

Policy and Procedure Manual

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ENVIRONMENT OF CARE PLAN OVERVIEW

OBJECTIVE

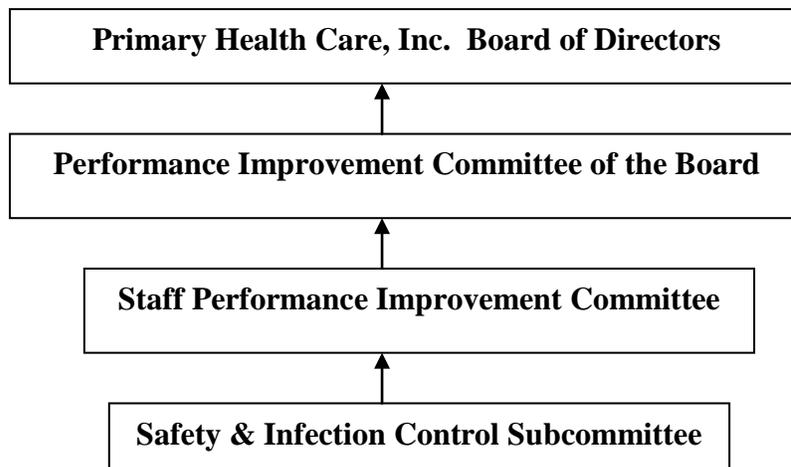
The objective of the Environment of Care Management Plan is to provide our patients, personnel and visitors a physical environment free of hazards by proactively managing risk through risk assessment activities aimed at reducing the risk for injuries.

AUTHORITY

The health center board of directors has established and supports and maintains PHC's Environment of Care Management Program that is based on the monitoring and evaluation of PHC's experience, applicable laws and regulations, and accepted practices as they pertain to safety. The Environment of Care Management Program is implemented through the Safety and Infection Control Subcommittee.

SAFETY PROGRAM COMMITTEE STRUCTURE

The Safety Committee structure is outlined in the organizational performance improvement plan. It is highlighted here and shows direct reporting relationships to the Board of Director.



SAFETY AND INFECTION CONTROL SUBCOMMITTEE

This multidisciplinary subcommittee ensures that systems are in place to meet the Safety Management Program objectives through review of activities at the subcommittee level. The subcommittee is comprised of representatives from senior leadership, clinical, and support services, and includes line staff as well as directors and managers.

The membership, responsibilities, reporting requirements, and frequency of meetings are outlined in detail in Section IV, paragraph 5 of the Performance Improvement Plan.

DESIGNATION OF SAFETY OFFICER

The Health Center will assign qualified individuals as safety officers to oversee development, implementation, and monitoring of the safety management program.

This position will be shared by the following individuals with duties outlined in the Safety Officer job description:

- The Clinic Director for SSC/ESC/GVC is responsible for management of all environment of care functions, except for Infection Control.
- The IC Coordinator is responsible for the functions relating to Infection Control.

These individuals have been authorized to intervene whenever conditions pose an immediate threat to the life or health or threaten damage to equipment or buildings.

These individuals have received education and training appropriate to their assigned responsibilities.

INCORPORATING PERFORMANCE IMPROVEMENT PRINCIPLES (look at PI and leadership chapter for necessary content)

- A. There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization-wide safety. The Safety and Infection Control subcommittee 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.
- B. For each of the environment of care functions/plans, the Safety and Infection Control subcommittee will measure performance in at least one or more of the following areas:
 1. Staff knowledge and skills;
 2. Level of staff participation;
 3. Monitoring and inspection activities;
 4. Emergency and event reporting;
 5. Inspection, preventive maintenance and testing of safety equipment.
- C. Performance measures will be selected based on the following criteria:
 1. High risk, high volume, and/or problem prone situations;
 2. Health center experiences and trends

3. Impact on patient safety
 4. Potential or actual sentinel event related occurrences
- D. Each environment of care function has identified performance measures. The Safety Subcommittee will determine data sources, frequency of data collection, and individual(s) responsible for data collection, aggregation and reporting.
 - E. To identify opportunities for improvement, the Safety and Infection Control subcommittee will follow the organization's improvement methodology, the Plan, Do, Study, Act (PDSA) model. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness.
 - F. Performance measures will be presented to the Staff Performance Improvement Committee on a quarterly basis and the Performance Improvement Committee of the Board. A summary of Safety and Infection Control subcommittee activities will be provided to staff at unit meetings and will also be provided to the Performance Improvement Committee of the Board and governing body quarterly.

DEVELOPMENT OF SAFETY POLICIES AND PROCEDURES

The Safety and Infection Control subcommittee is responsible for developing safety policies and procedures when it has been determined that they are needed to guide and direct activities relating to the safety program. The subcommittee is also responsible for distributing and enforcing safety policies and procedures. These policies and procedures will be reviewed at least every 3 years by the subcommittee.

RISK ASSESSMENT PROGRAM

The risk assessment program is designed to proactively evaluate the impact on patient care as it relates to the safety of buildings, grounds, internal physical systems and the safe practices of the health center employees. The health center will utilize results of the risk assessment to select and implement procedures and controls to achieve the lowest potential for impact on the safety and health of patients, visitors and staff.

A. Organizational Hazard Vulnerability Analysis.

A hazard vulnerability analysis will be conducted and/or reviewed on an annual basis by the Safety and Infection Control subcommittee.

The analysis will assist the organization in identifying potential emergencies that could affect the need for its services or the ability to provide those services, and it will assist the organization in identification and prioritization of hazards and/or threats. The analysis will encompass all environment of care functions and all locations. Results of the analysis will aid the Safety and Infection Control subcommittee in determining elements for the environment of care plans as well as any policies and procedures.

B. Environmental Tours.

1. Purpose. Environmental tours will be conducted to identify environmental deficiencies, hazards, and unsafe practices, including age related concerns. These tours will assist the organization in determining if current process for managing patient, public, and staff safety risks are being practiced correctly and are effective. The tours will also assess staff knowledge and help to identify opportunities to improve the environment.
1. Frequency. Environmental tours will be conducted at least every six months in patient care areas, and at least annually in non-patient care areas. A schedule will be developed for this purpose.
3. Responsibility. The subcommittee will assign responsibility for completion of these environmental tours.
4. Content. The organization will develop surveillance tour forms or checklists to assist in conducting the surveys.
5. Follow Up. When physical plan problems are identified, the clinic director/manager orders necessary maintenance and completes an event report. Other problems identified through the inspection process are referred to the appropriate clinic director/manager for correction and follow up.
6. Reporting of Results. Results of the inspections will be reported on a regular basis to the subcommittee. The subcommittee will review the problem/issue, determine if action is needed, establish a plan for corrective action, and monitor the implementation of the plan. Follow up inspections in areas with identified problems may be done to help determine the effectiveness of corrective actions.

C. Event Reporting.

1. The Safety and Infection Control subcommittee will establish an event reporting policy and system as outlined in EOC.6.03, Event Reporting Policy.

The department director/manager will investigate all accidents and events. The Safety Officer and the Safety Subcommittee will investigate serious accidents or an unusual frequency of accidents. All event reports will be reviewed and studied by the appropriate director/manager to determine the cause. The director/manager will make recommendations to the Safety and Infection Control Subcommittee to prevent the reoccurrence of events.

2. The Safety and Infection Control subcommittee will review all summaries of occupational illness, accidents or injuries to patients, visitors and/or personnel. Summary reports of events shall include evaluation of the event, conclusions, recommendations and actions taken.
3. All events will be aggregated and reported to the Safety and Infection Control subcommittee on a quarterly basis. The Safety Subcommittee will track and trend all

events by type and unit to determine if patterns exist. Once a pattern has been identified, a performance improvement project will be developed to improve performance.

ORIENTATION AND EDUCATION PROGRAM

The Safety and Infection Control subcommittee shall coordinate organization-wide educational activities in order to effect improvements in the safety of patients, visitors and staff. All staff will receive general safety orientation upon hire and annually thereafter.

A. New Employees.

New employees will attend a general safety orientation program which covers the following topics: event reporting, hazardous materials and waste/right to know, equipment management and medical device reporting, utility systems, emergency preparedness, security, fire safety, infection control/blood-borne pathogens, and body mechanics,. Attendance at orientation is mandatory for all new employees. A checklist is completed and maintained in the personnel file as a record that the training has been completed.

Relief and temporary personnel, students, and volunteers may receive a “mini” orientation manual which covers the basic information listed above. A checklist is completed and maintained in the appropriate file as a record that the training has been completed.

All new employees will also receive unit/program specific safety education. A copy of the signed department orientation checklist is kept in the personnel file as a record that the training was completed.

B. Ongoing education.

All employees will receive on-going safety education as determined by the organization. The organization will consider industry standards, safety related problems, trends and information in designing the on-going education provided.

Each of the following environment of care plans outline specific information that will be included in the annual safety training program.

Managers will also be educated regarding purchase of safety equipment and adapting their physical environment to improve safety conditions.

COMMUNICATION OF SAFETY INFORMATION TO HEALTH CENTER STAFF

Safety information will be communicated to staff in the following manner:

- A. Articles in the PHC newsletter
- B. E-mails to staff
- C. Safety summaries distributed at unit meetings
- D. PHC intranet site

PROBLEM IDENTIFICATION AND RESOLUTION PROCESS

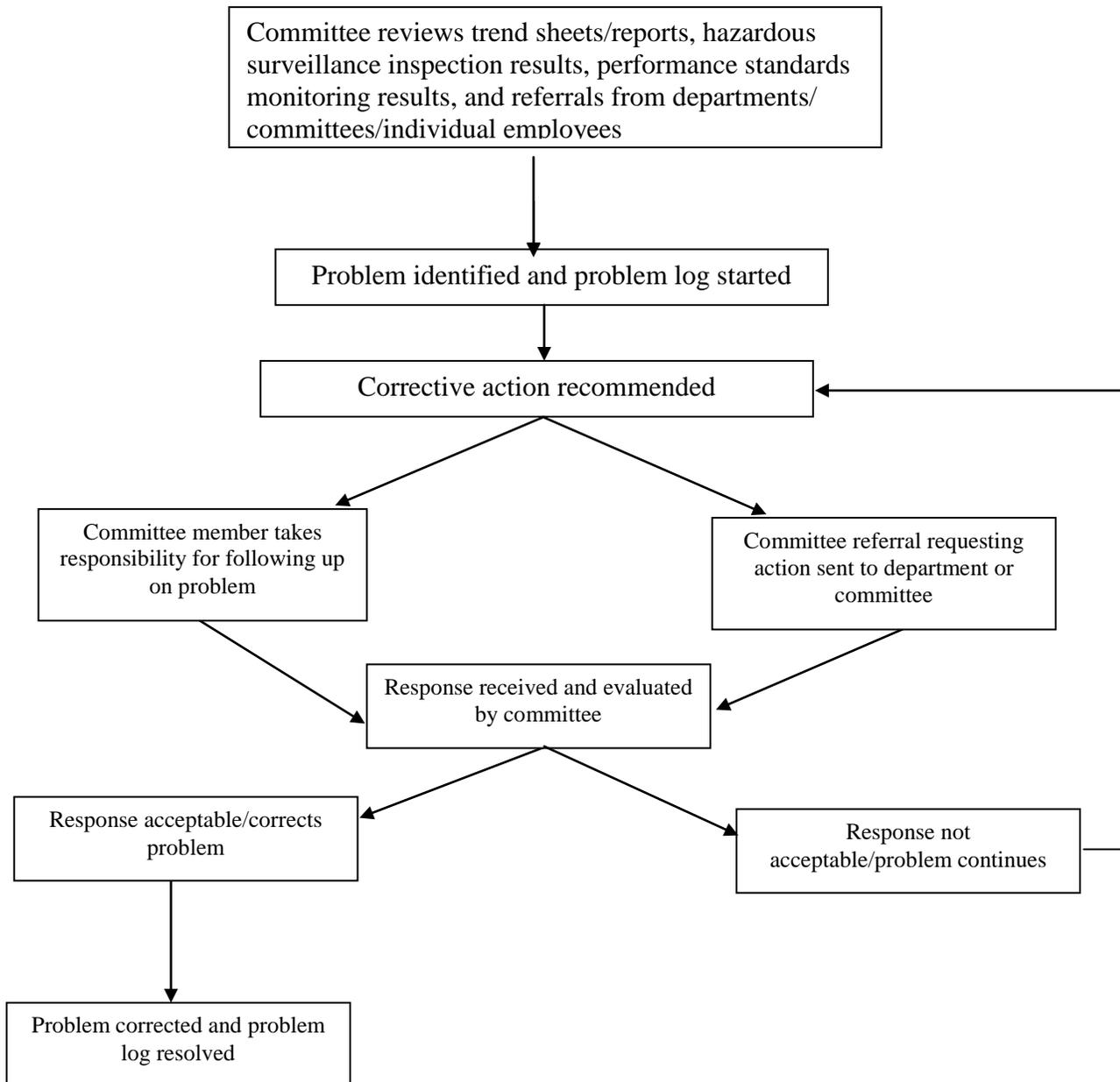
Safety issues are identified the safety program functions or by event reports or other reporting of problems.

Issues that need immediate attention to prevent risk to patients, staff and visitors, are addressed either by the clinic manager/director, Safety Officer, and/or the leadership team at the time the problem is identified. Problem resolution efforts are reported, along with the problem, to the Safety and Infection Control subcommittee for further monitoring and action.

The subcommittee utilizes the following resolution process to address and correct the problem:

1. The safety subcommittee reviews regularly presented reports and trend sheets including results from hazardous surveillance inspections, event reports, results from performance measures, and referrals regarding safety concerns or issues received from clinics, other committees, and from employees.
2. When a problem is identified, the subcommittee starts a problem log to track problem resolution efforts and discusses possible solutions to the problem.
3. Once corrective action is recommended, a subcommittee member may take responsibility for following up on the action or a subcommittee referral requesting action may be sent to another health center committee. A response is required by the next subcommittee meeting.
4. The response is reviewed by the subcommittee and evaluated for effectiveness.
5. If the response is acceptable and corrects the problem, the subcommittee agrees that the problem is resolved and closes out the problem log.
6. If the response is not acceptable or the problem continues, the subcommittee will review other possible corrective actions and request follow up by a subcommittee member or send another committee referral to the appropriate department or committee. This process continues until the problem is resolved and the problem log is closed out.

SAFETY PROGRAM PROBLEM IDENTIFICATION AND RESOLUTION PROCESS



ANNUAL EVALUATION OF ENVIRONMENT OF CARE PLANS

The Safety and Infection Control subcommittee shall perform an annual evaluation of the scope, objectives, goals, performance and effectiveness of the overall Environment of Care Management Plan, including all environment of care functions.

- A. The evaluation process shall include the following:
 - 1. A review of the scope of the Environment of Care Plan to evaluate the degree to which the program meets current JCAHO accreditation standards.
 - 2. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes.
 - 3. The overall effectiveness of the program will be evaluated by determining the degree to which objectives, goals and expectations were met. Effectiveness will also be determined by reviewing results of evaluations from emergency management and fire drills/response.
 - 4. Review and/or updating of the hazard vulnerability assessment tool will also be conducted as part of the evaluation process.
- B. The annual evaluation will be reported to the Staff Performance Improvement Committee, the Performance Improvement Committee of the Board and the Governing Body. The annual evaluation will also be shared with staff.
- C. As part of the evaluation process, monitoring of performance regarding actual or potential risks in the environment of care will be identified and communicated to the organization's leaders for consideration and possible inclusion in the health center's priority for improvements.

The above Environment of Care overview identifies processes and practices that are applicable to each of the specific environment of care functions. The remaining pages of the Environment of Care Plan address specific items relative to each function.

I. SAFETY MANAGEMENT PLAN:

A. Objective

The objective of the safety management plan is to provide our patients, staff and visitors with a physical environment free of hazards to reduce the risk of injuries.

B. Goals

- 1. Establishing a safety committee structure,

2. Providing safety officers who are responsible for the environment of care management plan with authority to intervene whenever there are threats to life or health or threats of damage to equipment or buildings,
3. Establishing safety policies and procedures to ensure safe work practices and to maintain an appropriate environment,
4. Establishing processes to enforce policies and to address identified safety issues,
5. Establishing a risk assessment program,
6. Establishing processes for reporting and investigating all incidents involving property damage, occupational illness, and all incidents involving patient, personnel or visitor injuries,
7. Maintaining and supervising all grounds and equipment,
8. Promoting a hazardous surveillance program through environmental tours,
9. Incorporating safety information in the orientation and training of all employees.
10. Utilizing performance improvement principles to manage and improve safety for our patients, personnel and visitors

C. Functions and Responsibilities:

1. Review and evaluate all incidents that involve patient or visitor injury
2. Review and evaluate all incidents that involve employee illness or injury
3. Review and evaluate environmental tour reports for safety management
4. Review and monitor safety/product recalls, taking action as needed
5. Develop and monitor performance measures related to staff knowledge and skill, level of staff participation, monitoring and inspection activities, and event reporting
6. Take necessary actions when education efforts are indicated
7. Conduct annual evaluation of the Safety Management Plan
8. Review and revise patient, visitor and employee safety policies
9. Conduct an annual risk assessment

D. Product safety recalls.

1. The Safety and Infection Control subcommittee will establish a mechanism for managing and responding to product safety recalls as outlined in the Product Recall Policy, EOC.6.04 and the Pharmacy Drug Recall Policy, EOC.6.18.
2. Product safety recalls will be monitored and reported through the Safety and Infection Control Subcommittee. The report will detail the recall alert and the steps taken in response to the alert.

E. Maintaining and supervising of all grounds and equipment.

The clinic director/manager has the responsibility to ensure all grounds and equipment are maintained through use of contract maintenance staff. Employees are also encouraged to report maintenance items through the event reporting process and/or to their supervisor. Any problems identified are reported to the Safety Subcommittee for review and action. In addition, inspection of the grounds is a component of the environmental tours addressed under section D, paragraph 1.

F. Orientation and Education Components

A designated individual will provide safety-related education to all employees at orientation and annually thereafter. Educational programs shall include:

1. Reporting of events
2. Management of product recalls
3. Knowledge of safety officer(s)

G. Performance Measures

1. Percent of environmental tours conducted per requirements (two times per year)
2. Number of total events reported (patient, visitor, and employee)

II. SECURITY MANAGEMENT PLAN

A. Objective

The objective of the Security Management Plan is to offer safety and security for all patients, visitors, personnel and property of the health center.

B. Goals

The goals of the Security Management Plan includes the following:

1. To provide education to personnel on the elements of the Security Management Plan;
2. To control access to and egress from sensitive areas (i.e., Medical Records, Pharmacy);
3. To reduce the risk of security incidents;
4. To address security concerns of patients, visitors, personnel and property.

C. Functions and Responsibilities

1. Ensure processes for identification of patients, visitors, and staff
2. Ensure access control to sensitive areas
3. Review of all security events
4. Review and evaluate environmental tour reports for security management
5. Develop and monitor performance measures related to staff knowledge and skill, level of staff participation, monitoring and inspection activities, event reporting, and inspections, preventative maintenance, and testing of equipment
6. Take necessary actions when educational efforts are indicated; ensures educational components required by JCAHO are completed
7. Review and revise security policies
8. Conduct an annual evaluation of the Security Management Plan
9. Conduct an annual security risk assessment for the health center

D. Appropriate Identification

All employees, volunteers and students shall wear health center identification badges. Visitors will be asked to sign in and wear a visitor badge. Health center staff will stop and question any unidentifiable person in a work area.

E. Sensitive Areas

A security risk assessment will be completed and those areas determined to be sensitive areas will have restricted access to and egress from. Sensitive areas include locations where medical records and pharmaceuticals are stored. Personnel assigned or working in these areas will receive orientation and education to the area-specific security practices to be utilized.

F. Emergency Security Procedures

1. Specific procedures have been developed for the security of the physical plant, property, patients, visitors and personnel during disaster situations. Personnel are trained in the actions to be taken in the event of a security incident; i.e., infant abduction, workplace violence, or civil disturbance.
2. Any VIPs entering the health center requires immediate notification of the clinic director/manager and administrative offices. Inquiries from the news media will be directed to the clinic director/manager with immediate notification to be provided to the administrative offices.
3. Additional security measures may be implemented for the protection of those needing additional physical protection.

G. Orientation and Education Components

A designated individual will provide security-related education to all employees at orientation and annually thereafter. Education programs shall include:

1. Staff responsibility under the Security Management Plan;
2. Reporting security incidents involving patients, personnel, visitors and property;
3. Emergency procedures to follow in the event of a security incident;
4. Security measures in place at the facility (i.e., access control, alarms);
5. Infant/child abduction;
6. Identification badges and visitor badges;
7. Workplace violence;

8. Specific security measures for sensitive areas including medical records and pharmaceuticals;
9. Forensic staff training.

H. Performance Improvement Measures

1. Number of security event reports submitted
2. Percent of employees observed wearing name tags

III. HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN

A. 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.

B. Goals

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

C. Functions and Responsibilities

1. Develop and monitor the processes used in the selection, handling, storage, use and disposal of hazardous materials from receipt through use and hazardous wastes from generation to final disposal
2. Ensure mechanisms exist for complying with regulations regarding the identification, evaluation, and inventory of hazardous materials and wastes used or generated by each department
3. Review hazardous materials and waste spills and exposure events, as well as other problems related to hazardous materials or waste
4. Monitor processes for monitoring and disposing of hazardous gases and vapors
5. Review and evaluate environmental tour reports for hazardous materials and waste
6. Develop and monitor performance measures related to staff knowledge and skill, level of performance, monitoring and inspection activities, event reporting, and inspections, preventative maintenance, and testing of equipment.
7. Take necessary actions when education efforts are indicated; ensure educational components required by JCAHO are completed.

8. Review and revise health center hazardous materials policies and procedures
9. Conduction annual evaluation of the Hazardous Materials and Waste Management Plan
10. Conduct an annual risk assessment for hazardous materials and waste

D. Written Criteria for Identification of Hazardous Materials

PHC will keep a list of materials classified as hazardous material and/or waste. This list will be based on criteria that is consistent with the Environmental Protection Agency (EPA) and the Occupational Safety and Health Administration (OSHA). A copy of the list will be kept in the Safety Officer's Office for reference.

E. Selection, Handling, Storage, Use and Disposal

1. A system 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 Safety and Infection Control subcommittee.
2. In an effort to reduce the use of hazardous materials, the Safety and Infection Control subcommittee and the Safety Officer shall review literature referencing the reduction of toxic materials and make recommendations regarding less hazardous products to the Safety and Infection Control subcommittee.

F. Maintenance of Required Documentation

The Clinic Manager/Director will be responsible for maintaining copies of manifests obtained in the disposal process, as well as any licenses or permits for chemicals. These documents will be maintained for life.

G. Orientation and Education Components

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 unit is responsible for training each individual handling hazardous materials and waste.
2. Employee orientation and education shall include the following:
 - a. Information about the hazard materials and waste program
 - b. Identification of the hazardous materials in their workplace and the health hazards associated with mishandling these materials

- c. Personal Protective Equipment (PPE)
3. The employee will be inserviced on the location of the following:
- a. Written description of Right To Know;
 - b. List of hazardous materials;
 - c. MSDS;
 - d. How to detect the presence of hazardous materials;
 - e. Specific measures that have been implemented to protect the employee;
 - f. How to read and interpret information on labels and MSDS;
 - g. Emergency procedures to use in the event of an exposure or spill;
 - h. Reporting procedures for incidents including spills and exposures;
 - i. Where to get more information;
 - j. Location of PPE.
4. Retraining will be done annually and whenever the hazard changes or a new hazard is introduced to the work environment.

G. Performance Measures

- 1. Percent of staff able to demonstrate their knowledge regarding their role in a chemical spill or exposure
- 2. Percent of containers properly labeled and stored

IV. EMERGENCY MANAGEMENT PLAN

A. Objective

The objective of the health center's Emergency Management Plan is to effectively and appropriately manage a disaster or civil disturbance.

B. Definition

An emergency is defined as a natural or man-made event that significantly disrupts the environment of care, such as damage to the health center's building(s) and grounds due to severe wind storms, tornadoes, hurricanes, or earthquakes. Also, an event that disrupts care and treatment, such as loss of utilities (power, water, telephones) due to floods, civil disturbances, accidents or emergencies within the health center or in the surrounding community.

C. Goals

1. To establish and implement procedures in response to an assortment of disasters or civil disturbances, including preparedness management, response mitigation and recovery.
2. To provide education to personnel on the elements of the Emergency Management Plan.
3. To identify alternate sources for supplies and services in the event of a disaster

D. Functions and Responsibilities

1. Develop emergency management plan for external and internal programs, making sure JCAHO standards are met
2. Plan, review, and evaluate emergency drills and ensure process meets JCAHO standards
3. Coordinate the health center's participation in community-wide and national emergency preparedness program
4. Review and evaluate actual events related to emergency preparedness
5. Review and evaluate environmental tour reports for emergency preparedness
6. Take any necessary actions when educational efforts are indicated; ensure educational components required by JCAHO are completed
7. Review and revise health center emergency preparedness policies
8. Develop and monitor performance measures related to staff knowledge and skill, level of participation, monitoring and inspection activities, event reporting, inspections,

preventative maintenance, and testing of equipment, use of space, replenishment of supplies, and management of staff

9. Conduct an annual evaluation of the Emergency Management Plan
10. Conduct an annual risk assessment of emergency management functions

E. Community Wide Emergency Response

At this time, the Health Center has no identified role in relation to a community wide emergency management response program. In the event that the organization becomes involved in such an emergency as required by the local authority having jurisdiction, that authority shall direct the activities of the organization to the limits allowed by law.

Whenever possible, health center staff will participate in community wide education and planning programs within the community.

F. Continuous Service

The health center is NOT designated by the emergency management plan or the local authority having jurisdiction to provide continuous service during a disaster or emergency.

G. Command Center

All emergency or disaster situations will be directed and coordinated out of the Administrative Offices.

H. Mitigation

Mitigation activities are those a health care organization undertakes in attempting to lessen the severity and impact a potential disaster or emergency may have on its operation. Such activities within this organization include but are not limited to the following:

1. The organization's leaders shall conduct a hazard vulnerability analysis as part of its annual evaluation (or more often as necessary) to identify the direct and indirect effect these hazards may have on the health care organization and its ability to provide services. This analysis will be performed by the Safety and Infection Control subcommittee and is discussed in earlier sections of this plan.
2. This analysis will be utilized to develop a list of those emergencies likely to occur in or near enough to the organization to have an impact on the organization's ability to provide services.

The following is a list of the contingency plans currently developed for this organization:

- Bioterrorism Readiness – see policy EOC 6.08

- Violence in the Workplace Prevention - see policy EOC 6.14
 - Bomb Threats – see Flip Chart
 - Infant Abduction - see Flip Chart
 - Hostage Situations - see Flip Chart
 - Tornado Warning/Watch - see Flip Chart
 - Fire - see Fire and Fire Alarm Response Procedures, EOC 6.13
 - Utility Failure - see Flip Chart
 - Chemical Spill - see Right to Know Policy, EOC 6.07
3. This list will then be utilized to develop contingency plans for the organization to respond to those emergencies in the event they occur.

I. Preparedness

Preparedness describes those activities that a healthcare organization undertakes to build capacity and identify resources that may be utilized should a disaster or emergency occur. Such activities within this organization include but are not limited to the following:

1. The organization shall educate its employee on the emergency management program as a part of their regular orientation. This education shall address the following:
 - Specific roles and responsibilities during emergencies;
 - The information and skills required to perform duties during emergencies;
 - All relevant backup communication systems used during emergencies; and
 - How supplies and equipment are obtained during emergencies.
2. An emergency management drill which involves participation of staff at all sites will be conducted annually in accordance with the Drill Policy, EOC. 6.12.
 - a. An evaluation tool has been developed to identify deficiencies and opportunities for improvement. This evaluation will be completed by the Director/Manager for each of the units.
 - b. The Safety and Infection Control subcommittee will review the evaluations as part of its annual evaluation process.
 - c. The reports and annual evaluations are kept on file for a period of at least four (3) years.
3. On-going monitoring of performance regarding actual or potential risks is accomplished through review of the following:
 - a. Environmental tour results which address staff knowledge and skills as well as monitoring and inspection activities

- b. Education records which address level of staff participation in training
- c. Event reports

I. Response (Contingency Plan Implementation)

Response activities are how the healthcare organization actually performs in response to an emergency situation. Ideally such activities would be guided by previously identified contingency plans that had been tested via an organized drill. Such activities within this organization include but are not limited to the following:

1. The Safety Officer, Director/Manager, or Administrative staff shall initiate the emergency management contingency plan as appropriate to the situation and as directed in the specific contingency plan.
2. The organization shall identify (where possible and advantageous) backup internal and external communication systems in the event of failure.
3. External authorities (fire, police, public safety, health department, etc.) shall be notified as appropriate to the contingency plan, and informed of the need for assistance in responding to the emergency.
4. Notification of personnel shall occur utilizing the PHC call list and in accordance with the specific contingency plan directives. This notification should occur at the earliest moment possible within the guidelines set forth in the specific contingency plan.
5. The organization will utilize name badges to identify personnel during emergencies.
6. Available personnel shall be assigned to cover all NECESSARY staff positions as appropriate to the situation and contingency plan.
7. The organization's contingency plans shall identify, as appropriate, alternate roles and responsibilities of personnel during emergencies.
8. The organization shall have a process for managing the following activities:
 - a. Patient activities for the duration of the response and recovery times. This may include but is not limited to the following:
 - (1) Scheduling of patients
 - (2) Modification of services/scheduling
 - (3) Discontinuation of services
 - (4) Appropriate control (i.e. confidentiality) of patient information, and
 - (5) Patient transportation

- b. Staff /family support activities (i.e. housing, transportation, and incident stress debriefing)
 - c. Logistics of critical supplies (i.e. pharmaceuticals, medical supplies, linen supplies, water supplies, etc.)
 - d. Security (i.e. access, crowd control, traffic control); and
 - e. Interaction with news media
9. The organization shall adopt (as applicable) methods for removing patients from chemical or radiological contamination. In addition, the organization has identified area hospitals as capable of decontamination and treatment of chemical and radiological exposures.
10. The facility shall be evacuated (both horizontally and, when applicable, vertically) when the environment cannot support adequate patient assessment and treatment.
11. In the event that the environment cannot support adequate patient care:
- a. If patients can be managed at another PHC site, arrangements will be made to reschedule these patients and/or transport them to the appropriate site.
 - b. If patients can not be managed at another PHC site, emergency situations will be routed to local emergency sites. Non-emergency patients will be asked to reschedule their appointments at a later date.
 - c. If and when appropriate, the Executive Director, in consultation with other appropriate persons, may establish an alternate care site. If other alternate care sites are to be used, the following issues shall be addressed:
 - Management of patient necessities (i.e. medications, medical records) to and from the alternative care site;
 - Patient tracking to and from the patient care site;
 - Inter-facility communication between the organization and the alternative care site;
 - Transportation of patients, staff, and equipment to the alternative care site

J. Recovery

The recovery period is defined as the transitional time between when the organization discontinues its response to an emergency and the time that it resumes normal operations. The recovery period can last as little as a few minutes and as long as a few days, depending on the size and scope of the emergency. However, this transitional period is every bit as important as the emergency period because several important management systems can be in a state of flux and the transition must be directed in a deliberate and thoughtful fashion to ensure continuity of care, safety, etc.

The Safety Officers and the management team shall oversee the recovery period intensely to ensure that the organization's management systems and processes are returned to their proper operation prior to giving the ALL CLEAR signal. Once the ALL CLEAR signal has been properly communicated throughout the organization, a formal evaluation of the organization's response to the emergency should be performed. This evaluation, at a minimum, should include completing a Drill Evaluation tool. Particular attention should be paid to opportunities for improvement in the Mitigation, Preparedness, Response, and Recovery processes related to the specific type of emergency encountered.

K. Orientation and Education Components

A designated individual will provide emergency management-related education to all employees at orientation and annually thereafter. The content is outlined under the Preparedness section of this plan, located on p. 24, Section I, paragraph 1.

L. Performance Measures

1. Percent of staff able to demonstrate their knowledge regarding where they would find their flip chart to identify emergency management responses
2. Percent of staff able to demonstrate knowledge of their responsibilities during a emergency management drill;

V. FIRE SAFETY MANAGEMENT PLAN

A. Objective

The objective of the Fire Safety Management Program is to design processes to prevent fires and protect patients in the event of a fire.

B. Goals

1. To assure that the building is in compliance with applicable NFPA standards;
2. To provide education to personnel on the elements of the Fire Safety Management Program including evacuation;
3. To test and maintain the fire alarm and detection systems;
4. To identify key areas for improvement;
5. To conduct an annual evaluation to determine level of Fire Safety Code compliance.

C. Functions and Responsibilities

1. Plan, review, and evaluate fire drills and ensure process meets JCAHO standards
2. Review and evaluate reports related to inspecting, testing, and maintaining fire alarm systems and annual preventative maintenance of all components
3. Review and evaluate reports related to managing portable fire extinguishers
5. Review Life Safety Code and fire protection deficiencies, failures, and user errors
6. Review and take action on problems identified from outside agencies; i.e., surveys by State Fire Marshall, etc.
7. Develop and monitor performance standards related to staff knowledge and skill, monitoring and inspection activities, emergency reporting and incident reporting, inspections, preventative maintenance, and testing of equipment use of space, replenishment of supplies, and management of staff
8. Take any necessary actions when educational efforts are indicated; ensure educational components required by JCAHO are completed
9. Review and revise health center fire safety policies

9. Conduct an annual evaluation of the Fire Safety Management Plan
11. Conduct an annual risk assessment of the fire safety function

D. Maintaining Building Structural Requirements for Fire Protection

The health center and all buildings, which serve to treat patients and are under the ownership or control of the governing body, will maintain compliance with the appropriate provisions of the 1997 edition of the Life Safety Code of NFPA 101. Documentation of all life safety requirements will be maintained. The Operations Director is responsible for maintaining and managing all structural elements of fire safety.

E. Inspecting, Testing and Maintaining Fire Protection and Life Safety Systems

The following fire alarm and detection equipment is tested as required by NFPA 1997:

1. All initiating devices are tested at least annually with an “intelligent” system
2. All supervisory signal devices (except valve tamper switches) are tested at least quarterly
3. All valve tamper switches and water flow devices are tested at least semi-annually
4. All duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes and smoke detectors are tested annually
5. Occupant alarm notification devices including all audible devices, speakers and visible devices are tested at least annually
6. Emergency forces notification transmission equipment is tested at least quarterly.
7. Portable fire extinguishers are inspected monthly and maintained annually.
8. Fire protection equipment:
 - Fire and smoke dampers - every 4 years to verify they fully close (with fusible links removed where applicable);
 - Automatic smoke detection shutdown devices for air handling equipment - annually;
 - Horizontal and vertical sliding and rolling fire doors – annually for proper operation and full closure.

F. Review of Proposed Acquisitions for Fire Safety

All purchases of health center furnishings and equipment will be reviewed by the clinic director/manager to determine if they meet fire retardant characteristics and flame spread necessary for continued fire safety. All materials must meet the requirements of the NFPA.

G. Fire Drills

Fire drills will be conducted at all sites on an annual basis at all sites in accordance with the Drill Policy, EOC. 6.12.

1. An evaluation tool has been developed to identify deficiencies and opportunities for improvement. This evaluation will be completed by the Director/Manager for each of the units.
2. The Safety and Infection Control subcommittee will review the evaluations as part of its annual evaluation process.
3. The reports and annual evaluations are kept on file for a period of at least four (3) years.

H. Reporting and Investigating Deficiencies, Failures, and User Errors

1. A comprehensive plan to correct any Life Safety deficiencies, which occur or are identified will be developed immediately in writing and reported via an event report which addresses:
 - a. All Fire Safety Code deficiencies;
 - b. Corrective actions (plan for improvement);
 - c. Total cost of actions and specific funding information;
 - d. A reasonable schedule for completion;
 - e. To be coordinated with available funding;
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.

I. Orientation and Education

A designated individual will provide security-related education to all employees at orientation and annually thereafter. Education programs shall include:

1. Location, use and functioning of fire alarm systems
2. Emergency number to dial, 911.

3. Containing smoke/fire with building compartmentalization
4. Preparing for building evacuation including knowledge of evacuation routes and procedures
5. Know the location of all exits.
6. RACE
7. Location of Flip Chart.

J. Performance Measures

1. Percent of staff able to demonstrate their knowledge of fire/response to fire (RACE);
2. Number of fire drills conducted per requirements;

VI. MEDICAL EQUIPMENT MANAGEMENT PLAN

A. Objective

The objective of Primary Health Care's Medical Equipment Management Plan is to assess and minimize the physical and clinical risks of medical equipment used in the diagnosis, treatment, monitoring and care of our patients.

B. Goals

1. To minimize the clinical and physical risks of medical equipment through inspection, testing, cleaning and regular maintenance;
2. To establish criteria for identifying, evaluating and inventorying medical equipment which is included in the program;
3. To provide education to personnel on the capabilities, limitations and special applications of medical equipment; operating, safety and emergency procedures; procedures to follow when reporting equipment management problems, failures and user errors.

C. Functions and Responsibilities

1. Review reports on inspections, testing, and maintenance of all health center equipment
2. Review and monitor any hazard notices and recalls
3. Review reports of any incidents that fall under the Safe Medical Devices Act
4. Review event reports of equipment problems, failures, and user errors
5. Develop and monitor performance standards related to staff knowledge and skill, monitoring and inspection activities, emergency reporting and incident reporting, and inspections, preventative maintenance, and testing of equipment
6. Take any necessary actions when educational efforts are indicated; ensures educational components required by JCAHO are completed.
7. Review and evaluate environmental tour reports for equipment management
8. Review and revise health center equipment policies
9. Conduct an annual evaluation of the Equipment Management Plan
10. Conduct an annual risk assessment for the equipment management function

D. Selection and Acquisition of Medical Equipment

An equipment request will be completed by each Manager/Director for replacement or new medical equipment and will be reviewed by the Medical Director. Equipment should meet appropriate space requirements, load and phase requirements, minimum safety standards, appropriate warranties and manufacturer's reliability prior to purchase.

The Safety Officer will also review the selection of equipment prior to purchase to ensure compatibility and consistency throughout the organization. If equipment does not meet the above specifications, it may not be ordered and an alternate choice must be submitted for approval. The Safety Officer may contact the contracted Bio-Medical service for recommendations.

E. Criteria for Inclusion on Medical Equipment Inventory

Electrical patient care equipment will be evaluated prior to use by the contracted Bio-Medical service based on risk categories. Incoming and existing medical equipment meeting the evaluation criteria are included in the medical equipment inventory.

1. equipment function,
2. clinical use,
3. preventative maintenance requirements,
4. equipment failure potential,
5. environment use classification
6. equipment history

F. Medical Equipment Inventory

1. The Bio-Medical service will maintain an equipment inventory of the organization's medical equipment items in a database. A printed copy is provided to the organization.
2. Each item that is inventoried by the Bio-Med service is tagged with an inventory number. This number is used for data tracking of the equipment-specific information as well as tracking repair history.

G. Critical Equipment

At this time, PHC does not have any equipment that is considered critical to patient safety.

H. Assessing and Minimizing Risks Through Inspection, Testing and Maintenance

1. Electrical patient care equipment will be evaluated prior to use by the contracted Bio-Medical service. Preventive maintenance for equipment in the program will be performed based on the manufacturer's recommendations or other standards; safety

inspections will be completed on equipment in the program at least annually. The results of inspection and preventive maintenance will be kept in the administrative offices.

2. Performance testing on sterilizers will be conducted in accordance with policy on Sterilization.
3. Medical equipment, including clinic owned, rental, demo, and loaner, shall be evaluated and inspected prior to use for patient care by the contracted Bio-Medical Service. Equipment that fails inspection shall not be approved for use.
4. Equipment displaying unusual repair history or unusual incidence of injury to staff or patients will be reviewed by the Safety and Infection Control subcommittee.
3. Most electronic equipment does not require “preventive maintenance” (maintenance designed to prevent unexpected equipment failure). However, on equipment where it can be beneficial, the Biotech contractor will perform minor preventive maintenance as part of the quality assurance inspections. Where major preventive maintenance is identified, appropriate work will be scheduled on individual items of equipment.

I. Non Medical Equipment Inspection

Non-medical electrically powered equipment will receive visual inspection by the clinic director/manager prior to use. This equipment will be visualized during the environmental tours and will be reviewed annually for events.

This equipment will include, but will not be limited to lamps, typewriters, televisions, calculators, radios and computers.

J. Contingency for Equipment Failure

If equipment fails, service will be requested through the Bio Med contractor or through the vendor. If necessary, referrals will be made to other organizations for service and/or back up equipment may be obtained from another PHC site.

K. Hazard Notices and Recalls

Equipment notices and recalls will be handled in accordance with the policy on Product Recall, EOC.6.04.

The Safety Officer will report quarterly to the Staff Performance Improvement Committee on any hazard notices and recalls affecting the organization and follow up activities undertaken.

L. Monitoring and Reporting of Medical Device Instruments Per Safe Medical Device Act of 1990

The Safe Medical Device Act of 1990 requires that device user facilities report events 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. This will be accomplished as outlined in EOC.6.15, Medical Device Event Reporting.

The Safety Officer is responsible for managing the Safe Medical Device Act reporting process and will report any occurrences to the Safety and Infection Control subcommittee.

M. Investigating and Reporting of Problems, Failures, and Unreproducible Errors

An event report will be completed by PHC employees as outlined in the Event Reporting policy, EOC.6.03, for all equipment failures, abuse and user errors, including the date, location, resolution and follow-up. These events will be investigated and reviewed by the Safety and Infection Control Subcommittee. In the event the equipment problem was caused by user error, the user(s) will be in serviced on the operation and use of the equipment by the appropriate clinic director/manager or designee. The contracted Bio Medical Contractor will be notified of all event reports.

N. Orientation and Education Program

A designated individual will provide equipment-related education to all employees at orientation and annually thereafter. Education programs shall include:

1. Capabilities, limitations, and special applications of equipment,
2. Basic operating and safety procedures,
3. Emergency procedures if failure occurs
4. Reporting procedures for equipment problems, failures and irreproducible errors included in the program

O. Performance Measures

1. Percent of staff able to demonstrate their knowledge regarding how to report an equipment problem and what to do if a critical piece of equipment fails
2. Number of equipment events reported;

VII. UTILITY SYSTEMS MANAGEMENT PLAN

A. Objective

The objective of the health center's Utility Systems Management Plan is designed to provide a safe patient care and treatment environment by managing the risks associated with safe operation and the functional reliability of the health center's utility systems.

B. Goals

1. To minimize the occurrence of unplanned utility systems failures or interruptions;
2. To provide preventive maintenance of the utility systems ensuring reliability;
3. To investigate and correct all utility system problems, failures or user errors.

C. Functions and Responsibilities

1. Review reports on inspections, testing, and maintenance of critical utility operating components
2. Review event reports of utility system problems, failures, and user errors
3. Develop and monitor performance standards related to staff knowledge and skill, level of involvement, monitoring and inspection activities, event reporting, and inspections, preventative maintenance, and testing of equipment
4. Take any necessary actions when educational efforts are indicated; ensures educational components required by JCAHO are completed.
5. Review and evaluate environmental tour reports for utility management
6. Take any actions needed when educational efforts are indicated; ensures educational components required by JCAHO are completed.
7. Review and revise health center utility system policies
8. Conduct an annual evaluation of the Utility Systems Management Plan
7. Conduct an annual risk assessment of the utility system function

D. Assess and Minimize Risk

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

2. There is a comprehensive preventive maintenance program, which includes a written testing and maintenance program for all critical utility components. It is the responsibility of the Safety Officer to keep the preventive maintenance program accurate and ongoing.

E. Criteria For Identifying, Evaluating and Taking Inventory

1. Equipment maintains the climatic environment in patient care areas;
2. Equipment is a part of a building system, which is used for infection control;
3. Equipment that is part of the communication system, which may affect the patient or the patient care environment;
4. Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment or infection control.

F. Systems included in Utility Systems Management Plan

1. Electrical Distribution System;
2. Natural Gas System
3. Heating, Ventilation and Air Conditioning Systems;
4. Plumbing and Water Delivery Systems;
5. Medical and Surgical Vacuum and Air Delivery Systems;
6. Communication Systems;
7. Sewage Removal Systems.

G. Inspecting, Testing and Maintaining

There is a scheduled maintenance system, which is used to schedule, monitor and document the testing and maintenance of each utility system at predetermined levels including before initial use. These intervals are based on manufacturer's recommendations, risk levels and experience.

H. Vacuum System Testing

A qualified contractor will test all vacuum systems when the systems are installed, modified, or repaired. The testing will include cross-connection testing, purity testing, and pressure testing.

I. Develop and Maintain Current Systems

A comprehensive preventive maintenance program, which includes written testing and maintenance programs for all utility components, shall help to ensure reliability, minimize risks and reduce failures of utility systems. It is the responsibility of the Safety Officer to keep the preventive maintenance program accurate and ongoing.

J. Mapping Distribution of Systems and Labeling Controls

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

K. Emergency Procedures for Disruptions and Failures

1. The Safety Officer, Clinic Director/Manager, and/or designee have been granted authority to shut off a malfunctioning system and notifying staff in the affected area(s).
2. The Safety and Infection Control subcommittee is responsible for coordinating activities and ensuring procedures are developed regarding specific action to be taken during the failure of major utility services.

Emergency procedures include:

- a. Alternate sources of utilities or back-up protection provided;
 - b. When alternate sources are not available procedures to follow until the utility system can be restored to normal function;
 - c. Location of emergency shutoff controls;
 - d. Conditions in which the utility may be shutoff;
 - e. Assign authority to use the shutoff controls;
 - f. How to report a failure or interruption;
 - g. Obtaining emergency repair services;
 - h. Specific information on emergency clinical interventions.
3. Clinic directors/managers, in conjunction with the Safety Officer and Administration, will determine appropriate emergency procedures.

L. Investigating and Reporting Events

1. An event report shall be completed for any problem, failure or user error of a vital or essential utility system as outlined in the Event Reporting policy, EOC.6.04.
2. The clinic director/manager, in conjunction with the Safety Officer, will immediately respond and intervene in any utility problems, failures, or errors within the scope of their operations in a timely manner.
3. The events will be reviewed by the Safety and Infection Control subcommittee and any additional interventions taken. Evidence of the actions taken to resolve identified problems can be located in the Event Reporting System.

M. Orientation and Education Program

A designated individual will provide utility system -related education to all employees at orientation and annually thereafter. Education programs shall include:

1. Process for reporting problems, failures, and user errors;
2. Procedures for maintaining essential functions during utility failures;
3. Location of emergency shut off controls and the procedures to follow if they alarm;
4. Communication equipment protocols

N. Performance Measures

1. Percent of staff able to demonstrate their knowledge regarding the location of their utility failure plan
2. Number of utility event/failure reports;