Bartlett Regional Hospital

To: Board of Directors of Bartlett Regional Hospital **January 20, 2023**

From: Lindy Jones, MD – Quality Committee Chair

♦ **ISSUE**

The board is being asked to approve the annual plans as presented through the Board Quality Committee.

♦ **BACKGROUND**

- The following annual plans were presented and approved at the Board Quality Committee meeting on Thursday, January 19th.
- The annual management plans are as follows:
    1) Medical Equipment Management Plan.
    2) Life Safety Management Plan
    3) Hazardous Materials and Waste Management Plan
    4) Safety Management Plan
    5) Security Management Plan
    6) Utility Systems Management Plan
    7) Utilization Management Plan
    8) Quality Management Plan
    9) Infection Control Plan
- Gail Moorehead, Executive Director of Quality will be present to brief the board.

♦ **OPTIONS**

Approve the annual plans as presented to the board.
Amend the annual plans and approve the amended plans.
Seek additional information.

♦ **LEADERSHIP'S RECOMMENDATION**

Approve the Management Plans as presented to the board.

♦ **SUGGESTED MOTION**

I move the Board of Directors of Bartlett Regional Hospital approve the Medical Equipment, Life Safety, Hazardous Materials and Waste, Safety, Security, Utility Systems, Utilization, Quality and Infection Control annual management plans as presented.

Bartlett Regional Hospital

Title: Medical Equipment Management Plan

Department: All

SCOPE:

The scope of the Medical Equipment Management Plan is 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.

POLICY:

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

A. **OBJECTIVES:** The objectives of Bartlett Regional Hospital's Medical Equipment Management Plan include the following:

A.1. To minimize the clinical and physical risks of equipment through inspection, testing and regular maintenance;

A.2. To establish criteria for identifying, evaluating and inventorying equipment, which is included in the program;

A.3. To provide education to personnel on the capabilities, limitations and special applications of equipment; operating, safety and emergency procedures of equipment; the procedures to follow when reporting equipment management problems, failures and user errors; and the skills and/or information to perform maintenance activities.

B. **RESPONSIBILITY:**

B.1. The Utilities and Equipment Sub Committee is responsible for maintaining the Medical Equipment Management Plan.

B.2. The Lead Biomedical Equipment Technician in consultation with the Facilities Director are responsible for maintaining the Medical Equipment Management Program.

B.3. Each department Director is responsible for orienting new staff members to the capabilities, limitations, special applications of equipment, basic operating and safety procedures, emergency procedures if failure occurs, maintenance responsibilities, if applicable, and the reporting procedures for equipment problems, failures and user errors.

C. **THE SELECTION AND ACQUISITION OF MEDICAL EQUIPMENT:**

C.1. A needs assessment will be completed by each department for replacement or new equipment. The Lead Biomedical Equipment Technician will determine if the equipment meets appropriate space requirements, load and phase requirements, Underwriters Laboratory requirements, minimum safety standards of 3 wire AC line cord with hospital grade plug, appropriate warranties and manufacturer's reliability prior to purchase. If the equipment does not meet the above specifications, it may not be ~~ordered~~ordered, and an alternate choice may be submitted for approval.

C.2. See Policy on Selection and Acquisition of Equipment.

D. **ESTABLISHING CRITERIA FOR IDENTIFYING, EVALUATING AND TAKING INVENTORY OF MEDICAL EQUIPMENT TO BE INCLUDED IN THE EQUIPMENT MANAGEMENT PROGRAM:**

D.1. All mechanical and electrical patient care equipment will be evaluated prior to use, based on function including diagnosis, care, treatment and monitoring; physical risks associated with use, maintenance requirements and history of equipment incidents. All incoming and existing equipment meeting the evaluation criteria are included in the Electronic Equipment Management Program, Total Maintenance System (TMS) by Accruent, Four Rivers Software Systems, Inc.

D.2. All new equipment shall be inventoried and inspected prior to use for patient care or any other use. Equipment that fails electrical safety tests shall not be approved for use until the deficiencies have been corrected. There is a current inventory of all equipment included located in the Electronic Equipment Management Program (TMS).

D.3. See Biomedical Equipment Management Policy, Equipment Management Numbers Formula/High Risk Inventory Policy and Electronic Equipment Management Program (TMS).

E. **HAZARD NOTICES AND RECALLS:**

E.1. All product safety alerts, hazard notices and recalls will be directed to the Lead Biomedical Equipment Technician and the Facilities Director. In the event the notices are not directed to these individuals, the notices will be immediately rerouted to the Risk Manager. Lead Biomedical Equipment Technician will check the clinical equipment inventory to screen for equipment matches and will evaluate the severity of the risk. In most cases, the notices may be addressed without removing equipment from service. In the event equipment must be removed from service, the equipment is replaced with a safe effective substitute. The Biomedical Engineering Department will impound equipment removed from use due to recall notices until it can be rendered safe.

E.2. The Risk Manager will report quarterly to the Environment of Care Committee on any hazard notices and recalls affecting the hospital and all follow up activities undertaken.

E.3. See Medical Device Recall Policy

F. **MONITORING AND REPORTING OF MEDICAL DEVICE INCIDENTS RESULTING IN DEATH, SERIOUS INJURY OR SERIOUS ILLNESS OF ANY INDIVIDUAL AS PER SAFE MEDICAL DEVICE ACT OF 1990:**

F.1. The Safe Medical Device Act of 1990 requires that device user facilities (including hospitals, outpatient diagnostic and treatment facilities, nursing homes, ambulatory surgical facilities) report incidents to the device manufacturer when the facility determines a device has or may have caused or contributed to the death or serious injury of an individual. The facility must also send a copy of the report to the FDA in the case of a death.

F.2. Bartlett Regional Hospital has established methods for reporting these events:

F.2.1. The appropriate personnel will be notified immediately.

F.2.2. All packaging and disposable materials will be returned.

F.2.3. The device will be inspected and control settings and any damage will be recorded.

F.2.4. The equipment will be bagged, tagged and sequestered by Security.

F.2.5. An investigation shall be conducted.

F.2.6. The Risk Manager is responsible for managing the Safe Medical Device Act reporting process.

F.3. See Safe Medical Devices Policy.

G. **INVESTIGATION AND REPORTING OF EQUIPMENT MANAGEMENT PROBLEMS, FAILURES AND USER ERRORS:**

G.1. All equipment failures will be investigated and reported via work order. Included in the work order will be the error/failure date, location of the equipment, cause or affected area, resolution and follow-up. In the event the equipment problem was caused by an operational error, the user(s) will be in-serviced on the operation and use of the equipment. If the error/failure caused an adverse patient or staff event an incident report must be filed to the Risk Manager within 24 hours.

G.2. See: Equipment Safety Reporting Malfunction Policy, Safe Medical Devices Policy.

H. **ASSESSING AND MINIMIZING CLINICAL AND PHYSICAL RISKS OF EQUIPMENT THROUGH INSPECTION, TESTING AND MAINTENANCE:**

H.1. All mechanical and electrical patient care equipment will be evaluated prior to use. Preventive maintenance and safety inspections will be completed on all equipment in the program. The results of inspections and maintenance will be kept in the Electronic Equipment Management Program (TMS).

H.2. Incident history is documented and maintained in the Biomedical Engineering office. Equipment displaying unusual repair history or unusual incidence of injury to staff or patients will be evaluated for necessary changes/replacement.

H.3. All other non-clinical electrically powered equipment, located in the patient care vicinity, will be evaluated prior to use and receive preventive maintenance. This equipment will include, but not be limited to lamps, televisions, calculators, radios and computers. This equipment will also be safety inspected at least annually by the Biomedical Engineering Department and a tag or sticker will be affixed.

H.4. The Lead Biomedical Equipment Technician will develop preventive maintenance procedure for all medical devices in the hospital. The preventive maintenance procedures are developed using the manufacturer's preventive maintenance recommendations, NFPA 99-2012 standards and ANSI standards. These procedures are located in the Equipment Management Software Program (TMS).
See: Preventative Maintenance Policy.

I. **THE MEDICAL EQUIPMENT MANAGEMENT PROGRAM INCLUDES AN ORIENTATION AND EDUCATION PROGRAM FOR EQUIPMENT MAINTAINERS:**

I.1. Thorough training will be provided to equipment maintainers upon hire and as needed thereafter regarding the maintenance and care of medical equipment.

I.2. All equipment maintainers will be evaluated annually for their knowledge and skills necessary to perform equipment repair and maintenance according to their job specifications.

I.3. Staff will be oriented and educated on the reporting process for equipment management problems, failures and user errors.

J. **EMERGENCY PROCEDURES:**

J.1. Devices, which meets Bartlett Regional Hospital's criteria for critical equipment to patient safety, shall have emergency procedures in the event a malfunction or failure occurs. Equipment considered critical to patient safety includes life support, life sustaining or other critical equipment whose malfunction or failure may result in an adverse patient outcome.

J.2. Each department will develop and follow specific clinical response procedures in the event of an equipment failure: (See Medical Equipment Failure Chart, 8360.633)?

J.2.1. Institute clinical emergency procedures required ensuring patient care is not compromised.

J.2.2. Equipment will be removed from service and tagged immediately.

Commented [KGS1]: Edward nor I know of this chart. Cannot find.

J.2.3. If replacement equipment is necessary; Biomedical Engineering will be notified to obtain a replacement. Backup equipment is available for many types of equipment within the user department.

J.2.4. Users may notify Biomedical Engineering of the need for service by calling the main shop phone number: 796-8461, Monday – Friday, 0800 – 1630. If alternate equipment is not available emergency coverage is provided, five-days-a-week 4:30PM – 8:00AM Monday – Friday and 24hours on Saturday and Sundays by calling ext. 8892, Be sure to receive the House Supervisor's approval before calling the after Hours Emergency On Call Phone.

J.2.5. Imaging equipment problems are reported by the department directly to the O.E.M. who maintains oversight and responsibility for those items.

J.3. See Medical Equipment Safety Reporting Malfunction.

K. **THE MEDICAL EQUIPMENT MANAGEMENT PLAN INCLUDES A MEDICAL EQUIPMENT ORIENTATION AND EDUCATION PROGRAM:**

K.1. Thorough training will be provided regarding the capabilities, limitations, special applications of equipment, basic operating and safety procedures, emergency procedures if failure occurs, maintenance responsibilities, if applicable, and the reporting procedures for equipment problems, failures and user errors included in the program by department managers or designees in involved departments. All users of equipment shall be evaluated annually for competency according to the components of their job specifications.

K.2. See Medical Equipment Safety Reporting Malfunction.

L. **PERFORMANCE STANDARDS:**

L.1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The Utilities and Equipment Sub-Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

L.1.1. The measure can identify the events it was intended to identify:

L.1.1.1. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;

L.1.1.2. The measure has defined data elements and allowable values;

L.1.1.3. The measure can detect changes in performance over time;

L.1.1.4. The data intended for collection are available;

L.1.1.5. Results can be reported in a way that is useful to the organization and other interested stakeholders.

L.1.2. The Utilities and Equipment Sub-Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:

L.1.2.1. Staff knowledge and skills;

L.1.2.2. Level of staff participation;

L.1.2.3. Monitoring and inspection activities;

L.1.2.4. Emergency and incident reporting;

L.1.2.5. Inspection, preventive maintenance and testing of safety equipment.

L.2. Other performance measures and outcomes will be established by the Utilities and Equipment Sub-Committee , based on the criterion listed above. Data sources, frequency

of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Utilities and Equipment Sub-Committee.

L.3. To identify opportunities for improvement, the Utilities and Equipment Sub-Committee will follow the organization's improvement methodology.

L.4. Should the Utilities and Equipment Sub-Committee feel a team approach is necessary for performance and process improvement to occur; they will follow the organization's performance improvement guidelines for improvement team member selection. Determination of team necessity will be based on those priority issues listed (high risk, volume and problem prone situations and sentinel event occurrence). The Utilities and Equipment Sub-Committee will review the necessity of team development, requesting team participation only in those instances where it is felt the Environment of Care Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.

L.5. Performance improvement monitoring and outcome activities will be presented to the Environment of Care Committee by the Facilities Director at least on a quarterly basis, with a report of performance outcome forwarded to the Governing Body annually.

M. **ANNUAL EVALUATION OF THE MEDICAL EQUIPMENT MANAGEMENT PLAN:**

M.1. The annual evaluation of the Medical Equipment Management Program will include a review of the scope according to the current The Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.

M.2. The performance and effectiveness of the Medical Equipment Management Program shall be reviewed by the Utilities and Equipment Sub Committee as well as the Environment of Care Committee.

This Document was last reviewed in ~~November 2021~~December 2022

Medical Equipment Management P... v.10.

Bartlett Regional Hospital
Title: Life Safety Management Plan

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

A. To assure that the building is in compliance with applicable Federal, state and local codes and standards, and National Fire Protection Association (NFPA) 101, 2012 standards for hospitals and The Joint Commission Standards;~~;~~
B. To provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire,
C. To assure that personnel training in the Life Safety Management Program is effective,
D. To test and maintain the fire alarm and detection systems,
E. To institute interim life safety measures during construction or fire alarm or detection systems failures.

RESPONSIBILITY:

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

POLICY:

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

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

A.5. Each department has departmental fire procedures which can be found in Policy Tech: Vol. 2 Annexes: Fire or for general response, refer to the Emergency Colored Flipchart

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

B.1. The following fire alarm and detection equipment is tested and documented as required by NFPA:

B.1.1. Initiating devices are tested:

B.1.1.1. All supervisory signal devices (except valve tamper switches) at least quarterly.

B.1.1.2. All valve tamper switches and water flow devices at least annually.

B.1.1.3. All duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm pull stations and smoke detectors annually

B.1.1.4. Occupant alarm notification devices are tested at least annually including all audible devices, speakers and visible devices.

B.1.1.5. Off-site emergency forces notification transmission equipment is monitored automatically and continually by the fire alarm system and alarm monitoring service. For more details see Fire Alarm System policy.

B.1.2. All automatic extinguishing and protection equipment shall be inspected and tested ~~as follows~~as follows:

B.1.2.1. Main drain tests - at least annually at all system risers;

B.1.2.2. Fire department connections - inspected at least quarterly;

B.1.2.3. Kitchen automatic fire extinguishing systems – every 6 months - (discharge of fire extinguishing system not required);

B.1.2.4. Portable fire extinguishers inspected at least monthly; maintained at least annually. For more details see the Fire Extinguisher Program policy.

B.1.2.5. Fire and smoke dampers - at least every 6 years to verify they fully close;

B.1.2.6. Automatic smoke detection shutdown devices for air handling equipment is monitored and tested annually;

B1.2.7. Helipad Fire Suppression will be tested annually

B.1.3. Fire Door Inspections

B.1.3.1 All fire doors shall be inspected annually in accordance with procedures given below.

B.1.3.2 Inspect condition of all door hardware (hinges, crash bar hardware, etc.).

B.1.3.3 Inspect for positive latching of doors when released and closing under own weight.

B.1.3.4 Any deficiencies shall be noted and immediate steps taken to correct them.

B.1.3.5. Horizontal and vertical sliding and rolling fire doors - at least annually for proper operation and full closure.

B.1.4 Elevator recall testing

B1.4.1 Firefighter Emergency Operations (FEO) systems, also referred to as elevator recall, will be tested monthly by a competent contractor. A written record of the findings will be made and kept on the premises.

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

C.1. A comprehensive plan to correct any Life Safety deficiencies, which occur or are identified will be developed immediately in writing and will address:

C.1.1. All Life Safety Code deficiencies

C.1.2. Corrective actions (plan for improvement)

C.1.3. Total cost of actions and specific funding information

C.1.4. Reasonable schedule for completion, prioritized with available funding and concurrent projects

C.1.5. Interim life safety measures will be implemented and enforced as necessary

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

D. ANNUAL EVALUATION OF THE LIFE SAFETY MANAGEMENT PLAN:

D.1. Review of the scope based the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards.

~~and the current risk assessment of the hospital.~~

~~D.2 Compare~~D.2 Compare expectations and actual results of the program to determine if the goals and objectives of the program were met.

D.3 Evaluate the overall effectiveness of the program determining the degree that expectations where met, including an evaluation of the effectiveness of personnel training related to the Life Safety Plan and its components.

D.4. The performance and effectiveness of the Life Safety Management Program shall be reviewed by the Environment of Care Committee, with summary reports delivered to the Board Quality Council.

D.5. Annual Evaluation documentation will be maintained.

E. PERFORMANCE STANDARDS:

E.1.The Environment of Care Committee monitors performance regarding actual or potential risk related to one or more of the following:

E.1.1. Staff knowledge and skills;

E.1.2. Level of staff participation;

E.1.3. Monitoring and inspection activities;

E.1.4. Emergency and incident reporting;

E.1.5. Inspection, preventive maintenance and testing of safety equipment

E.2. Performance improvement monitoring and outcome activities will be presented to the Environment of Care Committee by the ~~Safety Officer and~~ Life Safety Subcommittee annually.

E.3. The following performance measures are suggested:

E.3.1. Percent of staff able to demonstrate their knowledge, skill and level of participation in the life safety management program.

E.3.2. Number of fire drills conducted with at least 50% of these on an unannounced basis

E.3.3. Percent of staff who can describe organizational protocols for fire response

E.3.4. Percent of staff who can describe evacuation procedures for their unit

E.3.5. Percent fully operational fire doors

E.3.6. Percent of tests completed for:

E.3.6.1. Supervisory signal devices - Quarterly

E.3.6.2. Valve tamper switches - Semiannually

E.3.6.3. Duct detectors - Annually

E.3.6.4. Smoke detectors - Annually
E.3.6.5. Heat detectors - Annually
E.3.6.6. Manual fire alarm pull stations - Annually
E.3.6.7. Electromechanical releasing devices - Annually
E.3.6.8. Occupant alarm notification devices - Annually
E.3.6.9. Emergency forces notification transmission equipment - Quarterly

F. EMERGENCY PROCEDURES

F.1. Emergency procedures will be developed and updates maintained in ~~Policy Tech~~the document control system.

F.2. The following emergency procedures will be implemented in the event of a fire:

F.2.1. **R** = Rescue or remove person(s) from immediate fire scene / room.

F.2.2. **A** = Alert personnel by activating nearest fire alarm pull station, then call PAS (dial 8900) and report exact location of the fire.

F.2.3. **C** = Confine fire and smoke by closing all doors and windows in the area.

F.2.4. **E** = Extinguish the fire using fire extinguisher if safe to do so.

F.3. General Instructions for All Employees and LIPs:

F.3.1. Keep telephone lines clear for fire control.

F.3.2. Do not use elevators.

F.3.3. Make sure all fire, corridor and room doors are closed.

F.3.4. Clear all corridors of equipment and obstructions.

F.3.5. All nursing personnel shall report to their areas and remain there for instructions.

F.3.6. All other personnel shall report to their areas and await emergency assignment as needed.

F.3.7. Reassure patients. Inform them that the alarm has been turned in, the emergency plan is in effect, and there is an abundance of help to assist as needed.

F.3.8. Know evacuation routes

F.3.9 Keep exits clear of obstructions

F.4. See Emergency Management Plan; Vol. 2 Annexes: Fire

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

G.1. All purchases of hospital furnishings and equipment will be reviewed to assure that they meet the NFPA requirements for fire retardant or non-combustibility. ~~y.~~

G.2. The Facilities Director ~~Safety Officer~~ and the Director of Materials Management are responsible for reviewing new products to verify they meet code requirements.

G.2.1 Materials Management will inform the ~~Safety Officer~~Facilities Director of any unavailability of NFPA approved items.

G.3 The Facilities Director is responsible for the installation of fire rated products during construction.

H. ORIENTATION AND EDUCATION TO LIFE SAFETY PROGRAM

H.1. All personnel (including volunteers, students, interns, physicians and other licensed independent practitioners) will be oriented to the Life Safety Plan and their roles in the event of a fire. This includes:

H.1.1 use of fire alarm systems

H.1.2 containing smoke/fire with building compartmentalization,

H.1.3 preparing for building evacuation including the location and proper use of equipment to evacuate or transport patients to a safe area.

H.2 All new personnel will receive general fire safety information before beginning work in their respective departments.

H.3 Department specific orientation will be done in their home department by knowledgeable staff to include:

H.3.1 location of fire alarm pull stations and extinguishers,

H.3.2 evacuation routes, including all exits

H.3.3 department specific fire hazards,

H.3.4 department specific concerns.

H.4 All employees will review fire safety information at least annually in a mandatory continuing education program (classroom, self-study, or online review)

H.4.1 Attendance records will be maintained by the employee and the education department for mandatory training

~~H.4.2 The Life Safety Subcommittee will obtain data on the number of employees completing orientation and continuing education and report to the EOC Committee.~~

H.5 Fire Drills will be conducted based on recommendations:

H.5.1 Clinical Areas: one per quarter per shift

H.5.2 Business offices: one per year

H.6. Effectiveness of the education and training program will be evaluated via ongoing review of fire drill critiques and periodic random on-site "~~swarmingswarms~~".

I. MAINTAINING BUILDING STRUCTURAL REQUIREMENTS FOR FIRE PROTECTION:

I.1. All buildings associated with Bartlett Regional Hospital will maintain compliance with the appropriate provisions of the Life Safety Code of NFPA. Documentation of all life safety requirements will be maintained on an ongoing basis. The Facilities Director is responsible for maintaining and managing all structural elements of life safety.

I.2. During periods of construction, renovation, transition, see Interim ~~(Construction)~~ Life Safety Management Plan~~Policy~~.

REFERENCES:

Interim Life Safety Management Plan; document control reference number 1485, Interim (Construction) Life Safety Policy

Emergency Management Plan: Vol. 2 Annexes: Fire; document control reference number 2149, 08. Emergency Operations Plan ANNEX FIRE Vol 2 ~~(available in Policy Tech under Vol. 2 Annex: Fire)~~

Fire Extinguisher Program ;~~Policy~~ document control reference number 1486

Fire Alarm System; document control reference number 1487

Annual Evaluation of the Life Safety Management Program (available on the "W:\" drive)

National Fire Protection Association; NFPA 101, 2012 Edition

The Joint Commission Hospital Accreditation Standards Manual; EC.01.01.01 EP7, EC.04.01.01 EP9

The Joint Commission Hospital Accreditation Standards Manual; 2021 Life Safety Chapter

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

PURPOSE:

A. Bartlett Regional Hospital provides comprehensive healthcare and health promotion for the people of Juneau and communities of northern Southeast Alaska.

B. To this effort Bartlett Regional Hospital provides a healthy and safe environment for our patients, visitors and staff by maintaining a process to effectively manage hazardous materials and waste throughout the facility.

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

SCOPE:

A. The scope of the Hazardous Materials and Waste Management Plan defines the processes which Bartlett Regional Hospital utilizes to provide a safely controlled environment where hazardous materials are used in the facility by proactive risk assessments to reduce the risk of injury.

B. Hazardous materials and waste risks are continually assessed and reviewed duringstaff Relias training, the collection of information through occurrence reports, product management and review by the EOC Committee. Risk levels are determined by the level of potential consequences that are associated with the types, quantities, and inherent physical and chemical properties of the hazardous materials utilized by the facility.

C. Bartlett Regional Hospital is conditionally exempt small quantity generator. We have < 220 lb Flam/Tox (RCRA) per month.

D. Bartlett Regional Hospital uses a Sani Pak system, which is an alternative means of processing Medical Waste.

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

GOALS:

A. <u>The goals of the Hazardous Materials and Waste Management Plan include the following</u>:

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

RESPONSIBILITY: The Laboratory Manager and members of the subcommittee are responsible for developing and assessing the Hazardous Materials and waste Management Program.

PROCEDURE:

A. Hazardous Materials and Waste Selecting, Handling, Storing, Transporting, Using and Disposing from Receipt or Generation through Use or Final Disposal:
   A.1. A system of products and forms has been developed that addresses the identification of hazardous materials and waste from selection to the point of final disposal. Policies and procedures related to various hazardous materials and wastes are reviewed, revised and approved by the Pharmacy, Haz-Mat Sub-Committee and EOC.
   A.2. The department managers will review the use of hazardous materials in their departments. Recommendations should be taken to the Haz-Mat Sub-Committee.
   A.3. In an effort to reduce the use of hazardous materials, the department managers shall review literature referencing the reduction of toxic materials and make recommendations regarding less hazardous products to the Haz-Mat Sub-Committee.

B. Written Criteria is Established Which is Consistent with Local, State and Federal Law to Identify, Evaluate and Inventory Hazardous Materials Used or Generated per our Hazardous Communication Policy: Hazardous Chemical Communication Program
   B.1. Bartlett Regional Hospital will keep a list of materials classified by state and federal standards, i.e., OSHA, EPA, as being hazardous material or waste. The list will be kept on the network under MSDSonline.
   B.2. Each department will be responsible for identifying and labeling all hazardous materials and waste within their department/area.
   B.3. A SDS is to be obtained for every hazardous chemical used in the hospital. A master file of all known Safety Data Sheets is available on-line via Internet access under favorites.
      B.3.1. Each department manager is responsible for ensuring the current SDS is in the system.
      B.3.2 A Safety Data Sheet supplies you with detailed information on a chemical and its hazards.

C. The Management of Chemical Waste, Chemotherapeutic Waste, Radioactive Waste and Regulated Medical Waste (i.e., Sharps):

C.1. Policies and procedures relating to chemical and physical hazards shall be reviewed by the Haz-Mat Sub-Committee, EOC Committee and the Infection Control Committee for infectious hazards on an annual basis.

C.2. All antineoplastic drugs shall be handled with special precautions according to instructions from the manufacturer. All waste from antineoplastic drugs must be disposed of as hazardous waste in leak-proof, puncture-proof and appropriately marked containers specified for such. All antineoplastic drugs identified as hazardous by the US Environmental Protection Agency/Resource Conservation and Recovery Act (USEPA/RCRA) standards will be handled according to standards set forth by USEPA/RCRA, Occupational Safety and Health Administration (OSHA) standards, the Hazard Communication Standard, the Occupational Exposure to Hazardous Chemicals in Laboratories Standard and OSHA's Controlling Occupational Exposure to Hazardous Drugs guidelines.

C.3. All radioactive materials are disposed of in accordance with the Nuclear Regulatory Commission Regulations.

C.4. All sharps, including hypodermic needles and syringes, suture needles, knife blades, trocars from drains and opened glass ampoules of medicine will be disposed of into puncture-proof sharps containers.

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

D.1. All hazardous materials are received in the department by appropriate personnel and stored in a designated supply closet for chemicals only. Chemicals are properly labeled with a description of the hazard they represent.

D.2. Materials which ignite easily under normal conditions (flammable), are considered fire hazards and will be stored in a cool, dry, well-ventilated storage space, away from areas of fire hazard.

D.3. Highly flammable materials will be kept in a flammable safety cabinet and in areas separate from oxidizing agents (material susceptible to spontaneous heating, explosives, etc.).

D.4. The storage area for flammables will be supplied with fire-fighting equipment, either automatic or manual. There will be "flammable material" signs posted in and around the storage area.

D.5. Oxidizers will not be stored close to liquids of low flash point.

D.6. Acids and acid-fume-sensitive materials will be stored in a cool dry, well-ventilated area, preferably wooden.

D.7. Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids or acid fumes will be stored in a cool, well-ventilated place out of the direct rays of the sun. Incompatible toxic materials will be isolated from each other.

D.8. Corrosive materials will be stored in a cool, well-ventilated area (above their freeze point). The containers will be inspected at regular intervals to ensure they are labeled and kept closed. Corrosives will be isolated from other materials.

D.9. Personal protective clothing and equipment will be available for use when handling these materials. Staff are trained in the appropriate use of personal protective clothing and equipment by their department manager.

D.10. When performing a task where the eyes or body of a person may be exposed to injurious corrosive material, such as transferring containers of concentrated agents,

the individual will first make sure they are within immediate proximity (10 seconds) to an emergency eyewash station and/or shower.

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

F. All Hazardous Materials or Waste Spills, Exposures and Other Incidents are Reported and Investigated:
   F.1. An occurrence report will be completed on all hazardous materials and waste spills and exposures. The department managers shall investigate all hazardous materials and waste spills and exposure. Occurrence reports are continuously monitored reviewed and studied by the Risk Manager to determine the cause of the incident and if follow-up is needed by department managers. The Risk Manager will provide any reports of all hazardous materials occurrences to the Haz-Mat Sub-Committee.
   F.2. Emergency response is performed as described by implemented Haz Mat procedures and use of Code Orange by staff
   F.3. Hazardous Material committee members created Relias training to assure staff understands processes as part of emergency response.

G. Permits, Licenses and Adherence to Other Regulations are Maintained:
   G.1. Hazardous waste generation will be tracked, controlled and managed according to OSHA, DOT, EPA, state, CBJ regulations.
   G.3. Biohazard waste generated by the hospital is processed through the Sanipak system. All other items, identifiable body parts, liquids and radioactive and cytotoxic waste will be dealt with as appropriate in accordance with state and federal laws.

H. Required Manifests for Hazardous Materials and Waste are Maintained:
   H.1. A component of the management and disposition of hazardous wastes is the removal of these materials from the point of generation to a specified treatment, storage or disposal facility.
   H.2. Records will be maintained identifying the generator, quantity, type and disposal action of the hazardous material or waste.
      H.1.1. A signature is required from the generating facility on each tracking record at the time of pick-up.

H.1.2. A signature deems that the waste is compliant and packaged correctly according to regulations.

H.3. Hazardous waste manifests will be maintained by the Facilities Manager. The Facilities Manager is also responsible for maintaining all documents, including tracking records, shipping documents and the certificate of treatment or disposal for all hazardous materials removed from the facility.

I. Hazardous Materials and Waste are Properly Labeled per the Hazardous Communication Program:

I.1. Containers of hazardous chemicals must be labeled by the chemical manufacturer, importer or distributor with the following information prior to leaving the workplace:

I.1.2. Identity of the hazardous chemical(s) as it appears on the SDS and chemical list found on the network under MSDS online.

I.1.3. Name and address of the chemical manufacturer, importer or other responsible party

I.2. Labels must be , legible and prominently displayed on the container. Labeling should be per NFPA, OSHA's Blood borne Pathogens or by Hazardous Communication standards

I.3. Labels and other forms of warnings are legible.

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

J.1. All medical and hazardous waste will be segregated and contained separately from other waste at the point of generation. The department manager is responsible for ensuring there is appropriate separation and the waste is placed in properly constructed and labeled containers.

J.2. Trained Environmental Services (EVS) staff will utilize red rigid containers to transport biohazard waste bags from the various hospital departments. All containers will be labeled with the universal biohazard symbol. EVS staff will wear the appropriate personal protective equipment when handling and transporting biohazard waste.

J.3. Biohazard wastes will be stored in a designated locked and secured holding area for final disposal. Warning signs will be posted. Disposal of Hazardous Material is accomplished by transport to CBJ Hazardous Waste Depot by the Maintenance department.

J.4. Medical waste holding areas will be inspected routinely by the EVS Manager. Any deficiencies found will be dealt with promptly.

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

K.1. All persons required to manage or handle hazardous chemicals, materials or waste will be provided with appropriate orientation, personal protective equipment and job training. Each department is responsible for training each individual handling hazardous materials and waste. Employee orientation and education shall include the following:

K.1.1. Information about the hazard communication program

K.1.2. Identification of the hazardous materials in their workplace and the health hazards associated with handling these materials

L. Performance Standards:

L.1. EOC Committee will establish and prioritize performance measures.

L.1.1. Performance improvement monitoring and outcome activities will be presented to the EOC Committee by the Haz-Mat Sub-Committee at least on a quarterly basis.

L.2. Performance Measures:

L.2.1. Risk Management will maintain a record of all Hazardous Materials spills or fumes and determine the cause. Department Managers will report findings to Quality Review, who will report to the EOC. This is done by occurrence system for the hospital

L.2.2. Bio-Medical Technician will delegate the effectiveness of vent hoods throughout the hospital for proper gas/vapor removal, and report findings to the EOC. Testing is done by outside vendor. Departments with hoods maintain proof of inspections/maintenance records.

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

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

M.1.1. The performance and effectiveness of the Hazardous Materials and Waste Management Program shall be reviewed by the EOC Committee.

M.2. Changes in the plan will be forwarded to the EOC Committee for approval.

M.3. *See* Annual Evaluation of the Hazardous Materials and Waste Management Plan/Program.

REFERENCES:

NIOSH "Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Healthcare Settings", March 2016.

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

OSHA technical manual guidelines "Controlling Occupational Exposure to Hazardous Drugs"

Hazardous Chemical Communication Program

Bartlett Regional Hospital

Title: **SAFETY MANAGEMENT PLAN**

PURPOSE

Bartlett Regional Hospital's (BRH) commitment to a safety management plan is designed to provide a physical environment free of hazards. 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.

SCOPE

This comprehensive safety management plan will incorporate an interactive process involving and affecting all of Bartlett Regional Hospital's employees, contractors, patients, and visitors. The plan provides processes for:

A. Developing and maintaining a written management plan that describes processes implemented to effectively manage the environmental safety of patients, staff and other people coming to BRH.
B. Identifying an individual(s) designated by leadership to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminates summaries of actions and results.
C. Identifying an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten damage to equipment or buildings.
D. Conducting a proactive risk assessment that evaluates the potential adverse impact to buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff and other people coming to BRH facilities.
E. Identifying risks to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff and other people coming to BRH facilities.
F. Establishing safety policies and procedures that are distributed, practiced, enforced, and reviewed as frequently as necessary, but at least every three years.
G. Ensuring appropriate responses to product notices and safety recalls.
H. Ensuring that all grounds and equipment are maintained appropriately.
I. Conducting environmental tours to identify environmental deficiencies, hazards, and unsafe practices.
J. Environmental tours are conducted at least every six months in all patient care areas and at least annually in all non-patient areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate Environment of Care (EOC) risks.
K. Adhere to the City and Borough Tobacco Ordinance 2007-20 and implements a process for monitoring compliance within the hospital and developed strategies to eliminate the incidence of tobacco use policy violations when identified. BRH encourages patients who do smoke to quit and provides education including information about smoking cessation options. BRH is a "Tobacco Free Campus. The hospital policy prohibits tobacco use in all buildings and on its campus.
L. Utilizing internal sources, such as ongoing monitoring of the environment, results of

root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as *Sentinel Event Alerts*.

M. Selecting one high risk process at least every 18 months and complete a proactive risk assessment (LD.03.09.01 EP # 7).

N. The hospital identifies activities to minimize or eliminate the risk of worker injuries.

OBJECTIVES

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

ELEMENTS OF PERFORMANCE:

EC.01.01.01 The hospital plans activities to minimize risks in the environment of care. Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

EP 1 Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems or use errors.

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

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

The Board Quality Council receives reports of the activities of the Safety Management Plan, reviews reports, and communicates concerns about identified issues and regulatory compliance.

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

EC.02.01.01 The hospital manages safety and security risks.

EP 1 The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk

assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

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

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

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

EP 5: The hospital maintains all grounds and equipment.

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

EP 11: The hospital responds to product notices and recalls.

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

EP 17: The hospital conducts an annual worksite analysis related to its workplace violence prevention program.

The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

EC.02.01.03 The hospital prohibits smoking except in specific circumstances.

EP 6: The hospital takes action to maintain compliance with its smoking policy.

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

is a contractor, they will be asked to leave the facility.

EC.04.01.01 The hospital collects information to monitor conditions in the environment.

EP 15: Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

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

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

In addition, members of the Safety & Security Committee will conduct environmental tours to identify environmental issues, hazards and unsafe practices. Data will be aggregated and reported back to the Safety & Security Committee. Deficiencies will be reported to the department director and returned back to the Safety Committee completed.

EC.04.01.03 The hospital analyzes identified environment of care issues.

EP2 The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues.

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

The hospital uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the hospital facilities.

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

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

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

LD.04.01.07 The hospital has policies and procedures that guide and support patient

care, treatment and services.
EP 1: Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.

The Safety & Security Committee will develop, or review written policies and procedures to enhance safety within the hospital and its grounds. Departments may maintain individualized safety procedures as needed. All safety policies will be reviewed as necessary, and periodically no less than every three years. Material revisions or changes will be reviewed by the Safety & Security Committee, and the Policy Committee.
The ultimate responsibility for development and maintenance of current department specific safety procedures shall lie with the document owner with the assistance of the department director and Safety & Security Committee as appropriate.

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

Joint Commission Hospital Accreditation Standards. Accessed online January 2022 at https://e-dition.jcrinc.com. The Joint Commission, January 1, 2022. Environment of Care, Human Resources and Leadership Standards.

Bartlett Regional Hospital

Title: Security Management Plan

PURPOSE: 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.

POLICY:

A. The goal of the Security Management plan includes the following:
   - A.1. To provide education to personnel on the elements of the Security Management Plan;
   - A.2. To control access to and egress from sensitive areas (see chart below)
   - A.3. To reduce the risk of security incidents;
   - A.4. To address security concerns of patients, visitors, personnel and property.

SCOPE: All

A. RESPONSIBILITY: The Lead Security Officer, Facilities Director, Risk Manager, Safety Officer and Environment of Care Committee are responsible for developing, implementing, monitoring and managing the Security Management Plan.

B. Designation of Employees Responsible for Developing, Implementing and Monitoring the Security Management Plan:
   - B.1. The Facilities Director shall appoint as the Lead Security Officer a qualified individual to develop, implement, maintain and monitor the Security Management Plan. This delegated written authority has been approved by the Chief Financial Officer and Facilities Director of this hospital.
   - B.2. See Job Description Lead Security Officer.

C. Security issues which concern patients, visitors, staff and property are addressed.
   - C.1. Security vulnerability assessment, Security/Safety Swarms and Security reports are completed to indicate areas of risk, including security vulnerabilities of sensitive areas, security habits of personnel, staff knowledge and skill of security management. An assessment and Swarm gives a good indication of future danger and immediate steps shall be taken to eliminate the problems. See attached Vulnerability Inspection and Safety Swarm reports.

D. All security incidents involving patients, visitors, staff and property are reported and investigated.
   - D.1. An Occurrence Report is completed on all incidents involving patients, visitors, staff or property.
   - D.2. A security incident includes, but is not limited to:
     - D.2.1 Property damage, lost or stolen property,

D.2.2 Injuries to staff (i.e., injuries to staff caused by patients during assessment and treatment activities),
D.2.3. Any criminal activities.

D.3. An Occurrence Report will be completed by the security officer on-duty at the time of the incident. The Security Occurrence Report will be reviewed and evaluated by the Lead Security Officer, Facilities Director and Risk Manager to determine the cause of the incident. The Facilities Director, Risk Manager and Lead Security Officer will make recommendations to the Safety Committee to prevent the reoccurrence of related incidents.

D.4. The Safety and Security Committee shall review security Occurrence reports thru the Risk Manager. The Security Occurrence Report will be reviewed and evaluated through the evaluation of the incident, conclusions, recommendations and actions taken.

D.5. All incidents shall be aggregated on a quarterly basis and reported to the Safety Committee. The Safety Committee will track and trend all incidents by type to determine if patterns exist. Once a pattern has been identified, a performance improvement project will be developed to improve performance.

See Quarterly Report of Incidents and Security Management Plan for additional policies, procedures and forms.

E. All patients, staff and vendors will have appropriate identification.

E.1. All staff members shall wear hospital picture identification badges with blue back ground.

E.2. All out-patients and inpatients will wear permanent identification bands.

E.3. Vendors and contractors will wear appropriate contractor / vendor badge which they receive thru the Human resources and/or Reptrax system in Materials Management**.** The badges will have an orange background

E.4. All personnel shall stop and question any unidentifiable person in their area. Any person, who is not wearing a recognizable hospital identification badge or vendor badge, shall be considered a stranger.

F. Sensitive areas will have controlled access as determined by the Hospital Safety and Security Committee

F.1. A security risk assessment will be completed and those areas determined to be sensitive areas will have restricted access to and egress from.

F.2. All personnel assigned or working in these areas will receive orientation and education to the area-specific security practices to be utilized.

The following areas have been identified as being of a greater risk for a violation of security:

	TIME OF DAY FOR HIGHEST RISK	**THEFT/VANDALISM (T) PERSONAL HARM (P)**	**ACCESS**

AREA	(D=Day, E=Evening, N=Night)	CONFIDENTIAL INFORMATION (C)	LIMITED
Patient Care Areas	D, E, N	P, C, T	No
PAS (Patient Access Services)	D, E, N	T, P, C	Yes
Business Office	E, N	C, P, T	Yes
Information Systems	D, E, N	T, C	Yes
HIM (Health Information Management)	E, N	C, T	Yes
Nuclear Medicine	E, N	T, C	Yes
OB Nursery	D, E, N	P, C, T	Yes
Pharmacy	D, E, N	T, P, C	Yes
Clinical Areas (Laboratory, Diagnostic Imaging, Respiratory Therapy, Physical Rehab)	D, E, N	T, P, C	Yes
Surgical Services	D,E,N	T,P,C	Yes

F.1.1. Emergency Care Areas,
F.1.2. Newborn Nursery, Obstetrics,
F.1.3. Special Care Units, Pharmacies,
F.1.4. Behavioral Health Units,
F.1.5. Medical Records,
F.1.6. Cashier,
F.1.7. Outpatient Clinics and Specialty Outpatient Clinics (i.e., substance abuse).

F.3. Access to the emergency department shall be available to medical staff through access codes or by the granting of access by ED department staff. No access codes shall be shared with patients, families, visitors or non-hospital persons.

F.4. All employees have the responsibility to secure any unsecured area of the Hospital.

F.4.1. Employees have the responsibility to query strangers and request Security if needed.

F.4.2. Juneau Police Department (JPD) will be called for bomb threats, thefts, assaults, or when threats of personal harm are made by non-patient persons or at the discretion of the House Supervisor for assistance with violent patients.

G. Vehicular access to Emergency Department area is provided.

G.1. Security will keep the limited Emergency Department parking clear for authorized vehicles only. Security will be on hand for traffic control and will attempt to clear Emergency Department parking areas of infractions.

G.2. See Parking Control Policy.

G.3. Upon request and based on availability, Security Officers shall escort personnel to their cars, and/or meet personnel in parking lots after dark and escort them to the Hospital.

G.4. Security Officers may be contacted at any time for safety escort via Patient Access Service personnel or by calling the Security Officer's cellphone directly.

H. An orientation and education program for staff regarding security is in place.
- H.1. Security-related education for all employees will include:
  - H.1.1. Reporting security incidents involving patients, personnel, visitors and property;
  - H.1.2. Emergency procedures to follow in the event of a security incident;
  - H.1.3. Security measures in place at the facility (i.e., access control, CCTV, alarms);
  - H.1.4. Infant/Child abduction;
  - H.1.5. Identification badges;
  - H.1.6. Workplace violence.

I. Performance Standards.
- I.1. The Safety and Security Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem-prone situations and potential or actual sentinel event-related occurrences.

  Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
  - I.1.2. The measure can identify the events it was intended to identify.
  - I.1.3. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable.
  - I.1.4. The measure has defined data elements and allowable values.
  - I.1.5. The measure can detect changes in performance over time.
  - I.1.6. The measure allows for comparison over time within the organization or between the organization and other entities.
  - I.1.7. The data intended for collections are available.

J. The Safety and Security Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:
- J.1. Staff knowledge'
- J.2. Level of staff participation;
- J.3. Monitoring and inspection activities;
- J.4. Emergency and incident reporting;
- J.5. Inspection, preventive maintenance and testing of safety equipment.
- J.6. Other performance measures and outcomes will be established by the Safety and Security Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data

collection, aggregation and reporting will be determined by the Safety and Security Committee.

K. Performance improvement monitoring and outcome activities will be presented to the Safety and Security Committee by the lead security officer at least on a monthly basis, with a report of performance outcome forwarded to the Safety and Security Committee and the Environment of Care Committee annually.

L**.** Emergency Security Procedures.

L.1. There are provisions made for the security of the physical plant, property, patients, visitors and personnel of Bartlett Regional Hospital during disaster situations.

L.2. Personnel are trained in the actions to be taken in the event of a security incident..

L.4. Bartlett Regional Hospital shall seek to maintain a cooperative relationship with the news media, which balances the public need for information with the responsibility to safeguard the patient's right to privacy.

L.4.1. The release of information to the media will be by authorized personnel only.

L.4.2. Additional staff will be assigned from a contracted private security company to assist the Security Unit in controlling vehicular and foot traffic in the event of a disaster.

M. The Safety and Security Committee shall review the performance and effectiveness of the Security Management Program.

ATTACHMENTS:

Security Vulnerability Checklist and Inspection Report Corrective Actions
Security Authority
Safety and Security SWARM

Bartlett Regional Hospital

Title: Utility Systems Management Plan

Department: All

SCOPE:

The scope of the Utility Systems Management Plan is to define the processes by which utility systems in use at Bartlett Regional Hospital are monitored and maintained.

POLICY:

This Policy address the provision for a safe, comfortable patient care and treatment environment, by managing the risks associated with operation and the functional reliability of the hospital's utility systems.

OBJECTIVES:

The objectives of Bartlett Regional Hospital's Utility Systems Management Plan include the following:

1. To minimize the occurrence of unplanned utility systems failures or interruptions.
2. To provide preventative maintenance of the utility systems ensuring reliability.
3. To monitor and investigate all utility system problems, failures or user errors to learn from each occurrence in order to minimize reoccurrence of failures or errors.
4. To reduce the potential for organizational-acquired illness.

RESPONSIBILITY:

The responsibility for maintaining the Utility System resides with the following:

The Utilities and Equipment Sub Committee is responsible for maintaining the Utility Systems Management Plan.

The Maintenance Supervisor in consultation with the Lead Maintenance Mechanic and the Facilities Director is responsible for maintaining the Utility Systems Management Program.

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

A.1. The Utility Systems Management Program is designed to assure operational reliability, reduce the potential for organizational-acquired illness, assess risks, and respond to failures and train users and operators of the utility systems components, thus promoting a safe, controlled and comfortable environment.

A.2. There is a comprehensive preventative maintenance program, Total Maintenance System (TMS) by Accruent, Four Rivers Software Systems, Inc., which includes a written testing and maintenance program for all utility components included in the program at established intervals. (See section B2) It is the responsibility of the Maintenance Supervisor in consultation with the Lead Maintenance Mechanic and Facilities Director to keep the preventative maintenance program accurate and ongoing.

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

B.1. The Utility Systems Management Program shall include equipment that meets the following criteria:

B.1.1. Equipment that maintains the climatic environment in patient care areas.
B.1.2. Equipment that constitutes a risk to patient life support upon failure.
B.1.3. Equipment that is a part of a building system, which is used for infection control.
B.1.4. Equipment that is part of the communication system, which may affect the patient or the patient care environment.
B.1.5. Equipment that is an auxiliary or ancillary part of a system control or interface to patient care environment, life support or infection control.

B.2. The following systems are included in the Utility Systems Management Program:
B.2.1. Electrical Distribution System.
B.2.2. Emergency Power System.
B.2.3. Vertical and Horizontal Transport (elevators).
B.2.4. Heating, Ventilation and Air Conditioning Systems.
B.2.5. Aerosolizing Water Systems.
B.2.6. Plumbing and Potable Water Delivery Systems.
B.2.7. Boilers and Steam Delivery Systems.
B.2.8. Medical and Surgical Gas Delivery Systems.
B.2.9. Medical and Surgical Vacuum System.
B.2.10. Surgical Anesthetic Gas Disposal System.
B.2.11. Communication Systems.
B.2.12. Sewage Removal Systems.
B.2.13. Helipad System
B.2.14. Fire Alarm and Detection System.
B.2.15. Fire Sprinkler System
See DEFINITION OF UTILITY FAILURE

C. **INSPECTION, TESTING AND MAINTAINING OF CRITICAL OPERATING COMPONENTS:**
C.1. There is a scheduled maintenance system, which is used to schedule, monitor and document the inspection, testing and maintenance of each utility system based on the manufacturer's recommendations.

D. **INSPECTION, TESTING AND MAINTAINING OF PIPED MEDICAL GAS SYSTEM:**
D.1. The Maintenance Supervisor in consultation with the Lead Maintenance Mechanic and the Facilities Director will develop policies and procedures for the inspection, testing and maintenance of the piped medical gas system. The testing will include master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors and outlets.
D.2. See Policies: Failure of Medical Gas Systems, Definitions of Utility Failure, Emergency Medical Gas shut off,

E. **PIPED MEDICAL GAS TESTING WHEN SYSTEMS ARE INSTALLED, MODIFIED OR REPAIRED:**
E.1. A qualified person will test all piped medical gas systems when the systems are installed, modified, or repaired. The testing will include cross-connection testing, piping purity testing and pressure testing.

F. **MANAGEMENT OF PATHOGENIC BIOLOGICAL AGENTS IN DOMESTIC HOT WATER AND OTHER AEROSOLIZING WATER SYSTEMS:**
F.1. The Facilities Director in conjunction with the Infection Control Practitioner will develop policies and procedures for the inspection, testing and maintenance of all aerosolizing water systems to ensure optimal use of pathogenic biological agents.

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

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

The design parameters will follow the American Institute of Architects (AIA) Guidelines for Design and Construction of Hospital and Health Care Facilities 2014, Section 2.1-8.2.1.2 and 3.1-8.2.1.2, 3, "Ventilation Requirement for Areas Affecting Patient Care in Hospitals and Outpatient Facilities," and Table 6.4 page 5 "Minimum Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals".

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

G.2.1. Operating rooms
G.2.2. Special procedure rooms
G.2.3. Delivery rooms
G.2.4. Protective isolation rooms
G.2.5. Laboratories
G.2.6. Sterile supply rooms

G.3. Bartlett Regional Hospital will follow AIA guidelines for filter efficiencies, air pressure relationships, etc.

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

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

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

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

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

J.1. The utility systems incident reporting process is the responsibility of the Maintenance Supervisor in consultation with the Lead Maintenance Mechanic and the Facilities Director

J.2. A Utility Systems Failure Report shall be completed for any problem, failure or user error of a vital or essential system. See DEFINITION OF UTILITY FAILURE

J.3. The Maintenance Department will respond to and correct all identified problems within the scope of their operations in a timely manner. Evidence of the actions taken to resolve identified problems can be located in the Electronic Equipment Management Program (TMS).

J.4. The analysis of the utility systems incidents provides an opportunity to identify trends and/or patterns to determine if changes in the program may control or prevent future occurrences. The Utilities and Equipment Sub Committee, Chair supplies a summary of all utility systems failures to the Environment of Care Committee.

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

K.1. Department specific orientation and education to the utility systems safety is the responsibility of the department Director. All employees will be trained during general orientation and annually thereafter on the process for reporting problems, procedures for maintaining essential functions during utility failures, location of emergency shut off controls and the procedures to follow if they alarm, procedures to follow in the event of an elevator failure and communication equipment protocols. The training is documented and kept in the employee's department personnel file.

K.2. Personnel will be required to attend an orientation upon hire and regularly scheduled in-services that specifically address utility systems capabilities, limitations, special applications, emergency procedures if failure occurs, maintenance responsibilities, the location and instruction on use of emergency shut off controls and reporting procedures for utility systems problems, failures and user errors. All users/maintainers of equipment shall be tested for competency according to the components of their job specifications.

L. **PERFORMANCE STANDARDS:**

L.1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The Utilities and Equipment Sub Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

L.2. The measure can identify the events it was intended to identify.

L.2.1. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;

L.2.2. The measure has defined data elements and allowable values;

L.2.3. The measure can detect changes in performance over time;

L.2.4. The data intended for collection are available and results can be reported in a way that is useful to the organization and other interested stakeholders.

L.3. The Utilities and Equipment Sub Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:

L.3.1. Staff knowledge and skills

L.3.2. Level of staff participation

L.3.3. Monitoring and inspection activities

L.3.4. Emergency and incident reporting

L.3.5. Inspection, preventative maintenance, and testing of safety equipment

L.4. Other performance measures and outcomes will be established by the Utilities and Equipment Sub Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection and aggregation and reporting will be determined by the Utilities and Equipment Sub Committee.

L.5. To identify opportunities for improvement, the Utilities and Equipment Sub Committee will follow the organization's improvement methodology.

L.6. Quarterly, the Utilities and Equipment Sub Committee shall report to the Environment of Care Committee the outcome of improvement and activities. Annually, a report of performance outcomes will be presented to the Governing Body.

L.7. The following performance measures are recommended:

L.7.1. Percent of staff able to demonstrate their knowledge and skill of their role and expected participation in the Utility Systems Management Program

L.7.2. Number of utility incident reports

L.7.3. Number of user errors reported

L.7.4. Number of utility failures or interrupts

L.8. See Hospital Performance Improvement (PI) Committee Charter.

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

M.1. The Maintenance Supervisor in consultation with the Lead Maintenance Mechanic and Facilities Director is responsible for coordinating activities and ensuring procedures are developed that specify the action to be taken during the failure of major utility services. Emergency procedures include:

M1.1 Procedures to follow when a utility system malfunctions.

M1.2 Alternate sources of essential utilities.

M1.3 Shutoff procedures and controls of malfunctioning system,

M1.4 Procedures for notifying personnel in the affected areas.

M1.5 How to obtain repair services.

M1.6 Procedures to perform emergency clinical interventions.

M.2. All clinical department managers are responsible for developing and maintaining emergency procedures of the utility systems as it relates to their use and application in patient care or treatment areas where a failure, interruption or malfunction could result in a negative patient outcome including serious injury or death. The departmental emergency procedures will provide personnel with the essential information needed to perform during an emergency. The emergency procedures will include:

M.2.1. Alternate sources of utilities or back-up protection provided;

M.2.2. When alternate sources are not available procedures to follow until the utility system can be restored to normal function;

M.2.3. Location of emergency shutoff controls;

M.2.4. Conditions in which the utility may be shut off;

M.2.5. Assign authority to use the shutoff controls;

M.2.6. How to report a failure or interruption;

M.2.7. Obtaining emergency repair services;

M.2.8. Specific information on emergency clinical interventions.

The written procedures include a call system for summoning essential personnel and outside assistance when required.

M.3. See Policies: Emergency Management Plan, Vol. 1, Emergency Management Plan, Vol. 2,, ~~Maintenance Department Emergency Plan~~, Failure of Steam Delivery Boilers, Failure of the Water Distribution System, Failure of HVAC System, Emergency Generator Failure, and other utility specific policies.

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

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

N.2. The performance and effectiveness of the Utility Systems Management Program shall be reviewed by the Utilities and Equipment Sub Committee as well as the Environment of Care Committee.

N.3. See Annual Evaluation of the Utilities Management Program.

This Document reviewed in ~~November 2021~~December 2022, Utility Systems Management... v.9.

Bartlett Regional Hospital

Title: **UTILIZATION MANAGEMENT PLAN**

Department/s: All Clinical Departments

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

Updated: 12/2022~~1~~

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 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 services, resources, 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 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 Utilization Review Committee.

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

D. 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 Utilization Review Committee.

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 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:

E.1. 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 and applicable hospital policies.
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.
I.6. Provide education and communicate with individual providers when rules or polices are not followed. Escalate concerns when recurrent or significant.

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. When there are continued utilization management concerns that are not resolved with secondary review and communication with the treatment team, the case will be referred to the UR Committee for concurrent review with the attending provider.

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) (4) Milliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care, 25th edition, 2021.
(5) (5) InterQual LOC: Adult/Pediatric; BH: Adult and Geriatric Psychiatry/Behavioral Health Service, October 2022 release.
~~Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care, current edition, 2021~~

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

Attachment #3

Bartlett Regional Hospital
Utilization Management Report

Denials				
	Cases	**Initial Days**	**Days Reversed/obs/in appeal**	**Days Upheld**
Total				
Aetna				
Blue Cross				
Medicaid				
UHC				
MCR Replacement				
Other				
			Notes	
Case Mix Index (CMI)				
Payor	CMI	inpatients		
MCR				
MCD				
All Payers				
Medicare Monitoring				
1-day stays				
Observation >2MN				
Outliers- Total				
Psych				
Placement				
EOL				
Complex Medical				
Social				
Other				
Readmissions			Notes	
All Cause				
Medicare Readmissions				
AMI				
HF				
Pneumonia				
COPD				
THA/TKA				
Sepsis				
Stroke				
Other				

~~Q3~~

~~CY2021~~

~~Denials~~

-	
~~Totals~~	
~~Aetna~~	
~~Blue Cross~~	
~~Medicaid~~	
~~UHC~~	
~~Other~~	

~~Medicare Monitoring~~	
~~CMI~~	
~~1- day stays~~	
~~Observation >/= 2MN~~	
~~Outliers- Total~~	
~~Psych~~	
~~Placement~~	
~~EOL~~	
~~Complex Medical~~	
~~Social~~	
~~Other~~	

~~Readmissions~~	
~~All Cause~~	
~~Medicare Readmissions~~	
~~AMI~~	
~~HF~~	
~~Pneumonia~~	
~~COPD~~	
~~THA/TKA~~	
~~Sepsis~~	
~~Stroke~~	
~~Other~~	

A.

QUALITY MANAGEMENT PLAN

Patient Safety, Process Improvement

CY 2023~~2~~

Issued: August 2020
Revised: December 2,2022~~7,2021~~

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 identification, 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, and 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

The Board of Directors of Bartlett Regional Hospital is 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.

Scope

The Quality Management Program has been laid out by the Center for Medicaid and Medicare services (CMS) in the Conditions of Participation. CMS 482.21 states that we must "*develop, implement, and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involved 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. The hospital must maintain and demonstrate evidence of its program for review by CMS*". PSQI is a systematic process that identified, evaluated and alleviates systems, processes or situations that pose risk of harm to patients, visitors and staff of BRH.

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. The activities of the PSQI are connected with Quality and all departments of the hospital and are overseen by the Quality Director and the Quality Department. 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

Board of Directors

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 Board of Directors receives and reviews reports through the quality QAPI reporting structure.

Senior Leadership

The Senior Leadership Team (SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Officer, Chief Behavioral Health Officer, and Chief Human Resources Officer ensure that an integrated patient safety program is institutionalized and assumes the responsibility for the strategic direction and development of the patient safety program. Patient safety culture survey results provide feedback on patient safety practices, communication, teamwork, adverse event reporting, and leadership to help guide the 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. SLT supports transparency in communication related to patient safety and potential process changes.

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.

Departments

Individual departments are responsible for the quality management, regulatory compliance and risk reduction/identification activities related to the service lines they provide. Progress on department based activities are reported through the Quality committee structures.

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 The Joint Commission and CMS CoPs); Risk Management; Patient Safety; Infection Prevention and Control; and, Medical Staff Quality.

Medical Staff

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 QAPI 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 functions
- Blood and blood Product Use
- Pharmacy and therapeutics Functions
- 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
  - Renewal or revision of 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 as described in the Medical Staff Bylaws and Rules and Regulations.

Hospital Performance Improvement Committee

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 which 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 while providing patient centered quality care in a sustainable manner.

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– 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
- Serious Safety 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. Review and triage reports of potential or actual occurrences through the Occurrence Reporting system by any employee.
   b. Prioritize events, hazards and system/process weaknesses using the Safety Assessment Code (SAC) Matrix.
   c. Measure, report and collaborate with key stakeholder the frequency and severity of events to facilitate QAPI opportunities.
   d. Identify, investigate and report Sentinel Events to the Joint Commission based on our policy.
   e. Identify, investigate, and report serious reportable events required by the National Quality Forum.
   f. 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.
   g. 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 based on a Just Culture
   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, healthcare 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.
    b. Reporting our data to a patient safety organization (PSO) to provide comparison and benchmarks against state and national standards.
    c. Review quality performance indicators to evaluated potential risks and opportunities to develop strategies to reduce risk and improve patient safety.

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 process improvement 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 (NPSG)
- 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 (HAI)

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 (HPIC)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 2022~~1~~ PSQI Plan:

Accomplishments:

2022 Goals

Quality Goal	CY 2022 Metric	Evaluation
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 2022. Provide training for 75% of new leaders within 90 days of hire by 12/31/2022(Source: Quality Director)	Not Met: This goal will be moved to 2023 as a high-priority goal.
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~~peer-based rates. (Source: Scorecards through Credentialing Committee of provider types)	Partially met. Currently, three specialties are left to determine their specific measures.
Maintain Sepsis core measure compliance at or above national average. Current national average 60%.	Maintain annual percentage of compliance to at least 60% through 12/31/2022. (Source: Encore D, Early Management Bundle/Severe Sepsis/Shock, Annual Percentage)	Not met: 53%. Cases that were eligible for the measure and passes included 41/78.

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2023 Goals

Quality Goal	**CY 2023 Metric**	**Evaluation**
Develop and maintain quarterly area specific quality measure dashboard for directors to provide benchmarks against other units and national measures on specific goals.	**Quarterly dashboards that share at least 4 department specific actionable areas for improvement to at least 3 departments**	
Implement online peer review process to track all peer reviews through BRH	**By 12/23 have the MSQIC peer review process integrated into the re-credentialing process.**	
HCAHPS: Improve the 6 key areas for patient satisfaction.	**Increase the four Key Performance Indicator patient experience scores that are under the 75th percentile to reach the next highest percentile ranking by the end of 12/31/2023. Increase the Key Performance**	

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	Indicator patient experience percentile rankings, that are already above the 75th percentile, by 5% by 12/31/2023.	
Patient and Family Engagement (PFAC):	1. Increase patient experience scores by 3% by 12/31/2023. a. We will focus on questions related to comfort, respectful treatment, overall friendliness, and likelihood to recommend this hospital. Planned actions include: i. Working with prior patients within the transgender community to address hospital processes which support communication with transitions of care that include their preferred pronouns ii. Develop staff education on caring for the transgender community to help ensure they are receiving equitable care. 2. Increase patient/family PFAC membership by 100% a. We currently have two community members on our team, and we are looking to increase that number to four.	
Regulatory Readiness:	1. Increase staff perception of Joint Commission survey readiness by 15% by 12/31/2023. a. Planned actions include: i. Send out staff survey to get a baseline of their perception of readiness for a Joint Commission survey. A follow up survey will be conducted in the beginning of December 2023 to gauge any changes to their perception. ii. A new process was developed to provide staff education on survey readiness. This includes a new TJC survey topic each month with director and front-line staff involvement in activities.	

BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2023 Draft

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	David Miller MD	~~1/7/2022~~
Quality and Process Improvement Director	Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	~~1/7/2022~~
Infection Preventionist	Charlee Gribbon RN, MPH, CIC	~~1/7/2022~~

Bartlett Regional Hospital

Infection Prevention and Control Plan ~~2022~~2023

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 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 services, 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 and Safety Program Specialist is coordinating the health and safety program for patients, employees, visitors, and contractors during renovation, construction, and maintenance 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 infectious organisms/diseases.

Geographic Location and Community Environment

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 58 inpatient beds and ~~8~~ 12 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 ~~46,653~~45,147. 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 ~~31,848~~31,973 (US Census, 2021) This includes ~~5.8~~ 5 % who are under 5 years of age, ~~21.5~~ 20.6% persons who are under 18 years, and ~~12.5~~ 15.2 % that are over 65 years of age. (US Census, 2021) The underserved and disadvantaged population includes: ~~7.9~~ 8.1% with a disability and under 65 years of age; and ~~11.8~~ 10.4 % under 65 years of age without health insurance. (US Census, 2021) Additionally, ~~7.7~~ 8.1% of Juneau residents are living in poverty (US Census, 2021).

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~~April through October 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, COVID-19, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services ~~2019~~ 2020TB Summary Brief Report shows that Alaska's TB infection rate was 7.9 cases per 100,000 people, representing ~~a slight decrease~~ no change from the previous year (AK SOE, 202~~1~~0). Alaska still has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.2~~7~~ cases per 100,000 people. Southeast Alaska's incidence rate has ~~decreased~~ increased from ~~2.7 to~~ 1.4 to 2.8 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* [CDI]) 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 745 employees and ~~79~~ 93 licensed independent providers. ~~567~~ 555 (~~76~~ 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, 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 Central Staffing Office and Employee Health Nurse, and analyzed by 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.

~~2022~~ 2023

Infection Prevention and Control Plan

2022 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 maintained above 88% by 9/30/23.	1. Enlist Hand Hygiene Observations from directors of patient care areas. 2. Utilize technology to collect and analyze data. 3. Work with Patient and Family Engagement Team to increase patient feedback regarding Hand Hygiene. 4. Implement more touch free hand hygiene stations throughout the hospital.	Nursing Administration, Directors & Supervisors, Patient Care staff, Infection Prevention.	BRH hand hygiene compliance rate will be at or above 2022 (88%) hospital wide rates. Patient reported (Press-Ganey) hand hygiene scores will increase be maintained at or above 80%.

Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Reduce surgical site infection rate at or below 0.3 per 100 procedures by 9/30/2023.	1. Monitor staff compliance with pre procedural bathing, oral care and nasal decolonization. 2. Work with Surgical Services to improve patient education/ experience from pre-op to post-op.	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2022. Rate will be at or below 0.3 infections per 100 procedures.

Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
►Prepare for and protect staff, patients and our community from respiratory pathogens in an efficient and safe manner. (IC.02.04.01)	1. Increase full time/ part time staff influenza vaccination at or above 85% for the 2023-2024 season. 2. Increase full/part time staff that are up to date with COVID vaccination to 65%.	1. Participation in the influenza and COVID-19 prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Enforce/ educate standard precautions are in use for any aerosol-generating procedure. 4. Continue to monitor and report respiratory illness trends in the community and at BRH, and enforce universal masking when community rates rise above 100 cases per 100,000.	Leadership, all staff, IC, and employee health	Full time/ part time scheduled staff compliance rate with flu vaccination will be at 85% or greater by November 1st, 2023. There will be no identified cases of HAI flu or COVID between 10/1/2022 and 9/30/2023.

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