Bartlett Regional Hospital

Board Quality Committee
March 10, 2021
3:30 p.m.
Agenda

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

ZOOM Link:
Join Zoom Meeting
https://bartletthospital.zoom.us/j/94821462737

Dial in:
888 788 0099 US Toll-free
877 853 5247 US Toll-free
Meeting ID: 948 2146 2737

Call to order

Approval of the minutes – January 13, 2020

Standing Agenda Items:

- 2021 BOD Quality Dashboard — Deb Koelsch / Rebecca Embler

Old Business – Annual Management Plans:

- HIM/Utilization – **ACTION ITEM** — Jeannette Lacey
- Risk Management – **ACTION ITEM** — Gail Moorehead
- Infection Prevention – **ACTION ITEM** — Gail Moorehead
- Environment of Care – **ACTION ITEM** — Gail Moorehead
- Patient Safety & Quality Improvement – **ACTION ITEM** — Gail Moorehead

New Business:

- Antimicrobial Stewardship — Pharmacy
- CMS Survey Update — Gail Moorehead
- Upcoming Patient Safety Survey — Gail Moorehead

Next Scheduled Meeting: May 12, 2021 3:30 p.m.

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Quality Committee
January 13, 2020
Minutes

Called to order at 3:30 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig (Chair), Kenny Solomon-Gross, Hal Geiger, Mark Johnson, Lindy Jones

Staff: Gail Moorehead, Director of Quality, Billy Gardner, COO, Kevin Benson, CFO, Dallas Hargrave, Director of HR, Deborah Koelsch, RN Clinical Quality Data Coordinator, Rebecca Embler, Quality Systems Analyst

Approval of the minutes – 11 18 2020 Quality Committee Meeting – *minutes approved as written.*

Old Business: No old business discussed.

New Business:
BOD Quality Dashboard
Deb Koelsch presented the Quality Scorecard measure results for Q4 2020.

- For Risk Management measures, Injurious Fall Rate was 2.15 (total of 4 falls, all in the minor category; 1 unexpected) and there were 0 Serious Safety Events and 1 Sentinel Event. For Readmission Rate measures, 30-day Hospital Pneumonia rate was 0%, 30-day Hospital Heart Failure Rate was 0%. 30-day Hospital-wide Readmission Rate was 8.5%, slightly increased from 7.8% in Q2 2020.
- For Core Measures, Severe Sepsis/Septic Shock was 60%, which changed from last reporting by +7% and is at the national average of 60%, and Screening for Metabolic Disorders was 88%, decreased from 100% in Q2 2020. Great job to Behavioral Health for this metric.
- Mr. Kendziorek asked for clarification on what the Screening for Metabolic Disorders metric is looking at, and Deb described that sometimes it's just hidden information; MHU has a great process for looking up that data. Dr. Jones also clarified that this metric is just individuals admitted to MHU, and are on anti-psychotics.
- Ms. Hagevig asked if we will see changes in scores now that BH is back up and running, but we don't expect to.
- Ms. Hagevig asked about Sepsis measure; how much control do we have over it; Ms. Koelsch described that the number of cases is usually low and there are many factors that can make this metric have a fallout.

Rebecca Embler presented the Patient Experience and HCAHPS results for Q4 2020.

- For Patient Experience results, scores for all service areas except Emergency Department were above benchmark for Q4 2020. It was noted that this is due to lower scores in two survey questions; *Doctor's concern to keep you informed* and *Nurses attention to your needs*.
- For HCAHPS results, it was noted all scores are below the previous period for Q4 2020. This was due to Q3 2020 being a 6-quarter high-point, as well as COVID impacts on quality of communication, and is expected to increase in the coming quarters.
- Mr. Solomon-Gross asked if we expect survey return rates to be higher because of COVID considerations, and it was noted that we are seeing higher return rates due to electronic surveys, and also may expect to be getting more feedback due to the frustrating nature of the COVID situation.

Risk Management Plan

- Ms. Moorehead presented on the updates to the Risk Management Plan. The Risk and Compliance roles were combined this year, and some other small grammatical changes were made. There were some changes to the way information is reported to the BOD. Quality and Risk are still highly collaborative. The Safety Assessment Code (SAC) Matrix was removed as a required tool. Risk reporting will now be included in Performance Improvement committee meetings.
- Ms. Hagevig asked how approval for these updates happen. Ms. Moorehead said that this will be approved at this BOD Committee meeting and any changes will be incorporated into the report before going to the BOD.
- Mr. Solomon-Gross asked to clarify if any of the changes are substantive other than the PIC reporting. Ms. Moorehead confirmed. Mr. Johnson asked for a motion to approve the plan as written, and motion was approved.

Infection Prevention Plan

- Minor grammatical changes and community risk assessment. Expressly called out that we are in a pandemic, and dealing with a novel strain, so objectives reflect that. Structure of the department is not changing, but staffing has changed with the addition of a full-time Employee Health nurse and part-time Program Specialist for data entry and auditing.
- The Juneau community demographics haven't changed a lot; some decline in overall population, and some growth in the senior age group. Ms. Gribbon noted that the plan did not include employee travel considerations in previous years, and that has now been added.
- The Bartlett workforce size had increased since last year to 743 employees, of which 611 are full or part time and working on campus. This is the population that needs to be screened for vaccination and other diseases.
- 2021 Infection Control Plan Goals: 1) Improve compliance with CDC hand hygiene guidelines, 2) Reduce surgical site infections by reducing risk of infection, 3) Decrease risk of acquiring health care associated C diff, 4) Prepare for a protect staff, patients and community from influenza exposure at Bartlett, 5) Maintain established COVID

prevention policies, 6) Reduce the risk of HAI transmission risk attributable to surface contamination.
- New to the plan this year is Water Management-related risk.
- Mr. Geiger asked about goal to not have any hospital-acquired COVID in 2021; Ms. Gribbon clarified that this is any new illness, not a patient admitted with COVID. We have had staff acquire COVID.

Environment of Care Management Plan
Deferred to March

Patient Safety and Quality Improvement Plan
- Ms. Moorehead noted that the 2020 Patient Safety Plan was reviewed and no changes were made because all components are still applicable. For the evaluation of 2020 Plan, it was noted that there were a few accomplishments; re-establishing the Patient Safety Committee with a focus on targeted taskforces (Restraints, Falls, Inpatient Glycemic Controls), improving Press Ganey patient surveys to try to hone-in on the feedback we are getting from patients and implement improvements based on that, utilizing Smartsheet to make data more accessible and collaborative; and working to create successful metrics with ASHNA on Partnership for Patients.
- 2020 Goals include: 1) Demonstrate Antimicrobial Stewardship leadership within Juneau community, 2) Incorporate cross-sectional Patient Safety committee to review and assure Corrective Action plans are met and sustainable, 3) Improve Bartlett's Culture of Safety, 4) Improve compliance with Sepsis core measure
- 2021 Goals include: 1) Develop Performance Improvement onboarding methodology for all new management team members in order to enable them to identify PI opportunities, 2) Reduce Inpatient Fall rates via cross-departmental taskforce, 3) Update Provider review process, specifically around metrics and accessibility to data, 4) Maintain Sepsis core measure compliance at National Average.
- Mr. Solomon-Gross asked for clarification on Antimicrobial Stewardship, and it was noted that our pharmacy looks at all antibiotics that are used in our hospital to make sure we are using the right type and dosage for the infection we're trying to treat. Dr. Jones added that this is mostly for 24-hour pharmacy, and it's a great program we're doing at Bartlett to make sure we're not overprescribing antibiotics.
- Mr. Solomon-Gross asked about what types of falls are included in our metric, and it was noted that all falls are included, even if at Physical Therapy, but the ones we focus on are the anticipated falls, based on patient condition, medication, etc. Some of the unanticipated falls are behavioral and that is why we have 1:1 sitters.

Note: Will defer to send Annual Plan packet to the BOD until March meeting, after Environment of Care Management Plan is presented to this committee.

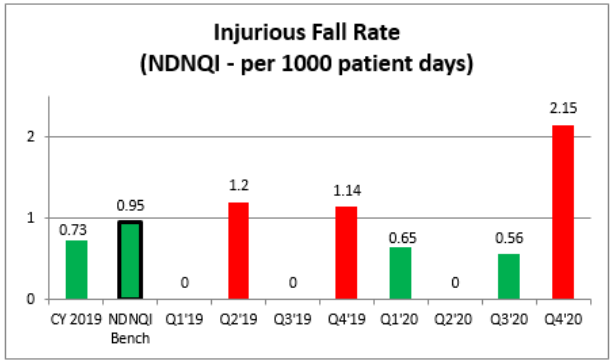
Adjourned at 4:40 pm

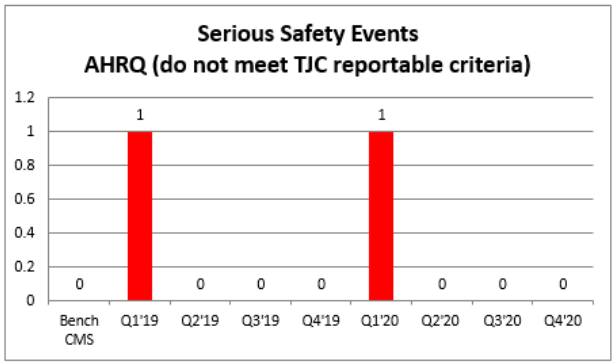
Next Quality Board meeting: March 10, 2020 @ 3:30pm

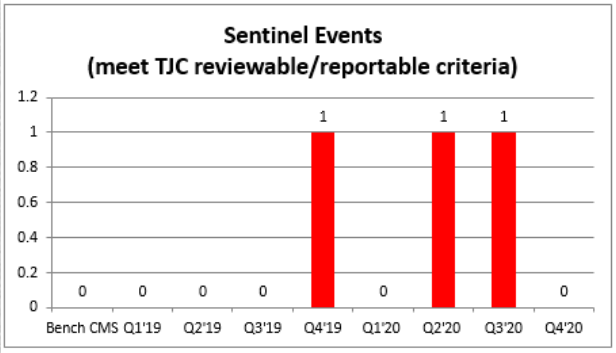
Bartlett Regional Hospital

Quality Dashboard

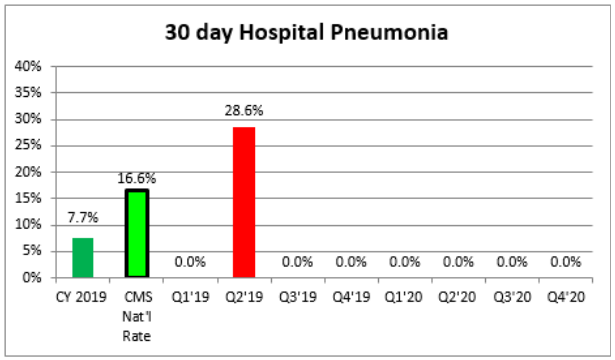
RISK MANAGEMENT – *lower is better*

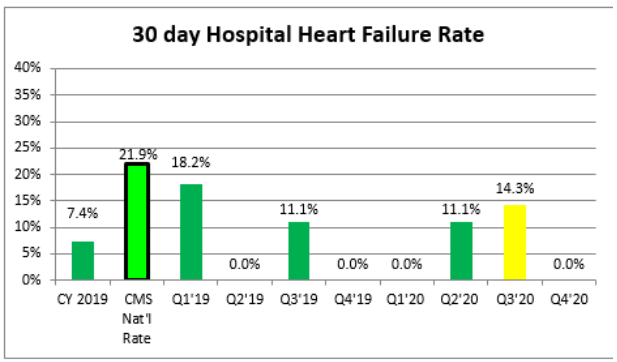


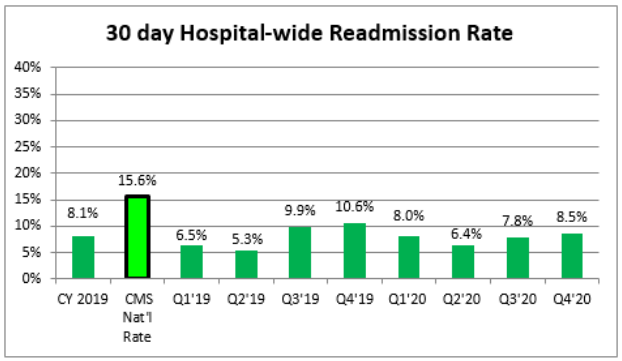




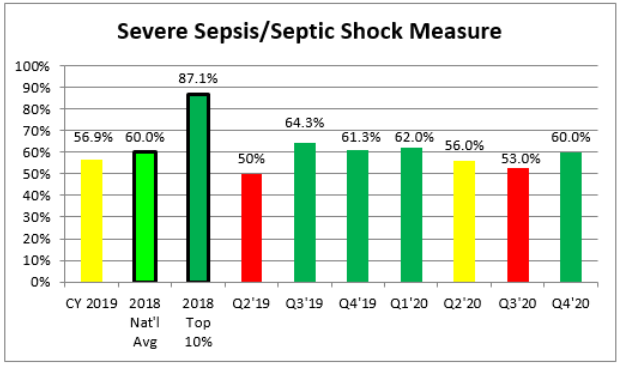
READMISSION RATES – *lower is better*

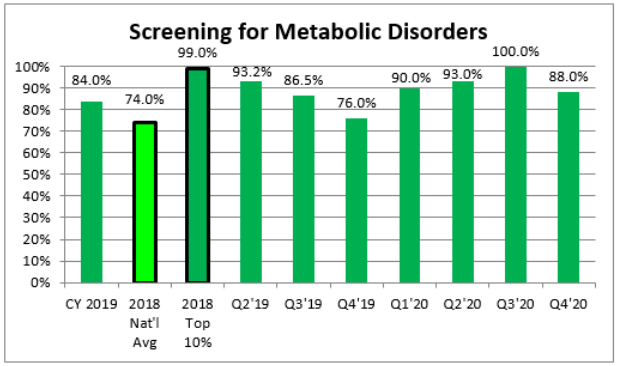






CORE MEASURES – *higher is better*





Sepsis: measure that demonstrates use of evidenced based protocols to diagnose and treat Sepsis.

Screening for Metabolic Disorders: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge.

Fall rates: Per the NDNQI definition, Med/Surg and CCU *only* with injury minor or greater.

SSEs: An event that is a deviation from generally accepted practice or process that reaches the patient & cause severe harm or death.

Pneumonia and Heart Failure: patient is readmitted back to the hospital within 30 days of discharge for *the same diagnosis*.

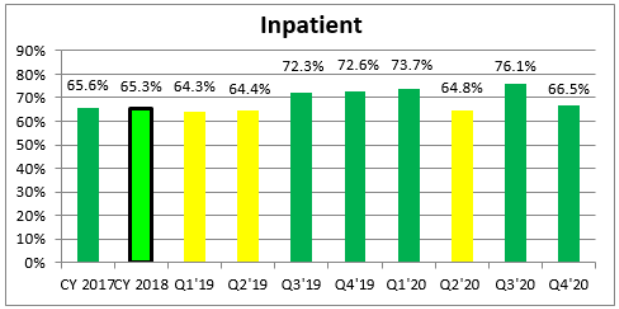
Hospital-wide: patient is readmitted back to the hospital within 30 days of discharge for *any* diagnosis.

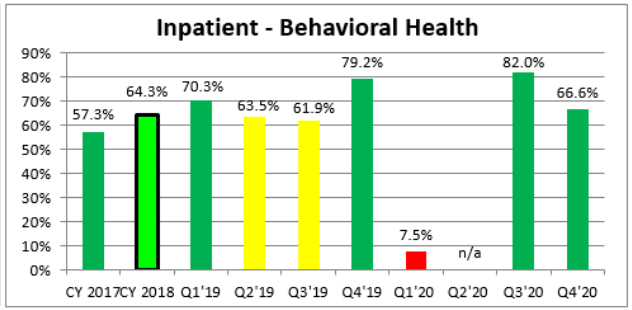
CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

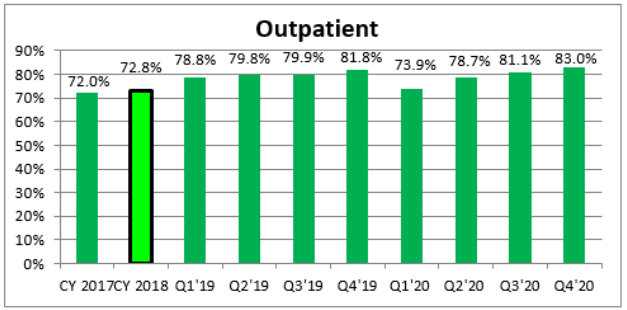
Bartlett Regional Hospital

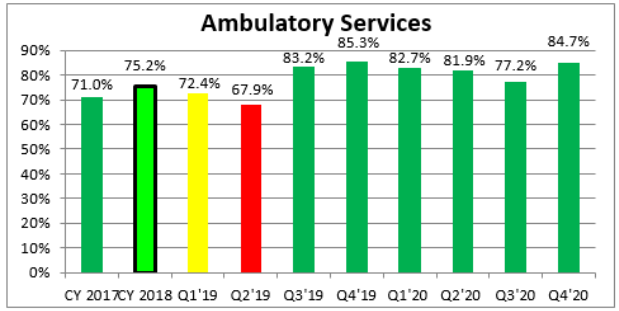
Quality Dashboard

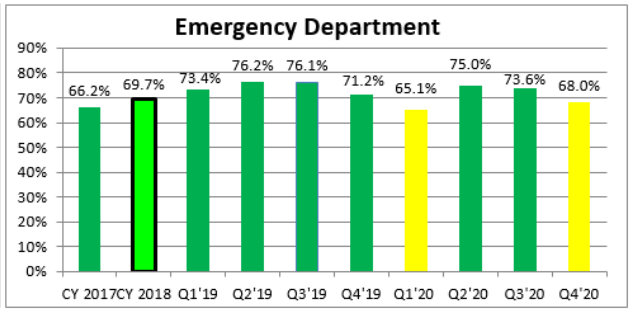
PATIENT EXPERIENCE











Notes:

- **Press Ganey** is the vendor for CMS Patient Experience and HCAHPS Scores. The data are publically reported.
- **HCAHPS =** Hospital Consumer Assessment of Healthcare Providers & Systems; includes only Med/Surg, ICU and OB.
- **Top Box** HCAHPS results are reported on Hospital Compare as "top-box," "bottom-box" and "middle-box" scores. The "top-box" is the most positive response to HCAHPS Survey items.

HCAHPS RESULTS

	Current Quarter		QoQ	YoY	CMS Achievement Threshold	CMS Benchmark	Baseline Period	
	Q4 2020	Percentile	Q3 2020	Q4 2019	50th %ile	Mean of Top 10th %ile	2018	Comments
Overall Rating (0-10)	69.2%	40	▼	▼	▼	▼	▼	Q3'20 score is a 6-quarter high point; Q4'19 was 71.4%
Comm w/Nurses	77.2%	32	▼	▼	▼	▼	▼	*Nurses explain in a way you understand* at 6 percentile
Comm w/ Doctors	79.7%	45	▼	▼	▼	▼	▼	*Doctors explain in a way you understand* at 28 percentile
Response of Hosp Staff	72.9%	84	▼	▼	▲	▼	▼	*Call button help as soon as you wanted* at 89 percentile
Comm About Medicines	58.8%	27	▼	▼	▼	▼	▼	*Tell you what new medicine was for* at 15 percentile
Hospital Environment	63.6%	37	▼	▼	▼	▼	▼	*Cleanliness of hospital environment* at 27 percentile
Discharge Information	85.3%	39	▼	▼	▼	▼	▼	*Info regarding symptoms/problems to look for* at 14 percentile
Care Transitions	56.8%	74	▼	▼	▲	▼	▲	*Good understanding managing health* at 86 percentile

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional ~~Hospita~~~~Bartlett Regional Hospital~~

Title: **UTILIZATION MANAGEMENT PLAN**

Department/s: All Clinical Departments

Original Date: 10/1997 Author: Jeannette Lacey, LMSW, ACM

Updated: ~~12/2018~~12/2020

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 appropriate resource utilization and discharge planning in accordance with CMS and to maintain high levels of integrity in keeping with the mission statement and vision of ~~BRH~~Bartlett Regional Hospital.

DEFINITIONS:

Milliman Care Guidelines (MCG): published by MCG Health, uses evidence-based best practices and care planning tools across the continuum of care to evaluate medical necessity and track length of stay (LOS).

Interqual Level of Care Criteria (IQ): published by McKesson Health Solutions, uses condition-specific, general and extended stay subsets to evaluate for medical necessity.

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.

Secondary Review: is a review performed by a physician with the contracted secondary review service, Sound~~–~~ Physician Advisory Services, when the IQ or MCG screening criteria suggest a different patient status or level of care other than that ordered by the patient's physician and/or for a potential quality concern.

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 (HIM/CM)~~ Utilization Review Committee as the oversight committee.

B. The Utilization Management Plan is based on CMS conditions of participation, The Joint Commission standards, and Interqual and/or MCG 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~~ Utilization Review Committee.

~~C. All patients, regardless of payment source, shall be evaluated to ensure that resources are utilized appropriately.~~

~~D. The written Scope of Services will serve to identify and delineate the activities of the department.~~

C. The Utilization Management Plan recognizes the authority of KEPRO and the assessment and monitoring of review activities performed by KEPRO.

~~E.~~ Utilization management and review are integral parts of the Process Improvement Plan at BRH and will be under the auspices of the CFO with direct reporting to the ~~HIM/CM Committee.~~

D. ~~The Case Managers~~ Utilization Review Committee.

~~F.~~E. Scope of Review: All patients, regardless of payment sources, shall be evaluated to ensure that resources are utilized properly. The Case Managers (CM) will be responsible for the process of ~~measuring and assessing,~~ maintaining and monitoring the effective utilization of hospital facilities, services, and resources related to inpatients and patients placed in observation status. This shall include, but not be limited to:

~~F~~E.1. ~~Managing LOS~~
~~F.2. Monitoring use of bed days~~
~~F.3. Managing 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. Identifying available discharge care resources and coordinating with Social Work Case Managers (SWCM) to develop a post-acute care plan that is compliant with CMS guidelines.~~
~~F.9..Requesting secondary review or HIM/CM Committee involvement as necessary.~~

~~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 HIM/CM Committee.~~

~~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, Livanata, the attending physician, members of the HIM/CM 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. Reviewing admission status based on accepted criteria and clarifying admission status with physician if in question and recommending a change to an appropriate status (ultimately it is physician's prerogative to decide the status).

I.3. Reviewing continued stay documentation and identifying needed changes or additions to ensure that documentation supports 'physician intent.'I.4. Coordinating care conferences with the physician and treatment team as indicated.

I.5. Involving physician in the discharge planning process.

J. The CM will consult with the appropriate physician(s) serving on the HIM/CM Committee regarding identified patient care matters.

K.. 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.

Patients that do not meet admission criteria 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(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

M. Case Management will present a report at the quarterly HIM/CM Committee on those patients who are considered outliers in length of stay or costs (data as defined by HIM/CM Committee), with readmissions prioritized, and identify the reasons that caused the outlier status.

N. Members of the HIM/CM Committee (including physician members as needed) will perform chart reviews quarterly for identified outliers, utilizing the identified audit tool, and make recommendations for service improvement as identified.

SCOPE

Applies to Case Management Coordination for all BRH inpatients and observation patients.

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:Hospital inpatient services under Medicare Part A, section1814(a) of the SocialSecurity Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.

C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.

C.2. Admission reviews will be performed within the first business day following admission

C.3. If RNCM is unable to determine the necessity for admission RNCM will initiate a secondary review.

C.4. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans and other documentation. Case Management 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.

References

(1) Certified Professional Utilization Review Study Guide
Interqual Products Group 2013

(2) Federal Register Volume 66, No. 231

(3) Livanta Quality Improvement Organization
ICD 10-CM and ICD-10 PCS, current volume

(4) Interqual Level of Care Criteria: Acute Adult / Acute Pediatric
McKesson Health Solutions 2016

(5) Medicare Hospital Manual section 230.6E

(6) Health Utilization Management Standards, Version 5.0
URAC 2006

(7) CMS Conditions of Participation 482.30 Utilization Review

(8) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care and Behavioral Health Care, current edition

Attachments

(1) Health Information Management/Case Management Committee report form templates:
1. Denied Days Status Report
2. Outlier Status Report
3. Utilization Management Report with Medicare Monitoring Summary

Performing admission, concurrent, discharge and retrospective reviews to assess for medical necessity

E.2. Identifying the appropriate level of care

E.3. Managing length of stay

E.4. Assessing potential transfers from lateral or higher levels of care

E.5. Managing denials and appeals

E.6. Tracking and monitoring utilization patterns and professional services furnished, including drugs and biologicals.

E.7. Identifying available discharge care resources to develop a post-acute care plan that is compliant with CMS guidelines.

E.8.Requesting secondary review or Utilization Review Committee involvement as necessary.

F. CM will collaborate with physicians to support the utilization management process by:
F.1. Maintaining open lines of communication.
F.2. Reviewing admission status based on accepted criteria and CMS rules and discussing concerns with the provider.
F.3. Reviewing continued stay documentation and identifying possible changes or additions to ensure that documentation supports physician intent.
F.4. Coordinating care conferences with the physician and treatment team as indicated.
F.5. Involving the physician in the discharge planning process.
F.6. Coordinating physician participation in the appeal process.

G. Patients that do not meet inpatient criteria may be placed in 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(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

H. Utilization Review Committee Composition:
H.1. Credentialed medical staff, at least 2 of which will be doctors of medicine or osteopathy. H.2. Staff from the Case Management (CM) Department
H.3. Staff from the Health Information Management (HIM) Department
H.4. Staff from the Quality Department.
H.5. Reviews may not be conducted by any individual who has a direct financial interest in the hospital; or was professionally involved in the care of the patient whose case is being reviewed.

I. Utilization Review Committee Functions: The Committee

I.1. Will meet quarterly

I.2. Will review

i.Outlier cases

ii. Denials

iii.Compliance with the 2-Midnight Rule

iv. Readmissions

I.3. May make determinations regarding admissions or continued stays. These may be made by one physician member if the attending concurs with the determination or fails to present their views when offered the opportunity; Determinations must be made with two physician members in all other cases. (See policies for CC44 and CCW2 for specific processes).

I.3. Support HIM, CM, and Clinical Documentation Integrity functions as defined in the Medical Staff Rules and Regulations.

I.4. Make recommendations regarding identified utilization or documentation matters.

I.5. Serve as a liaison to the medical staff regarding issues reviewed by the committee.

SCOPE

Applies to Case Management Coordination for all BRH inpatients and observation patients.

PROCEDURE: Utilization Review

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 notify the Case Management of reviews requested by payers at the time of verification.

C. Medical Necessity: Hospital inpatient services under Medicare Part A, section1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.

C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.

C.2. Admission reviews will be performed within the first business day following admission

C.3. A secondary review may be initiated if the RNCM is unable to determine medical necessity for the admission.

C.4. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans, and other documentation. Case Management 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.

References

(1) Medicare Hospital Manual section 230
(2) CMS Conditions of Participation 482.30 Utilization Review
(3) CMS Conditions of Participation 412.80 Outlier Cases
(4) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care and Behavioral Health Care, current edition, 2019

Attachments

(1) Health Information Management/Case Management Committee report form templates:
1. Denied Days Status Report
2. Outlier Status Report
3. Utilization Management Report with Medicare Monitoring Summary

Attachment #1

Bartlett Regional Hospital

HIM/UM Denied Days Status Report

Date:

Visit #	Admission Date	Discharge Date	LOS	Admitting Diagnosis	Days Auth	Days Denied	Insurance	Status

Attachment # 2

Bartlett Regional Hospital

Medicare Outlier Status Report

Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/ Procedures	Disposition/ Outlier Problem	CM Reviewer	Appropriate timing of D/C planning?	What else could have been done differently?	Reason for outlier
Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/ Procedures	Disposition/ Outlier Problem	CM Reviewer	Appropriate timing of D/C planning?	What else could have been done differently?	Reason for outlier

Attachment #3

Bartlett Regional Hospital
Utilization Management Report

Q4 CY2018			
Denials			
		Reversed	**Upheld**
Initial			
Aetna			
Blue Cross			
Medicaid			
Other			
Medicare Monitoring		Notes	
CMI			
1- day stays			
Observation > 2MN			
Outliers			
Psych			
Placement			
EOL			
Complex Medical			
Social			
Other			

Q4 CY2018			
Denials			
		Reversed	**Upheld**
Initial			
Aetna			
Blue Cross			
Medicaid			
Other			
Medicare Monitoring		Notes	
CMI			
1- day stays			
Observation > 2MN			
Outliers			
Psych			
Placement			
EOL			
Complex Medical			
Social			
Other			

Bartlett Regional Hospital
RISK MANAGEMENT PLAN
CY ~~2020~~2021

Issued: July 1, 2010
Revised: ~~December 18, 2019~~January 8, 2021
Submitted by: ~~Mary Crann, RN, MSN, CPHRM~~Nathan Overson, CHC

AUTHORITY AND RESPONSIBILITY

Board of Directors

The Board of Directors of Bartlett Regional Hospital is responsible for the quality and effectiveness of the patient care provided by the medical staff and other professional and support staff. It sets expectations, directs, and supports Bartlett Regional Hospital's (BRH) governance and management activities which include supporting the Risk Management Program to minimize preventable harm to patients, employees, visitors and property. It 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 appoints, through the Chief Executive Officer, a Director of ~~Quality~~Compliance and Risk. The Director of ~~Quality~~ Compliance and Risk is responsible for the Risk Management program. It 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, property damage, financial loss, or damage to the facility's reputation.

Risk Management Supervision

The Director of ~~Quality supervises~~Compliance and Risk is the Risk Manager and Employee Safety Officer. The Risk Manager works closely with the Lead Security Officer, and the Quality Director who is also the Patient Safety Officer. ~~(RM&PSO) and~~The Risk Manager acts as a designee of the Chief Executive Officer. S/He 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 Performance Improvement Committee (PIC) and the Environment of Care (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 the Risk Manager in close coordination with the Quality Director who helps facilitate the peer review process as a representative of hospital administration. The Quality Director in conjunction with the Medical Staff identifies~~clinical criteria to identify~~ specific patient cases with potential risk in the clinical aspects of patient care and safety.

PURPOSE AND PHILOSOHY

The purpose of the Risk Management Plan is to support the mission and vision of Bartlett Regional Hospital to provide patient centered quality care in a sustainable manner. Risk Management fulfills this by acting to protect, patients, staff and visitors from injury, physical property from damage and financial assets from being wasted. Risk Management acts to support BRH's reputation and standing in the community.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing vulnerabilities. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating ~~them~~these vulnerabilities.

The philosophy of the Risk Management Program is that patient safety and risk management is the responsibility of each employee of Bartlett Regional Hospital. Teamwork and active participation among management, providers, and staff are essential for an efficient and effective risk management program.~~–~~ The Risk Manager plays a central role in leading the organization towards fulfilling the mission and vision of BRH to provide patient centered sustainable quality care.

SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose risk of harm to patients, visitors and staff of BRH. 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 Department and the Compliance & Risk ~~Management~~ Department via the Director of Quality and the Compliance & Risk Department. The integration of hospital risk management with quality assurance activities ensures information about patient care and safety are exchanged.

STRUCTURE

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

Board of Directors

The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Performance Improvement Committee (PIC), the Environment of Care (EOC) Committee, and reports by the Risk Manager ~~& Patient Safety Officer~~ or Director of Quality. The Board of Directors designates the Chief Executive Officer the responsibility for the patient grievance process who ~~Director of Quality and~~delegates to the Risk Manager the responsibility of managing the patient and visitor complaint process. ~~& Patient Safety Officer to function~~The Performance Improvement Committee (PIC) serves as the Grievance Committee for ~~complaint processing that cannot be resolved by the department managers~~a system analysis approach to investigate system concerns or issues.

Senior Leadership Team:

The Senior Leadership Team(SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief ~~Clinical~~ Operations Officer, Chief Nursing Officer, Chief Behavioral Health Officer~~, Chief Legal Officer~~ and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the strategic direction and integration of all Risk Management activities. Patient safety culture survey results provide feedback on workplace patient safety practices, communication, teamwork, adverse event reporting, and leadership to help guide vision and goals of the organization. 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. SLT supports transparency in communication related to the risk management process.

Departments

Individual departments are responsible for quality management, regulatory compliance, and risk management activities relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Risk Manager ~~and Director of Quality~~.

RISK MANAGEMENT PROCESS

Risk management and quality improvement are complementary and continuous processes that link activities to BRH's mission and strategic plan. The risk management process ensures all employees have a risk management philosophy and are the first line of defense. The process should be outcome oriented; the Risk Manager will work closely with Quality to ensure change elements are measured by quality indicators and dashboards.

METHODS

Establishing a consistent definition and measurement process supports the goal of preventing harm and delivering safe care to patients by allowing rapid identification of Serious Safety Events, quick mitigation to prevent further harm, and consistent evaluation of prevention methods. A clear and consistent plan for conducting investigations is imperative along with establishing common definitions and a shared mental model.

Risk Management activities include:

1. Review and triage occurrence reports completed by staff and providers in the occurrence reporting software system.
2. Prioritize events, hazards, and system vulnerabilities. ~~utilizing the Safety Assessment Code (SAC) Matrix.~~
3. Measure and report frequency and severity of events to transform risk management into a pro-active program.
4. Ensure timely execution of Root Cause Analysis, mitigation, and corrective action plans using ~~the RCA2~~RCA best practice guidelines and tools.
5. Collaborate with the Director of Quality identifying near misses or trends and utilizing evidence-based tools for process improvement and quality assessment activities.
6. Collaborate with the Director of Quality to communicate data and investigation findings to the BOD, SLT and staff.
7. Participation in litigation processes by attending depositions, supporting staff, providing documentation, and acting as liaison to BRH legal counsel.
8. Report potential medical malpractice liabilities to the risk manager at the City and Borough of Juneau and appropriate insurance liability carriers and agents.
9. Identify, investigate, and report Sentinel Events as required by Joint Commission standards.
10. Identify, investigate and report Serious Reportable Events required by the National Quality Forum.
11. Model and support evidence-based risk reduction concepts and tools to improve communication, and other high risk areas.
12. Review quality performance indicators to evaluate risks and strategies.
13. Review of patient grievances and responding following BRH policy, Centers for Medicare and the Medicaid Conditions of Participation ~~Patient Rights regulations~~.
14. Evaluate grievance data using system analysis with a grievance function of the PIC committee and incorporate into QAPI

15. Collaborate with the Director of Quality in completing a patient safety culture survey and developing risk and quality plans that incorporate staff input and participation.
16. Collaborate with the City and Borough of Juneau (CBJ) risk managers in litigation, property damage, and employee events and attend and participate in Joint Safety meetings.

COMMUNICATION

Communication of risk management availability and 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 Hospital Quality Committee reports
4. Management Team meeting
5. Patient Safety Committee Meeting
6. ~~Patient Grievance~~Performance Improvement Committee (PIC)

An annual review and revision of the risk management plan and objectives are provided to the Hospital ~~Process~~ Performance Improvement Committee (PIC) and the Board of Directors.

BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2021

This plan is developed with input and collaboration from the following:

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

Infection Prevention and Control Plan Reviewed by:

	Signature	Date
Infection Prevention and Control Committee Chair	~~Dr.~~ David Miller MD	1/11/2021
Quality and Process Improvement Director	~~Sarah Hargrave RN, MSN~~ Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	1/11/2021
Infection Preventionist	Charlee Gribbon RN, BSN, CIC	1/11/2021

Bartlett Regional Hospital

Infection Prevention and Control Plan 2021

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 (BRH) Infection Prevention and Control Program (IPC) 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. Interact with community health agencies through activities such as surveillance and emergency preparedness to respond to community outbreaks and special pathogens (novel strains such as COVID-19, or ~~such as~~ Ebola).
8. Manage effectively the seasonal influx of potentially infectious patients during Southeast Alaska's tourist season.
9. Enhancement of hand hygiene practices by all persons within the hospital system.
10. Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
11. Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
12. 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 and Control Program Oversight and Organization
Authority and Responsibility

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 a hospital acquired infection or infectious disease (IC 01.01.01)

A. The Infection Prevention and Control (IPC) Committee:

A.1. The Infection Prevention team is made up of the Chair of the Infection Prevention and Control Committee (IPCC), which directs the IPC program and one full-time Infection Preventionist.

A.1.1. In accordance with Medical Staff Bylaws and/or Rules and Regulations, the physician members of the Infection Prevention and Control Committee are appointed by the Chief of the Medical Staff.

A.1.2. The appointed term is reevaluated on a yearly basis.

A.1.3. The IPC Program will identify and evaluate potential risk factors (including environmental factors) and monitor trends in incidence of epidemiologically relevant infections at BRH. This is achieved through effective surveillance, evaluation and communication to senior leadership, hospital stakeholders, medical staff, employees, and community.

A.1.4. The ICP Plan is updated on an annual basis, reviewed and approved by the IPC Committee. This update is based on a review of the prior calendar year's activities, surveillance program, risk assessments and goals (IC 01.05.01). The review of the prior calendar year's activities, surveillance program, risk assessments and goals will be completed and approved by the IPC Committee during the first quarter of the upcoming calendar year and will be implemented in second quarter of the calendar year. (IC 01.03.01)

A.2. Members of the Infection Prevention and Control (IC) Committee and/or the Infection Preventionist have the authority to institute surveillance, prevention, and control measures.

A.2.1. Where there is reason to believe that any patient or personnel may be in danger of acquiring a hospital acquired infection or communicable disease; control measures may include closure of rooms, units, departments, enhanced cleaning methods, and/or management of hospital visitors.

A.2.2. The Chair of the IPC 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, respiratory pathogens and TB testing when indicated.

A.3. The IPC committee oversees the infection prevention process through evaluation, analysis and interpretation of the infection prevention data. The performance-improvement framework is used to design, measure, assess and improve the organization's performance of the surveillance, prevention and control of infection. The committee is responsible for approving and documenting the selection of surveillance programs designed to improve the quality of care.

A.3.1. Clinical interaction through education, quality improvement efforts, and communication is maintained to increase the effective application of infection prevention and control principles.

A.3.2. The BRH leadership provides adequate resources (human, informational, physical, and financial) to support infection prevention and control activities. (IC 01.02.01)

A.4. BRH services include emergency care, surgical, critical care, obstetrics, general medical, diagnostic imaging (mammography, CT, MRI, ultrasound and radiology), laboratory, chemo/infusion therapy, oncology, hematology, physical/occupational/speech therapy, mental health inpatient treatment, outpatient psychiatric, chemical dependency residential and outpatient treatment, and sleep studies.

A.4.1. New programs or services within the hospital will have to be evaluated by an Infection Control Risk Assessment (ICRA). More frequent reviews may be initiated depending on emerging diseases, changes in services or identification of specific risks in populations served. If significant change occurs, the IPC Program will respond in a timely manner, review/approve a plan with the multidisciplinary IPC Committee and re-prioritize risks as necessary.

A.5. Time-sensitive or critical issues:

A.5.1. The scheduled quarterly meeting of the IPC Committee may not be timely to address time-sensitive issues. In the event that time-sensitive issues endanger life or create a patient or employee safety concern, immediate action will be taken to alert those necessary to correct the situation.

A.5.2. 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.

A.5.2.1. Critically significant situations should be brought to the attention of the IPC Committee physician chair as soon as they are identified.

A.5.2.2. The level of criticality should guide committee decisions for referral or action when an infection safety issue is identified.

A.5.2.3. Actions appropriate for the IPC Committee chair to take may include:

A.5.2.3.1.1. Calling an *ad hoc* IPC Committee meeting, if appropriate for timely response.

A.5.2.3.1.2. Directly contacting the physician chair of the committee that has authority over the situation.

A.5.2.4. The IPC Committee chair may directly contact another staff (physician or Senior Leaders) who has authority to correct the critical situation without further delay.

A.5.2.5. 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:

A.5.2.5.1.1. Committee Chair of the specific Service Line wherein the threat is occurring.

A.5.2.5.1.2. Medical Staff Quality Improvement Committee (MSQIC) Chair.

A.5.2.5.1.3. Medical Staff Executive Committee Chair.

A.5.3. IPC Committee and medical staff will collaborate with others as appropriate to make decisions based on patient/employee safety.

A.5.4. All situations that are identified, their level of criticality, actions taken, and any follow up recommendations will be reported through the IPC Committee to the MSQIC and/or Hospital Quality Council (HQC), as appropriate.

A.6. The Infection Prevention and Control Committee reviews and approves, annually all hospital-wide and department-specific policies and procedures related to the infection surveillance, prevention, and control programs of the IPC Committee and all departments.

A.7. Physicians, Quality Management, Nurses and the Infection Preventionist actively pursue continuing education in Infection Prevention and Control and collaborate with local, state, and national experts in infection prevention to maintain a working knowledge base. Competency and continuing education is required and is maintained annually.

A.8. The IPC Committee operates as a review organization, and so is entitled to the protections offered by Alaska Statute (AS 18.23.030) and federal law.

A.9. The minutes of the Infection Prevention Control Committee are forwarded to the Medical Staff Executive Committee.

B. The Infection Preventionist is designated as the Infection Prevention and Control Officer, and is responsible to develop and implement policies governing control of infection and communicable disease.

B.1. In the absence of the Infection Preventionist (after hours or during periods of leave), the House Supervisor will assume responsibility for daily infection prevention and surveillance, ensuring that isolation protocols are initiated and/or discontinued for patients as indicated.

B.2. The Infection Preventionist will monitor infection prevention activities throughout the organization, with special emphasis on the surgical suite, central sterile processing, environmental services, the kitchen, and nursing units. This monitoring will include regular surveillance and observation activity. (NPSG 07.05.01)

B.2.1. The IP will monitor hand hygiene compliance facility-wide on a monthly basis.

B.2.1.1. Department managers will assist in recruiting and retaining unit Hand Hygiene Champions.

B.2.1.2. IC will report compiled information obtained from these observations to department leaders, facility leadership, and all staff.

B.2.2. The Infection Preventionist will notify the appropriate regulatory agency, to include but not limited to, the Alaska Department of Health and Social Services (DHSS), State of Alaska (SOA) Section of Epidemiology (SOE), or Centers for Disease Control and Prevention (CDC) of any mandatory reportable disease or epidemiological important organism in a timely manner. (IC.01.05.01 & IC.02.01.01)

B.2.2.1. The IC program at BRH will use an epidemiological approach consisting of surveillance, routine analysis, and emerging threat identification through collaboration with microbiology, DHSS, SOA Section of Epidemiology, CDC, community partners, and employees.

B.2.2.2. BRH will communicate with community partners (DHHS, SOA, other facilities, physician's offices, clinics, and other hospitals) of known or discovered infectious events or patient movement in a timely manner for continual surveillance, education, and prevention of infectious disease transmission.

B.2.3. The Infection Preventionist will act in an advisory and supportive role to ensure the Occupational Health~~safety~~ and ~~health~~ Safety Program Specialist is coordinating the health and safety program for ~~of~~ patients, employees, visitors, and contractors during renovation, construction, and maintenance at the hospital.

~~B.2.3.1. IC will collaborate with a multi-disciplinary team to perform Infection Control Risk Assessment (ICRAs) on all construction, renovation, and maintenance projects being performed at the hospital.~~

B.2.4. The Infection Preventionist will act in an advisory and supportive role to ensure that high quality disinfection, sterilization, and safe use of non-critical, semi-critical, and critical reusable medical equipment (RME) is maintained.

B.2.5. The Infection Preventionist will oversee and provide guidance to Employee Health and Infection Prevention that includes but is not limited to: Respiratory Protection Program, Immunization screening, TB screening, and correct PPE utilization (IC.02.04.01).

B.2.6. The Infection Preventionist will assist in the organizational Emergency Preparedness to include, but not limited to, pandemic respiratory viral illness, emerging special pathogens, influx of infectious patients, and natural disasters. (IC.01.06.01).

B.2.7. IPC will participate in the Clinical Product Review Committee to facilitate and approve new safety engineered devices/supplies.

Risk Assessment and Prioritization of Goals (IC 01.04.01)

The Infection Prevention and Control Committee, in collaboration with hospital leadership, identifies risks for transmitting and acquiring infection within the organization, based on the many factors discussed below. The Committee will develop a risk assessment at least annually, or when significant changes materially change risk prioritization (noted below), using information from all applicable committees and individuals as appropriate. Consideration will be given to those issues that are high risk, high volume, and/or problem prone, and to new techniques or procedures, or related to emerging trends. The Committee will develop action plans to address these issues (see current Risk Assessment and Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: Hospital Acquired Infections, Antimicrobial Stewardship , Hand Hygiene, influenza and novel respiratory pathogens, medical devices, occupational exposures, and ~~transmission based~~ infectious organisms/diseases.

Geographic Location and Community Environment

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 56 inpatient beds and 16 residential substance abuse treatment facility beds in the Rainforest Recovery Center. In addition to the communities of Juneau and Douglas, we serve all the Southeast Alaska communities of Yakutat, Skagway, Haines, Sitka, Hoonah and Angoon. The primary and secondary service area has a combined population estimate of 52,771. Bartlett serves a 29,991-square-mile region in the northern part of Southeast Alaska. Juneau, the largest city in the region and the capital of Alaska is accessible only by water or air. The population of the city and borough of Juneau is ~~32,241~~31,974 (US Census, 2019) This includes 5.7~~6~~% who are under 5 years of age, 21.1% persons who are under 18 years~~18.7% that are aged 6-19 years~~, and 14~~9.2~~% that are over 65 years of age. (US Census, 2019) The underserved and disadvantaged population includes: 7.9% with a disability and under 65 years of age; and ~~,~~10.9 % under 65 years of

age without health insurance. (US Census, 2019) Additionally, ~~7.3% (2365 persons) which live below the poverty line, and 9.8 % (3169 persons) live below 125% of the poverty line.~~ 6.3% of Juneau residents are living in poverty (US Census, 2019).

Characteristics of the Population Served

Bartlett Regional Hospital is the largest provider of hospital services in Southeast Alaska. It serves a diverse community of residents. Tourism expands the service area population by approximately 30% from May to September each year, welcoming visitors from 50 or more countries. These include the workers for the fisheries, mining and tourism agencies that are seasonal; approximately 27,000 people work seasonally in Southeast Alaska every year; 70% are non-residents, and many are foreign born from high TB incidence countries. The fisheries, mining and cruise ships provide tight living quarters for their seasonal employees, which may increase the incidence of any disease. The cruise lines bring tourists and workers from many different countries. BRH must consider ship quarantine or influx of infectious diseases. This seasonal influx in local population presents ongoing significant potential for mass trauma and communicable disease outbreak, requiring BRH to maintain careful surveillance, awareness of global emerging infectious disease trends (Pandemic or Novel strains of Influenza, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services 2018 TB Summary Brief Report shows that Alaska's TB infection rate was 8.5 cases per 100,000 people, an increase from the previous two years (AK SOE, 2019). Alaska has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.8 cases per 100,000 people. Southeast Alaska has an incidence rate of 2.7 cases per 100,000.

Results of Analysis of Bartlett Regional Hospital Infection Prevention Data

Bartlett Regional Hospital conducts hospital-wide surveillance for all types and categories of infection. The surveillance results from surgical site infections (SSI), device-related infections (Central Line Associated Blood Stream Infection[CLABSI], Catheter Associated Urinary Tract Infection [CAUTI], Ventilator Associated Events [VAE], Methicillin-Resistant Staphylococcus Aureus [MRSA], and *Clostridioides difficile* ~~Clostridium Difficile~~ [CDI ~~Diff~~]) rates and communicable disease exposure events are reviewed for variance and reported to hospital leaders, the Patient Safety Committee, the Critical Care Committee, and medical staff as appropriate. A yearly Infection Prevention and Control Plan and a summary analysis of the prior year's plan, goals, strategies, activities, and issues are submitted annually to the Governing Board.

Evaluation of the Infection Control and Prevention Plan

Plan evaluation is an ongoing process that is measured and reported annually by comparing the described measurable objective to the observations/measurements as described in the plan. If the objective is met, then that particular goal is considered to be met for the plan year.

Care, Treatment, and Services Provided

Bartlett Regional Hospital's current strategic plan notes twenty-four services that are provided on campus. High-risk and high volume services are included in the risk assessment process.

Employee Health

Bartlett Regional Hospital provides a safe working environment for its approximately ~~670~~ 743 employees, of which 611~~493~~ (82~~74~~%) are full or part time scheduled and working on campus. This is accomplished through coordination of Infection Prevention policies and practices, and through the services provided by the Employee Health Program such as Hepatitis B vaccination, ~~annual~~ TB testing, and screening for immunity to vaccine-preventable diseases. Employees that handle or contact hazardous drugs participate in the medical surveillance program. Employee illnesses are categorized and logged daily by the ~~House Supervisor~~Central Staffing Office and Employee Health Nurse, and analyzed by ~~the Infection Preventionist~~Employee Health. The goal is to identify and mitigate infectious conditions that may pose a risk to patients, visitors, or staff, and to ensure that staff are immune to vaccine-preventable diseases.

Emergency Preparedness

Bartlett Regional Hospital maintains readiness to respond to both internal and external threats and emergencies through its Emergency Management Plan, Emergency Management Team, Environment of Care Committees, and Infection Prevention Committee and Policy Manual.

2021

Infection Prevention and Control Plan

2021 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
►Improve compliance with CDC Hand Hygiene Guidelines (NPSG 07.01.01, EP1).	BRH hand hygiene rates will be improved by 5% over 2020's hand hygiene compliance rate by 12/31/2021. Press-Ganey hand hygiene scores will increase by 5 % over 2020's reported scores.	1. Form Hand Hygiene Champion Group to meet quarterly on compliance tracking. 2. Develop shared place to show compliance rates to hospital. 3. Consistently and more directly meet with observers to encourage more observation. 5. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene. 6. IP will round/talk directly with visitors, patients and families on proper hand hygiene. 7. IP will compare Press-Ganey reported hand hygiene.	Nursing Administration, Patient Care staff, Infection Prevention, Employee Health, Patients and visitors.	BRH hand hygiene compliance rate will increase or be equal to 2020 hospital wide rates. Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2020's reported rates.

Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Maintain surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2021.	1. Monitor staff compliance with patient skin and nasal decolonization. 2. Reduce the number of sterile processing failures. 3. Continue to monitor ATP in OR suites and use Sterile Meryl daily in OR. 4. Develop glucose screening plan for all surgical patients with BMI ≥ 30. 5. Decrease the risk of contamination of surgical instruments. 6. Work towards JC Surgical Center of Excellence.	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2020. Rate will be ≤ 0.3 infections per 100 procedures.

Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
►Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and maintain HAI CDI rates of 2 infections	1. Continue to monitor compliance for recommended specimen testing.	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2020 baseline.

	per 10,000 patient days by 12/31/2020.	2. Increase utilization of Sterile Meryl for all isolation terminal cleaning. 3. Ensure appropriate cleaning and disinfection products (sporicidal) are available for C. difficile rooms and area is cleaned per protocol. 4. Prohibit unnecessary antibiotic use.		There will be no increase in HAI- C. Difficile rates for 2020.
Infection Prevention Goal #4	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**
►Prepare for and protect staff, patients and our community from influenza exposure at BRH in an efficient and safe manner. (IC.02.04.01)	1. Maintain full time/ part time scheduled staff influenza vaccination at rates 98 % or greater for the 2021-2022 influenza season.	1. Participation in the influenza prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Enforce standard precautions are in use for any aerosol-generating procedure. 3. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH. 4. Participate in state wide influenza infection prevention meetings.	Leadership, all staff, IC, and employee health	Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2021. Report data via NHSN.

		5. Increase public awareness of importance of vaccination.		
Infection Prevention Goal #5	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**
Maintain established COVID prevention, employee heath monitoring, and associated policies.	1. Employee health will continue to track and monitor Employee symptoms, testing, and quarantine.	1. Continue to monitor State Public Health mandates. 2. Continue to provide COVID vaccinations as needed for identified staff. 3. Continue to monitor, test, and quarantine staff according to current mandates and Infection Control Policies through Employee Health. 2. Ensure all staff are provided adequate PPE. 3.Develop action plan to scale activities on an as needed basis depending on the tourism season.	Nursing, Staff Development, Infection Prevention and Employee Health.	Measure HAI COVID infections for 2021. There will be no HAI COVID cases identified for 2021.
Infection Prevention Goal #7	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**

Reduce the risk of HAI transmission risk attributable to surface contamination.	ATP pass rates will improve be 90% by 12/31/2021	1. Verification of cleaning will be audited with use of objective measures such as ATP swabbing of surfaces and observation of cleaning practices.	EVS, Infection Prevention, Education, Nursing Directors and all patient care staff.	All high touch surfaces will show a 90% ATP pass rate.

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BARTLETT REGIONAL HOSPITAL

Environment of Care

Annual Report

CY 2020

Approvals
Environment of Care Committee: November 12, 2020
Performance Improvement Council: (scheduled January 12, 2021)
Board Quality: (scheduled January 12, 2021)

INTRODUCTION

The goal of the Environment of Care (EOC) Program is to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses the following five programs/areas:

- Safety Management (Nathan Overson Director of Compliance and Employee Safety)
- Security Management (Nathan Overson Director of Compliance and Employee Safety)
- Hazardous Materials and Waste Management (John Fortin Laboratory Department Director)
- Medical Equipment Management (Kelvin Schubert Maintenance Supervisor)
- Utility Systems Management (Kelvin Schubert Maintenance Supervisor)

In addition, the BRH Emergency Management and Life Safety Management Programs are integrated with the EOC Program.

The EOC Program and work groups are overseen by the EOC Committee. The EOC Committee and work groups:

- Identify risks and implements systems that support safe environments.
- Works to ensure that hospital staff are trained to identify, report and take action on environmental risks and hazards.
- Sets and prioritizes the hospital's EOC goals and performance standards and assesses whether they are being met.
- Works with the BRH Joint Commission Coordinator to ensure the hospital is compliant with the EOC-related requirements of all applicable regulatory bodies.

Membership of the EOC Committee is comprised of:

- Program managers for each of the five EOC Management Programs, Emergency Management and Life Safety Management Programs.
- Representatives from Nursing, Infection Control, Clinical Laboratory, Environmental Services, Quality Management, Human Resources and Senior Leadership.

EOC projects and initiatives include opportunities for improvement identified during ongoing hazard surveillance, risk assessment and other EOC activities to promote a culture of safety awareness.

This report highlights the activities of the EOC Program in Calendar Year 2020. For each of the major areas, it is organized as follows:

- Scope
- Accomplishments
- Program Objectives
- Performance Measures
- Effectiveness
- Opportunities for Improvement

SAFETY MANAGEMENT

SCOPE

No Changes

Bartlett Regional Hospital's commitment to a safety management plan is designed to provide a physical environment free of unmitigated hazards and to manage staff activities to minimize the risk of human injury. It shall ensure that personnel are trained to interact effectively in their environment and with the equipment they use. All elements of the Environment of Care (EOC) are incorporated or serve to support the BRH Safety Management Plan.

The Safety Management Plan incorporates an interactive process involving and affecting all of Bartlett Regional Hospital's employees, contractors, patients, and visitors.

ACCOMPLISHMENTS

- Crystalline Silica Dust Protection evaluation performed at BRH
- Workplace hazard assessment performed for employee work stations for COVID-19
- Addition of Plexiglas screens throughout the hospital (offices/public areas/break areas)
- Ongoing workplace violence work through WSHA in the Emergency Department and HR
- Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19Hazard
- Reduction in lost time injuries over prior year
- Reduction in serious injuries (level of treatment) to staff
- No OSHA defined workplace exposures to COVID-19 (different from COVID-19 reporting requirements)
- Better integration with CBJ safety programs and initiatives
- Better analysis and review of employee related occurrences over 2019
- Better alignment of the organization safety program with AKOSH and OSHA regulations over 2019

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
Identify opportunities to improve safety performance	**Met**	Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19Hazard
Provide regular safety education to all staff	**Met**	New employee education and required annual safety education

Objectives	Met / Not Met	Comments and Action Plans
Enforce current safety practices for staff, patients, physicians, and visitors	**Met**	EOC Rounds were completed as and follow-up rounds were conducted to monitor specific regulatory survey findings.
The hospital manages its environment during demolition, renovation, or new construction to reduce risks.	**Met**	Continue to incorporate Infection Prevention and Safety Management in Construction Planning.
An annual evaluation of the scope, objectives, key performance indicators, and the effectiveness of the Safety Management plan and programs is conducted.	**Met**	Completed via this document.

The Environment of Care Committee has evaluated these objectives for the Safety Management Program and determined that they have been met.

PERFORMANCE MEASURES

The following measures provide the Environment of Care Committee with information needed to evaluate performance of the Safety Management Program activities and to identify further opportunities for improvement:

Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Combine and enhance all the workplace violence (WPV) elements (policies, procedures and related training curriculum) into a complete comprehensive program.	100%	100%	**Met** Many of the program elements have been successfully made more comprehensive. Due to the dynamic nature this program it is still in a state of enhancement review. Additional resources and initiatives such as our current participation in a WPV workgroup hosted by the Alaska State Hospital and Nursing Home Association (ASHNHA) is informing many of these enhancements.

Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries: • Number of recordable lost workdays • Injuries by cause • Injuries by body part • Needle sticks and body fluid exposures	100%	100%	**Met**
Implement a working-at-heights (WAH) program	100%	0%	**Changed Direction** Focus of this goal has changed to support CBJ and BRH integration of WAH program. Initiative now in early stages (also includes Confined Space Entry and Hearing Conservation etc.).

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance metrics fit current organizational needs. The Safety Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021:

- Outline emphasis areas, specific tasks and responsibilities for areas supported or proposed to be supported by the CBJ Safety program that would meet the needs of the BRH Safety program and identifying efficiencies and alignment of the two programs where appropriate.
- Conducted a feasibility review of having the CBJ Safety Officer have a workstation onsite at the BRH campus for a scheduled amount of time to promote additional ease of collaboration between BRH and CBJ.

The proposed performance measures for these goals are:

Safety Management Proposed Performance Measures for 2021	Target	Comments & Action Plan
AIM: Create a new and efficient way to meet the Joint Commission requirements to collect information on staff's knowledge of Employee Safety topics and to survey the physical environment (replace SWARMS)	**Complete 100%**	All updates will be reviewed and approved by multi-disciplinary EOC Committee.
AIM: Reduce OSHA recordable injuries to staff by 50% (7 for 2020)	**3 or less**	A multi-disciplinary team will be used including members from Risk Management and Human Resources.

SECURITY MANAGEMENT

SCOPE (No Change)
Bartlett Regional Hospital's Security Management Plan is to provide a program that shall protect employees, patients and visitors from harm, and define the responsibilities, reporting structure and action for maintaining a secure environment. This plan includes all facilities and activities directly related to Bartlett Regional Hospital.

ACCOMPLISHMENTS

- A comprehensive 1:1 sitter training to respond to a broader scope of 1:1 sitter scenarios .
- Additional employee badge proximity readers have been added to security doors throughout the hospital to enhance security in those areas. More to be added in 2021 along with enhanced lockdown capabilities.
- Security response to physically limit control points to the hospital as a response to COVID-19 safety precautions.
- The hospital appropriately responded to dynamic visitor policy and visitor incident directives based on needs assessment.
- Security role appropriately prioritized to ED screening entrance to ensure safety and security of screening staff in the screening tent.
- New Psychiatric Emergency Services staff has supported the security response requests in the Emergency room.

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital takes action to minimize or eliminate identified security risks in the physical environment.	**Met**	BRH Security Supervisor attends daily safety huddles. BRH adjusts security patrols and response procedures as needed. e.g. Second security officer posted on night shifts with a priority to post in the ED. Progress continues towards achieving afterhours lock-down of the facility.
When a security incident occurs, the hospital follows its identified procedures.	**Met**	Hospital staff follow established protocols for security incidents as outlined in the BRH Emergency Code Directory.

Objectives	Met / Not Met	Comments and Action Plans
The hospital establishes a process for continually monitoring, internal reporting and proactive risk assessments to identify potential security risks.	**Met**	Accomplished through reports to the EOC Committee and annual Security Management plan updates. Continue to use the BRH Occurrence Reporting System.
The hospital reports and investigates incidents of damage to its property or the property of others.	**Met**	Reports are reported through the BRH Occurrence Reporting System.
The hospital will utilize a multi-disciplinary safety and security team to review all policies, procedures and operations to identify and respond to hazards that exist currently and plan for future threats.	**Met**	The Safety and Security Committee meets to discuss violence prevention policies, education and exercises. Threats to public safety will be mitigated by a combination of physical and procedural controls. The Safety and Security Committee discusses potential solutions and makes recommendations to improve the safety and security of patients, visitors and staff.

PERFORMANCE MEASURES

An analysis of the program objectives and performance measures is used to identify opportunities to resolve security issues and evaluate the effectiveness of the program. Additionally, it provided the Environment of Care Committee with information that can be used to adjust the program activities to maintain performance or identify opportunities for improvement.

Security Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
Increase Facility-wide Security Afterhours **AIM:** BRH will complete prioritized security systems installations over the next year to equate to approximately 55% of the overall project. These installations will be as follows: • Secure facility to limit after-hours access to the ED • Move Vending Machines • Development of patient visitor policy/procedure • Installation of select internal door security systems	55% of the overall project. = 20% = 10% = 5% = 20%	55% of the overall project. = 20% = 10% = 5% = 20%	**Met**
Improve Customer Satisfaction **AIM:** BRH will improve customer satisfaction by decreasing the number of in-patient property loss incidents.	**Decrease incidents by 50%** In 2019 16 in-patient property Loss incidents	Decreased by 44% In 2020 there were 9 Property Loss incidents	**Partially Met**
Improve the Security Camera System Functionality **AIM:** Assess the existing security camera systems to drive an improvement project recommendation. Steps to complete the assessment include: • Inventory Systems 10% • Develop Needs Assessment 40% • Compare current capabilities against needs assessment to identify gaps 40% • Present recommendations 10%	50% of the entire project 10% 40% 40% 10%	33% of the entire project =10% =10% =10% =3%	**Partially Met** Available man-hours to work towards this goal have been minimal.

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance measures fit current organizational needs. The Security Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021

The following goals have been identified:

- **Improve Safety**: The Security Management Committee will Improve Safety by creating variable lock down procedures for active threat events to the Hospital, RRC, BSSC, BMOC and both Admin Buildings. All external exits to hospital, RRC, and both Admin Buildings are to have badge reader access capabilities.
- **Decrease Potential for Workplace Violence:** The Security Management Committee will decrease the potential for workplace violence by Finalizing the disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment; independent of calling for law enforcement.

The proposed performance measures for these goals are:

Security Management Proposed Performance Measure for 2021	Target
Improve Facility Safety Through Security **AIM:** BRH will Improve Safety by creating variable lock down procedures for active threat events to the Hospital, RRC, BSSC, BMOC and both Admin Buildings. All external exits to hospital, RRC, and both Admin Buildings are to have badge reader access capabilities.	Procedures in place and hardware installed.
Decrease Potential for Workplace Violence **AIM:** BRH will decrease the potential for workplace violence by Finalizing the disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment; independent of calling for law enforcement.	Complete the Document.

HAZARDOUS MATERIALS & WASTE MANAGEMENT

SCOPE (No Change)

It is the practice of Bartlett Regional Hospital to comply with all federal and State of Alaska laws and regulations relating to the proper and safe handling and disposal of all hazardous materials and waste. Bartlett Regional Hospital provides comprehensive healthcare and health promotion for the people of Juneau and communities of northern Southeast Alaska.

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.

The program also works to control the risk of exposures to hazardous components such as asbestos in existing building materials which may be disturbed during construction and renovation activities.

ACCOMPLISHMENTS

- Creation of the Hazardous Materials Relias training
- Maintained volumes to remain as a small quantity generator, <220 lbs.
- The subcommittee maintained all policies and procedures as per compliance needs. Subcommittee will update policies and procedures as indicated by Risk or Quality.
- Assured that safety features (eye wash, showers) are maintained per compliance. Assured general knowledge of Haz-Mat concerns are brought to the employees through use of SWARMS.
- Review of all areas to assure they have current Safety Data sheets.

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments & Action Plan
To assure items in departments have current SDS information in our system, and that staff are able to access the SDS.	**Partially Met**	Swarm data indicates this objective has been partially met. The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
To assure staff are able to safely identify spill clean-up resources.	**Met**	Staff were able to describe spill containment locations and competence in their use.
To assure staff understand waste streams: White, Red, Sharps and Liquids.	**Met**	This objective has been met as demonstrated by staff during swarms and as evidenced by compliance with disposal requirements.

Objectives	Met / Not Met	Comments & Action Plan
To assure Nursing Departments are familiar with the pharmaceutical waste process.	**Partially Met**	Nearly all departments have demonstrated competency in this objective. Committee members will continue to work with Department Directors as needed and will continue to monitor compliance through swarms.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to direct hazardous materials and waste management in a positive proactive manner.

PER*FORMANCE MEASURES*

The following measure provide the Environment of Care Committee with information needed to evaluate performance of the Hazardous Materials and Waste Management Program activities and to identify further opportunities for improvement:

HazMat Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
AIM: Review area for products that need Safety Data Sheets. Ask staff to find one item in the system. Need to assure items are uploaded to MSDS Online.	100%	92%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: When would it be necessary to initiate a code "Orange"? Does staff know the difference between incidental vs non-incidental spill?	95%	59%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: Staff Understand that eye wash and shower stations are to be checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)	100%	76%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
AIM: Staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304	90%	95.52%	**Met;**

HazMat Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
AIM: Nursing Departments – Verify staff familiar with pharmaceutical waste. Check area for labels on the disposal buckets. Pre-label before putting into use.	95%	75%	**Partially Met;** The committee will continue to provide department specific education as needed and monitor the results of the training efforts.

EFFECTIVENESS

Effectiveness is based on how well the scope fits current organizational needs and the degree to which current performance metrics result meet stated performance goals. The Environment of Care Committee has evaluated the Hazardous Materials and Waste Management Program and considers it to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021

- The Hazardous Materials committee transferred collection of performance measures to the hospitals education program, called Relias. Using similar format used with Swarms, the committee took the questions and created a training, with a test to collect performance measures. The Hazardous Materials was the first of the EOC committees to create this process. The challenge is the lack of ability to set benchmarks, as this is a new system. For this reason, 2020 will be the starting point for most questions, which benchmarks will be set for 2021.
- Committee decision based on compliance needs by TJC, CAP or CMS, requires 100% for three specific Relias questions from 2020. Our scores maintained mostly the same from 2019, which shows human error, which indicates continued review and process of Relias to maintain standards.
  - Committee decision to maintain Goals/Benchmark to 100% for the following Relias questions:
    - How do you find a Safety Data Sheet at Bartlett Regional Hospital?
    - Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?
    - How often must an eyewash, shower or personal wash bottle be checked?

The proposed performance measures for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Measures 2021	Target
AIM: How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%
AIM: How many elements are included in a Safety Data Sheet?	86%
AIM: What section on a Safety Data Sheet addresses First Aide?	83%
AIM: Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%
AIM: What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	59%
AIM: If your unit has a common bottle of Methanol, you must have at a minimum a plumbed eyewash station on the unit?	13%
AIM: How often must an eyewash, shower or personal wash bottle be checked?.	100%
AIM: You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	75%
AIM: You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	63%
AIM: You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	96%

LIFE SAFETY MANAGEMENT

SCOPE (No Changes)

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.

To assure that the building is in compliance with applicable Federal, state and local codes and standards, and National Fire Protection Association (NFPA) 101, 2012 standards for hospitals,

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,

To assure that personnel training in the Life Safety Management Program is effective,

To test and maintain the fire alarm and detection systems,

To institute interim life safety measures during construction or fire alarm or detection systems failures.

ACCOMPLISHMENTS

- Life Safety Code requirements reviewed as compliant with current TJC standards .
- Fire plan and evaluation completed for Juneau Medical Center Building (BOPS.
- Hospital updated and completed Life Safety prints for the hospital building.
- Facilitated a site visit for the Fire Marshall to evaluate the Juneau Medical Center building.
- Risk assessment and Interim Life Safety Plan for BOPS completion and supported a process to monitor compliance with the plan.
- Better way to collect data and evaluate the knowledge of Life Safety topic of employees.

PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Notes/Action Plan(s)
The Life Safety Management Plan defines the hospital's method of protecting patients, visitors, and staff from the hazards of fire, smoke, and other products of combustion and is reviewed and evaluated at least annually.	**Met**	At a minimum, annually review the BRH Fire Plan.
The fire detection and response systems are tested as scheduled.	**Met**	The Fire Alarm system serving BRH is routinely tested and repaired as necessary.
Summaries of identified problems with fire detection, NFPA code compliance, fire response plans, drills and operations in aggregate, are reported to the EOC Committee.	**Met**	Any problems or deficiencies of the fire alarm system are reported to the Environment of Care (EOC) Committee.
Fire extinguishers are inspected monthly, and maintained annually, are placed in visible, intuitive locations, and are selected based on the hazards of the area in which they are installed.	**Met**	Fire extinguishers are inspected regularly, and as required. All extinguishers are appropriate to their use and location.
Annual evaluations are conducted of the scope and objectives of this plan, the effectiveness of the programs defined, and the performance measures.	**Met**	Items monitored in the annual report and fire drills are assessed for effectiveness and improvement.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to Life Safety Management in a positive proactive manner

PERFORMANCE MEASURES

The following measure provide the Environment of Care Committee with information needed to evaluate performance of the Life Safety Management Program activities and to identify further opportunities for improvement:

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
AIM: Establish and incorporate Fire Drill/process for RRC/Withdrawal Unit and BOPS new location	100%	100%	**Met**.
Update Life Safety Swarms process and complete for all units/departments	100%	85%	**Partially Met:** We have implemented a new process through Smart Sheet.

EFFECTIVENESS

The multi-disciplinary Environment of Care Committee has evaluated the Life Safety Management Program and considers it to be effective based on the objectives and performance metrics indicated in the Plan.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021

- Creating Life Safety Swarms education in Relias for annual training and use Smart sheets monitor and track responses to training. Use Smart sheet data to identify areas needing additional education for staff.
- Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias and monitor and track through Smart sheets.

The proposed performance measures for these goals include**:**

Life Safety Proposed Performance Measures for 2021:	Target	Comments and Action Plan
AIM: Refine the process for accounting for all people following a fire evacuation.	100%	
AIM: Provide an education campaign to clinical staff to learn about what is expected with an evacuation, where the fire containments are, and how to horizontal or vertically evacuate when needed.	100%	
AIM: Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias.	100%	
AIM: Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations.	100%	

UTILITY SYSTEMS MANAGEMENT

SCOPE (Minor Changes)

The Utility Systems Management Plan monitors and evaluates the utility systems in use at Bartlett Regional Hospital. 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. The major utility systems include but are not limited to: electrical distribution, water and waste systems, vertical transportation (elevators), communication systems, heating, ventilation and air conditioning (HVAC), Medical Gases, Helipad System, Fire Alarm and Detection System and the Fire Sprinkler System.

ACCOMPLISHMENTS

- We installed cameras in a few Patient Rooms in MHU (for patient and staff safety.).
- Installed two new camera servers with 90-day recording capacity.
- Decommissioned all legacy access layer switching hardware across the hospital campus (11) and re-cabled all network closets to improve access and reduce airflow restriction.
- Decommissioned (2) legacy racks of equipment to make room for new VxBlock hardware and improved airflow in the main datacenter.
- Replaced all large UPS units (10) across the hospital including the main datacenter.
- Constructed 2 COVID tents.
- Constructed walls for ED Isolation room (cast and suture) with additional (HEPA) High-efficiency particulate air ventilation filters and booster fan.
- Added grease duct access doors in kitchen hood system for better entree for cleaning.
- Added electrical disconnects to kitchen griddle for safer hood cleaning by staff.

Maintenance Storeroom before

Maintenance Storeroom after

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital minimizes the occurrence of unplanned utility systems failures or interruptions.	**Met**	Inventory of equipment for major utility systems maintained in equipment database including PM documentation.
The hospital provides preventative maintenance of the utility systems ensuring reliability.	**Met**	Documentation of activities is entered into TMS, the automated work order system.
The hospital monitors and investigates all utility system problems, failures or user errors to learn from each occurrence in order to minimize reoccurrence of failures or errors.	**Met**	Documentation of activities is entered into TMS, the automated work order system.
The hospital reduces the potential for organizational-acquired illness.	**Met**	This is assured through preventive maintenance and annual quality assurance check of ventilation system pressure relationships and air exchange rates.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct Utilities Management in a proactive manner.

PERFORMANCE MEASURES

The following measure provide the Environment of Care Committee with information needed to evaluate performance of the Utilities Management Program activities and to identify further opportunities for improvement:

Utilities Management Performance Measures 2020	Target	Outcome	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures.	50%	40%	**Partially Met**; This will be a multi-year project to review and rewrite all procedure
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	25%	**Partially Met**; This will be a multi-year project to review and rewrite all inventories.

EFFECTIVENESS

The Utility Management Program has been evaluated by the EOC Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021

- Design and install a workable ventilation system that services the Laboratory. This department is extremely hot in the summer and spaces exceed environmental limits for many of the reagents stored and used in the unit. This problem is closely related to the ventilation of the boiler room. The boiler room has historically been excessively hot and the Lab is located directly above
- Catalog and scan all historical blueprints to electronic format.
- Replace feed piping to and from the underground fuel tank to bring it into compliance with EPA Standards.
- Replace fan unit AHU 11 which provides air to the Operating Rooms. This fan has failed many times in the past few years causing the OR surgical schedules to be canceled.
- Install a glycol heat exchanger on AHU 1 to prevent the freezing of the heating coil at cold temperatures. This is the oldest air handling unit in the hospital that services the Medical Surgical section of the hospital.
- Replace a closed-loop water chiller that has reached its end of life. It needs major components replaced and it is more cost effective to replace the unit rather than fix the failing or failed parts.

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2021	Target	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures. Make certain all utility equipment has an asset number assigned with a PM schedule in the Electronic Equipment Management Program (TMS). The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components and utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance program.	**60%**	This will be a multi-year project to review and rewrite all inventories. (It was learned through experience this year that reviewing all assets with their preventative maintenance procedures was a loftier goal than possible to achieve. Adding new assets to the mix caused the opportunity of improvement to be even greater. Work this year has been focused on writing procedures for new assets as they are added to the management program. Ongoing

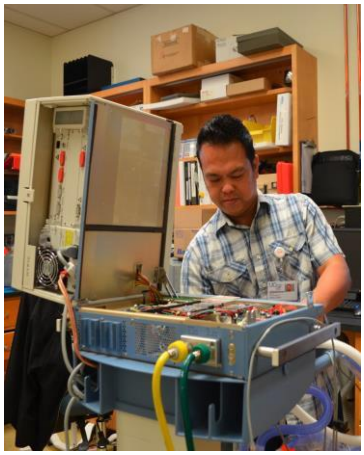
Utilities Management Proposed Performance Measures 2021	Target	Comments and Action Plan
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department. For all parts: reducing the load of unused and outdated stock as well as maintaining adequate stock to perform necessary tasks. This will be a multi-year project to clean out old stock. Even though we were not able to enter inventory locations and quantities as proposed, we were able to reduce the load of unused and outdated inventory. The store room has been remodeled: walls painted, floor floated and painted, and new racks and shelving installed. We have worked at organizing and purging old unused equipment that is left over from assets that are no longer in the hospital. Major strides have been accomplished. We propose to break this project into smaller sections. 1. Sort and condense inventory into a smaller footprint. This will not only include the main stock room but items yet left in the basement of the old Bartlett Outpatient Services building (BOPS). We will be moving and organizing inventory into the refrigeration container located next to the Bartlett House. We are about 50 percent complete on this major first step. We anticipate step one on the project will be significantly completed by this time next year, November 2021. 2. Quantify each item with manufacturer, description and stock numbers. This will include placing each item into a known “warehouse” and known “bin location”. 3. Enter inventory into the TMS system and learn how to add and remove supplies assigning their use to an individual work order with replacement pricing.	Percent of the overall project Nov 2021 30% Nov 2022 50% Nov 2023 100%	See comparative photos contained in this report.

MEDICAL EQUIPMENT MANAGEMENT

SCOPE (NO CHANGE)

The Medical Equipment Management Plan is designed to define the processes by which Bartlett Regional Hospital provides for the safe and proper use of medical equipment used in the patient care setting.

The physical and clinical risks of all equipment used in the diagnosis, treatment, monitoring and care of patients will be assessed and controlled.



ACCOMPLISHMENTS

Program activities highlights for 2020 include:

- Placed into service, 52 new TR 300 PARP.
- Received 6 new ultrasound units for the DI.
- Placed into service 8 new beds in MS department.
- Placed a new sonic cleaner into Central Sterile.
- Calibration of all Biomed Test Equipment.

PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plan
The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.	**Met**	Inventory is kept in the Computerized Maintenance Management System Database (TMS), categorized by risk level and associated with all related historical records.
The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience.	**Met**	As evident in TMS software
Annual evaluations are conducted of the scope, objectives of this plan, the effectiveness of the programs defined, and the performance monitors	**Met**	The Environment of Care Committee reviews and approves the annual plan.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Medical Equipment Management Program continues to direct medical equipment procurement and maintenance in a proactive manner.

PERFORMANCE MEASURES

Equipment Management Performance Measures	Target	Outcome	Comments and Action Plan
To promote proactive equipment replacement. Medical equipment needs to be managed within a unified system. We propose to identify the unified system by February 2020	100%	15%	**Not Met**; This process is still considered as needing improvement and work will continue in 2021.
Within the new system we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by August 2020. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.	100%	0%	**Not Met;** This goal is directly tied to the goal listed above and is also still considered as needing improvement, work will continue in 2021.

EFFECTIVENESS

The Medical Equipment Management Program has been evaluated by the multi-disciplinary Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT FOR 2021

- Need to organize and complete TMS PM updates by the end of the March 2021.

The proposed performance measures for 2021 are:

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
AIM: To promote proactive equipment replacement. Medical equipment needs to be managed within a unified system. We propose to identify the unified system by February 2020	**100%**	Researching the market for capable systems that match the Biomedical department tasks and performance metrics, and develop a proposed solution.

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
AIM: Within the new system we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by August 2020. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.	**100%**	
AIM: Work with Material Management to develop a process for disposing of surplus medical equipment and implement disposal within 3 months of removing it from the Medical Equipment inventory.	**100%**	
AIM: To organize and complete TMS PM updates by the end of the March 2021.	**100%**	

EMERGENCY MANAGEMENT

SCOPE (No Changes)

Bartlett Regional Hospital's Emergency Management Program is designed to assist the hospital in preparing for emergencies and disasters so the hospital experiences the least amount of damage to human lives and property, and maximizes the continuity of services. This effort is led by a multi-disciplinary team of staff through the Emergency Management Committee.

Emergency management is the art and science of managing complex systems and multi-disciplinary personnel to address events across "all-hazards," and through the phases of mitigation (including prevention), preparedness, response and recovery. This Emergency Management Program utilizes best practices to ensure the Program's activities are executed properly and consistent with other responding and receiving organizations.

The program considers a full range of risks that could potentially impact Bartlett Regional Hospital either directly or indirectly. The program and its efforts are designed to reduce risk to the organization's stakeholders, property and operations. This mission is fulfilled through an ongoing process of assessing threats, mitigating risk and reducing vulnerabilities, planning and policy development, capability and resource building and acquisition, training and practical application through drills and exercises.

The Emergency Management Plan and the Emergency Operations Plan apply to all members of hospital administration and staff, in all departments. In addition, this plan applies to all non-staff members who, in the course of their duties, find themselves performing work activities on hospital property, including (but not limited to) clinical providers, technicians, contractors, students, hospital ancillary staff, volunteers, and traveling or rotating personnel from other institutions.

ACCOMPLISHMENTS

- New Committee Chairperson has been appointed.
- All existing policies have been reviewed.
- Missing documents (COOP and Mass Casualty) identified.
- 96 Hour Tool completed, improved with Smartsheet integration.

PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plans
The hospital conducts an annual hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the potential impact and consequences of those events. The HVA is updated when significant changes occur in the hospital's services, infrastructure, or environment.	**Met**	Updated and shared with CBJ.
The hospital develops and maintains a written all-hazards Emergency Operations Plan that describes the response procedures to follow when emergencies occur. The plan and associated tools facilitate management of the following critical functions to ensure effective response regardless of the cause or nature of an emergency: • Communications • Resources and Assets • Safety and Security • Staff Responsibilities and Support • Utilities and Critical Systems • Patient Clinical and Support Activities	**Met**	Improved, tested, and revised PAS activation steps of the Emergency Operations Plan.
The hospital implements its Emergency Operations Plan when an actual emergency occurs.	**Met**	Covid Activities
BRH's emergency response plan and incident command system facilitate an effective and scalable response to a wide variety of emergencies and are integrated into and consistent with the Department of Public Health Disaster Plan and the City and Borough of Juneau Emergency Operations Plan, and are compliant with the National Incident Management System (NIMS).	**Met**	Demonstrated plan effectiveness and scalability throughout 2020.
The hospital trains staff for their assigned emergency response roles.	**Met**	• New Employee Orientation • HICS Section training conducted for ICS sections. • ICS 300 and 400 Training
The hospital conducts exercises and reviews its response to actual emergencies to assess the appropriateness, adequacy and effectiveness of the Emergency Operations Plan, as well as staff knowledge and team performance.	**Met**	Completed After Action Reports and performance evaluations.
Annual evaluations are conducted on the scope, and objectives of this plan, the effectiveness of the program, and key performance indicators.	**Met**	Annual Evaluation by the Emergency Management Committee completed.

The Emergency Management Team and the Environment of Care Committee have evaluated these objectives and determined that they have been met. The program continues to direct emergency management preparedness and response in a positive and proactive manner.

PERFORMANCE MEASURES

Performance Measures	2020 Goal	2020 Results	Comments & Action Plan
AIM: Completion of Joint Commission required 96hr plan.	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.
AIM: Annual Hazard and Vulnerability Assessment.	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.
AIM: Annual update of the Continuity of Operations Plan**.**	**100%**	**100%**	**Met.** The goal shifted direction as new priorities were developed with new Chairmanship.

EFFECTIVENESS

The Emergency Management program has been evaluated and is considered to be effective by both the Emergency Management Committee and the Environment of Care Committee. The program continues to direct and promote emergency and disaster preparedness and response capabilities in a proactive manner.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2021

- Cross-sectional positioning of EMT.
- Integration and alignment of EMT with CBJ/Public Health, particularly of Unified Command Structure and Incident Management Structures.

The proposed performance measures for these goals include:

Emergency Management Proposed Performance Measures for 2021	Target	Comments & Action Plan
AIM: HVA Updated with Inclusion of CBJ and Public Health HVAs	**100%**	
AIM: EOP Reviewed and Updated Annually, Inclusion of 96 Hr. Tool.	**100%**	
AIM: COOP Created and Approved by All Designated Personnel.	**100%**	
AIM: Staff Survey to Evaluate Willingness to Respond.	**100%**	
AIM: Community Resource Survey following completion of COOP.	**100%**	
AIM: Notify CBJ of gaps in resources and request collaborative solutions.	**100%**	

PATIENT SAFETY and QUALITY IMPROVEMENT PLAN

CY 2021

Issued: August 2020
Revised: January 5, 2021

Submitted by: Gail Moorehead, MHL, RN, NPD-BC, CMSRN, CPHQ, CPPS

Purpose

The purpose of the Patient Safety and Quality Improvement (PSQI) Plan for Bartlett Regional Hospital (BRH) is to describe how the organization monitors the care provided to our patients to assure that the BRH mission is fulfilled and to describe the components of the Quality Program.

Mission of Bartlett Regional Hospital: To provide the community with quality, patient-centered care in a sustainable manner.

The PSQI Plan is established by the hospital and is supported and approved by the governing body, which has the responsibility of monitoring all aspects of patient care and services.

The Bartlett Regional Hospital Quality Program provides for the development, implementation, and maintenance of an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The program reflects the complexity of the hospital's organization and services; involves all hospital departments and services, (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

Quality Framework

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, reduce and prevent medical / health care errors. The BRH PSQI Plan uses the Institute of Medicine (IOM) framework to describe overarching aims of a quality health care system. The IOM identifies the following as key characteristics:

- Safe: Avoiding harm to patients from the care that is intended to help them
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waste and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

To achieve these aims, the Quality Program works to:

- Establish and maintain a culture of patient safety to prevent inadvertent harm to patients. This culture focuses on safety where we openly report mistakes and take action to make improvements in our processes. We strive to maintain a Just Culture within our entire hospital.
- Assure mechanisms are in place for staff and providers to provide safe, quality clinical services and demonstrate improvement in patient outcomes.
- Assess performance with objective and relevant measures to achieve quality improvement goals in an organization-wide, systematic approach in collaboration with patients and families.
- Continually assess and assure compliance with regulatory and accrediting bodies, including the CMS Conditions of Participation, The Joint Commission, and other regulatory bodies.
- Promote systems thinking and effective teamwork in care design and delivery.
- Monitor patient satisfaction, and support providers, staff, and departments to focus on areas where the patient experience may be improved.

- Optimize allocation of resources to reduce waste and ensure the delivery of safe, efficient, equitable, and effective care.
- Partner with colleagues, providers, staff, programs and services to help create and maintain a work environment that is safe, purposeful, meaningful and where we can take joy in our work.
- Annually evaluate the objectives, scope, and organization of the improvement program; evaluate mechanisms for reviewing monitoring, assessment, and problem-solving activities in the performance improvement program; and take steps to improve the program.

Authority and Scope

The Board of Directors of Bartlett Regional Hospital is ultimately responsible for the quality of care provided by the hospital. The Board of Directors provides 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 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.

The Medical Staff, through its by-laws, rules and regulations, 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.

Organizational performance improvement is a hospital-wide activity under the direction of hospital leadership, and in collaboration with medical staff. Everyone at Bartlett Regional Hospital is responsible to improve the quality of care provided. It is the responsibility of hospital leadership to establish a culture of quality and assure performance improvement activities are given a high priority among department activities.

The scope of the Quality Program is broad to include any strategic or operational priorities, and all organizational departments and units that impact the aim of the IOM framework described earlier. Quality and safety activities are addressed throughout the organization and reported through the Hospital Performance Improvement Committee, which then reports to the Board of Directors.

The review and improvement of the Environment of Care (EOC) is under the direction of 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 seven Management Plans for the Environment of Care.

Structure and Reporting

The Board of Directors has established a Quality Committee to communicate information to the Board of Directors concerning the hospital quality program and the mechanisms for monitoring and evaluating quality, identifying and resolving problems, and identifying opportunities to improve patient care.

The Quality Program operations are carried out by the organization's administration, medical staff, clinical, and organizational support services. The Medical Staff Executive Committee and the Hospital Performance Improvement Committee provide the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the organization. The Senior Director of Quality is responsible for the day-to-day operations of the Quality Program, and reports directly to the Chief Executive Officer.

Components of the Program:

While having influence and supporting organizational quality across the hospital, the Quality Program is made up of a variety of components that broadly include: Core Measure monitoring, abstraction, and data submission; Patient Satisfaction, Accreditation (both Joint Commission and CMS); Risk Management; Patient Safety; Infection Prevention and Control; Complaint Management; and, Medical Staff Quality.

The medical staff monitors, assesses, and evaluates the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges through 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.

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 Medical Staff Executive Committee and the General Medical Staff through Committee chairs.

- At routine meetings of the medical staff or among its various committees, these quality of 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
    - Utilization Management
    - Other processes as determined by the individual committee
    - Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
    - Assessment of the performance of the patient care and organizational functions are included.

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

The Hospital Performance Improvement Committee is an administrative committee responsible for identifying and reporting on performance improvement issues that affect patient care and services.

The purpose of the Hospital Performance Improvement Committee is to identify and prioritize performance improvement issues within each Department, encourage accountability, and review the effectiveness of performance improvement activities. Departments are responsible for conducting continuous quality improvement on services and care delivery.

Reporting:

The results of the department-level initiatives are reported to the Hospital Performance Improvement Committee on a regular schedule.

Data related to Patient Safety issues including (but not limited to) medication incidents are reviewed at the Hospital Performance Improvement Committee.

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 relevant hospital committees and/or administrative leadership. In these cases, reporting of results will be routed both through the relevant Medical Staff committee, and hospital committee or leadership team.

Relevant quality-related results of Medical Staff committees are reported to the Medical Executive Committee and General Medical Staff Body.

Patient Safety

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.

A culture of safety is a core value for the organization. Safety is led from the top. In an organization with a refined culture of patient safety, events are reported, safety is transparent and safety events are disclosed. Hospital leaders work to ensure the following characteristics exist in the organization:

- Everyone is empowered and expected to stop and question when things don't seem right
- Everyone is constantly aware of the risks inherent in what the organization does
- Learning and continuous improvement are true values. There is non-punitive response, feedback, and communication about errors.
- Effective teamwork is a requirement, and leadership provides mechanisms for staff to improve the functioning of teams.
- Removing intimidating behavior that might prevent safe behaviors
- Resources and training are provided to take on improvement initiatives

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, clinical quality 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 – 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 – 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; or 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. Additionally, any event otherwise defined by the Joint Commission as "reviewable / reportable," which may change from time to time.

The responsibilities of the Director of Quality include oversight of 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. Tasks include, but are not limited to:

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.
   b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Administrator On-Call determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.

2. Response to actual or potential patient safety risks is 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.
   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. Communication and consultation occurs with the City and Borough of Juneau's safety team for all environmental related issues.
   c. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the hospital Performance Improvement Committee.

3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (*Sentinel Event Policy* and *Occurrence Reporting Policy*). A root cause analysis of processes, conducted on either a Sentinel Event or Significant Event, 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. 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 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. 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 on administrative rounds

b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
c. Comments from patient Complaints or Grievances

8. 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.
   c. Evaluating informational barriers to effective communication among caregivers.

9. The following methods are used to maintain and improve staff competences in patient safety science:
   a. Providing information and orientation to reporting mechanisms to new staff in orientation training.
   b. Providing on-going training to staff on patient safety initiatives and methods as applicable.
   c. Evaluating staff's willingness to report medical errors through the AHRQ Culture of Patient Safety Survey.

10. Data Analysis:
    a. The hospital routinely analyses data to proactively identify quality and patient safety risks, and uses data analyses to develop and monitor responses.

Performance Improvement Methodology

The Bartlett Microsystems methodology is used to drive continuous performance improvement of systems and processes related to patient care, patient safety, and workflow efficiency 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.

Quality improvement priorities are those areas and issues that are high risk, high volume, or problem prone areas. The following are routinely considered when selecting quality improvement initiatives: Incidence, prevalence, severity of problems; effect on health outcomes, patient safety and quality of care.

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

Data Collection and Analysis

The data analysis program will include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes.

BRH *measures, analyzes, and tracks quality indicators and other aspects of performance that assess processes of care, hospital service and operations. The data analysis in the Quality program incorporates quality indicator data including patient care data, and other relevant data. The hospital uses the data collected to monitor the effectiveness and safety of services and quality of care. The frequency and detail of data collection is specified by the hospital's governing body.*

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 is monitored related to the following processes:

- Management of hazardous conditions
- Medication management
- Complications of operative and other invasive procedures
- Blood and blood product documentation
- Restraint use
- Outcomes related to resuscitation
- National Patient Safety Goals
- Organ procurement effectiveness: conversion rate data is collected and analyzed and when reasonable, steps are taken to improve the rate.
- Core Measures
- Healthcare Acquired Conditions

Other 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

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, are reported to the Hospital Performance Improvement Committee or Medical Staff Quality Improvement Committee (MSQIC) on an annual or other basis as designated.

Strategic Quality Objectives

Please see Appendix A for the evaluation of the prior year plan, and the current year's objectives and measures.

Annual Evaluation

The organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary. This is to assure 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.

Confidentiality

All information related to performance improvement activities performed by the medical staff or hospital personnel in accordance with this plan is confidential per AS 18.23.030, AS 18.23.070(5), and 42 USC 11101 60.10 (HCQIA).

Confidential information may include (but is not limited to): medical staff committee meetings, dashboards, hospital committee minutes, electronic data gathering and reporting, occurrence reporting, and clinician scorecards.

Approval

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

_____	_____
Chief Executive Officer	Date
_____	_____
Chief of Medical Staff	Date
_____	_____
Board Chair	Date

Appendix A

Evaluation of 2020 PSQI Plan:

Accomplishments:

- Successful establishment of the Patient Safety Committee
- Creation of Patient Safety Task Forces for Restraints, Fall Prevention and Inpatient Glycemic Control
- Success integration of patient feedback through Press Ganey surveys utilizing e survey options
- Implementation of Smart Sheet Dashboards for staff communication and current practices
- Successful metrics with the Partnership for Patients ASHNA/WSHA collaborative

Quality Goal	CY 2020 Metric	Outcome
Demonstrate Antimicrobial Stewardship Leadership within the Juneau community	Maintain overall antimicrobial stewardship rate of 200 days of therapy/1000 patient days or less through 2020 (Source: QBS, Partnership for Patients)	Overall antimicrobial stewardship rate of 142 days of therapy/1000 patient days through 11/30/2020. (Source: QBS, Partnership for Patients)
Fully incorporate a cross-sectional Patient Safety Committee to review and assure corrective action plans from RCA2s are met and sustainable.	The Patient Safety Committee will meet at least twice to review RCA2 corrective action plans. (Source: Quality Director)	Exceeded. Patient Safety Committee has identified and completed three RCA2 and developed corrective action plans. (Source: Quality Director)
Improve Bartlett's Culture of Patient Safety	The Team STEPPS implementation team will implement at least 1 hand-off communication project to address intradepartmental communication. (Source: Staff Development Director)	Exceeded. 1. Bedside shift reports with standardized hand-off project on Med/Surg unit. 2. Patient Sitter Hand off communication training ongoing (Source: Staff Development, Patient Family Engagement Coordinator)
Improve compliance with Sepsis core measure	Increase annual percentage of compliance to at least 58% by 12/31/2020 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)	Met. The annual compliance for the Sepsis core measure was 58% for all quarters of 2020. (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)
Assure workforce	Hire and onboard Quality Director	Met.

2021 PSQI Goals

Quality Goal	CY 2021 Metric
Develop PI Methodology onboarding orientation for all new management team members	Initiate training for new management team to include: Directors, Supervisors and Leads by July 2021. Provide training for 75% of new leaders within 90 days of hire by 12/31/2021(Source: Quality Director)

Reduce Inpatient Fall Rates	Reduce inpatient total fall rate to 5/1000 patient days by 7/31/2020. Maintain rate through 12/31/2020. (Source: Patient Harm Dashboard, QBS)
Update Ongoing Professional Practice (OPPE) to include metric comparison with peers	Revise scorecards and provide data to providers based on metrics that include personal scores and peer based rates. (Source: Scorecards through Credentialing Committee of provider types)
Maintain Sepsis core measure compliance at or above national average. Current national average 60%.	Maintain annual percentage of compliance to at least 60% through 12/31/20201. (Source: Encore D, Early Management Bundle/Severe Sepsis/Shock, Annual Percentage)

Antimicrobial Stewardship
Bartlett Regional Hospital

Ursula Iha RPh Director of Pharmacy
Christopher Sperry PharmD BCPS SIDP
Evan Deisen PharmD SIDP
March 10, 2021

"The primary goal of antimicrobial stewardship is to optimize clinical outcomes while minimizing unintended consequences of antimicrobial use, including toxicity, the selection of pathogenic organisms (such as Clostridium difficile), and the emergence of resistance."

Dellit TH et al. *Clin Infect Dis* 2007; 44:159-77.

Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

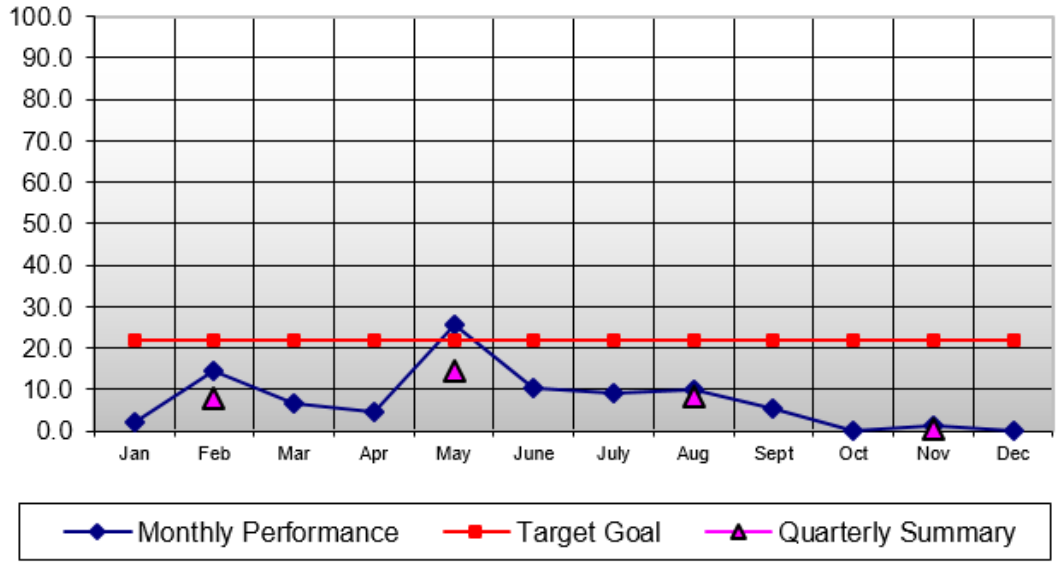
Performance Improvement Goal

Days of Therapy of Carbapenem

Improvement Opportunity: **Reduce the use of Carbapenem anitbiotics in order to reduce resistance and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

Carbapenem



		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	2	13	5	2	16	7	8	8	5	0	1	0
Denominator	Number of Patient days	893	893	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	2.2	14.6	6.7	4.4	25.7	10.3	9.3	10.1	5.4	0.0	1.2	0.0
Target Goal	(Change target goal if needed)	22.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0
Quarter Summary			**7.9 Qtr 1**			**14.3 Qtr 2**			**8.1 Qtr 3**			**0.4 Qtr 4**	

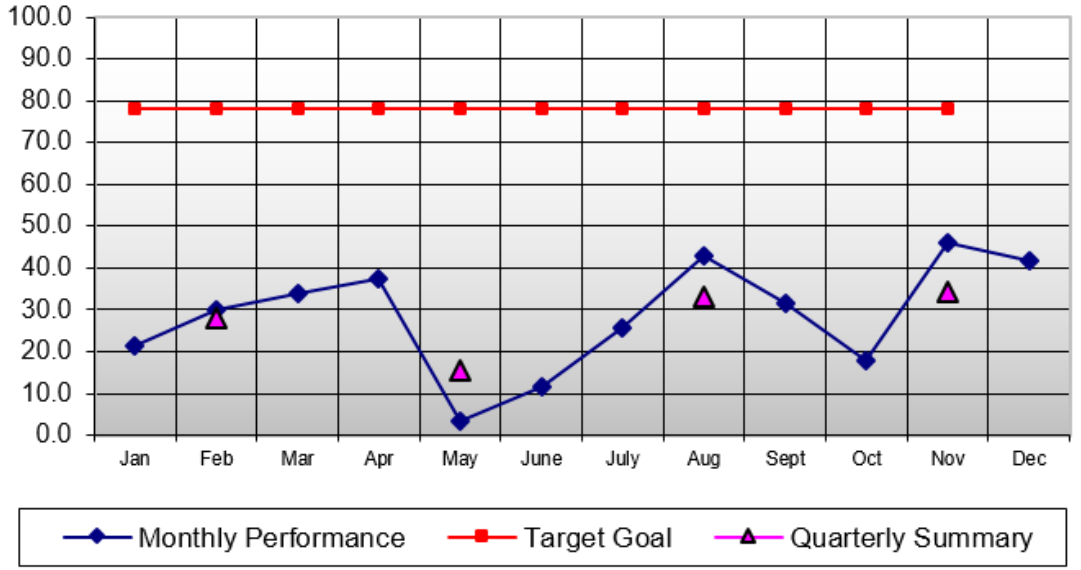
Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

Fluoroquinolones



Performance Improvement Goal

Days of Therapy of Fluoroquinolones

Improvement Opportunity: **Reduce the use of Fluoroquinolone anitbiotics in order to reduce, side effects, resistance, and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	19	28	25	17	2	8	22	34	29	17	38	35
Denominato	Number of Patient days	893	938	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	21.3	29.9	33.7	37.6	3.2	11.8	25.5	43.0	31.4	17.7	45.9	41.9
Target Goal	(Change target goal if needed)	78.0	78.0	78.0	78.0	78.0	78.0	78.0	78.0	78.0	78.0	78.0	
Quarter Summary			**28.0** Qtr 1			**15.4** Qtr 2			**33.0** Qtr 3			**34.3** Qtr 4	

Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

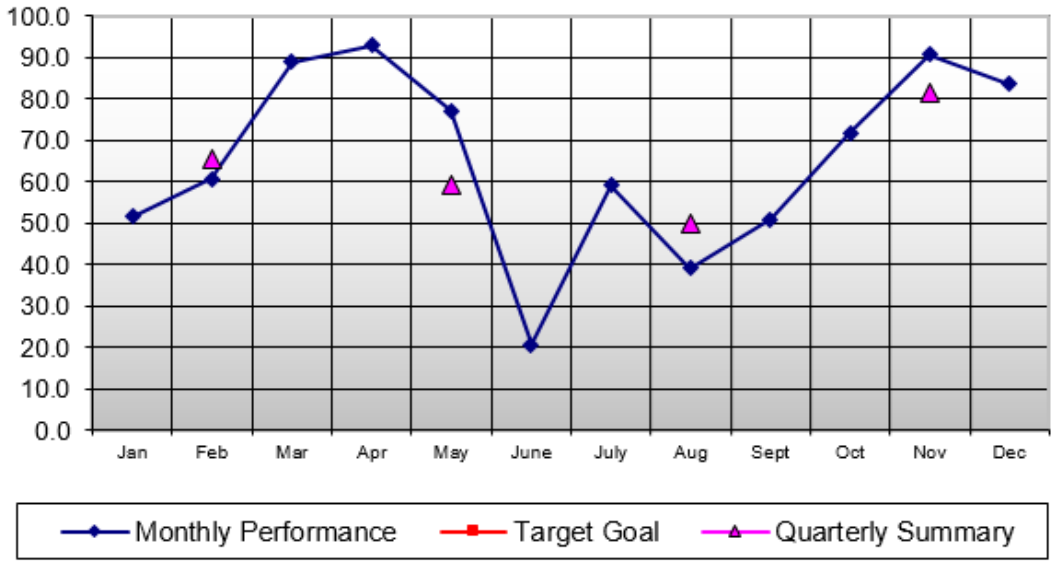
Performance Improvement Goal

Days of Therapy of Broad Spectrum Cephalosporins

Improvement Opportunity: **Reduce the use of broad spectrum Cephalosporin anitbiotics in order to reduce resistance and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

Broad Spectrum Cephalosporins



		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	46	57	66	42	48	14	51	31	47	69	75	70
Denominato	Number of Patient days	893	938	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	51.5	60.8	89.1	92.9	77.2	20.6	59.1	39.2	50.9	71.9	90.7	83.7
Target Goal	(Change target goal if needed)	121.0	121.0	121.0	121.0	121.0	121.0	121.0	121.0	121.0	121.0	121.0	121.0
Quarter Summary			**65.7 Qtr 1**			**59.3 Qtr 2**			**50.0 Qtr 3**			**81.6 Qtr 4**	

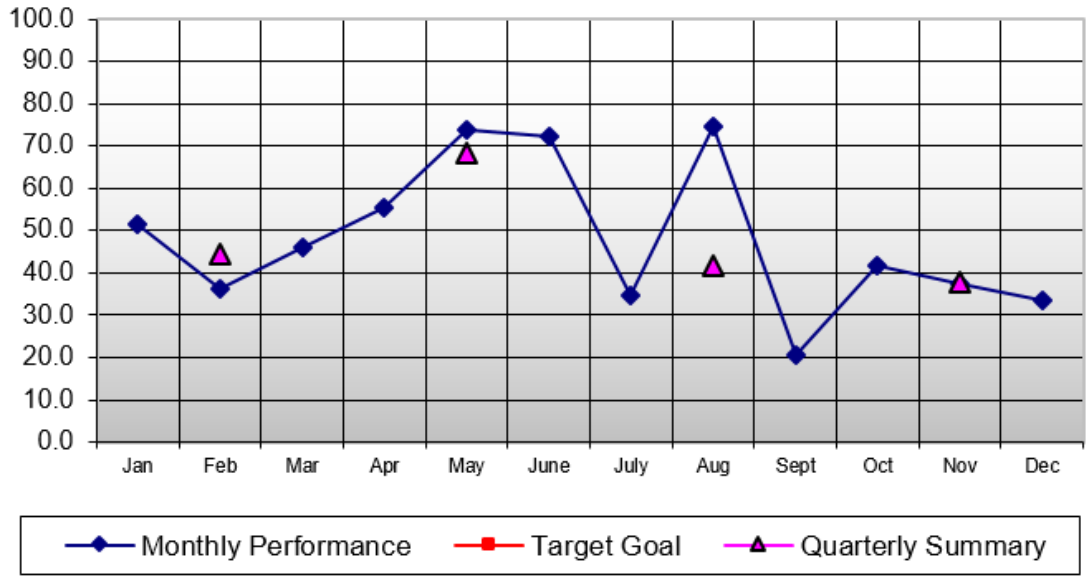
Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

Broad Spectrum Penicillins



Performance Improvement Goal

Days of Therapy of Broad Spectrum Penicillins

Improvement Opportunity: **Reduce the use of broad spectrum penicillin anitbiotics in order to reduce, side effects, resistance, and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	46	34	34	25	46	49	30	59	19	40	31	28
Denominato	Number of Patient days	893	938	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	51.5	36.2	45.9	55.3	74.0	72.2	34.8	74.6	20.6	41.7	37.5	33.5
Target Goal	(Change target goal if needed)	102.0	102.0	102.0	102.0	102.0	102.0	102.0	102.0	102.0	102.0	102.0	102.0
Quarter Summary			**44.3** Qtr 1			**68.5** Qtr 2			**41.9** Qtr 3			**37.7** Qtr 4	

Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

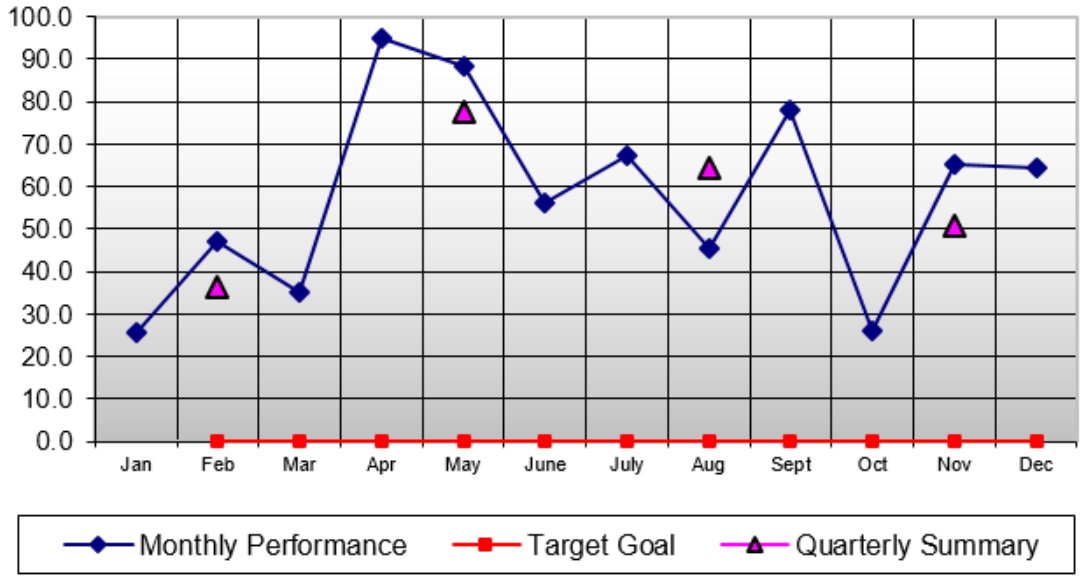
Performance Improvement Goal

Days of Therapy of Vancomycin

Improvement Opportunity: **Reduce the use of Vancomycin in order to reduce, side effects, resistance, and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

Vancomycin



		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	23	44	26	43	55	38	58	36	72	25	54	54
Denominator	Number of Patient days	893	938	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	25.8	46.9	35.1	95.1	88.4	56.0	67.2	45.5	77.9	26.0	65.3	64.6
Target Goal	(Change target goal if needed)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Quarter Summary			**36.2 Qtr 1**			**77.6 Qtr 2**			**64.4 Qtr 3**			**50.7 Qtr 4**	

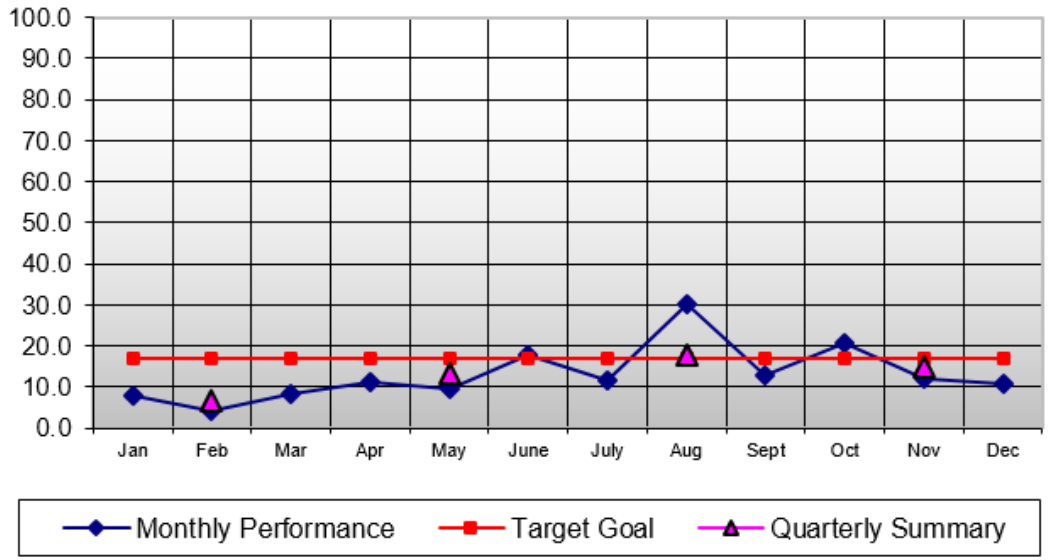
Bartlett Regional Hospital

Performance Improvement Report - 2020

Antimicrobial Stewardship Team

Pharmacy

Clindamycin



Performance Improvement Goal

Days of Therapy of Clindamycin

Improvement Opportunity: **Reduce the use of Clindamycin anitbiotics in order to reduce, side effects, resistance, and maintain potency.**

Data Collection Methodology: Numerator is A Day Of Therapy (DOT) is at least one dose of antibiotic on a calendar day to an inpatient. Denominator is total inpatient days.

		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Numerator	Number of DOT	7	4	6	5	6	12	10	24	12	20	10	9
Denominator	Number of Patient days	893	938	741	452	622	679	863	791	924	960	827	836
Rate	DOT per 1000 patient-days	7.8	4.3	8.1	11.1	9.6	17.7	11.6	30.3	13.0	20.8	12.1	10.8
Target Goal	(Change target goal if needed)	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0
Quarter Summary			**6.6 Qtr 1**			**13.1 Qtr 2**			**17.8 Qtr 3**			**14.9 Qtr 4**	

Survey on Patient Safety

Hospital Survey on Patient Safety

This survey asks for your opinions about patient safety issues, medical error, and event reporting and will take about 20 minutes to complete. If a question does not apply to you or you don't know the answer, please select "Does Not Apply or Don't Know."

The Culture of Patient Safety Survey is completed every two years and the feedback you give in this survey is anonymous. Please take your time and give open feedback so we can identify opportunities for improving Patient Safety.

* 1. What is your position in this hospital?

- [ ] Registered Nurse
- [ ] Advanced Practice Nurse
- [ ] Certified Nursing Assistant/Behavioral Health Assistant
- [ ] Physician
- [ ] Pharmacist/Pharmacy Technician
- [ ] Dietitian
- [ ] Physical, Occupational, or Speech Therapist
- [ ] Other (please specify)

- [ ] Respiratory Therapist
- [ ] Social Worker, Case Manager
- [ ] Laboratory Technician
- [ ] Director, Supervisor, Department Manager, Clinical Leader
- [ ] Senior Leader, Executive
- [ ] Facilities
- [ ] Food Services

- [ ] Environmental Services
- [ ] Information Technology, Health Information Services, Clinical Informatics
- [ ] Security
- [ ] Unit Clerk, Office Staff - Clinical Based
- [ ] Administrative Staff, Office Staff - non clinical based

* 2. Think of your "unit" as a work area, department, or clinical area of the hospital where you spend MOST of your time. What is your primary unit or work area in the hospital?

- [ ] Medical/Surgical
- [ ] Critical Care
- [ ] OB
- [ ] Emergency Room
- [ ] Operating Room/PACU
- [ ] Same Day Care
- [ ] Mental Health Services
- [ ] Rehabilitation Services PT/OT/Speech
- [ ] Respiratory Therapy
- [ ] Laboratory
- [ ] Environmental Services/Laundry
- [ ] Rainforest Recovery Center
- [ ] Patient Access Services
- [ ] Facilities
- [ ] Food Services
- [ ] Quality/Risk Management/Staff Development
- [ ] Food Services
- [ ] Infusion Services
- [ ] Physician Services/Oncology
- [ ] Hospitalist Service
- [ ] Physicians- Independent Providers
- [ ] Behavioral Health Outpatient Services
- [ ] Information Services
- [ ] Other (please specify)

3. **SECTION A: Your Unit/Work Area**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. In this unit, we work together as an effective team.	○	○	○	○	○	○
2. In this unit, we have enough staff to handle the workload.	○	○	○	○	○	○
3. Staff in this unit work longer hours than is best for patient care.	○	○	○	○	○	○
4. This unit regularly review work processes to determine if changes are needed to improve patient safety.	○	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
5. This unit relies too much on temporary, float or PRN staff.	○	○	○	○	○	○
6. In this unit, staff feel like their mistakes are held against them.	○	○	○	○	○	○
7. When an event is reported in this unit, it feels like the person is being written up, not the problem.	○	○	○	○	○	○
8. During busy times, staff in this unit help each other.	○	○	○	○	○	○
9. There is a problem with disrespectful behavior by those working in this unit.	○	○	○	○	○	○
10. When staff make errors, this unit focuses on learning rather than blaming individuals.	○	○	○	○	○	○
11. The work pace in this unit is so rushed that it negatively affects patient safety.	○	○	○	○	○	○
12. In this unit, changes to improve patient safety are evaluated to see how well they worked.	○	○	○	○	○	○
13. In this unit, there is a lack of support for staff involved in patient safety errors.	○	○	○	○	○	○
14. This unit lets the same patient safety problems keep happening.	○	○	○	○	○	○

4. **SECTION B: Your Supervisor, Manager, or Clinical Leader**

How much do you agree or disagree with the following statements about your immediate supervisor, manager, or clinical leader?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.	○	○	○	○	○	○
2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it mean taking shortcuts.	○	○	○	○	○	○
3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.	○	○	○	○	○	○

5. **SECTION C: COMMUNICATION:**

How often do the following things happen in your unit/work area?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. We are informed about errors that happen in this unit.	○	○	○	○	○	○
2. When errors happen in this unit, we discuss ways to prevent them from happening again.	○	○	○	○	○	○
3. In this unit, we are informed about changes that are made based on event reports.	○	○	○	○	○	○
4. In this unit, staff speak up if they see something that may negatively affect patient care.	○	○	○	○	○	○
5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.	○	○	○	○	○	○
6. When staff in this unit speak up, those with more authority are open to their patient safety concerns.	○	○	○	○	○	○
7. In this unit, staff are afraid to ask questions when something does not seem right.	○	○	○	○	○	○

6. **SECTION D: Reporting Patient Safety Events**

Think about your unit/work area:

	Never	Rarely	Sometimes	Most of the time	Always	Does Not Apply or Don't Know
1. When a mistake is caught and corrected before reaching the patient, how often is this reported?	○	○	○	○	○	○
2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	○	○	○	○	○	○

7. In the past 12 months, how many patient safety events have YOU reported?

- ☐ None
- ☐ 1 - 2
- ☐ 3 - 5
- ☐ 6 - 10
- ☐ 11 - or more

8. **SECTION E: Patient Safety Rating**

How would you rate your unit/work area on patient safety?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

9. **SECTION F: Your Hospital**

How much do you agree or disagree with the following statements about your hospital?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The actions of hospital management show that patient safety is a top priority.	○	○	○	○	○	○
2. Hospital management provides adequate resources to improve patient safety.	○	○	○	○	○	○
3. Hospital management seems interested in patient safety only after an adverse event happens.	○	○	○	○	○	○
4. When transferring patient from one unit to another, important information is often left out.	○	○	○	○	○	○
5. During shift changes, important patient care information is often left out.	○	○	○	○	○	○
6. During shift changes, there is adequate time to exchange all key patient care information.	○	○	○	○	○	○

10. **SECTION G: Empowerment to Improve Efficiency**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. We are encouraged to come up with ideas for more efficient ways to do our work.	○	○	○	○	○	○
2. We are involved in making decisions about changes to our work processes.	○	○	○	○	○	○
3. We are given opportunities to try out solutions to workflow problems.	○	○	○	○	○	○

11. **SECTION H: Efficiency and Waste Reduction**

How often do the following statements apply to your unit/work area?

	Never	Rarely	Sometimes	Most of the time	Always	Does Not Apply or Don't Know
1. We try to find ways to reduce waste (such as wasted time, material, steps, etc.) in how we do our work.	○	○	○	○	○	○
2. In our unit, we are working to improve patient flow.	○	○	○	○	○	○
3. We focus on eliminating unnecessary tests and procedures for patients.	○	○	○	○	○	○

12. **SECTION I: Patient Centeredness and Efficiency**

How much do you agree or disagree with the following statements about your unit/work area?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. In our unit, we take steps to reduce patient wait time.	○	○	○	○	○	○
2. We ask for patient or family member input on ways to make patient visits more efficient.	○	○	○	○	○	○
3. Patient and family member preferences have led to changes in our workflow.	○	○	○	○	○	○

13. **SECTION J: Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste**

How much do you agree or disagree with the following statement about your supervisor, manager, or clinical leader?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does Not Apply or Don't Know
1. Recognizes us for our ideas to improve efficiency.	○	○	○	○	○	○
2. Provides us with reports on our unit performance.	○	○	○	○	○	○
3. Takes action to address workflow problems that are brought to his or her attention.	○	○	○	○	○	○
4. Places a high priority on doing work efficiently **WITHOUT** compromising patient care.	○	○	○	○	○	○

14. **SECTION K: Experience With Activities to Improve Efficiency**

In the past 12 months, have you done the following activities to improve efficiency, add value or reduce waste in your hospital?

	Yes	NO
1. I received training on how to identify waste and inefficiencies in my work.	○	○
2. I helped map a workflow process to identify wasted time, materials, steps in a process.	○	○
3. I have shadowed/follow patients in this hospital to identify ways to improve their care experience.	○	○
4. I looked at visual displays or graphs to see how well my unit was performing.	○	○
5. I made a suggestion to management about improving an inefficient work process.	○	○
6. I made a suggestion to management about improving patient's care experiences.	○	○
7. I served on a team or committee to make a work process more efficient.	○	○
8. I monitored data to figure out how well an activity to improve efficiency was working.	○	○

15. **SECTION L: Overall Rating**

Overall, how would you rate your unit/work area on each of the following areas?

	Poor	Fair	Good	Very Good	Excellent
1. Patient Centered: Is responsive to individual patient preferences, needs and values.	○	○	○	○	○
2. Effective: Provides services based on scientific knowledge to all who could benefit.	○	○	○	○	○
3. Timely: Minimizes waits and potentially harmful delays.	○	○	○	○	○
4. Efficient: Ensures cost-effective care (avoids waste, overuse and misuse of services).	○	○	○	○	○

16. **Your Hospital's Electronic Health Record (EHR) System**

Do you use your hospital's Electronic Health Record system(s) to enter or review patient information?

- ○ Yes
- ○ No - [Go to Background questions]

17. **SECTION M: EHR Patient Safety and Quality Issues**

If you used more than one EHR system, please think about the one you use the most. The following items describe things that can affect patient safety and quality when using EHR systems. **In the past 3 months,** how many times did you discover the following issues with the EHR system in your hospital?

	None	1-5 times	6-10 times	11-20 times	21-50 times	More than 50 times	Does Not Apply or Don't Know
1. Information was not complete	○	○	○	○	○	○	○
2. Information was not accurate	○	○	○	○	○	○	○
3. Important information was hard to find	○	○	○	○	○	○	○
4. Information was entered into the wrong patient health record	○	○	○	○	○	○	○
5. Incorrect information was copied and pasted	○	○	○	○	○	○	○

18. **SECTION N: EHR System Training**

How much do you agree or disagree with the following statements?

	Strongly disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. We are given enough training on how to use our EHR system.	○	○	○	○	○	○
2. Training on our EHR system is customized for our work area.	○	○	○	○	○	○
3. We are adequately trained on what to do when our EHR system is down.	○	○	○	○	○	○

19. **SECTION O: EHR and Workflow/Work Process**

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. There are enough EHR workstations available when we need them.	○	○	○	○	○	○
2. Our EHR system requires that we enter the same information in too many places.	○	○	○	○	○	○
3. There are too many alerts or flags in our EHR system.	○	○	○	○	○	○

20. **SECTION P: EHR System Support and Communication**

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree or Dsagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. Problems with our EHR system are resolved in a timely manner.	○	○	○	○	○	○
2. We are asked for input on ways to improve our EHR system.	○	○	○	○	○	○
3. We are made aware of issues with our EHR system that could lead to errors.	○	○	○	○	○	○

21. **SECTION Q: Overall EHR System Rating**

How satisfied or dissatisfied are you with your hospital's EHR system

- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Satisfied
- ◯ Very Satisfied

22. **BACKGROUND QUESTIONS**

How long have you worked in this hospital?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11 or more years

23. In this hospital, how long have you worked in your current unit/work area?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11 or more years

24. Typically, how many hours per week do you work in this hospital?

- ◯ Less than 30 hours per week
- ◯ 30-40 hours per week
- ◯ More than 40 hours per week

25. In your staff position, do you typically have direct interaction or contact with patients?

- ◯ Yes, I typically have direct interaction or contact with patients.
- ◯ No, I typically do NOT have direct interaction or contact with patients.

26. Please feel free to provide any comments about how things are done or could be done in your hospital that might affect patient safety.