privileges.
- H. The MSQIC will use the following to monitor and evaluate patient care and clinical performance:
  - H.1. Focused Professional Practice Evaluation (FPPE, review-based indicators):
    - H.1.1. Medical assessment and treatment of patients either as a component of normal patient care delivery or those identified as a concern or a deviation from expected standards of care
      - H.1.1.1. Unexpected deaths
      - H.1.1.2. Unexpected complications, including post-operative complications or other events potentially related to operative or invasive procedures
      - H.1.1.3. Adverse outcomes potentially resulting from patient care, including adverse drug reactions or other medication-related events involving the medical staff
      - H.1.1.4. Sentinel events (including the risk thereof)
      - H.1.1.5. Significant departures from established patterns of clinical practice
    - H.1.2. Peer Review Process
    - H.1.3. Patient/Staff complaints or concerns about a medical staff member's provision of care
  - H.2. Ongoing Professional Practice Evaluation (OPPE):
    - H.2.1. General Medical Staff or service line-specific indicators, including:
      - H.2.1.1. Rate-based indicators
      - H.2.1.2. Rule-based indicators
- I. The MSQIC is responsible for:
  - I.1. Implementing a systematic peer review process.
  - I.2. Assuring that all clinical service lines review cases for appropriate quality of care.
- J. FPPE and OPPE are mechanisms to improve the quality of care. FPPE and OPPE activities provide a framework for assessing competency for privilege delineation of practitioners at BRH.
  - L.1. Cases are identified for peer review through:
    - L.1.1. Retrospective record review
    - L.1.2. Quality of care concern referrals
    - L.1.3. Complaints received from patient/families or other sources related to quality of care concerns.
    - L.1.4. Risk Management referrals.
- K. Medical Staff Service Line-Specific Indicators
  - O.1. Each medical service line will identify specific indicators for quality performance monitoring based on identified standards of care, problems or trends, changes in services, or new technology.
  - O.2. Review of general medical staff or service line-specific indicators informs peer review activities.

**SCOPE:** Applies to all active medical staff at BRH. On a case-by-case basis, the scope of peer review may expand to include associate, allied, consulting, or locum tenens providers, as well as associate medical staff, as appropriate.

## REFERENCES:

- The Joint Commission CAM-H, MS and PI Chapters, 2015
- State of Alaska, Statutes, 18.23.007-18.23.070
- Medicare Conditions of Participation, 482.22, Medical Staff

## ATTACHMENTS

State of Alaska Statutes related to confidentiality of record and peer review (Statutes updated 2000)

### Attachment A

#### AS 18.23.005. Patient Access to Records:

Notwithstanding the provisions of AS 18.23.005 - 18.23.070 or any other law, a patient is entitled to inspect and copy any records developed or maintained by a health care provider or other person pertaining to the health care rendered to the patient.

#### Sec. 18.23.010. Limitation for persons providing information to review organization:

(a) A person providing information to a review organization is not subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) A privilege of confidentiality arising from a physician- patient relationship may not be invoked to withhold pertinent information from review by a review organization.

#### Sec. 18.23.020. Limitation on liability for members of review organizations:

A person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is not liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function, or activity of the review organization, unless the performance of the duty, function, or activity was motivated by malice toward the affected person. A person is not liable for damages or other relief in an action by reason of performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made

#### SEC. 18.23.030. Confidentiality of records of review organization:

(a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, a person described in AS 18.23.020 may not disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter that is the subject of consideration by the review organization. Information, documents, or records otherwise available from

original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness may not be asked about the witness's testimony before a review organization or opinions formed by the witness as a result of its hearings, except as provided in (b) of this section.

- (b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.
- (c) Nothing in AS 18.23.005 - 18.23.070 prevents a person whose conduct or competence has been reviewed under AS 18.23.005 - 18.23.070 from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records, and other evidence adduced before the review organization.
- (d) Notwithstanding the provisions of (b) and (c) of this section, information contained in a report submitted to the State Medical Board, and information gathered by the board during an investigation, under AS 08.64.336 is not subject to subpoena or discovery unless and until the board takes action to suspend, revoke, limit, or condition a license of the person who is the subject of the report or investigation.

#### AS 18.23.040. Penalty for Violation

Other than as authorized by AS 18.23.030, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable by imprisonment for not more than one year or by a fine of not more than \$500.

#### AS 18.23.050. Protection of Patient

Nothing in AS 18.23.005 - 18.23.070 relieves a person of liability that the person has incurred or may incur to a person as a result of furnishing health care to the patient.

#### AS 18.23.060. Parties Bound By Review.

When a review organization reviews matters under AS 18.23.070(5)(A)(viii) a party is not bound by a ruling of the organization in a controversy, dispute, or question unless the party agrees in advance, either specifically or generally, to be bound by the ruling.

#### AS 18.23.070. Definitions For AS 18.23.005 - 18.23.070

In AS 18.23.005 - 18.23.070, unless the context otherwise requires,

- (1) "Administrative staff" means the staff of a hospital or clinic;
- (2) "Health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home, or other institution for the hospitalization or care of human beings;
- (3) "Health care provider" means an acupuncturist licensed under AS 08.06; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate

licensed under AS 08.86; a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment;

(4) "Professional service" means service rendered by a health care provider of the type the provider is licensed to render;

(5) "Review organization" means

- (A) A hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and that is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C. 1320c-1, to gather and review information relating to the care and treatment of patients for the purposes of
- (i) Evaluating and improving the quality of health care rendered in the area or medical institution;
  - (ii) Reducing morbidity or mortality;
  - (iii) Obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness, and injuries;
  - (iv) Developing and publishing guidelines showing the norms of health care in the area or medical institution;
  - (v) Developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;
  - (vi) Reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;
  - (vii) Acting as a professional standards review organization under 42 U.S.C. 1320c;
  - (viii) Reviewing, ruling on, or advising on controversies, disputes, or questions between a health insurance carrier or health maintenance organization and one or more of its insured or enrollees; between a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board; between a health care provider and the provider's patients concerning diagnosis, treatment, or care, or a charge or fee; between a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or between a health care provider or the provider's patients and the federal or a state or local government, or an agency of the federal or a state or local government;
  - (ix) Acting on the recommendation of a credential review committee or a grievance committee;
- (B) The State Medical Board established by AS 08.64.010;
- (C) A committee established by the commissioner of health and social services and approved by the State Medical Board to review public health issues regarding morbidity or mortality; at least 75 percent of the committee members must be health care providers.

**Bartlett Regional Hospital  
RISK MANAGEMENT PLAN  
CY 2015~~14~~**

Issued: July 1, 2010  
Revised: November 2014~~August 2013~~  
Submitted by: ~~Bethany Rogers, RN, CPHQ, Quality Director~~ Sara Parker,  
BSN, RN, Compliance / Risk Manager



## AUTHORITY AND RESPONSIBILITY

### Board of Directors

The Board of Directors of Bartlett Regional Hospital (BRH) supports the Risk Management Program in order to minimize risks to patients, employees, and visitors. The Board of Directors has the final authority and responsibility for the program, but delegates the authority and accountability for the operation of the program to the Administrative and Medical Staff of BRH. It authorizes and supports the establishment of the Environment of Care Committee and appoints, through the Chief Executive Officer, a Director of Quality. The Director of Quality is responsible for the ~~ComplianceRegulatory / Risk Manager and the~~ Risk Management program. The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Quality ~~Improvement Committee~~Council (HQIC), the Environment of Care (EOC) Committee, and reports by the ~~Compliance / Risk Manager or~~ Director of Quality. The Board of Directors designates the Director of Quality and the ~~ComplianceRegulatory /~~ Risk Manager to function as the Grievance Committee for complaint processing.

### Risk Management

The Director of Quality acts as a designee of the Chief Executive Officer, and has the responsibility for monitoring, coordinating, planning, and implementing all loss prevention activities and programs that have as their goal a safe environment for patients, employees, and visitors to the hospital. Trending and tracking of potential problems are included in this responsibility as well as the integration of information with the HQIC and the EOC Committee.

### Medical Staff

The Medical Staff actively participates in peer review via the identification of potential risk in clinical areas that represent a significant source of actual or potential patient injury. This is achieved through clinical criteria approved by the Medical Staff to identify specific cases with potential risk in the clinical aspects of patient care and safety.

## PURPOSE AND PHILOSOPHY

The purpose of the BRH Risk Management process is to support the mission and vision by ensuring the delivery of safe, quality patient care, as defined by the patients we serve, the physicians who practice here, and regional and professional standards.

The philosophy of the Risk Management process is implementation of an effective and continual program to measure, assess and improve performance. Through examination and improvement in culture and process, we believe we can enhance our organization's mission, improve the quality of patient care provided, and enhance customer satisfaction.

BRH aligns the organizational strategies and departmental risk management activities, allowing individuals to align their own personal work habits and goals to support these key strategic processes.

To achieve our vision, we believe we must focus on two basic levels in the organization: culture and process improvement. We recognize that organizational culture is the system supporting the environment of care delivered to our patients, and must be championed by all leaders to be successfully embraced by employees. We further recognize that process improvement contributes to quality patient care by improving the methodologies of work. Through examination and improvement in culture and process, we believe we can enhance our organization's mission, improve the quality of patient care provided, and enhance customer satisfaction.

## GOALS AND INITIATIVES

The goal of the Risk Management plan at BRH is to identify, evaluate and alleviate practices and/or situations that pose harm to patients, visitors and staff. Risk management will promote a "culture of safety" without blame, to protect patients, visitors, and staff from avoidable harm.

The Organizational Risk Management initiatives include:

- Identifying and prioritizing key processes that promote optimum outcomes.
- Aligning medical staff risk management activities with those of BRH and working collaboratively to integrate efforts.
- Improving patient safety and minimizing risk factors that may contribute to unanticipated outcomes.
- Identifying and monitoring risks associated with integration implementation of the nNew Electronic Health Record System.

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## SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose harm to patients, visitors and staff of BRH. The Board of Directors of Bartlett Regional Hospital recognizes the importance of a Risk Management Program and provides resources and support to prevent such events that may result in injury to patients, staff, or visitors as well as property damage, loss, or damage to the facility's reputation.

The risk management plan is designed to protect the assets and revenue from a single loss or an accumulation of losses that could significantly affect its financial stability. Emphasis is placed on advocating the exercise of loss prevention strategies intended to preserve the resources of Bartlett Regional Hospital and its professional staff from loss attributed to professional liability.

The Risk and Quality Management activities at BRH are mutually compatible and interdepartmental and are part of the organization's performance improvement system. BRH's Risk Management Program is designed to comply with all federal and state regulatory requirements. Resources are provided to the Quality and Risk Management Department via the Regulatory / Risk Manager and the Director of Quality.

Access to healthcare services at BRH is delivered through an integrated continuum of health and wellness programs, acute care, and ambulatory care. Bartlett Regional Hospital delivers patient care in a variety of settings across the continuum to fulfill the mission, vision and core values of BRH. All relevant individuals, professions, and departments are involved in planning and designing improvement activities. Everyone is accountable for risk management processes.

## **STRUCTURE**

Risk management activities are established by BRH leaders, based on needs assessment, as guided by the mission, vision, and core values, and defined by strategic and operational plans, budgets, resource allocation, and standards.

### Board of Directors

The Board of Directors of Bartlett Regional Hospital bears the ultimate responsibility for assuring the quality and effectiveness of the patient care services provided by the medical staff and other professional and support staff. The Leaders set expectations, direct, and support BRH governance and management activities.

### Senior Leadership Team (SLT):

The SLT, comprised of the Chief Executive Officer, Chief Financial Officer, ~~Chief,~~ Chief Nursing Officer, and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the overall strategic direction and integration of all Risk Management activities. It is the responsibility of the SLT to set expectations, plan, assess, measure and contribute to the general management of the quality process, and provide the communication and education link between the internal quality activities and the Board of Directors. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized, and that the efforts of Risk Management support and integrate the strategic objectives of the organization and feedback from all community and hospital connections. Resources are allocated as needed for performance improvement, ~~regulatory compliance,~~ patient safety, and infection control.

#### Departments

Individual departments are responsible for quality management, ~~regulatory compliance,~~ and risk management activities within their departments relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Director of Quality, and for review at HQIC. Departments, as required by regulatory agencies, will monitor quality control data.

## **RISK MANAGEMENT PROCESS**

Successful Risk Management activities begin at the strategic planning stage. Leaders place priority on monitoring and improving high volume, high risk, and problem prone processes. Emergent needs, such as sentinel events, problems identified through data collection and assessment, changes in environment of care or community, changes in regulatory requirements, and/or significant changes in patient matters, and/or increased evidence of medical/legal matters, also influence the process of prioritizing risk management activities.

## **METHODS**

The science of Risk Management is dependent on local standards of care for informed decision making. The hospital dashboards are used to display internal data over time and provide comparisons with benchmarks, targets and goals. Control charts and local standards of care are used to determine clinical significance and clinical experts are expected to identify significant patterns and/or trends. Risk Management methodologies include:

1. Electronic filing and review of occurrences house wide
2. Review of patient complaints and grievances
3. Participation in active litigation processes

4. Process improvement based on mitigation of identified risks
5. Review of quality or trends of certain activities
6. Customer satisfaction surveys and patient suggestions
7. Customer complaints
8. Internal employee opinion surveys
9. Comparative data from other facilities and/or data bases
10. Internal and external benchmarking activities
11. Sentinel events, near misses, or trends from quality assessment activities
12. Current literature and best practice guidelines
13. Medical record, patient complaints, and quality data in various studies-studies.
- ~~13.~~14. Recommendations from accreditation bodies, state, and fFederal law enforcement agencies.

## COMMUNICATION

Communication of risk management outcomes to all levels of BRH is vital. Conclusions, recommendations, and actions are communicated to leadership, and/or individuals responsible for implementing and coordinating improvements through various presentations or reports. Examples of meetings where relevant information may be reported include:

1. Medical Staff Service Line meetings
2. Individual Department Staff meetings (when appropriate)
3. Board and/or Board Quality Committee reports
4. Management Team meeting

An annual review and revision of the risk management plan and objectives are provided to HQIC and forwarded to SLT and the Board of Directors.

## BARTLETT REGIONAL HOSPITAL INFECTION CONTROL PLAN 20154

This plan has been developed with input and collaboration from the following:

- Infection Control Committee
- Quality and Process Improvement
- Medical Staff
- Department Managers

### Infection Control Plan Reviewed by:

	Signature	Date
Infection Control Committee Chair		
Quality and Process Improvement Director		
Infection Preventionist		

## Bartlett Regional Hospital

### Infection Prevention Plan 20154

**Mission:** To provide a safe environment across the continuum of settings for all patients, visitors, and healthcare workers through the prevention of infection transmission and the provision of a safe environment.

**Objectives:** The objectives of the Bartlett Regional Hospital Infection Prevention Program are:

- 1 Early identification of infections, both expected and unexpected
- 2 Timely implementation of interventions when infections or risks thereof are identified
- 3 Analysis of organizational and individual practices that impact transmission of infection
- 4 Implementation of evidence-based practices known to reduce the transmission of infection
- 5 Education of healthcare workers, patient, families, and visitors on infection risk-reduction practices
- 6 Limitation of unprotected exposure to pathogens throughout the organization
- 7 Enhancement of hand hygiene practices by all persons within the hospital system
- 8 Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices
- 9 Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
- 10 Provision of Employee Health services, including appropriate screening, testing, immunization, counseling, and education for staff and others who have the potential for exposure to communicable disease.

## Infection Prevention Authority and Responsibility (9430.000)

**PURPOSE:** To institute any surveillance, prevention, and control measures when there is reason to believe that any patient or personnel may be in danger of ~~acquiring a hospital acquired~~ nosocomial infection or infectious disease

~~A. Administration, Medical Staff, and Governing Body approve the authority statement.~~

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~~B. The authority statement is reviewed and authenticated every two years.~~

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~~C.A.~~ In accordance with Medical Staff Bylaws, the physician members of the Infection Control Committee are appointed by the President of the Medical Staff; the appointed term is for one year.

~~D.B.~~ Members of the Infection Control (IC) Committee and / or the Infection Preventionist have the authority to institute surveillance, prevention, and control measures. When there is reason to believe that any patient or personnel may be in danger of acquiring a ~~hospital acquired~~ nosocomial infection or communicable disease, control measures may include closure of rooms, units, departments, or management of hospital visitors.

~~E.C.~~ In the absence of the Infection Preventionist (after hours or during periods of leave), the House Supervisor will assume responsibility for daily infection ~~prevention~~ control and surveillance, ensuring that isolation protocols are initiated and/or discontinued for patients as indicated.

~~F.D.~~ The Chair of the Infection Control Committee and/or the Infection Preventionist (or designee) have the authority to establish controls to reduce and stop the spread of infection and communicable disease, including the ordering of microbiological cultures and TB skin testing when indicated.

~~G.E.~~ The scheduled quarterly meeting of the IC Committee will not be timely to address time-sensitive issues. In the event that time-sensitive issues ~~that~~ endanger life or create a patient or employee safety concern, immediate action will be taken to alert those necessary to correct the situation.



H.F. Issues or situations of any level of criticality may be brought to the attention of the committee members through the Infection Preventionist, Case Managers, Department Directors, other medical or unit staff, or the Quality/ Risk Management department.

I.G. Critically significant situations should be brought to the attention of the IC Committee physician chair as soon as they are identified.

J.H. The level of criticality should guide committee decisions for referral or action when an infection safety issue is identified.

K.I. Actions appropriate for the IC Committee chair to take may include:

K-1.I.1. Calling an ad hoc IC Committee meeting, if appropriate for timely response.

K-2.I.2. Directly contacting the physician chair of the committee that has authority over the situation.

L.J. The IC Committee chair may directly contact another staff (physician or Senior Leaders) who has authority to correct the critical situation without further delay.

M.K. When a safety issue is identified, and the committee requires additional information or resources, the committee will bring the issue immediately to the attention of one of these functioning committees:

M-1.K.1. Specific Service Line Committee Chair in which the threat is occurring

M-2.K.2. Medical Staff Quality Improvement Committee (MSQIC) Chair

M-3.K.3. Medical Staff Executive Committee Chair.

N.L. IC Committee medical staff will collaborate with others as appropriate to make decisions based on patient/employee safety.

O.M. All situations that are identified, their level of criticality, actions taken, and any follow up recommendations will be reported through the IC Committee to the MSQIC and/or Board Quality Council (BQC) Hospital Quality Improvement Committee (HQIC), as appropriate.











Infection Prevention Goal #5	Measurable Objective	Measurement/Evaluation
▶ Prevent transmission of MRSA in the facility	Maintain zero percent rate of inpatient transmission of healthcare-acquired MRSA infections for <del>2015</del> 2014.	Measure and report MRSA infection transmission for <del>2015</del> 2014 Report MRSA rates via NHSN.
Infection Prevention Goal #6	Measurable Objective	Measurement/Evaluation
▶ Prepare for and protect staff, <del>patients and our community</del> from influenza exposure <del>at BRH</del> in the workplace	Staff influenza vaccination at rates <del>90% or greater for the 2015-2016 influenza season</del> greater than 2013-2014 season.	Compile staff influenza vaccination rates for <del>2014-2015</del> 2013-2014 seasons and compare to prior year. Report data via NHSN.
Infection Prevention Goal #7	Measurable Objective	Measurement/Evaluation
▶ Prevent transmission of norovirus in the facility	No norovirus transmission will be identified in <del>2015</del> 2014.	No documented norovirus transmission among patients <del>or staff</del> in <del>2015</del> 2014.

## **Bartlett Regional Hospital**

Title: **UTILIZATION MANAGEMENT PLAN**

Department/s: All Clinical Departments

Original Date: 10/1997

Author: Betty Stidolph

### **PURPOSE:**

1. The Utilization Management Plan is an organization wide, interdisciplinary approach to balancing the quality, cost, and risk concerns in the provision of patient care.
2. This plan strives to promote and maintain high levels of integrity in keeping with the mission statement and vision of BRH.

### **DEFINITIONS:**

Intensity of Services (IS) is criteria that consist of monitoring and therapeutic services, singularly or in combination that can only be administered at a specific level of care.

Severity of Illness (SI) is criteria that consist of objective, clinical indicators of illness that focus on an individual patient's clinical presentation rather than the diagnosis.

Condition Specific Subsets are used as another form of Interqual Review. These are appropriate for reviewing only the disease process identified.

Utilization Management (UM) is evaluation of the medically necessary appropriateness and efficiency in the use of healthcare service, procedures and facilities.

Utilization Review (UR) is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered.

### **Policy**

- A. The Board of Directors of Bartlett Regional Hospital has delegated the responsibility for the performance of utilization review activities to the Case Managers (CM) with the Health Information Management/Case Management Committee as the oversight committee.
- B. The Utilization Management Plan is based on CMS conditions of participation, JCAHO standards and Interqual criteria for healthcare utilization and seeks to resolve problems that cause or result in either deficient or excessive resource utilization. The plan will be reviewed at least annually by the Health Information Management/Case Management Committee.
- C. All patients, regardless of payment source, shall be evaluated using the same criteria to determine the severity of illness and intensity of services to ensure that resources are utilized appropriately.



- D. The written Scope of Services will service to identify and delineate the activities of the department.
- E. Utilization management and review are integral parts of the Process Improvement Plan at BRH and will be under the auspices of the CEO with direct reporting to the Health Information Management/Case Management Committee.
- F. The Case Managers will be responsible for the process of measuring and assessing, maintaining and monitoring the effective utilization of hospital facilities and services resources. This shall include, but not be limited to:
  - F.1. Management of LOS
  - F.2. Monitoring use of bed days
  - F.3. Management of transfers
  - F.4. Identifying the appropriate level of care
  - F.5. Managing denials and appeals
  - F.6. Performing admission, concurrent, discharge and retrospective reviews
  - F.7. Tracking and monitoring cost and quality (Including examining patterns of utilization)
  - F.8. Concurrent review of Core Measures on most inpatient populations
- G. The Utilization Management Plan recognizes the authority of Livanta and the assessment and monitoring of review activities performed by Livanta. Outliers will be reviewed by the Health Information Management/Case Management.
- H. Patient and physician confidentiality will be maintained at all times in accordance with the BRH compliance policy and peer review laws of the State of Alaska. Case Management daily work and/or studies will be available only to representatives of the Medicare intermediary, third party payers, Livanta or QHC, the attending physician, members of the Health Information Management/Case Management Committee, the hospital administrator and the Bartlett Regional Hospital Board of Directors.
- I. The CM will keep the physician involved in the utilization management process by:
  - I.1. Maintaining open lines of communication.
  - I.2. Review admission status based on accepted criteria and clarify admission status with physician if in question and recommend a change to appropriate status (ultimately it is physician's prerogative to decide the status).
  - I.3. Review continued stay documentation and identify needed changes or additions to ensure that documentation supports 'physician intent.'
- J. The CM will involve the medical staff in Appeals and Denials through direct communication to provide the information needed to deal with the appeal or denial.
- K. Patients that do not meet admission criteria for severity of illness or intensity of services may be admitted to observation status by the admitting provider if observation criteria are met. Those patients who do not meet criteria for inpatient care or observation services shall be notified by the CM that the services are not covered and that the individual or family may be responsible for payment of the services. The appropriate Hospital Issued Notice of Non Coverage will be given to the patient or their representative.

- L. Case Management will present a report at the quarterly Health Information Management/Case Management Committee on those patients who are considered outliers in length of stay (greater than 14 days) or costs and identify the reasons that caused the outlier status.

## **SCOPE**

Applies to Case Management Coordination for all BRH inpatients, RRC inpatients and outpatients

## **PROCEDURE:**

- A. Preadmission certification for outpatient procedures, surgical procedures, specialties care and inpatient admissions (if required) will be the responsibility of the provider's office.
- B. Patient Access Services will perform insurance verification and inform the Case Management Department within 1 business day of required reviews.
- C. Medical Necessity:
  - 1. Hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. Case Management will assess the order to admit for:
    - a. Authentication of the order: the physician certifies that the inpatient services were in accordance with the Medicare regulations governing the order. This includes
  - D. Reason for inpatient services: The reason for either- (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for cost outlier cases under the inpatient prospective payment system (IPPSA)
    - C.1. CM will establish the medical necessity for admissions and continued stay based on a set of support criteria that are intended for use as a guideline in conjunction with sound clinical judgment as a risk adjuster.
    - C.2. Admission reviews will be performed within the first working day following admission. If CM is unable to determine the necessity for admission, the Health Information Management/Case Management Committee will notify the physician to obtain more information regarding the need for admission or to explore the provision of care in an acceptable setting.
    - C.3. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans and other documentation. The Health Information Management/Case Management Committee will remain in contact with the attending physician, the business office and the payer during the hospital stay to resolve questions and to share information regarding discharge plans.

- D. Continued Stay Reviews will be conducted for all patients who exceed the standard length of stay for the primary diagnosis. The Health Information Management/Case Management Committee will review the physician's documentation to determine why the stay is exceeding the standard length of stay and work with the primary care provider to ensure that justification exists for the continued stay.

### **References**

- (1) Certified Professional Utilization Review Study Guide  
Interqual Products Group 2013
- (2) Federal Register Volume 66, No. 231
- (3) Llvanta Quality Improvement Organization
- (4) ICD 9 CM: Hospital and Payer Volumes 1, 2 & 3  
Medicare 2006
- (5) Interqual Level of Care Criteria: Acute Adult / Acute Pediatric  
McKesson Health Solutions 2014  
Length of Stay by Diagnosis Western Region 2012  
Solucient LLC
- (6) Length of Stay by Operation Western Region 2005  
Solucient LLC
- (7) Medicare Hospital Manual section 230.6E
- (8) Health Utilization Management Standards, Version 5.0  
URAC 2006
- (10) CMS Conditions of Participation 482.30 Utilization Review

### **Attachments**

- (1) Health Information Management/Case Management Committee report forms:
  - 2.1 Denied Days Status Report
  - 2.2 Disposition Status Report  
Outlier Status Report
  - 2.3 Medicare Observation letter
  - 2.4 Advanced Beneficiary Notice
  - 2.5 HINN letters
  - 2.7 Certification of Inpatient Level of Care

**Attachment #1**

**Bartlett Regional Hospital  
HIM/Case Management  
Denied Days Status Report  
Date**

MEDICAL RECORD #	ADMISSION DATE	DISCHARGE DATE	ADMITTING DIAGNOSIS	REASON FOR DENIAL

**Bartlett Regional Hospital**Title: **SAFETY MANAGEMENT PLAN**Department: **EOC Safety** Document Owner/Department: **ALL**Original Date: **12/27/13**Author: **Safety Committee**

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**PURPOSE**

Bartlett Regional Hospital's (BRH) commitment to a safety management plan is designed to provide a physical environment free of hazards and to manage staff activities to minimize the risk of human injury. It shall be directed to the safety of all employees, patients, and visitors interacting with the facility. This safety management program will be an interactive process involving all staff members in its implementation and will be comprehensive in scope. It shall ensure that personnel are trained to interact effectively with their environment and the equipment they use. All elements of the Environment of Care (EOC) are incorporated or serve to support the BRH Safety Management Plan.

**SCOPE**

Bartlett Regional Hospital has established and maintains a Safety Management Plan. The Safety Management Plan is risk based and describes how the organization will provide a physical environment free of hazards and manages staff activities to minimize the risk of injuries. This safety management program will be an interactive process involving all staff members in its implementation and will be comprehensive in scope. It shall ensure that personnel are trained to interact effectively with their environment and the equipment they use.

The plan provided processes for:

- A. Develop and maintain a written management plan that describes processes implemented to effectively manage the environmental safety of patients, staff and other people coming to BRH.
- B. Identify an individual(s) designated by leadership to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminates summaries of actions and results.
- C. Identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten damage to equipment or buildings.
- D. Conduct a proactive risk assessment that evaluates the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff and other people coming to BRH facilities.
- E. Identify risks to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff and other people coming to BRH facilities.
- F. Establish Safety policies and procedures that are distributed, practiced, enforced, and reviewed as frequently as necessary, but at least every three years.
- G. Ensure appropriate responses to product notices and safety.
- H. Ensure that all grounds and equipment are maintained appropriately.
- I. Conduct environmental tours (Swarms) to identify environmental deficiencies, hazards, and unsafe practices.

- J. Environmental tours are conducted at least every six months in all patient care areas and at least annually in all non-patient areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate Environment of Care (EOC) risks.
- K. Adhere to the City and Borough Tobacco Ordinance 2007-20 and implements a process for monitoring compliance within the hospital and developed strategies to eliminate the incidence of tobacco use policy violations when identified. BRH encourages patients who do smoke to quit and provides education including information about smoking cessation options. BRH has a "Tobacco Free Campus Policy" that resides in Policy Tech. The hospital policy prohibits tobacco use in all buildings and on its campus.
- L. Utilize internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as *Sentinel Event Alerts*.
- M. Select one high risk process at least every 18 months and complete a proactive risk assessment (LD.04.04.05 EP # 10).
- N. The hospital identifies activities to minimize or eliminate the risk of worker injuries.

**OBJECTIVES**

- A. Comply with all relevant safety standards and regulations.
- B. Enforce current safety practices for staff, patients, physicians, and visitors.
- C. Provide regular safety education to all staff.
- D. Monitor the effectiveness of the safety program
- E. Identify opportunities to improve safety performance

**ELEMENTS OF PERFORMANCE:**

**EC.01.01.01 (1.)**

Leaders identify an individual-(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results.

BRH appoints a Safety Committee to be responsible for developing, implementing, monitoring, administering and directing an ongoing, organization-wide process to collect information about opportunities for improvement in the BRH Safety Management Program. The Chief Executive Officer appoints a Safety Officer to have the authority and duty to take immediate and appropriate action in the event that a hazardous condition exists which poses threat of life, personal injury illness, or the threat of damage to property.

The Safety Committee (a multidisciplinary team composed of representatives of Administration, Quality, Risk Management, Clinical Services, Support Services, Infection **Prevention**, Facilities, and the BRH Safety Officer) examines and addresses all safety and health issues to ensure these issues are analyzed and addressed in a timely manner.

The Board Quality Council receives reports of the activities of the Safety Management Program, reviews reports, and communicates concerns about identified issues and regulatory compliance. The Board of Directors provides support to facilitate the ongoing activities of the Safety Program.

The Joint Commission places the responsibility for ensuring a safe environment on Senior Management. The CEO receives regular reports of the activities of the Safety Program through EOC. The CEO may delegate these functions to another member of the Senior Management team. The designee shall report to the CEO on all safety issues.

**EC.01.01.01 (2.)**

Leaders identify an individual(s), to intervene whenever environmental conditions immediately threaten health or threaten damage to equipment or buildings.

Administration has delegated to the Safety Officer, or his designee, the authority to take action when hazardous conditions or potential hazardous conditions exist or to intervene whenever environmental conditions immediately threaten life, health or threaten to damage equipment or buildings.

The Safety Committee is comprised of members who are chosen based upon their specific roles in the facility, special skills or experience, and their ability to work proactively in a group to provide action and results. Members are to include representation from Administration and supervisory personnel from clinical and support services. Members of the Safety Committee also have the authority to intervene when hazardous conditions exist that could result in personal injury to individuals or damage to equipment or buildings.

**EC.02.01.01 (1.)**

~~The hospital conducts annual comprehensive proactive risk assessments of high-risk processes that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff and other people coming to the hospital's facilities.~~ The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.

BRH Safety and Security Patrols provide comprehensive proactive risk assessments and any occurrences are reported to Risk Management. This is designed to proactively evaluate the impact on patient care as it relates to the safety of the buildings, grounds, internal physical systems and the safe practices of hospital employees.

The ongoing monitoring of performance regarding actual or potential risks in the environment of care is identified and communicated to the organization's leaders at least annually for consideration and possible inclusion in the Hospital's priority for improvements.

1. Through a multi-disciplinary approach, all hospital personnel participates in creating an environment and culture of safety.
2. Risk management policies and procedures on adverse incidents/occurrences and sentinel events are reviewed/revised annually to reflect changing and emerging trends related to patient and environmental safety.

**EC.02.01.01 and EC.04.01.03**

The hospital uses the risks identified to select and implement procedures and controls to achieve the

lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the hospital facilities.

Results of incident reporting aggregated data is reported by the Risk Manager through the appropriate hospital committees with recommendations for process/systems improvement.

Based on outcome, implementation of performance improvements are monitored by the Risk Manager for sustained process/systems improvement and results are reported for tracking and trending.

Through a proactive Risk Management Plan, risk exposure assessment of loss, control and risk reduction activities are identified through the internal incident reporting system. A corrective action plan is implemented with interventions, monitoring and evaluation for performance improvements which are addressed by the leadership, medical and hospital staff.

**LD.04.01.07 (2.)**

The hospital manages the implementation of safety policies and procedures that are distributed, practiced, and reviewed as frequently as necessary, but at least every three years.

The Safety Committee will develop written policies and procedures to enhance safety within the hospital and its grounds. Departments may maintain individualized safety policies as needed. All safety policies will be reviewed as necessary, but at a minimum of every three years. Revisions or changes will be reviewed by the Safety Committee.

The ultimate responsibility for development and maintenance of current department specific safety policies shall lie with the department directors with the assistance of the Safety Committee as appropriate.

**EC.02.02.01 (11.)**

The hospital responds to product notices and safety recalls.

An ongoing hazard surveillance program including response to product notices and safety recalls shall be maintained and reported through Risk Management to the Safety Committee then forwarded to the Environment of Care Committee. Hazard Surveillance Inspection Surveys (Swarms) will be conducted semi-annually in each area where individual department are service-oriented and annually in all other departments of the hospital. All surveys will be evaluated to determine if trends or patterns are present. A report will then be submitted to the Environment of Care Committee identifying deficiencies, recommendations, action taken and resolutions of the deficiencies following each survey.

All product safety alerts, hazard notices and recalls will be directed to the appropriate Department Director. The Biomedical staff or /designee will check the clinical equipment inventory for equipment matches and evaluate the severity of the risk. In most cases, the notices will be addressed without removing equipment from service. In the event equipment must be removed from service, the equipment is replaced with a safe effective substitute. The Facilities Director, Biomedical staff or designee will impound equipment removed from use due to recall notices until it can be rendered safe. Hazard notices, recalls and follow up will be reported monthly to the Environment of Care Committee.

**EC.02.01.01 (5.)**

The hospital maintains all grounds and equipment.

The Facilities Director/designee is responsible for supervising the activities of the ground's maintenance crew. The ground's maintenance crew will maintain the property and equipment according to the expectations of the hospital.



**EC.02.01.03 (6.)**

The hospital takes action to maintain compliance with its smoking policy.

Patients and visitors are reminded of the Tobacco Free Campus policy. All employees are requested to inform violators of the tobacco use policy. If there is resistance or the patient or visitor refuses to comply, the Security Officer/designee may be asked to intervene and escort the visitor from the building or the patient's admitting physician will be contacted and asked to resolve the situation or discharge the patient. If an employee is found smoking their direct supervisor will be notified and disciplinary action will be taken, if it is a contractor, they will be asked to leave the facility.

**EC.04.01.01 (14.)**

The hospital uses its tours to identify environmental deficiencies, hazards, and unsafe practices.

Members of the Safety Committee conduct environmental tours (Swarms) to identify environmental issues, hazards and unsafe practices. Data will be aggregated and reported back to the Safety Committee. Deficiencies will be reported to the department director and returned back to the Safety Committee completed.

**EC.04.01.01 (15.)**

Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

The annual evaluation of the Safety Management Program will include a review of the scope according to the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.

The performance and effectiveness of the Environment of Care Management Program shall be reviewed by the Environment of Care Committee and the Board Quality Council and Administration.

**EC.04.01.03 (1.)**

Representatives from clinical, administrative, and support services participate in the analysis of environment of care data.

BRH's Environment of Care Committee includes representatives from clinical, administrative, and support services who participate in the analysis of environment of care data on an annual basis.

**REFERENCE:** BRH P&P "*Tobacco Screening Inpatient Treatment and Referral.*" (Published policy resided in the Respiratory Department); 2013 HAS, January (EC1-EC28).

[Joint Commission Hospital Accreditation Standards. The Joint Commission, 2013.](#)

| [Environment of Care and Leadership Standards.](#)

<b>Bartlett Regional Hospital</b>	
Title: Life Safety Management Plan	
Department/s: All Departments	
Original Date: January 2002	Author: M. Walker

**PURPOSE:** To provide an environment of care that is fire-safe and to design processes to prevent fires and protect patients, staff, and visitors in the event of a fire. The goals include the following:

- A. To assure that the building is in compliance with applicable NFPA standards for hospitals;
- B. To provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire,
- C. To assure that personnel training in the Life Safety Management Program is effective,
- D. To test and maintain the fire alarm and detection systems,
- E. To institute interim life safety measures during construction or fire alarm or detection systems failures.

**RESPONSIBILITY:**

- The Facilities Manager and the Life Safety Management sub-committee of the Environment of Care committee share joint responsibility for the Life Safety Program and maintaining compliance with the Life Safety Code.
- Each department manager is responsible for orienting new staff members to the department and job specific fire safety procedures.
- All employees of Bartlett Regional Hospital are responsible for learning the hospital wide and departmental fire safety plans.

**POLICY:**

**A. THE PROTECTION OF PATIENTS, EMPLOYEES, VISITORS AND PROPERTY FROM FIRE, SMOKE AND OTHER PRODUCTS OF COMBUSTION:**

- A.1. Provide appropriate fire protection equipment, employee training and interim life safety measures.
- A.2 In-service employees on the organizational response to fire, general fire safety, instructions for their departments and/or worksites, location of fire extinguishers, oxygen shutoffs and evacuation routes.
- A.3. Oxygen shutoffs will be the responsibility of the supervisor in charge of the area in which these valves are located. Turn off valves only if told to do so.
- A.4. Fire Emergency required knowledge for all employees:
  - A.4.1. Know the location of the nearest fire alarm.
  - A.4.2. Know the emergency number to dial. Dial "8900".
  - A.4.3. Know the location of fire extinguishers and how to use them.
  - A.4.4. Know the location of all exits.
  - A.4.5. Know proper evacuation procedures and routes.
- A.5. Each department has departmental fire procedures which can be found in Policy Tech: Vol. 2 Annexes: Fire or for general response, refer to the Emergency Colored Flipchart

## **B. INSPECTING, TESTING AND MAINTAINING FIRE PROTECTION AND LIFE SAFETY SYSTEMS:**

- B.1. The following fire alarm and detection equipment is tested and documented as required by NFPA:
  - B.1.1. Initiating devices are tested:
    - B.1.1.1. All supervisory signal devices (except valve tamper switches) at least quarterly.
    - B.1.1.2. All valve tamper switches and water flow devices at least annually.
    - B.1.1.3. All duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm pull stations and smoke detectors annually
    - B.1.1.4. Occupant alarm notification devices are tested at least annually including all audible devices, speakers and visible devices.
    - B.1.1.5. Off-site emergency forces notification transmission equipment is monitored automatically and continually by the fire alarm system and alarm monitoring service. For more details see Fire Alarm System policy.
  - B.1.2. All automatic extinguishing and protection equipment shall be inspected and tested as follows
    - B.1.2.1. Main drain tests - at least annually at all system risers;
    - B.1.2.2. Fire department connections - inspected at least quarterly;
    - B.1.2.3. Kitchen automatic fire extinguishing systems – every 6 months - (discharge of fire extinguishing system not required);
    - B.1.2.4. Portable fire extinguishers inspected at least monthly; maintained at least annually. For more details see the Fire Extinguisher Program policy.
    - B.1.2.5. Fire and smoke dampers - at least every 6 years to verify they fully close;
    - B.1.2.6. Automatic smoke detection shutdown devices for air handling equipment is monitored and tested annually;
    - B.1.2.7. Helipad Fire Suppression will be tested annually
  - B.1.3. Fire Door Inspections
    - B.1.3.1 All fire doors shall be inspected annually in accordance with procedures given below.
    - B.1.3.2 Inspect condition of all door hardware (hinges, crash bar hardware, etc.).
    - B.1.3.3 Inspect for positive latching of doors when released and closing under own weight.
    - B.1.3.4 Any deficiencies shall be noted and immediate steps taken to correct them.
    - B.1.3.5. Horizontal and vertical sliding and rolling fire doors - at least annually for proper operation and full closure.

## **C. REPORTING AND INVESTIGATING LIFE SAFETY CODE AND FIRE PROTECTION DEFICIENCIES, FAILURES AND USER ERRORS:**

- C.1. A comprehensive plan to correct any Life Safety deficiencies, which occur or are identified will be developed immediately in writing and will address:
  - C.1.1. All Life Safety Code deficiencies
  - C.1.2. Corrective actions (plan for improvement)
  - C.1.3. Total cost of actions and specific funding information
  - C.1.4. Reasonable schedule for completion, prioritized with available funding and concurrent projects
  - C.1.5. Interim life safety measures will be implemented and enforced as necessary

C.2. All fire protection equipment failures or user errors shall be reported immediately and appropriate action taken. When a user error occurs, retraining will be conducted.

**D. ANNUAL EVALUATION OF THE LIFE SAFETY MANAGEMENT PLAN:**

- D.1. Review of the scope based the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital.
- D.2 Compare expectations and actual results of the program to determine if the goals and objectives of the program were met.
- D.3 Evaluate the overall effectiveness of the program determining the degree that expectations where met, including an evaluation of the effectiveness of personnel training related to the Life Safety Plan and its components.
- D.4. The performance and effectiveness of the Life Safety Management Program shall be reviewed by the Environment of Care Committee, with summary reports delivered to the Board Quality Council.
- D.5. Annual Evaluation documentation will be maintained.

**E. PERFORMANCE STANDARDS:**

- E.1. The Environment of Care Committee monitors performance regarding actual or potential risk related to one or more of the following:
  - E.1.1. Staff knowledge and skills;
  - E.1.2. Level of staff participation;
  - E.1.3. Monitoring and inspection activities;
  - E.1.4. Emergency and incident reporting;
  - E.1.5. Inspection, preventive maintenance and testing of safety equipment
- E.2. Performance improvement monitoring and outcome activities will be presented to the Environment of Care Committee by the Safety Officer and Life Safety Subcommittee annually.
- E.3. The following performance measures are suggested:
  - E.3.1. Percent of staff able to demonstrate their knowledge, skill and level of participation in the life safety management program.
  - E.3.2. Number of fire drills conducted with at least 50% of these on an unannounced basis
  - E.3.3. Percent of staff who can describe organizational protocols for fire response
  - E.3.4. Percent of staff who can describe evacuation procedures for their unit
  - E.3.5. Percent fully operational fire doors
  - E.3.6. Percent of tests completed for:
    - E.3.6.1. Supervisory signal devices - Quarterly
    - E.3.6.2. Valve tamper switches - Semiannually
    - E.3.6.3. Duct detectors - Annually
    - E.3.6.4. Smoke detectors - Annually
    - E.3.6.5. Heat detectors - Annually
    - E.3.6.6. Manual fire alarm pull stations - Annually
    - E.3.6.7. Electromechanical releasing devices - Annually
    - E.3.6.8. Occupant alarm notification devices - Annually
    - E.3.6.9. Emergency forces notification transmission equipment - Quarterly

**F. EMERGENCY PROCEDURES**

- F.1. Emergency procedures will be developed and updates maintained in Policy Tech.
- F.2. The following emergency procedures will be implemented in the event of a fire:

- F.2.1. **R** = Rescue or remove person(s) from immediate fire scene / room.
- F.2.2. **A** = Alert personnel by activating nearest fire alarm pull station, then call PAS (dial 8900) and report exact location of the fire.
- F.2.3. **C** = Confine fire and smoke by closing all doors and windows in the area.
- F.2.4. **E** = Extinguish the fire using fire extinguisher if safe to do so.
- F.3. General Instructions for All Employees:
  - F.3.1. Keep telephone lines clear for fire control.
  - F.3.2. Do not use elevators.
  - F.3.3. Make sure all fire, corridor and room doors are closed.
  - F.3.4. Clear all corridors of equipment and obstructions.
  - F.3.5. All nursing personnel shall report to their areas and remain there for instructions.
  - F.3.6. All other personnel shall report to their areas and await emergency assignment as needed.
  - F.3.7. Reassure patients. Inform them that the alarm has been turned in, the emergency plan is in effect, and there is an abundance of help to assist as needed.
  - F.3.8. Know evacuation routes
  - F.3.9 Keep exits clear of obstructions
- F.4. See Emergency Management Plan; Vol. 2 Annexes: Fire

## **G. REVIEW OF PROPOSED ACQUISITIONS OF FURNISHINGS AND EQUIPMENT FOR FIRE SAFETY**

- G.1. All purchases of hospital furnishings and equipment will be reviewed to assure that they meet the NFPA requirements for fire retardant or non-combustibility.
- G.2. The Safety Officer and the Director of Materials Management are responsible for reviewing new products to verify they meet code requirements.
  - G.2.1 Materials Management will inform the Safety Officer of any unavailability of NFPA approved items.
- G.3 The Facilities Director is responsible for the installation of fire rated products during construction.

## **H. ORIENTATION AND EDUCATION TO LIFE SAFETY PROGRAM**

- H.1. All personnel (including volunteers, students, interns, physicians and other licensed independent practitioners) will be oriented to the Life Safety Plan and their roles in the event of a fire. This includes:
  - H.1.1 use of fire alarm systems
  - H.1.2 containing smoke/fire with building compartmentalization,
  - H.1.3 preparing for building evacuation including the location and proper use of equipment to evacuate or transport patients to a safe area.
- H.2 All new personnel will receive general fire safety information before beginning work in their respective departments.
- H.3 Department specific orientation will be done in their home department by knowledgeable staff to include:
  - H.3.1 location of fire alarm pull stations and extinguishers,
  - H.3.2 evacuation routes, including all exits
  - H.3.3 department specific fire hazards,
  - H.3.4 department specific concerns.
- H.4 All employees will review fire safety information at least annually in a mandatory continuing education program (classroom, self-study, or online review)

- H.4.1 Attendance records will be maintained by the employee and the education department for mandatory training
- H.4.2 The Life Safety Subcommittee will obtain data on the number of employees completing orientation and continuing education and report to the EOC Committee.
- H.5 Fire Drills will be conducted based on recommendations:
  - H.5.1 Clinical Areas: one per quarter per shift
  - H.5.2 Business offices: one per year
- H.6. Effectiveness of the education and training program will be evaluated via ongoing review of fire drill critiques and periodic random on-site “swarming”.

**I. MAINTAINING BUILDING STRUCTURAL REQUIREMENTS FOR FIRE PROTECTION:**

- I.1. All buildings associated with Bartlett Regional Hospital will maintain compliance with the appropriate provisions of the Life Safety Code of NFPA. Documentation of all life safety requirements will be maintained on an ongoing basis. The Facilities Director is responsible for maintaining and managing all structural elements of life safety.
- I.2. During periods of construction, renovation, transition, see Interim (Construction) Life Safety Policy.

**REFERENCES:**

Interim (Construction) Life Safety Policy  
 Emergency Management Plan: Vol. 2 Annexes: Fire (available in Policy Tech under Vol. 2 Annex: Fire)  
 Fire Extinguisher Program Policy  
 Fire Alarm System  
 Annual Evaluation of the Life Safety Management Program (available on the “W” drive)

Approval/Review/Revision					
Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)
03/13/08	revised				
05/29/09	Revised Debbi Lehner, COO				
02/11/10	Review				
2/8/13	revised				
12/23/13	revised				

**POLICY:** It is the policy of Bartlett Regional Hospital to comply with all federal, State of Alaska laws and regulations relating to the proper and safe handling and disposal of all hazardous materials and waste.

**PURPOSE:**

- A. Bartlett Regional Hospital provides comprehensive healthcare and health promotion for the people of Juneau and communities of northern Southeast Alaska.
- B. To this effort Bartlett Regional Hospital provides a healthy and safe environment for our patients, visitors and staff by maintaining a process to effectively manage hazardous materials and waste throughout the facility.

**DEFINITIONS:** Hazardous Material: Any material for which there is a physical or health hazard.

**SCOPE:**

- A. The scope of the Hazardous Materials and Waste Management Plan defines the processes which Bartlett Regional Hospital utilizes to provide a safely controlled environment where hazardous materials are used in the facility by proactive risk assessments to reduce the risk of injury.
- B. Hazardous materials and waste risks are continually assessed and reviewed during hazard surveillance rounds, the collection of information through occurrence reports, product management and review by the EOC Committee. Risk levels are determined by the level of potential consequences that are associated with the types, quantities, and inherent physical and chemical properties of the hazardous materials utilized by the facility.

**OBJECTIVE:** The objective of the Hazardous Materials and Waste Management Plan is to develop a system that addresses the identification, selection, handling, storage, use and disposal of hazardous materials and wastes.

**GOALS:**

- A. The goals of the Hazardous Materials and Waste Management Plan include the following:
  - A.1. To provide education to personnel on the elements of the Hazardous Materials and Waste Management Program.
  - A.2. To identify, evaluate and inventory hazardous materials and waste generated or used consistent with applicable regulations and laws;
  - A.3. To establish emergency procedures to use during hazardous materials and waste spills or exposures.



**RESPONSIBILITY:** The Laboratory Manager and members of the subcommittee are responsible for developing and accessing (through monthly swarms) the Hazardous Materials and waste Management Program.

**PROCEDURE:**

- A. Hazardous Materials and Waste Selecting, Handling, Storing, Transporting, Using and Disposing from Receipt or Generation through Use or Final Disposal:
- A.1. A system of products and forms has been developed that addresses the identification of hazardous materials and waste from selection to the point of final disposal. Policies and procedures related to various hazardous materials and wastes are reviewed, revised and approved by the Haz-Mat Sub-Committee and EOC.
  - A.2. The department managers will review the use of hazardous materials in their departments. Recommendations should be taken Haz-Mat Sub-Committee.
  - A.3. In an effort to reduce the use of hazardous materials, the department managers shall review literature referencing the reduction of toxic materials and make recommendations regarding less hazardous products to the Haz-Mat Sub-Committee.
- B. Written Criteria is Established Which is Consistent with Local, State and Federal Law to Identify, Evaluate and Inventory Hazardous Materials Used or Generated:
- B.1. Bartlett Regional Hospital will keep a list of materials classified by state and federal standards, i.e., OSHA, EPA, as being hazardous material or waste. A copy of the list will be kept on the "W" drive under MSDS.
  - B.2. Each department will be responsible for identifying and labeling all hazardous materials and waste within their department/area.
    - B.2.1. Each department manager is responsible for ensuring the updated MSDS is added to the system.
  - B.3. A Material Safety Data Sheet is to be obtained for every chemical used in the hospital and identified as hazardous. A master file of all Material Safety Data Sheets is available on-line via Internet access under favorites.
- C. The Management of Chemical Waste, Chemotherapeutic Waste, Radioactive Waste and Regulated Medical Waste (i.e., Sharps):
- C.1. Policies and procedures relating to chemical and physical hazards shall be reviewed by the Haz-Mat Sub-Committee, EOC Committee and the Infection Control Committee for infectious hazards on an annual basis.
  - C.2. All antineoplastic drugs shall be handled with special precautions according to instructions from the manufacturer. All waste from antineoplastic drugs must be disposed of as hazardous waste in leak-proof, puncture-proof and appropriately marked containers specified for such. All antineoplastic drugs identified as hazardous by the US Environmental Protection Agency/Resource Conservation and Recovery Act (USEPA/RCRA) standards will be handled according to standards set forth by USEPA/RCRA, Occupational Safety and Health Administration (OSHA) standards, the Hazard Communication Standard, the Occupational Exposure to Hazardous Chemicals in Laboratories Standard and OSHA's Controlling Occupational Exposure to Hazardous Drugs guidelines.

- C.3. All radioactive materials are disposed of in accordance with the Nuclear Regulatory Commission Regulations.
- C.4. All sharps, including hypodermic needles and syringes, suture needles, knife blades, trocars from drains and opened glass ampoules of medicine will be disposed of into puncture-proof sharps containers.

D. Adequate and Appropriate Space and Equipment is Provided for the Safe Handling and Storing of Hazardous Materials and Waste:

- D.1. All hazardous materials are received in the department by appropriate personnel and stored in a designated supply closet for chemicals only. Chemicals are properly labeled with a description of the hazard they represent.
- D.2. Materials which ignite easily under normal conditions (flammable), are considered fire hazards and will be stored in a cool, dry, well-ventilated storage space, away from areas of fire hazard.
- D.3. Highly flammable materials will be kept in an area separate from oxidizing agents (material susceptible to spontaneous heating, explosives, etc.).
- D.4. The storage area for flammables will be supplied with fire-fighting equipment, either automatic or manual. There will be "flammable material" signs posted in and around the storage area.
- D.5. Oxidizers will not be stored close to liquids of low flash point.
- D.6. Acids and acid-fume-sensitive materials will be stored in a cool dry, well-ventilated area, preferably wooden.
- D.7. Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids or acid fumes will be stored in a cool, well-ventilated place out of the direct rays of the sun. Incompatible toxic materials will be isolated from each other.
- D.8. Corrosive materials will be stored in a cool, well-ventilated area (above their freeze point). The containers will be inspected at regular intervals to ensure they are labeled and kept closed. Corrosives will be isolated from other materials.
- D.9. Personal protective clothing and equipment will be available for use when handling these materials. Staff are trained in the appropriate use of personal protective clothing and equipment by their department manager.

E. Hazardous Gas and Vapors Monitoring and Disposing:

- E.1. Cylinder trucks and supports and cylinder valve protection caps will be used. All full cylinder storage areas shall be protected from extremes of heat and cold and from access by unauthorized individuals.
- E.2. Regular visual inspections of compressed gas cylinders are performed to ensure cylinders are in safe condition.
- E.3. All pressure relief safety devices meet the Compressed Gas Association (CGA) requirements.
- E.4. Oxygen cylinders must be stored a minimum of 20 feet apart from fuel-gas cylinders or combustible materials.
- E.5. Oxygen equipment must not come in contact with any form of grease or oil.
- E.6. Areas using formaldehyde will be identified and monitored according to federal and state law.

F. All Hazardous Materials or Waste Spills, Exposures and Other Incidents are Reported and Investigated:

F.1. An occurrence report will be completed on all hazardous materials and waste spills and exposures. The department managers shall investigate all hazardous materials and waste spills and exposure. The occurrence report will be reviewed and studied by the Risk Manager to determine the cause of the incident and if follow-up is needed by department managers. The Quality Improvement (Q.I.) Department will provide a monthly report of all hazardous materials occurrences to the Haz-Mat Sub-Committee.

G. Permits, Licenses and Adherence to Other Regulations are Maintained:

- G.1. Hazardous waste generation will be tracked, controlled and managed according to OSHA, DOT, EPA and state regulations.
- G.2. Bartlett Regional Hospital processes biohazard waste from various medical offices and other businesses.
- G.3. Biohazard waste generated by the hospital is processed through the Sanipak system. All other items, identifiable body parts and radioactive and cytotoxic waste will be dealt with as appropriate in accordance with state and federal laws.

H. Required Manifests for Hazardous Materials and Waste are Maintained:

- H.1. A component of the management and disposition of hazardous wastes is the removal of these materials from the point of generation to a specified treatment, storage or disposal facility.
- H.2. Records will be maintained identifying the generator, quantity, type and disposal action of the hazardous material or waste.
  - H.1.1. A signature is required from the generating facility on each tracking record at the time of pick-up.
  - H.1.2. A signature deems that the waste is compliant and packaged correctly according to regulations.
- H.3. Hazardous waste manifests will be maintained by the Facilities Manager. The Facilities Manager is also responsible for maintaining all documents, including tracking records, shipping documents and the certificate of treatment or disposal for all hazardous materials removed from the facility.

I. Hazardous Materials and Waste are Properly Labeled:

- I.1. Containers of hazardous chemicals must be labeled by the chemical manufacturer, importer or distributor with the following information prior to leaving the workplace:
  - I.1.2. Identity of the hazardous chemical(s) as it appears on the MSDS and chemical list
  - I.1.3. Name and address of the chemical manufacturer, importer or other responsible party
- I.2. Labels must be in English, legible and prominently displayed on the container.
- I.3. Labels and other forms of warnings are legible in English.

J. Hazardous Materials and Waste Storage and Processing Areas are Separated from Other Areas of the Facility:

- J.1. All medical and hazardous waste will be segregated and contained separately from other waste at the point of generation. The department manager is responsible for ensuring there is appropriate separation and the waste is placed in properly constructed and labeled containers.
- J.2. Trained Environmental Services (EVS) staff will utilize red rigid containers to transport biohazard waste bags from the various hospital departments. All containers will be labeled with the universal biohazard symbol. EVS staff will wear the appropriate personal protective equipment when handling and transporting biohazard waste.
- J.3. Biohazard wastes will be stored in a designated locked and secured holding area for final disposal. Warning signs will be posted in English.
- J.4. Medical waste holding areas will be inspected routinely by the EVS Manager. Any deficiencies found will be dealt with promptly.

K. An Orientation and Education Program for Employees who Manage or Have Contact with Hazardous Materials and Wastes is in Place:

- K.1. All persons required to manage or handle hazardous chemicals, materials or waste will be provided with appropriate orientation, personal protective equipment and job training. Each department is responsible for training each individual handling hazardous materials and waste. Employee orientation and education shall include the following:
  - K.1.1. Information about the hazard communication program
  - K.1.2. Identification of the hazardous materials in their workplace and the health hazards associated with handling these materials

L. Performance Standards:

- L.1. EOC Committee will establish and prioritize performance measures.
  - L.1.1. Performance improvement monitoring and outcome activities will be presented to the EOC Committee by the Haz-Mat Sub-Committee at least on a quarterly basis.
- L.2. The following performance measures are recommended:
  - L.2.1. Quality Review will maintain a record of all Hazardous Materials spills and determine the cause. Department Managers will report findings to Quality Review, who will report to the EOC.
  - L.2.2. A Bio-Medical Technician will evaluate the effectiveness of vent hoods throughout the hospital for proper gas/vapor removal, and report findings to the EOC.

M. Annual Evaluation of the Hazardous Materials and Waste Management Plan's Objectives, Scope, Performance and Effectiveness:

- M.1. The annual evaluation of the Hazardous Materials and Waste Management Program will include a review of the scope according to the current Joint Commission (TJC) standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall

performance of the program will be reviewed by evaluating the results of performance improvement outcomes. Each year the overall effectiveness of the program will be evaluated by review of the plans, objectives, scope, performance and effectiveness.

- M.1.1. The performance and effectiveness of the Hazardous Materials and Waste Management Program shall be reviewed by the EOC Committee.
- M.2. Changes in the plan will be forwarded to the EOC Committee for approval.
- M.3. See Annual Evaluation of the Hazardous Materials and Waste Management Plan/Program.

**REFERENCES:**

NIOSH “Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Healthcare Settings”, March 2004.

OSHA standards: Hazard Communication Standard (29 CFR 1910.1200);  
Occupational Exposure to Hazardous Chemicals in Laboratories (29 CFR 1910.1450)

OSHA technical manual guidelines “Controlling Occupational Exposure to Hazardous Drugs”

**ATTACHMENTS:**

Approval/Review/Revision					
Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)
09-01-03	(last version)	120213	Haz-Mat Subcommittee		
12-14-09	Haz-Mat Subcommittee				
012612	Haz-Mat Subcommittee				

## **Bartlett Regional Hospital**

Title: Utility Systems Management Plan

Department: Maintenance

Author: Marc Walker

### **SCOPE:**

The Utility Systems Management Plan monitors and evaluates the utility systems in use at Bartlett Regional Hospital according to applicable laws and regulations.

### **POLICY:**

A safe, comfortable patient care and treatment environment shall be provided by managing the risks associated with safe operation and the functional reliability of the hospital's utility systems.

### **OBJECTIVES:**

- A. The objectives of Bartlett Regional Hospital's Utility Systems Management Plan includes the following:
  - A.1. To minimize the occurrence of unplanned utility systems failures or interruptions;
  - A.2. To provide preventative maintenance of the utility systems ensuring reliability;
  - A.3. To investigate all utility system problems, failures or user errors.

### **RESPONSIBILITY:**

The Facilities Director is responsible for maintaining the Utility Systems Management Program.

#### **A. ASSESS AND MINIMIZE RISKS OF UTILITY FAILURES, REDUCE THE POTENTIAL FOR ORGANIZATIONAL-ACQUIRED ILLNESS AND ENSURE OPERATIONAL RELIABILITY OF SYSTEMS:**

- A.1. The Utility Systems Management Program is designed to assure operational reliability, reduce the potential for organizational-acquired illness, assess risks, respond to failures and train users and operators of the utility systems components, thus promoting a safe, controlled and comfortable environment.
- A.2. There is a comprehensive preventative maintenance program, which includes a written testing and maintenance program for all utility components included in the program at established intervals. It is the responsibility of the Facilities Director to keep the preventative maintenance program accurate and ongoing.
- A.3. See Utility Systems Preventative Maintenance Policies and Forms.

#### **B. CRITERIA ARE ESTABLISHED FOR IDENTIFYING, EVALUATING AND TAKING INVENTORY OF CRITICAL OPERATING COMPONENTS OF SYSTEMS TO BE INCLUDED IN THE UTILITY MANAGEMENT PROGRAM:**

- B.1. The Utility Systems Management Program shall include equipment that meets the following criteria:
  - B.1.1. Equipment maintains the climatic environment in patient care areas;
  - B.1.2. Equipment that constitutes a risk to patient life support upon failure;

- B.1.3. Equipment that is a part of a building system, which is used for infection control;
- B.1.4. Equipment that is part of the communication system, which may affect the patient or the patient care environment;
- B.1.5. Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support or infection control.
- B.2. The following systems are included in the Utility Systems Management Program:
  - B.2.1. Electrical Distribution System
  - B.2.2. Emergency Power System
  - B.2.3. Vertical and Horizontal Transport (elevators)
  - B.2.4. Heating, Ventilation and Air Conditioning Systems
  - B.2.5. Aerosolizing Water Systems
  - B.2.6. Plumbing and Water Delivery Systems
  - B.2.7. Boilers and Steam Delivery Systems
  - B.2.8. Medical Gas Distribution
  - B.2.9. Medical and Surgical Vacuum and Air Delivery Systems
  - B.2.10. Communication Systems
  - B.2.11. Sewage Removal Systems

**C. INSPECTION, TESTING AND MAINTAINING OF CRITICAL OPERATING COMPONENTS:**

- C.1. There is a scheduled maintenance system, which is used to schedule, monitor and document the testing and maintenance of each utility system based on the manufacturer's recommendations.
- C.2. See Preventative Maintenance Policies.

**D. INSPECTION, TESTING AND MAINTAINING OF PIPED MEDICAL GAS SYSTEM:**

- D.1. The Facilities Director will develop policies and procedures for the inspection, testing and maintenance of the piped medical gas system. The testing will include master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors and outlets.
- D.2. See Preventative Maintenance - Medical/Surgical Air and Vacuum System, Preventative Maintenance - Medical Gas System, Piped Medical Gas System Testing.

**E. PIPED MEDICAL GAS TESTING WHEN SYSTEMS ARE INSTALLED, MODIFIED OR REPAIRED:**

- E.1. A qualified person will test all piped medical gas systems when the systems are installed, modified or repaired. The testing will include cross-connection testing, piping purity testing and pressure testing.
- E.2. See Preventative Maintenance - Medical Gas System and Piped Medical Gas System Testing.

**F. MANAGEMENT OF PATHOGENIC BIOLOGICAL AGENTS IN DOMESTIC HOT WATER AND OTHER AEROSOLIZING WATER SYSTEMS:**

- F.1. The Facilities Director in conjunction with the Infection Control Practitioner will develop policies and procedures for the inspection, testing and maintenance of all aerosolizing water systems to ensure optimal use of pathogenic biological agents.
- F.2. See Maintenance and Monitoring of Water Systems Policy.

**G. INSTALLATION AND MAINTAINING APPROPRIATE PRESSURE RELATIONSHIPS, AIR EXCHANGE RATES AND FILTRATION EFFICIENCIES FOR VENTILATION SYSTEMS SERVING AREAS SPECIALLY DESIGNED TO CONTROL AIRBORNE CONTAMINANTS:**

G.1. To reduce the potential for nosocomial infections caused by biological agents, the Utilities Management Program will include the correct design, installation and maintenance of the hospital's air-handling and ventilation systems. Areas of the facility that treat or house patients who may be autoimmune suppressed include operating rooms, special procedure rooms, delivery rooms, protective isolation rooms, laboratories and sterile supply rooms.

The design parameters will follow the American Institute of Architects (AIA) Guidelines for Design and Construction of Hospital and Health Care Facilities, Table 2, page 58, "Ventilation Requirement for Areas Affecting Patient Care in Hospitals and Outpatient Facilities," and Table 3, page 60 "Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals".

G.2. The Facilities Director in conjunction with the Infection Control Practitioner will develop policies and procedures for the inspection, testing and maintenance of all ventilation systems serving areas specially designed to control airborne contaminants such as biological agents, gases, fumes and dust. These areas include, but may not be limited to:

G.2.1. Operating rooms

G.2.2. Special procedure rooms

G.2.3. Delivery rooms

G.2.4. Airborne communicable disease rooms (i.e., "TB" rooms)

G.2.5. Protective isolation rooms

G.2.6. Laboratories

G.2.7. Sterile supply rooms

G.3. The Infection Control Practitioner will maintain a pressure differential log for all negative air pressure rooms used for TB patients.

G.4. The Facilities Director will follow AIA guidelines for filter efficiencies, air pressure relationships, etc.

**H. DEVELOP AND MAINTAIN CURRENT UTILITY SYSTEMS OPERATIONAL PLANS ENSURING RELIABILITY, MINIMIZING RISKS AND REDUCING FAILURES:**

H.1. A comprehensive preventative maintenance program, which includes written testing and maintenance programs for all utility components shall help to ensure reliability, minimize risks and reduce failures of utility systems. It is the responsibility of the Facilities Director to keep the preventative maintenance program accurate and ongoing at the established intervals.

H.2. See Utility Systems Preventative Maintenance Policies and Forms.

**I. MAPPING DISTRIBUTION OF UTILITY SYSTEMS AND LABELING CONTROLS:**

I.1. There are illustrations mapping the distribution of utility systems, which indicate the controls for partial or complete shutdown of each utility system. All emergency shutoff controls for the utility systems components shall be labeled clearly, visibly and permanently throughout the facility.

I.2. See Utility Systems Record Drawings.



**J. INVESTIGATION AND REPORTING INCIDENTS AND CORRECTIVE ACTIONS OF UTILITY SYSTEMS MANAGEMENT PROBLEMS, FAILURES AND USER ERRORS:**

- J.1. The utility systems incident reporting process is the responsibility of the Facilities Director or his/her designee.
- J.2. A Utility Systems Failure Report shall be completed for any problem, failure or user error of a vital or essential system.
- J.3. The Maintenance Department will respond to and correct all identified problems within the scope of their operations in a timely manner. Evidence of the actions taken to resolve identified problems can be located in the Maintenance Department's Daily Log, the completed work orders file and the utility systems failure log.
- J.4. The analysis of the utility systems incidents provides an opportunity to identify trends and/or patterns to determine if changes in the program may control or prevent future occurrences. The Facilities Director supplies a summary of all utility systems failures to the Environment of Care Committee.
- J.5. See Utility Systems Management Problems, Failures, User Errors Policy, Utilities Management Identified Problems Policy, System Failure Report Form, System Failure Report Log Form, Quarterly Report to Environment of Care Committee - Utility System Incidence.

**K. UTILITY MANAGEMENT PLAN INCLUDES AN ORIENTATION AND EDUCATION PROGRAM:**

- K.1. Department specific orientation and education to the utility systems safety is the responsibility of the department Director. All employees will be trained during general orientation and annually thereafter on the process for reporting problems, procedures for maintaining essential functions during utility failures, location of emergency shut off controls and the procedures to follow if they alarm, procedures to follow in the event of an elevator failure and communication equipment protocols. The training is documented and kept in the employee's department personnel file.
- K.2. Personnel will be required to attend an orientation upon hire and regularly scheduled in-services that specifically address utility systems capabilities, limitations, special applications, emergency procedures if failure occurs, maintenance responsibilities, the location and instruction on use of emergency shut off controls and reporting procedures for utility systems problems, failures and user errors. All users/maintainers of equipment shall be tested for competency according to the components of their job specifications.
- K.3. See Utilities Management User/Maintainer Training Policy, Maintenance Department Training Log Form, Utilities User/Maintainer Training Log Form, Utilities Management Continuing Education Policy, and User Training for Utilities Equipment Log, Sample Outlines and Competency Forms.

**L. PERFORMANCE STANDARDS:**

- L.1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organizational Environment of Care Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem

prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

- L.2. The measure can identify the events it was intended to identify:
  - L.2.1. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;
  - L.2.2. The measure has defined data elements and allowable values;
  - L.2.3. The measure can detect changes in performance over time;
  - L.2.4. The data intended for collection are available and Results can be reported in a way that is useful to the organization and other interested stakeholders.
- L.3. The Environment of Care Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:
  - L.3.1. Staff knowledge and skills
  - L.3.2. Level of staff participation
  - L.3.3. Monitoring and inspection activities
  - L.3.4. Emergency and incident reporting
  - L.3.5. Inspection, preventative maintenance, and testing of safety equipment
- L.4. Other performance measures and outcomes will be established by the Environment of Care Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection and aggregation, reporting will be determined by the Environment of Care Committee.
- L.5. To identify opportunities for improvement, the Environment of Care Committee will follow the organization's improvement methodology.
- L.6. Performance improvement monitoring and outcome activities will be presented to the Environment of Care Committee by the Facilities Director at least on a quarterly basis, with a report of performance outcome forwarded to the Governing Body annually.
- L.7. The following performance measures are recommended:
  - L.7.1. Percent of staff able to demonstrate their knowledge and skill of their role and expected participation in the Utility Systems Management Program
  - L.7.2. Number of utility incident reports
  - L.7.3. Number of user errors reported
  - L.7.4. Number of utility failures or interrupts
- L.8. See Performance Improvement Plan and Performance Measures.

**M. EMERGENCY PROCEDURES FOR UTILITY SYSTEMS DISRUPTIONS AND FAILURES:**

- M.1. The Facilities Director is responsible for coordinating activities and ensuring procedures are developed that specify the action to be taken during the failure of major utility services. Emergency procedures include: procedures to follow when a utility system malfunctions; alternate sources of essential utilities; shutoff procedures and controls of malfunctioning system; procedures for notifying personnel in the affected areas; how to obtain repair services; and procedures to perform emergency clinical interventions. The written procedures include a call system for summoning essential personnel and outside assistance when required.
- M.2. All clinical department managers are responsible for developing and maintaining emergency procedures of the utility systems as is relates to their use and application in patient care or treatment areas where a failure, interruption or malfunction could result in a negative patient outcome including serious injury or death. The departmental emergency procedures will provide personnel with the essential information needed to perform during an emergency. The emergency procedures will include:

- M.2.1. Alternate sources of utilities or back-up protection provided;
  - M.2.2. When alternate sources are not available procedures to follow until the utility system can be restored to normal function;
  - M.2.3. Location of emergency shutoff controls;
  - M.2.4. Conditions in which the utility may be shutoff;
  - M.2.5. Assign authority to use the shutoff controls;
  - M.2.6. How to report a failure or interruption;
  - M.2.7. Obtaining emergency repair services;
  - M.2.8. Specific information on emergency clinical interventions.
- M.3. See Guidelines for Procedure for Failure of Essential Equipment Policy, Emergency Numbers List, and Failure of Utility Systems Policies.

**N. ANNUAL EVALUATION OF THE UTILITY SYSTEMS MANAGEMENT PLAN:**

- N.1. The annual evaluation of the Utility Systems Management Program will include a review of the scope according to current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
- N.2. The performance and effectiveness of the Utility Systems Management Program shall be reviewed by the Environment of Care Committee.
- N.3. See Annual Evaluation of the Effectiveness of the Utility Systems Management Program.

**Credentials Committee**  
**Hospital Privileges for Board of Director's Consideration**  
**Tuesday, March 24, 2015 5:15 p.m. – Robert F. Valliant Center Boardroom**

**REAPPOINTMENTS TO THE MEDICAL STAFF:**

<u>Name</u>	<u>Category</u>	<u>Privileges In</u>
1. Jon Ekstrom, MD	Consulting	Teleradiology

Dr. Jon E. Ekstrom graduated from the Oregon Health Sciences University School of Medicine in 1983. Dr. Ekstrom is a board certified teleradiologist for Radiology Associates.

2. Nathan P. Peimann, MD	Active	Emergency Medicine
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Dr. Nathan P. Peimann graduated from the St. Louis University School of Medicine in 1996. Dr. Peimann is an board certified emergency medicine physician for BRH Emergency Department.

3. Paul A. Peterson, MD	Consulting	Cardiology
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Dr. Paul A. Peterson graduated from the Medical College of Wisconsin in 1985. Dr. Peterson is a board certified cardiology physician for Alaska Heart Institute.

4. Jon A. Reiswig, MD	Consulting	Orthopedic Surgery Surgical Assist
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Dr. Jon A. Reiswig graduated from the Loma Linda University School of Medicine in 1965. Dr. Reiswig is a board certified orthopedic surgical assistant and is semi retired.

5. Stephan G. Thiede, MD	Consulting	Teleradiology
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Dr. Stephan G. Thiede graduated from the University of North Carolina at Chapel Hill in 1998. Dr. Thiede is a board certified radiologist for Radiology Associates.

6. Chloe Wurr, MD	Locum Tenens	Family Medicine w/OB
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Dr. Chloe Wurr graduated from the University of CA San Diego School of Medicine in 1990. Dr. Wurr is a board certified family medicine physician who provides locum tenens services to SEARHC - Juneau.

7. Iola G. Young, PAC	AHP	Inpatient Care on SEARHC Patients (Round and Write Orders) Under Sponsoring MD, H&P, and Outpatient Laboratory and Radiology
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Ms. Iola G. Young graduated from the University of Colorado Physician Assistant Program in 1997. Ms. Young is a certified physician assistant for S.E.A.R.H.C. - Alder.

**ADDITIONAL /EXPANDED PRIVILEGES:**

1. Taylor Dunn, MD – (Cesarean Section)

**MEDICAL STUDENT:**

1. **Emily Eck, MSIII** – (University of Washington SOM – BRH MHU/BOPS; Evaluate/Treat Patients, Inpatient H&P, Write Orders/Progress Notes, Draw Blood, Start IV's, and Other Minimally Invasive Procedures Under Direct Supervision of the Supervising Physician and Per Policy 9500.105)

**REQUEST FOR WITHDRAWAL:**

1. **John Graber, MD** – (Consulting - Virginia Mason Medical Center; Cardiology)
2. **Jonathan Halper, MD** – (Courtesy – JEMA; Emergency Medicine)
3. **Jose Suraez, MD** – (Consulting – Midnight Sun Oncology; Oncology)
4. **Matthew Thomson, MD** – (Consulting – RAPC; Teleradiology)
5. **John Zimmermann, MD** – (Consulting – Midnight Sun Oncology; Oncology)

**MEDICAL RESIDENT:**

1. **Erynne Elleby, MD** – (Belleville Family Health Center/SEARHC; Family Medicine w/OB)

**CHANGE OF STATUS:**

1. **Gordon Preecs, MD** – (Courtesy – Tongass Regional Eye Clinic; Ophthalmology)

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**BARTLETT REGIONAL HOSPITAL**  
**RULES & REGULATIONS**

**III. MEDICAL RECORDS**

**B. The medical record is the property of the hospital.**

The following categories of health care professional are allowed to make entries in the medical record:

- a. Physician (MD, DO, DPM)
- b. Mid-level practitioner (Physician's Assistant, Advanced Nurse Practitioner, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, other AHPs credentialed by the hospital)
- c. Student or Resident: Medical, Physician's Assistant, Nursing
- d. Physician Assistant Student
- e. Clinical Social Worker
- f. Physical Therapist, Occupational Therapist, or Speech Therapist
- g. Orthotics/Prosthetics Fitter
- h. **Registered** Dietitian **Nutritionist**
- i. Respiratory Therapist
- j. Registered Nurse
- k. Licensed Practical Nurse
- l. Certified Nursing Assistant
- m. Pharmacist
- n. Chiropractor
- o. Psychologist or Counselor
- p. Marriage and Family Therapist
- q. Mental Health Assistant
- r. Mental Health Consultant/Crisis Intervention Worker
- s. Orthopedic Technician
- t. Sleep Studies Technician or Polysomnographer

**BARTLETT REGIONAL HOSPITAL  
RULES & REGULATIONS**

**V. MEDICAL STAFF COMMITTEES**

**R. ~~Continuing Medical Education Committee (CME)~~ Provider Education Committee (PEC)**

1. The duties of the ~~Continuing Medical Education Committee (CME)~~ Provider Education Committee (PEC) shall be to:
  - a. Develop, plan, and participate in programs of continuing education that are designed to keep the Staff informed of significant new developments and new skills in medicine and that are responsive to evaluation findings;
  - b. Evaluate, through the Medical Staff Office, the effectiveness of the educational programs developed and implemented;
  - c. Act upon continuing education recommendations from the MSEC and committees responsible for patient care evaluation, quality, and monitoring functions;
  - d. Maintain a permanent record of education activities, specifically including their relationship to the findings of the patient care evaluation and patient care monitoring functions of the Medical Staff;
  - e. Maintain a record of continuing medical education attendance for each member of the Medical Staff, and report that information to the individuals and the Credentials Committee; and
  - f. Supervise the Hospital's professional library services, and analyze and make recommendations on a continuing basis regarding the Medical Staff's needs for professional library services and continuing medical education;**
  - g. Meet at the call of the chair.

**~~S. Library Committee~~**

- ~~1. The duties of the Library Committee shall be to:~~
  - ~~a. Supervise the Hospital's professional library services, and analyze and make recommendations on a continuing basis regarding the Medical Staff's needs for professional library services and continuing medical education;~~
  - ~~b. Meet at the call of the chair.~~

# April 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6 Noon -Executive Committee BR	7	8	9 Noon- Planning Committee BR	10	11
12	13 07:00 Credentials Committee BR	14	15 5:15 Finance Committee BR	16	17	18
19	20	21	22	23	24	25
26	27	28 5:15 Board of Directors BR	29	30		