SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
April 25, 2023

OPEN SESSION (5:00 PM – 5:05 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. **Approval of Agendas**
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. **Closed Session Business**

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report (Time Limit – 5 minutes)

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

  1. Evaluation – Quality of Care/Peer Review/Credentials

  2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item) Estimated Date of Disclosure – April 2024

D. Pursuant to Gov. Code Section 54956.9(d)(2): Conference with Legal Counsel, Anticipated Litigation

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item) Estimated Date of Disclosure – July 2024

F. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item)

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

<u>OPEN SESSION</u>

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

Bindusagar Reddy Zone 1 | Gaurang Pandya Zone 2 | Hans Kashyap Zone 3 | Liberty Lomeli Zone 4 | Areli Martinez Zone 5

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
   Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update –Quality Report
   Recommended Action: Approve/Disapprove Report as Given

C. Discussion Regarding Trade Secret – Pertaining to Service
Recommended Action: Information only; no action taken

D. Conference with Legal Counsel
Recommended Action: Information only; no action taken

E. Discussion Regarding Trade Secret – Strategic Planning
Recommended Action: Information only; no action taken

F. Conference with Legal Counsel about recent work product
Recommended Action: Information only; no action taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any

item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. **March 28, 2023 Minutes of the Annual Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove March 28, 2023 Minutes of the Annual Meeting of the Board of Directors

IX. Business Items

A. **Porterville Academy of Health Science (PAHS) Health Careers Scholarship**
Recommended Action: Approve/Disapprove

B. **March 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – May 23, 2023 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

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Senior Leadership Team	4/25/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	4/25/2023

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SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
April 25, 2023
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	Action
Policies:		Approve
1. Cellular Phones	1-6	↓
2. Emergency Operations Plan	7-23	
3. Employee Education Assistance	24-32	
4. Evacuation Procedures	33-38	
5. Food Purchasing and Receiving	39-40	
6. Hazardous Materials and Waste Management Plan	41-51	
7. Life Safety Management Plan	52-61	
8. Medical Equipment Management Plan Security Management Plan	62-71	
9. Scope of Service Food and Nutrition	72-74	
10. Security Management Plan	75-85	
11. Shelter – In – Place Plan	86-87	
12. Utility Systems Management Plan	88-98	
13. Utility Systems Operations Plans and Failure Procedures	99-130	
14. Workplace Violence Prevention Plan	131-145	
Forms:		
1. Community Physician Direct Admit to SVMC Checklist	146-147	
2. Repatriation Back to SVMC Checklist	148-149	
3. SVMC Reciprocal Interfacility Transfer Agreement	150	
4. Transfer Into SVMC Checklist	151-154	

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SUBJECT: **CELLULAR PHONES**	SECTION: ***Information Technology*** **Page 1 of 6**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

In order to conduct business in a timely and safe manner, it may be necessary for employees to make use of wireless communication devices, such as cellular phones. This policy defines the available options for departments to provide wireless technology to those members requiring such technology in the course of daily business. The purpose of these procedures is to establish consistent and clear rules for the issuance and/or use of Sierra View Medical Center (SVMC) or personal mobile communication devices for business purposes and payment and costs related to the cellular phone.

POLICY:

A. Eligibility will be determined by the Department Director and respective Vice President (VP) based on job responsibilities that require routine response to urgent business. Approval must be obtained by the respective VP. Some departments may have a cell phone issued to the department rather than an individual to be used as a shared resource.

B. Employees who are required to have a cell phone will be offered two options. The first option is to use a SVMC-issued phone. The second option is to use your personal cellular phone and be paid a stipend, which is an allowance towards your personal cell phone service plan for hospital business. The stipend does not cover the purchase of the device, which is the responsibility of the employee. An employee's use of such technology shall be consistent with specific requirements set forth in this policy to ensure appropriate, efficient, ethical and legal use of the wireless equipment. Calls and/or text messages of obscene, threatening, demeaning, harassing or otherwise offensive nature that are illegal, inappropriate or in violation of any applicable SVMC policy are strictly prohibited. In order to ensure confidentiality of protected health information (PHI), you must never utilize traditional text messaging, multimedia messaging services, or screen capture when sending work-related data via your personal device.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

PROCEDURE:

Non-exempt Employees: In the event that a non-exempt employee is authorized to use a cellular phone for work purposes outside regular working hours, such employee must record their time in the appropriate time reporting system (KRONOS) as "hours worked." SVMC does not generally monitor employee's use of their devices during personal time and therefore must assume non-exempt employees are not utilizing such devices for work purposes unless such time is recorded.

Non-exempt/Exempt Employees: Employees may not use their personal devices for work purposes during periods of leave. SVMC reserves the right to deactivate any company applications on a personal device, as well as access to company systems through the employee's personal device during periods of leave.

Hospital issued phone option:

- Department Director/ Vice President (VP) determines that the employee needs to have wireless phone service for business purposes.
- Employee's respective VP approval is required.
- IT will issue a phone to the employee once the SVMC cellular phone agreement is signed.
- The phone will remain the property of the hospital and must be turned in if employment is terminated.
- SVMC-owned phones must be used until the device is no longer physically usable, is unable to run required software or operating systems, or must be upgraded for other technical reasons as identified by the IT department.
- Employee must protect SVMC business-related data. (See Information Technology Workstation Use and Security Policy)
- If the phone is lost or stolen, the employee must immediately notify IT so the device can be remotely wiped.

Personal cell phone stipend option:

- Department Director determines that the employee needs to have wireless phone service for business purposes.
- Employee's respective VP approval is required.
- Employee must sign SVMC cellular phone agreement with IT department.
- Employee must protect SVMC business-related data.
- If the phone is lost or stolen, the employee must immediately notify IT so the device can be remotely wiped.
- Employee assumes all charges associated with cellular service and device, including accessories and lost, damaged or stolen equipment.
- Employees accepting a stipend are responsible for negotiating, managing, and paying for all services in the phone contract.
- Employee must agree to set a password or PIN on their cell phone to protect SVMC data residing on the device. (See Information Technology Information Security Policy)
- SVMC is not responsible for troubleshooting personally-owned devices or instructing the employee on how to use the device.

- Using a personal device for SVMC business purposes including email may result in personal records being subject to public disclosure to the extent permitted by law. (See Information Technology E-Mail Policy)

- Employees will be offered a $50 stipend per month toward the monthly service plan.

- Stipends are not considered additional base pay and therefore they are not eligible for benefits calculated on base pay. Stipends are treated as taxable income.

- The phones must be able to run current operating systems and software.

- Employees receiving a stipend are required to properly manage their accounts; including paying invoices from providers on a timely basis so as not to cause the service to become discontinued.

- The stipend is an allowance towards the on-going monthly service costs and does not cover the purchase of the device. The purchase, replacement and/or upgrade of the device is the responsibility of the employee.

- Employees will submit a check request for the stipend. Employees must include their cell phone bill summary with the check request.

CROSS REFERENCES:

- WORKSTATION USE AND SECURITY
- INFORMATION TECHNOLOGY INFORMATION SECURITY
- INFORMATION TECHNOLOGY E-MAIL POLICY

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PERSONAL ELECTRONIC DEVICE USE AGREEMENT

This document provides standards and rules of behavior for the use of personally-owned smart phones and/or tablets by Sierra View Medical Center employees to access SVMC resources and/or services. Access to and continued use is granted on condition that each user reads, signs, respects, and follows the SVMC's policies concerning the use of these resources and/or services.

This Agreement is intended to protect the security and integrity of SVMC's data and technology infrastructure. Limited exceptions to the Agreement may occur due to variations in devices and platforms.

Expectation of Privacy

- SVMC will respect the privacy of your personal device and will only request access to the device by technicians to implement security controls or to respond to legitimate discovery requests arising out of administrative, civil, or criminal proceedings. This differs from policy for SVMC provided equipment and/or services, where employees do not have the right, nor should they have the expectation, of privacy while using equipment and/or services.

Acceptable Use in the Workplace

- The company defines acceptable business use as activities that directly or indirectly support the business of SVMC.
- The company defines acceptable personal use on company time as reasonable and limited personal communication or recreation, such as reading or game playing.
    - Personal Electronic Devices may not be used at any time in the workplace to:
        - Store or transmit illicit materials
        - Store or transmit proprietary information
        - Harass others
        - Engage in outside business activities

- ***SVMC has a zero-tolerance policy for texting or emailing while driving and only hands-free talking while driving is permitted.***

Devices and Support

- The following devices with compatible operating systems are supported:
    - iPhone, iPad, Android, Blackberry, Windows, etc…

- Connectivity issues to SVMC's network are supported by IT; employees should contact the device manufacturer or their carrier for operating system or hardware-related issues.
- Devices must be presented to IT for proper job provisioning and configuration of standard apps, such as browsers, office productivity software and security tools, before they can access the network.

Security

- In order to prevent unauthorized access, devices must have a pin/password. Simple PINs, such as '1234' are prohibited.
- The device must lock itself with a password or PIN if it is idle for five minutes.
- Rooted (Android) or jailbroken (iOS) devices are strictly forbidden from accessing the network.
- Smartphones and tablets belonging to employees are only allowed to connect to SVMC's guest or employee wireless networks and are prohibited from connecting to corporate networks.
- Employees' access to company data is limited based on user profiles defined by IT and automatically enforced.
- The employee's device may be remotely wiped of SVMC data if:
  - The device is lost or stolen.
  - The employee terminates his or her employment.
  - IT detects a data or policy breach, a virus or similar threat to the security of the company's data and technology infrastructure.

Risks/Liabilities/Disclaimers

- While IT will take every precaution to prevent the employee's personal data from being lost in the event it must remote wipe a device, but it is the employee's responsibility to take additional precautions, such as backing up email, contacts, etc.
- The company reserves the right to disconnect devices or disable services without notification.
- Lost or stolen devices must be reported to the company within 24 hours. Employees are responsible for notifying their mobile carrier immediately upon loss of a device.
- The employee is expected to use his or her devices in an ethical manner at all times and adhere to the company's acceptable use policy as outlined above.
- The employee is personally liable for all costs associated with his or her device.
- The employee assumes full liability for risks including, but not limited to, the partial or complete loss of company and personal data due to an operating system crash, errors, bugs, viruses, malware, and/or other software or hardware failures, or programming errors that render the device unusable.
- SVMC reserves the right to take appropriate disciplinary action up to and including termination for noncompliance with this policy.

User Acknowledgment and Agreement

I acknowledge, understand and will comply with the above referenced security policy and rules of behavior, as applicable to my BYOD usage of SVMC services. I understand that business use may result in increases to my personal monthly service plan costs. I further understand that reimbursement of any business related data/voice plan usage of my personal device is not provided.

Employee Name: ____

BYOD Device(s): ____

Employee Signature: ________________________________ Date: __________

SUBJECT: **EMERGENCY OPERATIONS PLAN**	SECTION: ***Emergency Management Program*** **Page 1 of 17**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

SCOPE OF SERVICES:

The scope of Sierra View Medical Center (SMVC)'s Emergency Operations Plan is to provide for a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. This hospital has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Wound Healing Center, Urology Clinic, Sierra View Community Health Clinic Clinical Lab, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Emergency Operations Plan (EOP) and associated Emergency Management Program extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates, including contracted services of Sierra View Medical Center.

OBJECTIVES:

- Six (6) critical areas of emergency response shall be managed in order to assess the hospital's needs and prepare personnel to respond to incidents. The six critical areas are:
  - Communication
  - Resources and assets
  - Safety and security
  - Personnel responsibilities
  - Utilities management
  - Patient clinical and support activities
- The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency, and restore the facility to the same operational capabilities as pre-emergency levels, to include the following:
  - Identify procedures to prepare and respond to potential disasters or emergencies
  - Provide education to personnel on the elements of the Emergency Operations Plan
  - Establish and implement procedures in response to an assortment of disasters and emergencies
  - Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare

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systems; public health departments; hazardous materials response teams; local fire department; local police departments; area pharmacies; medical supply vendors

- Identify recovery strategies and actions to be activated in the event of a disaster or emergency

GOAL:

- Work with offsite Clinic Leaders to perform all required Emergency Management drills.

RESPONSIBILITY:

- The Safety Officer, in conjunction with the Safety Committee, is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including hazard vulnerability analysis, mitigation, preparedness, response and recovery.
  - The Safety Officer shall also track National Incident Management System (NIMS) implementation.
  - It is understood that the Safety Officer has a working knowledge of emergency management, hospital operations (daily operations and emergency operations) and the Hospital Incident Command Center operations.
- Hospital leaders, as well as medical personnel, shall actively participate in the organization's Emergency Operations Plan.
- The Emergency Operations Plan shall be developed in coordination with community agencies.
  - The Hospital shall communicate its needs and vulnerabilities to community emergency response agencies, and identify the capabilities of the community in meeting the needs of the hospital.

SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THIS HOSPITAL:

- The Hospital has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the Hospital will perform routine Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the Hospital.
- The HVA is evaluated on an annual basis and input from the local fire department and community agencies will be obtained to assure that the Hospital is aware of hazards in the community to which an emergency response may be required.
- This hospital has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities

Disruption Matrix is based on the hospital being self-sufficient for up to 96 hours without the assistance of external resources.

- For each emergency identified in the hospital's HVA, the following shall be defined:
  - Mitigation activities that are designed to reduce the risk of and potential damage due to an emergency
  - Preparedness activities that organize and mobilize essential resources
  - Response strategies and actions to be activated during the emergency
  - Recovery strategies/actions that will help to restore the systems that are critical to resuming normal operations of the Hospital
  - A documented inventory of assets and resources on-site that are needed during an emergency. At a minimum, this inventory should include:
    - Personal Protective Equipment (PPE)
    - Water
    - Fuel
    - Staffing
    - Linen
    - Cleaning Supplies
    - Food
    - Medical and surgical resources
    - Pharmaceutical resources
  - The inventory of assets and resources shall be evaluated on an annual basis or as needed
  - Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency

  See Hazard Vulnerability Analysis (HVA) Policy / Utilities Disruption Matrix

DEFINE AND INTEGRATE THE FACILITY'S ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTEROPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

- The Emergency Operations Plan shall be tested. Exercises shall be developed based on the Hospital's HVA. Exercises should validate the effectiveness of the Emergency Operations Plan and identify opportunities to improve.

- The Emergency Operations Plan shall be tested a minimum two (2) times per year, either in response to an actual emergency or in a planned exercise.

- One (1) exercise per year shall include an influx of volunteer or simulated patients.

- At least one (1) exercise per year shall be evaluated to see how effectively the Hospital performs when the Hospital cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise.)

- If applicable, the Hospital will participate in at least one (1) community-wide drill annually that is relevant to the priority of emergencies identified in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise.)

- The Manager of the Environment of Care is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.

- The Hospital cooperates with all local, county and state emergency management drills. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies any large scale drills. Tulare County Department of Public Health & Human Services Agency/Emergency Medical Services (EMS) and statewide disaster planning efforts coordinate with local police, fire and ambulance services in conjunction with the acute care facilities.

  See Emergency Operations Plan - Hospital Incident Command System Responsibilities Job Checklists, Hospital Command Center Policy and Emergency Management Evaluation Policy.

COMMAND STRUCTURE:

The command structure utilized by this facility in coordination with the community-wide command structure is the Hospital Incident Command System (HICS).

INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

The plan will be initiated when it has been determined that a disaster or emergency has occurred or has the potential for occurring.

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Definition of Emergency:

- The Joint Commission's definition of an emergency is *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organization's services. Some emergencies are called 'disasters' or 'potential injury-creating events'."*

When the facility is notified of an emergency, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation, whether it be an internal or external emergency. The Nursing House Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer, or his/her designee, the status of the situation. The Chief Executive Officer or his/her designee will evaluate the emergency to determine whether the Emergency Operations Plan will be activated. If the plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to call "Triage Code 1" (Internal) or "Triage Code 2" (External).

The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command Center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence.

- Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency. If the Labor Pool is not opened, the House Supervisor may assign additional help to the Emergency Area as needed. Additional personnel will be called in as needed via the staff callback system.

- The House Nursing Supervisor will notify additional outside agencies that may need to assist the hospital in the event of an internal emergency. (i.e. fire department, police department or other agencies).

The recovery phase will be initiated after the emergency is over and the Engineering Department has evaluated the facility. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

COMMUNICATION:

Notification of External Authorities:

- The Hospital shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.

- The hospital will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications satellite phones, ham radios or portable 800 MHz radios may be used.

- The Security/Branch Director will approve media access to the facility, with only the appointed Public Information Officer interacting with the media.

  A medical record system will be used to meet the minimum requirements of emergency management operations.

  See Disaster Communications Policy – Emergency Operations Policy Procedure Manual

PERSONNEL RESPONSIBILITIES:

Notification of Personnel When Emergency Operations Plan is initiated:

- In an emergency which is so widespread to be considered an emergency and/or involving mass casualties, all hospital personnel, regardless of position, are expected to report to the hospital for duty as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the callback list.

- In the event that there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel for future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for assignments.

  See Hospital Incident Command System Responsibilities Job Checklists.

Alternate Roles and Responsibilities of Personnel During Emergencies:

- Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs, which will be considered vital to the effective operation of the hospital. Personnel will be assigned duties based on the needs of the hospital. If personnel are not needed in their usual units/departments, they will be sent to the Labor Pool for assignment.

See Hospital Incident Command System Responsibilities Job Checklists and Labor Pool Policy

Identification of Personnel in Emergencies:

- Personnel on duty during activation of the Emergency Operations Plan will be identified by picture identification nametag, which is to be worn at all times by all personnel while on duty.

- Only persons wearing proper identification or possessing valid credentials shall be allowed entrance into the hospital during an emergency.

Personnel Activities and Support:

- The Hospital has made provisions for staff support that can be implemented in the event of a community-wide emergency. Such provisions may include, but not limited to:
  - Temporary housing/lodging needs
  - Transportation needs
  - Family support needs, as necessary (including short term child care)
  - Incident stress debriefing and counseling

Orientation and Training:

- Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster.
- In-service education will be given to specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster.
- The Safety Officer or designee is responsible for in-servicing personnel to the hospital wide Emergency Operations Plan.
- The department directors are responsible for in servicing department personnel on the department specific responsibilities during an emergency/disaster.

EMERGENCY CREDENTIALING OF CAREGIVERS:

- To provide a mechanism for emergency credentialing and granting of privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.

The Chief Executive Officer or Chief of Staff or their designee(s) may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal, or regulatory agency) e.g., driver's license or passport, and at least one of the following:

- A current license to practice or primary source verification of the license.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.

- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Verification of Information:

- Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.

Conditions of Emergency Privileges:

- The emergency designee must practice under the direction and supervision of an existing member of the Sierra View Medical Center Medical Staff.

  See Emergency / Disaster Credentialing & Privileging Of Non-Staff Practitioners and Allied Professionals – Medical Staff Policy & Procedure Manual.

  Authorization for Volunteer Caregivers During Disasters – Emergency Operations Procedure Manual – Response & Assignment of Staff

RESOURCES AND ASSETS:

- The Hospital keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster. At a minimum, the inventory should include:

  - Linen
  - Cleaning supplies
  - Personal protective equipment
  - Water
  - Food
  - Fuel
  - Staffing
  - Medical resources and assets
  - Surgical resources and assets
  - Pharmaceutical resources and assets

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- Methods are established to monitor quantities of assets and resources during an emergency or disaster.
- Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/disaster supporting services may include:
  - Transportation
  - Communications
  - Traffic control
  - Food supplies
  - Utility maintenance
  - Medical supplies
- These arrangements must be coordinated with the assistance of the Safety Officer, Tulare County Department of Public Health, or the local Emergency Management Agency Director, whenever possible.
- The hospital shall estimate its emergency needs for each kind of support and, when feasible, arrange to have supporting supplies, equipment and manpower pre-designated for hospital use.
- Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to 96 hours when the hospital cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
- In the event that the hospital cannot be supported by the local community for at least 96 hours, the Chief Executive Officer/Incident Commander, Incident Command staff, in consultation with community leaders, will evaluate the following options and implement those options that best serve the hospital and community:
  - Conservation of resources
  - Curtailment of services
  - Supplementing of resources from outside of the local community
  - Staged evacuation

- Total evacuation

See Emergency Management - Bed Space Availability Form, Emergency Water Supply Policy, Equipment and Supplies - Emergency Management Policy.

SAFETY AND SECURITY:

- Efficient traffic flow must be established:
  - Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans
  - Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic
  - Assign and train volunteers to perform traffic control and security functions
- At the time the Emergency Operations Plan is activated, the Security Department personnel on duty will be responsible for locking all exits and entrances with the exception of the ambulance entrance. The security staff shall maintain control of entry and egress from the facility. Personnel of the hospital are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the hospital during an emergency.

  See Disaster Response Security Policy – Emergency Operations Procedure Manual

- Radioactive or Chemical Isolation and Decontamination:
  - There is a designated decontamination room with a separate ventilation system or ventilation shutoff available for radioactive or chemical isolation and decontamination. Personnel are trained in the response to radiological, biological, chemical or hazardous material contamination.
  - Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of hospital personnel who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the hospital as a part of its essential emergency supply equipment.

    See Contamination With Radioactive Materials Policy – Emergency Operations Procedure Manual

UTILITIES MANAGEMENT:

- The hospital will provide for alternative sources of essential utilities, including:
  - An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back-up generators

- An alternate source of safe water
- An alternate source for medical gas and vacuum delivery
- An alternate means of waste disposal in the event of sewage system failure
- Sufficient fuel to last for at least 96 hours of expanded operation

See Disruption of Services Procedure Policy, Disruption of Hospital Services Notification Policy,. See additional policies in the Utilities Management subsection.

PATIENT CLINICAL AND SUPPORT ACTIVITIES:

- Management of Patients During Emergencies (i.e., Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation):
  - Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the hospital will be limited to those whose survival depends upon services obtainable only through hospital bed care.
  - Outpatient care will be restricted to those whose lives may ultimately depend upon the present expenditure of medical supplies and health manpower time.

All elective admissions and procedures will be canceled, including elective surgery, non-emergent outpatient procedures and transferring patients who are stable to be discharged.

- Patients may be transferred to other facilities, so that emergency victims may be accommodated.
- Individuals may be redirected or relocated for a Medical Screening Exam in the event that the hospital's Emergency Operations Plan is activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
- In the event that the hospital's Emergency Operations Plan is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency, the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act and CFR §489.24(a)(2)).

  See Admissions and Bed Capacity Policy – Emergency Operations Procedure Manual

EVACUATION OF THE FACILITY:

- When a situation arises requiring evacuation of patients from threatened or affected areas, safety of lives is Sierra View Medical Center's primary concern. Authority to order an evacuation is vested

only in the Chief Executive Officer, his/her designee, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.

- All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the hospital.
- Relocation to alternate health facility or place of safety (i.e., churches, schools):
  - Prepare maps of routes to the relocation site
  - Confirm periodically the availability of the relocation site
  - Establish lists of supplies and equipment, by priority, to be relocated
  - Arrange adequate transportation for evacuation and relocation

See Evacuation Procedure Policy – Emergency Operations Procedure Manual

Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care:

- Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for inter-facility communication between the hospital and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:
  - Ambulance contract agreements for transfer of patients between facilities
  - Transfer agreements will be made between neighboring facilities
  - Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc.

NOTE: Alternate care sites must be able to provide the necessary resources to care for patients, i.e., emergency power, site access and security, access to or the ability to obtain utility resources, such as medical gases, vacuum, etc., communications, personnel.

See Evacuation Procedures Policy – Emergency Operations Procedure Manual

CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- The hospital has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Facilities Manager, Safety Officer, Risk Manager and administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the facility can safety provide medical care to the community and provide a safe environment for patients, personnel and visitors.

  - Pictures and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off-campus structures.

  - Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.

  - All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is not leakage into the local sewer or water system or any other impact on other environmental concerns.

  - Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if personnel and the hospital have been directly impacted by the emergency.

  - Clear debris and secure unsafe buildings as necessary.

  - Restore internal and external communication devices.

  - Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Pictures/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.

Notify the community through local media services regarding the services the hospital will be providing and where they will be provided in the event that services are moved off the hospital campus.

- Notify the hospital's insurance provider and contact a third-party expert to prepare the claim.

- Ensure records and data have been protected and restore information as necessary from backup tapes.

- Keep detailed records.

NIMS PREPAREDNESS FUNDING:

- The Hospital shall establish a working relationship with State and Tulare County Department of Health and Human Services Agency / EMS and state hospital associations to identify activities to obtain and appropriately allocate preparedness funding.

- A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

PERFORMANCE STANDARDS:

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organizational Safety 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:

  - The measure can identify the events it was intended to identify

  - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable

    - The measure has defined data elements and allowable values

    - The measure can detect changes in performance over time

    - The measure allows for comparison over time within the organization or between the organization and other entities

    - The data intended for collection is available

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

- The Safety Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:

  - Personnel knowledge and skills

  - Level of personnel participation

- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of safety equipment
- Other performance measures and outcomes will be established by the Safety 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 Committee.

- To identify opportunities for improvement/corrective action, the Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed, and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Safety Committee feel a team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Safety Committee 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 Safety Committee will review the necessity of team development, requesting team participation only in those instances where it is felt the Safety 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.

- Performance improvement monitoring and outcome activities will be presented to the Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome forwarded to the Organizational Performance Improvement Patient Safety Committee, Medical Executive Committee and Board of Directors quarterly.

ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Emergency Operations Plan will include a review of the scope according to the current Joint Commission standards and National Incident Management System (NIMS) requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements 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.

- The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.

- The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Safety Committee, the Performance Improvement/Patient Safety Committee, and Administration and reported to the Board of Directors.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EM.12.01.01 Joint Commission Resources. Oak Brook, IL.

- Section 1135(b) of the Social Security Act. (n.d.) https://www.ssa.gov/OP_Home/ssact/title11/1135.htm.

- Code of Federal Regulations §489.24(a)(2). (1991). https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=060daea35afcfbf6b1c6a8bf685d6f87;rgn=div5;view=text;node=42:5.0.1.1.7;idno=42;cc=ecfr.

CROSS REFERENCES:

- ACTIVATION OF THE COMMAND CENTER
- ADMISSIONS AND BED CAPACITY
- AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS
- CONTAMINATION WITH RADIOACTIVE MATERIALS
- DISASTER COMMUNICATIONS
- DISASTER RESPONSE SECURITY
- DISRUPTION OF SERVICES

- EVACUATION PROCEDURES
- MEDICAL GASES
- PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN
- UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES

SUBJECT: **EMPLOYEE EDUCATION ASSISTANCE**	SECTION: **Page 1 of 9**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the process by which eligible employees may receive education assistance or reimbursement for tuition for approved academic programs or courses and to encourage employee self-development.

To provide employees with support for outside education and/or certification that will enhance competency within an employee's present Sierra View Medical Center (SVMC) position or offer growth toward a SVMC position to which an employee may transfer or progress in the future.

POLICY:

A. Sierra View Medical Center (SVMC) encourages the development of an educated, highly skilled workforce. Each fiscal year, funds will be budgeted for Education Assistance purposes. SVMC reserves the right of fund discretion.

B. Education Assistance should be considered as a privilege rather than a right of a staff member. If Educational Assistance is approved, it will be considered as an interest-free loan and will be forgiven when the staff member has met the required work time payback and/or other criteria as outlined in this policy.

C. Approved courses: Courses must be academic courses toward an undergraduate degree or higher level and not continuing education units (CEU), workshops, or general education classes.

D. Approved certifications are awarded by a national, professional organization. The certification awarded denotes that the participant possesses a minimum educational level, licensure and experience, plus additional knowledge, skills, or competencies.

DEFINITIONS:

1. Academic courses: Courses taught by education institutions for which credit may be given towards a degree, or approved certificate.

2. Professional certifications: Certifications address a professional body of knowledge, which typically has been defined in a scope and standards of practice. Professional certification is a voluntary process by which a non-governmental body grants time-limited recognition and use of a credential to individuals who have demonstrated that they have met predetermined and standardized criteria for required knowledge, skill, or competencies. The certification is available at a national level (i.e., it is not a state-based or system-based certification). Skill-based and technical certificates or provider cards such as Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP), etc., do not meet this requirement.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE SVMC PERSONNEL (RESIDENTS: REFER TO YOUR SPECIFIC GME RESIDENCY POLICIES.)*

PROCEDURE:

A. Academic Course Selection, Approved Schools & Professional Organizations

1. Education institutions approved for this program may include any accredited public or private secondary school, university, scientific or technical institute, vocational, correspondence, extension, or business school. Online programs offered by these institutions are also acceptable.

2. Correspondence courses given by an accredited school may be included.

3. Recognized professional organizations offering concentrated courses of instruction are acceptable. Conference or conventional activities are NOT included.

4. Employees receiving college credit by challenge exam for a course that would have been approved for tuition assistance may submit proof of credit and receive reimbursement for the challenge examination fee with the same limits as applied to regular course work.

5. Certifications must be attained from a professional certification program.

6. Courses and Certifications must meet one or more of the following criteria:

   a. Provide/demonstrate particular knowledge, skills, or competencies directly applicable to present position

   b. Prepare an individual for career advancement at SVMC

   c. Be a required part of a degree program which is directly applicable to present position or area of work

   d. Prepare an individual for another position within SVMC

B. Eligibility

1. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance based on their course of study. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying to the employee education assistance program.

2. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance (reimbursement) for a first-time (one time only) completion of a qualified professional certification. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying.

3. Employees must remain in full time status throughout the time taking courses and during the work payback period.

4. Employees will be disqualified from the Education Assistance Program and any monies paid in assistance by SVMC must be repaid by the employee if any of the following occur:

   a. Grade below "C" or "Fail" if "Pass/Fail" for any course work or a withdrawal from a course

   b. A grade of "incomplete" will be considered a "Fail" if not corrected within 60 days of the end of the course

   c. An overall rating below 2% of eligible points on their most recent work performance evaluation

   d. Is within the Disciplinary Action Process and has received a written warning or higher

   e. Any type of Personal Leave of Absence (PLOA) from SVMC during the school term

   f. Termination of employment prior to completion of the course work and/or prior to submitting grades and receipts

   g. Changes to less than full time employment status.

   h.

5. If the employee terminates employment and/or is disqualified from the Education Assistance Program for any reason, he/she will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the work payback period as defined below in Section C.2.

6. SVMC has the right to select applicants based on the course of study and their tenure with SVMC. (See Education Assistance Programs available on page 7-8.)

7. SVMC Nursing School with Unitek: Per Diem and Full-Time employees are eligible for sponsorship after 6 months of hire, at the time of application ($10,000 per year, up to 3 years if attend all three years towards a BSN degree, OR, Per Diem and Full-Time employees after 6 months of hire, prior to submitting an application, of tuition reimbursement up to 3 years in the BSN program. Grades have to be consistently at the "C" level or better to receive sponsorship or tuition reimbursement. SVMC reserves the right to determine the number of sponsored and tuition reimbursement selected students for each cohort.

C. Application Process for Educational Assistance - Degree

1. Staff must apply for assistance and complete the *Education Assistance Application Form* available in Education Department.

2. Employees applying for the program must agree to a work payback period for SVMC for no less than 12 months for each year reimbursed but not more than 12 months after receiving reimbursement.

3. Applications will be accepted twice per year in the months of May and November.

4. Employees who terminate or are terminated from employment with SVMC for any reason before the required work payback time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

5. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. The *Contingent Repayment Authorization Form* must be signed by the employee at the time tuition reimbursement is distributed.

7. The Education Coordinator will forward copies of the *Contingent Repayment Authorization Form* as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

8. The *Employer Provided Educational Assistance Form* must be signed by the employee and Director upon application for Education Assistance. The Department Director is responsible for identifying the job-related or non-job-related areas. This form must be sent with the *Education Assistance Application Form* to the Education Department. Federal and Social Security taxes will be deducted from the reimbursed amount for those courses which are non-job related.

9. The *Education Assistance Application Form* must be completed and signed by the staff member's Department Director with a letter of recommendation and forwarded to the respective Vice President (VP) for signature before routing to the Education Assistance Committee for final approval and processing.

10. Applicants will be required to indicate their education goals.

11. The Director and respective VP have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

12. Requests for tuition reimbursement will be considered for any coursework completed within the last six months of the application deadlines.

13. SVMC School of Nursing with Unitek – prospective student must register with Unitek College. Options for selecting sponsorship or tuition reimbursement is part of the registration process. The SVMC Education Department has additional templates and documents for prospective students to use in the application process to SVMC.

D. Approval Process for Professional Certification Reimbursement:

1. Staff planning on sitting for national professional certification must submit a request for reimbursement and receive approval from their Director and the Selection Committee. If staff have already taken a certification exam, they will still be considered for reimbursement if they have taken the exam within 6 months from submitting for reimbursement.

2. Only one time/first time certification will be reimbursed. Certification renewal fees are not reimbursable.

3. The Director and respective Vice President have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

4. Employees requesting reimbursement for a professional certification must agree to a work payback period for SVMC for not less than twelve (12) months.

5. Employees who terminate or are terminated for any reason before the required work time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

7. The *Contingent Repayment Authorization* must be signed by the employee at the time tuition reimbursement is distributed.

8. The Education Coordinator will forward copies of this form as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

9. SVMC School of Nursing with Unitek – SVMC will use a grading rubric, documents submitted from the student, along with a personal interview in the decision-making process for sponsored and tuition reimbursement. Sponsored and Tuition Reimbursement programs required a 1:1 year of payback working at SVMC full-time after graduation. Failure to finish the program and graduate, will be a required payback of any financial assistance/support to SVMC

E. Department Director Responsibility

1. In determining whether to approve a request for tuition/certification reimbursement, Department Directors and Vice Presidents will consider the necessity of the "Job Enhancement", the priority of the position to be achieved, as well as the length of service of the staff member (minimum of 12 months) and their job performance and/or attendance.

2. A letter of recommendation for degree completion (not certification reimbursement) written by the Department Director must accompany the employee's application when forwarded to the respective VP or Employee Education Assistance Committee (EEAC) for review.

3. Department Directors will notify staff that has been denied eligibility due to these factors.

F. Employee Education Assistance Committee (EEAC)

1. The EEAC shall consist of the following members:

    a. Vice President of Finance

    b. Vice President Patient Care Services

    c. Vice President of Human Resources

    d. Director of Nursing Education

2. The EEAC will be responsible for reviewing all applications presented looking at the following factors:

    a. Completeness of application packet

    b. The nature and purpose of the course of study

    c. The benefits to be derived by the staff member and by the District

3. Only those applications with all required information will be considered.

4. The EEAC will make the decision for final approval prior to processing.

    The Education Department will notify the employee and the employee's Department Director of the EEAC's decision.

G. Reimbursement

1. At successful completion of their course of study, and after receiving approval from the EEAC, staff members must submit receipts for approved expenses to the Education Department for reimbursement.

NOTE: Employees will only receive reimbursement upon successful completion of the course or first time approved certification.

2. The Education Department will then ensure that reimbursement is based upon actual receipts that are attached to the original form and forwarded for processing.

3. Costs excluded from the program are:

    a. Insurance

    b. Seminars and conventions

    c. Institutions/programs not approved by the District

    d. Report preparation

    e. Supplies (i.e., pens, pencils, calculators, recording devices, notebooks, etc.)

    f. Uniforms

    g. Transportation/mileage

    h. Parking expense

    i. Meals and lodging

    j. Skill-based and technical certificates or certification tuition such as ACLS

4. After successful completion of EACH grading period with a course grade, or passing a "pass-fail" course, or completion of a recognized professional certification, the staff member will submit the transcript of the grades received or copy of the certification and receipts to the Education Department.

    a. Future reimbursement will not be made until this information is received

    b. Anything lower than a grade of "C", "Fail", or "Incomplete" will not be reimbursed

5. To be eligible for reimbursement, the receipt must be turned in within thirty (30) days after completion of the course, or it will not be paid.

6. The Education Department will submit a Check Request to the Accounting Department along with the required supporting documents to have a check issued as follows:

   a. If the courses or certification exam taken were job-related, so that there are no payroll deductions, separate checks will be sent to the employee's Department Director for distribution to the employee

   b. If the courses or certification exam taken were not job-related, or otherwise subject to payroll deductions, the reimbursement money will be included in the employee's bi-weekly payroll check

Note: All checks will be processed according to current Accounts Payable and Payroll Policies and Procedures.

H. Miscellaneous

1. Class attendance, completion of study assignments, and certification exam preparation will be accomplished outside of the staff member's regularly scheduled working hours.

2. It is expected that educational activities/preparation will not interfere with the staff member's work. However, exceptions will be decided on a case-by-case basis by the respective Department Director and VP.

3. Any unsatisfactory job performance or attendance issues during enrollment may result in termination of education assistance, as well as affecting the individual's employment status, as it would for employees who are not receiving educational assistance.

4. Employees will be reimbursed for up to 2 years maximum for an undergraduate degree and up to 2 years maximum for a graduate degree and higher. However, in the SVMC School of Nursing with Unitek, the sponsorship or tuition reimbursement is for up to 3-years.

I. Education Assistance Programs Available:

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Bachelors, Masters, Post Graduate Certificate, Doctorate	Up to $3,000/fiscal year. Last day of course determines which year reimbursement will apply (max 2-years) SVMC School of Nursing with Unitek – Sponsored program for up to 3-years of

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	$10,000 or up to 3-years for Tuition Reimbursement program. Requires at least 6 months of FT or PD status prior to application to the program.

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Professional Certification which addresses a professional body of knowledge, defined in a scope and standards of practice.	Up to $500 x one (1) time reimbursement of certification exam fee – First time only!

NOTE: Annual reimbursement of costs are based on a fiscal year and divided into two 6-month periods beginning on July 1st and January 1st.

J. Terms and Conditions

1. It is naturally expected that staff members who have received education assistance will remain with SVMC and will apply their acquired skills and knowledge to improve SVMC's overall performance.

2. A staff member who voluntarily leaves SVMC's employment or who is terminated for cause prior to completing the course or who does not complete their course will be expected to repay monies per contractual provisions.

K. Disclaimer

1. Nothing in this program represents an assurance of continued employment with SVMC.

2. Employment is at the mutual consent of the employee and SVMC and is entirely at will. No one is authorized to modify this Program without the consent of the Board of Directors.

SUBJECT: **EVACUATION PROCEDURES**	SECTION: ***Evacuation*** **Page 1 of 6**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

Evacuating patients, staff, and visitors may be necessary in response to a situation which renders the facility unsafe for occupancy or prevents the delivery of necessary patient care. Evacuation may be partial, as in horizontally or vertically from one section of the building to another, or may involve a complete evacuation of the facility (i.e., bomb threat, fire, building collapse, earthquake, and flood). Maps indicating evacuation routes are posted throughout the facility.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS*

PROCEDURE:

1. Authority to Evacuate:

   a. Evacuation of the facility or a portion thereof can only be authorized by:

      - Public Safety Officer (Fire or Police)
      - Chief Executive Officer (CEO) or designee
      - Safety Officer
      - Nursing House Supervisor

   b. In the event of an acute and life threatening emergency situation, such as fire on a unit, the decision to evacuate the immediate area will be made by the nurse in charge.

   c. The decision to evacuate from unsafe or damaged areas will be based on the following:

      - The Engineering Department's evaluation of the utilities and/or structure of the department.
      - The medical staff and/or Nursing Department's determination of whether adequate patient care can continue.
      - Evacuation should only be attempted when you are certain the areas chosen for the evacuees is safer than the area you are leaving.

2. Communication of Evacuation:

   a. If the Emergency Operations Plan has not already been initiated at the time of the evacuation decision, then it must be initiated prior to evacuation in order to establish the Command Center.

b. The switchboard should be asked to page "Triage Code I" for Internal Disaster.

c. The City of Porterville Command Center will be notified of any evacuation.

3. Complete Evacuation – patients are transferred from SVMC to an outside area, other hospital, or alternative sites.

   a. Complete Evacuation may be indicated in the event of a natural disaster or major structural damage that threatens the safety and welfare of patients and staff, or in the event of a disruption of the ability to provide services.

   b. In the event of a complete evacuation, the Emergency Department will notify Tulare County Ambulance Dispatch (TCAD), Tulare County EMS, and surrounding Base Hospitals that ambulance patients must be diverted to another facility due to internal disruption of services.

   c. The building should be evacuated from the top down as evacuation at lower levels can be more easily accelerated if the danger increases rapidly.

4. Partial Evacuation – Patients are transferred within the hospital in situations in which a specific area of the hospital is uninhabitable for patient and staff safety.

   a. Horizontal – initial response. Patients are moved horizontally on the same floor to one side of a set of fire barrier doors.

   b. Vertical – Patients are moved to a safe area on another floor or outside the building. This evacuation is more difficult due to stairways and will require the use of an Evacu-Chair and two staff members.

5. Preparation of an Evacuation:

   a. Place all portions of the patient medical record and medications cassette with the patient.

   b. Place all personal belongings in bag with the patient.

   c. Instruct nursing staff to prepare all patients for evacuation by securing lines and equipment.

- IVs: Convert to Saline Lock or remove from pump and adjust to TKO. If the patient requires fluid volume infusion to maintain vital signs, remove pump from pole and place on bed.

- Continuous Drug Infusions: Place pump on bed and take with the patient.

- Chest Tube: Disconnect from suction source and carry bottle below level of patient.
- Nasogastric (NG) tubes: Disconnect from suction and maintain open to gravity.
- Oxygen: Use portable "E" cylinder if patient cannot be removed for transport.
- Traction: Slowly disconnect weights and apparatus for transport.
- Incubators: Remove patient and wrap in blankets. Babies and mothers should be moved together if at all possible.
- Respiratory Isolation: Mask the patient prior to moving.
- Ventilator Patients: Obtain portable O_2 tanks and bag the patient.
- Art Lines/Swan-Ganz: Disconnect transducer from patient cable and take pressure bag with the patient.
- Operating Room Patients: If anesthesia has begun, but the surgical procedure has not started, the anesthesiologist shall terminate the anesthetic as soon as it is safe to do so and accompany the patient to a predetermined safe location. If a surgical procedure is in progress, the surgeon and anesthesiologist shall determine when it is safe to terminate the procedure and accompany the patient to a predetermined safe location.

d. Assign patients to a member of the staff for movement to specified location. If evacuating for fire, move patients to a location behind the fire doors that provide compartmentalization to the unit.

e. Follow the directions of the Engineering Department or Fire Department. They will identify the immediate re-location areas. The Command Center will assume responsibility for identification of re-location points, facilities accepting transfers, or other holding locations.

6. Evacuation Procedures for Patient Units:

a. Patients in immediate danger will be evacuated first.

b. Patients who are ambulatory will be evacuated second. Assign staff to escort group of patients from the area.

c. Non-ambulatory patients can be moved by pushing the bed or by utilizing mattresses from beds or stretchers. A blanket or sheet under the patient will provide a means of moving the patient away from danger. An Evacu-Chair can also be utilized to move non-ambulatory patients down stairs in the event of a vertical evacuation.

d. Infants may be moved by wheeling them in basinets or placing several infants in a bath blanket or sheet and carrying the blanket or sheet with the infants in it, taking care to not obstruct infant airways.

e. If a vertical evacuation (between floors or down stairs) is necessary, non-ambulatory patients will be placed on an Evacu-Chair and taken to a designated safe area. Elevators MUST NOT BE USED during a fire or significant seismic activity.

f. Visitors or other patients may be used to assist with the evacuation.

g. Fire Department or non-nursing staff assisting with evacuation will need instructions to assist with patients as they may be unfamiliar with equipment and lines.

h. The on duty nurse in charge of the unit will be the last to leave the patient care area.

i. The unit census sheet listing all patients should be taken to utilize in checking those evacuated. The nurse in charge should account for all patients, visitors, and staff.

j. If the situation allows for planned evacuation, all patients will be evaluated by the attending physician or physician assigned by the Medical Staff Officer and categorized for discharge or transfer. Patients who may be discharged or transferred will be prepared and evacuated as soon as possible by Discharge Planning Staff.

k. The patient's family will be notified of the discharge/transfer and the location of the patient.

l. Transportation will be necessary to relocate patients to other facilities. Local ambulance companies will be contacted for assistance.

7. Hospital Incident Command Responsibilities:

a. Command Center:

Evaluate available information and establish evacuation schedule in coordination with Section Chiefs. Consideration to be given to:

- Structural, non-structural, and utility evaluation from Engineering
- Patient status reports from Planning Section
- Evaluate manpower levels and authorized activation of staff call-in plans as needed.

b. Liaison Officer:

Maintain contact with Public Safety Officials, Department of Public Health, and EMS Agency.

c. Logistics Section:

- Advise Command Center regarding safe areas to be used for relocation within the facility.
- Assign and assemble transportation teams from the labor pool.
- Obtain equipment/supplies needed for use in areas where evacuated patients are relocated as necessary. (Portable toilets, Privacy Screens, supply cart, etc.)

d. Transportation Officer:

- Ensure coordination of any off-campus patient transportation with County EMS in coordination with Liaison Officer.
- Assign six people to each floor for evacuation manpower.
- Arrange for transportation devices (gurneys, wheelchairs, etc.)
- Coordinate evacuation with the Nurse Manager/Charge Nurse.

e. Nursing House Manager/Vice President of Patient Care Services (VPPCS):

- Designate holding areas for patients in cooperation with Engineering.
- Organize efforts to meet the medical needs and staffing needs of the holding areas.
- Request Medical Staff Officer to notify physicians of need for transfer/discharge orders.
- Contact other hospitals in the county and local extended care facilities to determine places to relocate patients. In cooperation with the Liaison Officer, contact Tulare County EMS for out of county resources.

f. Nurse Managers/Charge Nurses:

- Coordinate patient readiness for evacuation and staffing needs to provide continued care.
- Using unit census sheet, account for all patients after relocation.

- Assign a person to record the Evacuation Activity including name of patient, time and method of evacuation, current location of patient and number of evacuated room and forward information to the Command Center.

g. Safety Officer:

- Assign a security person (for traffic control) to each area being evacuated.
- Turn off oxygen and lights as the situation demands.
- Verify complete evacuation of a unit has taken place and that no patients or staff remain.
- Notify command Center of completed evacuation. Place sign on door to unit indicating Date and Time of Evacuation completed.

h. Labor Pool:

- Secure all available Environmental Services and general hospital staff not previously assigned to incident to assist in the movement of patients.
- Initiate staff call-in as needed.

8. Directions and plans for relocation of patients and services back into the facility will be issued from the Incident Commander.

REFERENCES:

- Title 22: Section 70741, 70743, 70746
- The Joint Commission (2023) Hospital accreditation standards. EM.12.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Emergency Operations Plan
- Activation of the Command Center

SUBJECT: **FOOD PURCHASING AND RECEIVING**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To be utilized as guidelines for all purchasing and receiving food and supplies for the Food and Nutrition Service (FNS) Department.

POLICY:

All food items shall be purchased from reliable vendors that meet regulations specified by federal, state, and local health care agencies. Only high quality food products will be accepted when receiving deliveries.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. All food items shall be purchased from a reputable vendor.
2. All dairy and egg products shall be pasteurized.
3. Special request food items shall be purchased from a local supermarket.
4. Special nutritional supplements are purchased from a reputable vendor.
5. The quantity of foods shall be purchased to meet inventory and the planned menus' needs.
6. At the time of delivery, the food items shall be checked for accuracy against the invoice. Only quality food will be received. Products deemed unsatisfactory will be refused and returned for credit.
7. Items requiring refrigeration or those that are frozen will be put away immediately.
8. Dry storage items will be put away as soon as possible.
9. All empty boxes, crates and other packaging shall be disposed of immediately to eliminate potential harboring places for vermin. Original product packaging shall be retained for lot and manufacturing information identification needed for recall items.
10. Invoices are processed and sent to accounts payable weekly for payment.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html.

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Food and Drug Administration (2023). Retail Food Protection. Retrieved from https://www.fda.gov/food/retail-food-protection/fda-food-code.

I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Hazardous Materials and Waste Management Program is designed to identify and manage the risks related to the presence of several types of materials and waste present in the buildings and portions of buildings operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by applying appropriate criteria to materials and waste to determine which have hazards. A Hazardous Material and Waste Management Program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Hazardous Materials and Waste describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Hazardous Materials and Waste Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Medical Office Building, Urology Clinic, Sierra View Community Health Clinic, Clinical Lab, Surgery Clinic and Wound Healing Department of Sierra View Medical Center. The Hazardous Materials and Waste Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. The activities of the Hazardous Materials and Waste Management program are designed based on applicable national, state, and local codes and regulations and the inventory of materials in use and waste generated at each location housing healthcare services of Sierra View Medical Center.

B. The specific activities, environments, protective equipment and engineering controls required to the risk of adverse human or environmental impact related to the handling, use, storage or disposal of materials and waste are determined from Safety Data Sheets (SDS) or other documents provided by suppliers and manufacturers.

C. The four basic management requirements for assuring the minimum potential of adverse human or environmental impact of hazardous materials or hazardous waste include:

1. Appropriate design of space, including installation and maintenance of engineering control systems and other equipment to manage the hazards of the types of materials or waste to be stored in the area.

2. Regular inspection and maintenance of the spaces where hazardous materials or hazardous waste is stored, handled, held for disposal, etc. to assure that all engineering controls are working properly, that proper procedures and controls for the separation, storing, and handling of hazardous materials or hazardous waste are being implemented, and that other equipment is used effectively.

3. Education and training of staff responsible for handling and using any hazardous materials or hazardous waste that addresses the specific hazards of each type and the procedures and controls required to manage those hazards.

4. Development and testing of emergency response procedures designed to minimize the human and environmental impact of any exposure to, release of, or spill of hazardous materials or hazardous waste.

III. OBJECTIVES

A. Develop and maintain a site and area-specific inventory of Hazardous Materials or Hazardous Waste, SDS, and other appropriate documentation for each location housing healthcare services of Sierra View Medical Center.

B. Develop and manage procedures and controls to select, transport, store, and use the identified hazardous materials or hazardous waste.

C. Inspect all areas where hazardous materials and hazardous waste are stored, handled, and disposed of at least annually.

D. Monitor hazardous gases and vapors as required by law, regulation, or industry standards of practice.

E. Educate and train staff about the specific risks of hazardous materials and hazardous waste they use or are exposed to in the performance of their assigned duties and the procedures and controls for managing them.

F. Respond to spills, releases, and exposures to hazardous materials and hazardous waste in a timely and effective manner.

G. Analyze and report all spills, releases, and exposures to hazardous materials and hazardous waste as required by law, regulations, and the incident reporting process of Sierra View Medical Center.

H. Manage the Hazardous Materials and Hazardous Waste Program to assure compliance with the Joint Commission's requirements and other regulatory agency requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer works with the Safety Committee to conduct a risk assessment of hazardous materials and hazardous waste throughout the organization. The results of the risk assessment are used to develop appropriate procedures and controls as the foundation of an appropriate Hazardous Material and Hazardous Waste Management Program is implemented. The Safety Officer also collaborates with the Manager of Safety and Security to develop reports of the Hazardous Material and Hazardous Waste performance for presentation to the Safety Committee on a quarterly basis.

B. The reports summarize organizational experience, performance management and improvement activities, and other Hazardous Materials or Hazardous Waste issues.

C. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste Program from the Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior leaders to assure budget and staffing resources are available to support the Hazardous Materials and Hazardous Waste program.

D. The CEO or designee of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste program. The CEO or designee collaborates with the Safety Officer and other appropriate staff to address Hazardous Materials or Waste Management issues and concerns. The CEO or designee also collaborates with the Safety Officer to develop a budget and operational objectives for the Hazardous Materials and Waste program.

E. The Director of Environmental Services, staff and selected outside service company staff schedule and complete all activities required to assure safe, effective management of hazardous chemical waste and regulated medical waste.

F. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE HAZARDOUS MATERIALS AND WASTE PLAN

EC.01.01.01 EP6 – Management Plan for Hazardous Materials & Waste

The Hazardous Materials and Waste Management program is described in this management plan. The Hazardous Materials and Waste Management plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse Hazardous Material (HAZMAT) event.

EC.02.02.01. EP1 – Identifying and Inventorying Hazardous Materials & Hazardous Waste

The manager(s) of the components of the Hazardous Materials and Waste Program develop criteria based on law, regulation, or industry standards to identify the types of HAZMAT addressed by this program.

The manager(s) of the components of the Hazardous Materials and Waste Program participate in the proactive risk assessment with the Safety Committee to coordinate the development of a departmentalized inventory of hazardous materials and waste. The inventory lists the quantities, types, and location of hazardous materials and waste found in each department. The list includes chemicals, chemotherapeutic materials, and radioactive materials, regulated medical waste including medical sharps, gases and vapors. The inventory is updated at least annually.

The inventory of Hazardous Materials or Hazardous Waste is used to develop procedures and controls for selecting, handling, storing, transporting, using, and disposing. It is the policy of Sierra View Medical Center to use the least hazardous materials that are effective for their intended purpose.

EC.02.02.01 EP3/4 – Emergency Response Procedures

The manager(s) of the Hazardous Materials and Hazardous Waste components develop and maintain written emergency procedures and controls designed to assure rapid, effective response to spills and releases or exposures.

The emergency procedures and controls are designed to evaluate spills to determine if outside assistance is necessary. Incidental spills are managed by staff with training appropriate to the type of spill. All spills are documented as incidents.

Spills exceeding the capability of the trained staff of Sierra View Medical Center to neutralize the hazard and to manage the clean-up and disposal of the waste generated require implementation of the Code Orange hazardous materials emergency response plan.

In all such cases, the Incident Commander, or designee, assigns qualified staff to assess the area affected to determine if evacuation, ventilation, isolation, or other actions are required to manage the hazards until a commercial or fire department HAZMAT team arrives on site. The Sierra View Medical Center Incident Commander, or designee, works with the outside Incident Commander to coordinate the procedures for neutralizing and cleaning up the spill in a manner that minimizes human and environmental impact.

The Sierra View Medical Center Incident Commander or designee and the Safety Officer prepare and file appropriate incident reports regarding the Hazardous Materials spill with the Risk Management Department and other outside regulatory agencies as required.

If spill kits, personal protective equipment, or other equipment and supplies were expended during the management of a hazardous material spill, the Safety Officer is responsible for acquiring and stocking replacements to appropriate areas.

EC.02.02.01 EP5 – Hazardous Chemicals

Hazardous chemicals and chemical waste are managed in accordance with the organization procedures and controls and applicable laws and regulations from the time of receipt to the point of final disposal. The inventory of hazardous chemicals is maintained by the Safety Officer. The inventory for each department is maintained in a departmental log. The Safety Data Sheets corresponding to the chemicals in the inventory are available through an online electronic service and a fax on demand option for the same service. In addition, a complete set of current Safety Data Sheets is maintained by Environmental Services. Some department managers may choose to maintain hard copies of Safety Data Sheets for training and for immediate access due to the high risk of a spill or exposure related to normal daily operations.

The manager of each department with an inventory of hazardous materials implements the appropriate procedures and controls for the safe selection, storage, handling, use and disposal of them.

The procedures and controls include use of Safety Data Sheets to evaluate products for hazards before purchase, orientation and ongoing education and training of staff, management of storage areas, and participation in the response and analysis of spills and releases of or exposures to Hazardous Materials or Hazardous Waste.

The Director of Laboratory Services maintains an inventory of all laboratory chemicals as part of the Chemical Hygiene Plan. The plan is available for reference at all times. The Director of Laboratory Services is responsible for maintaining the plan, including an up to date reference library of Safety Data Sheets.

EC.02.02.01 EP6 – Radioactive Materials

Radioactive materials are managed by the Radiation Safety Officer (RSO). The RSO is responsible for assuring that all areas where radioactive materials are used are maintained in compliance with applicable Nuclear Regulatory Commission regulations.

All areas where radioactive materials are stored and where wastes are decayed are secured from entry by unauthorized staff. All second and third shift deliveries of radioactive materials by representatives of outside radio-pharmacy companies are monitored by the on duty RSO. A log of each delivery is maintained.

Spills of and unwanted exposures to radioactive materials are managed by the RSO. Appropriate decontamination, monitoring, and treatment of any contaminated or exposed persons are managed by a qualified member of the medical staff or by referral to a qualified physician.

Reports of spills and exposures are reported to the Environmental Safety Committee and to outside agencies in accordance with applicable regulations.

If any outside inspections result in findings of inappropriate management of radioactive materials, the RSO shall develop and implement a plan of correction as soon as possible.

EC.02.02.01 EP7 – The hospital minimizes risks associated with selecting and using hazardous energy sources

All equipment that emits ionizing and non-ionizing radiation is inventoried as part of the Medical Equipment Management Program.

The energy emitted by each piece of equipment is analyzed to determine the hazards posed to patients, staff and licensed independent practitioners.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what procedures and controls are required to minimize the risks. All staff and licensed independent practitioners who work with or around hazardous energy sources are oriented and trained to develop an understanding of how to perform work related tasks or how to interact with the environment where the source of the hazardous energy is in use. Staff and licensed independent practitioners are also provided with appropriate personal protective equipment including energy monitoring devices when appropriate.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what quality control programs are required to manage each type of hazardous energy source and for conducting any required quality control measurement, maintenance, calibration, testing, or monitoring.

When equipment or staff performance does not meet established standards, the Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for taking action to address the identified deficiencies.

EC.02.02.01 EP8 – The hospital manages risks associated with disposing of hazardous medications

As part of the Hazardous Materials and Waste program, the Director of Pharmacy and the Nursing Directors of Oncology and Medical Surgical departments are responsible for the safe management of dangerous hazardous medications including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of hazardous medications. All materials mixed on site are managed in accordance with applicable regulations for assuring product safety and purity. All hazardous medications are managed at the bedside to assure that the

materials, doses, and patients are all correct before any are administered. All hazardous medication waste including the material, tubing, bags, syringes, needles, etc. are disposed of in containers designed for and labeled as hazardous medication waste. Spills of hazardous medications are cleaned up by a trained member of the nursing staff. Spills ≥5 cc will be cleaned up by the HAZMAT First Responder team following appropriate procedures.

All staff exposed to hazardous medications is offered the option of treatment through the employee health program.

EC.02.02.01 EP1 & IC.02.01.01 EP6 – Management of Infectious and Regulated Medical Waste Including Sharps

Regulated medical waste are managed by the Environmental Services (EVS) department, which distributes and collects appropriate containers for collection for regulated medical waste and medical sharps. The containers are leak proof and puncture resistant.

The Environmental Services staff is responsible for collecting the filled containers and transporting them to a holding room.

The containers are then transported to a processing facility where the materials are sterilized and rendered unrecognizable. Once the materials are rendered harmless they are disposed of in accordance with applicable community waste regulations.

Any staff member, patient, or visitor exposed to regulated medical waste or suffering a subcutaneous injury related to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.

All spills of blood or body fluids will be cleaned up by nursing or environmental services staff. The areas affected will be sanitized following appropriate procedures for the material involved.

EC.02.02.01 EP9 – 10 – Management of Hazardous Gases and Vapors

The Director of Environmental Services and the Laser Safety Officer is responsible for identifying needs for monitoring gases and vapors. Monitoring requirements and action levels are determined from regulations and industry standards. In addition to chemical gases and vapors, the vapors related to the use of electro-cauterizing devices and lasers during surgical procedures are considered to be hazardous.

The Director of Environmental Services is responsible for identifying all locations requiring monitoring, appropriate test methods, and the appropriate standards against which results of monitoring are compared.

Results of monitoring are documented and reported to the Safety Committee as part of the quarterly report of Hazardous Materials and Hazardous Waste activities.

If a monitored level is higher than the regulatory or industry standard action level, staff activity in the area is suspended or staff is supplied with appropriate protective equipment until the conditions that caused the excessive level are corrected.

EC.02.01.01 EP11 – Management of Permits, Licenses and Manifests

The Director of Environmental Services will maintain all required permits and licenses which are updated as required. Copies of the permits and licenses are posted in areas as required by law or regulation.

The Director of Environmental Services will maintain copies of all manifests required by law or regulation. The manifests are reviewed monthly to assure copies are returned from haulers. If a required manifest copy is not returned from the hauler within 30 days, the appropriate manager contacts the hauler. If a required manifest copy is not returned within 90 days, the affected manager reports the deficiency to the appropriate agency for follow-up action.

EC.02.01.01 EP12 – Labeling of Hazardous Materials and Waste

All staff using hazardous materials or managing hazardous waste are required to follow Federal DOT regulations for labeling. The team conducting environmental tours evaluates compliance with labeling requirements. Deficiencies are reported to appropriate managers for immediate follow-up, including re-education of the staff involved.

EC.02.02.01EP17-18 – The Hospital Monitors Radiation Exposure of Radiology Staff

The Radiation Safety Officer will review staff dosimetry monitoring on at least a quarterly basis to assess whether staff radiation exposure levels are "as low as reasonably achievable and below regulatory limits. The findings are reported to the Radiation Safety Committee for review.

EC.02.02.01EP19 – Routine Storage and Disposal of Waste

The Environmental Services Department will collect, transport, and dispose of regular waste in accordance with all state and local regulations.

EC.04.01.01.1 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.

The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety (PIPS) Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management sections of the Environment of Care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks.

The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include

aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, benchmarking programs, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The Safety Officer is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership, or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the Environment of Care Management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement. All final improvement reports are summarized as part of the annual review of the program and is presented to hospital, performance improvement, and patient safety leadership.

Goal:

Continue to work with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. The current rate is at the 72nd percentile in the Osborne Engineering Benchmarking Database.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the Environment of Care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department with assistance from the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care Manager, department heads, the Vice President of Quality and Regulatory Affairs the Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee.

When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission. Comprehensive Accreditation Manual for Hospitals. (2023) EC 01.01.01 EP6 Oakbrook Terrace, IL.

CROSS REFERENCES:

- CODE ORANGE- INTERNAL HAZARDOUS MATERIALS SPILL

SUBJECT: **LIFE SAFETY MANAGEMENT PLAN**	SECTION: ***Life Safety Management*** **Page 1 of 10**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Life Safety describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Center, Wound Healing Center, Urology Clinic, Clinical Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. All buildings of Sierra View Medical Center housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the National Fire Protection Association (NFPA) Life Safety Code.

B. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.

C. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.

D. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

III. OBJECTIVES

A. Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.

B. Conduct required fire drills in all buildings of Sierra View Medical Center that house patient care services.

C. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.

D. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2012 edition of the NFPA Life Safety Code.

E. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer assures that an appropriate maintenance program is implemented. The Safety Officer also collaborates with the Safety Officer, Facilities Manager and Manager of Environment of Care to develop reports of Life Safety Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.

B. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

C. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Life Safety Management program.

E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address fire safety

issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Life Safety Management Program.

V. ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN

EC.01.01.01 EP7 – Life Safety Management Plan

The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse outcome in the event of a fire.

EC.02.01.01 EP1 – Processes for Protecting Building Occupants and Property

The Facilities Manager and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.

Design

The Safety Officer, Facilities Manager and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Sierra View Medical Center.

Management

The Facilities Manager oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.

The Facilities Manager is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

Fire Response Process

The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Sierra View Medical Center. The current fire response plan is based on the "RACE" principle (remove from immediate

danger, activate alarms, confine fire, extinguish or evacuate area). Area-specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.

EC.02.01.03 – The hospital prohibits smoking on all facility grounds

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

EC.02.03.01 EP4 – The hospital maintains free and unobstructed access to all exits

Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director of the area where the deficiency was identified, the Safety Officer, and the Safety Committee.

Repeated violations are evaluated to determine the probable cause and to develop a solution. Directors, where there are multiple violations over a 12 month period of time, may face disciplinary action through the Human Resources process.

EC.02.03.01 EP9 – The hospital has a written fire response plan

The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE (Rescue/Remove, Alert/Activate, Confine, and Extinguish/Evacuate) response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service-specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.

The department and area-specific fire response plans include information about:

1. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.

2. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

   Note: Sierra View Medical Center believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many

volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

3. Operation of the fire alarm system

4. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff

EC.02.03.03 EP1 – 7 Fire Drills

A comprehensive fire response plan is designed to each specific building or portion of a building housing care, treatment, or service areas owned or operated by Sierra View Medical Center. Each fire plan is modified to address physical limitations of occupants and features of the occupied spaces. All staff is educated about the general fire response procedure and the specific manner in which it is applied in assigned work areas.

Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.

If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.

All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.

EC.02.03.05 EP1 – 28 - Inspection, Testing, and Maintenance of Fire Safety Systems

The Facilities Manager works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards.

When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be

corrected. All ILSM plans are monitored for effect, and documentation demonstrating compliance with the plan is maintained by the Safety Officer.

LS.01.01.01 EP1 – Life Safety Management

The Safety Officer is responsible for maintaining the Statement of Conditions. The Safety Officer prepares a quarterly report of the rate of completion of any Plan for Improvement/Requirement for Improvement for the Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Safety Officer is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.

LS.01.02.01 EP1 – 15 – Management of Fire Safety Risks

A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed. The Facilities Manager and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.

The Safety Officer and Facilities Manager are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Facilities Manager take appropriate action to resolve the deficiencies.

All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center.

Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting

bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care Program for the preceding calendar year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, The Board of Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the leadership of the hospital, performance improvement, or patient safety concurs with Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.

GOAL:

Complete the Fire Alarm System upgrade and test all devices to ensure full coverage of the main facility.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1& EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department assisted by the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.01.01.01 EP7 Joint Commission Resources. Oak Brook, IL.

- National Fire Protection Association (NFPA) Life Safety Code 2012 Edition. Retrieved from https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/Codes-and-Standards.

CROSS REFERENCES:

- FIRE RESPONSE PLAN

SUBJECT: **MEDICAL EQUIPMENT MANAGEMENT PLAN**	SECTION: ***Medical Equipment Management*** **Page 1 of 11**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center (SVMC) present unique challenges. The specific medical equipment risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Medical Equipment Management plan, based on various risk criteria, including risks identified by outside sources such as The Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Medical Equipment Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Medical Equipment Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Medical Equipment Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services, and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted staff and services of Sierra View Medical Center.

II. PRINCIPLES

A. Selection of appropriate equipment to support the services of Sierra View Medical Center is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

B. Orientation, education, and training of operators of medical equipment are an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

C. Assessment of needs for continuing technical support of medical equipment and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that medical equipment is safe and reliable.

D. Effective management of medical alarms is a critical part of the patient safety program.

III. OBJECTIVES

A. Use established criteria to identify unique equipment risks. The identified risks are used to develop appropriate procedures and controls for maintenance and orientation and education programs.

B. Identify and respond appropriately to equipment hazards and recall notices in a timely manner.

C. Record, report, and analyze medical equipment problems, failures and user errors.

D. Any event involving medical equipment and resulting in patient injury or death is treated as a Sentinel Event as defined by The Joint Commission. A complete Root Cause Analysis (RCA) is performed for each Sentinel Event.

E. Manage the Medical Equipment Management program to assure compliance with The Joint Commission's requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer is responsible for maintaining the Medical Equipment Management Program. 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.

B. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Medical Equipment Management Program.

C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address medical equipment issues and concerns. The Chief Executive Officer collaborates with the Safety Officer to develop a budget and operational objectives for the Medical Equipment Management Program.

D. The Safety Officer assures that an appropriate Medical Equipment Maintenance Program is implemented.

E. The Safety Officer will develop reports of Medical Equipment Management Performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other medical equipment issues.

F. The biomedical equipment technicians and selected outside contracted service staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of medical equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

V. ELEMENTS OF THE MEDICAL EQUIPMENT PROGRAM

EC.01.01.01 EP8 – Medical Equipment Management Plan

The Medical Equipment Management Program is described in this Management Plan. The Medical Equipment Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse event while being monitored, diagnosed or treated with any type of medical equipment.

EC.02.04.01.EP2 – Written Criteria and Inventory

The Safety Officer is responsible for the development of criteria used to identify risks associated with medical equipment.

The criteria are used to evaluate risks related to the function of medical equipment, physical risks related to the use of equipment, and any history of patient safety issues related to the use of the equipment in the healthcare market.

The Safety Officer is responsible for assuring that all medical equipment is screened at the time of commissioning. The Medical Equipment Management screening procedure is applied, as appropriate, to loaner equipment, demonstration equipment, and equipment owned by physicians or other qualified individuals that is used as part of the care or treatment of a patient in any service of Sierra View Medical Center.

EC.02.04.01.EP3 – Identifying High Risk Inventory

The Safety Officer and the Biomedical Department identifies high risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.

EC.02.04.01 EP4-5 - Inspection, Testing, and Maintenance Intervals

The Safety Officer uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Safety Officer is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

The hospital's activities and frequencies for inspecting, testing, and maintaining the following items are in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Note: Maintenance history includes any of the following documented evidence:

- Records provided by the hospital's contractors
- Information made public by nationally recognized sources
- Records of the hospital's experience over time

EC.02.04.01.EP9 - Emergency Procedures

The Safety Officer and appropriate clinical caregivers collaborate to identify life-critical medical equipment. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient, dependent on the function of the equipment.

The Safety Officer and the caregivers are responsible for developing appropriate resources to manage the response to the failure or disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All medical equipment emergency procedures are reviewed annually.

EC.02.04.01 EP10- Quality Control and Maintenance of Radiologic Equipment

The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET, magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

EC.02.04.03 – Medical equipment is maintained, tested, and inspected

The Safety Officer ensures that all medical equipment is inspected, tested and maintained.

EC.02.04.03 EP1 - Equipment Inventory and Initial Testing

The Safety Officer and the Manager of the Environment of Care establishes and maintains a current, accurate, and separate inventory of all equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center, leased and rented equipment, and personally owned equipment used for the diagnosis, treatment, and monitoring of patient care needs.

The Safety Officer assures effective implementation of the program of planned inspection and maintenance. All equipment in the program is tested for performance and safety prior to use on patients.

EC.02.04.03 EP2 - Testing of High Risk Equipment

The Safety Officer assures that scheduled testing of all life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.04.03 EP3 - Testing of Non-High Risk Equipment

The Safety Officer assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter.

If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.04.03 EP4 - Testing of Sterilizers

The Director of Surgical Services, staff and contracted service providers are responsible for testing and maintenance of all types of sterilizers used in Sierra View Medical Center. Records of load testing and regular maintenance are maintained by the Director of Surgical Services. Any improper results are documented as patient safety incidents and reported to Risk Management for evaluation and action.

EC.02.04.03 EP5 - Testing of Dialysis Water Systems

The Director of Acute Renal Services is responsible for maintenance of dialysis equipment used in Sierra View Medical Center. The program of maintenance includes regular cleaning and disinfection of all dialysis equipment and testing for compliance with biological and chemical standards for the dialysis water supply. All out of range results will be documented as patient safety incidents and reported to Risk Management for evaluation and action. Any event resulting in a patient injury or death will be treated as a Sentinel Event.

EC.02.04.03 EP16- Testing & Calibration of Nuclear Medicine Equipment

Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented.

EC.02.04.03 EP18- Quality of Radiological Images

The Hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. (See also EC.02.04.01, EP 10)

EC.02.04.03 EP20- Dosage Measurements

The Director of Radiology ensures that for diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: (1) Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. (2) Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.

EC.02.04.03 EP21- Evaluation of Computed Tomography (CT) Equipment

For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: 1) Imaging uniformity 2) Slice thickness accuracy 3) Slice position accuracy (when prescribed from a scout image) 4) Alignment light accuracy 5) Table travel accuracy 6) Radiation beam width 7) High contrast resolution 8) Low contrast resolution 9) Geometric or distance accuracy 10) CT number accuracy and uniformity 11) Artifact evaluation .

EC.02.04.03 EP22- Evaluation of Magnetic Resonance Imaging (MRI) Equipment

At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity for all radiofrequency (RF) coils used clinically (2) Signal to noise (SNR) for all coils used clinically (3) Slice thickness accuracy (4) Slice position accuracy (5) Alignment light accuracy (6) High contrast resolution (7) Low contrast resolution (or contrast to noise ratio) (8) Geometric or distance accuracy (9) Geometric or distance accuracy (10) Magnetic field homogeneity (11) Artifact evaluation.

EC.02.04.03 EP23- Evaluation of Nuclear Medicine (NM) Equipment

At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and presented to the Radiation Safety Committee. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity/system uniformity (2) High contrast resolution/system spatial resolution (3) Sensitivity (4) Energy resolution (5) Count rate performance (6) Artifact evaluation.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Electronic incident reports are completed by a witnessing staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer, Board of Directors, and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management areas of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care (EC) functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an EC program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each EC program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the leadership of the hospital, Performance Improvement, or Patient Safety concurs with Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

GOAL:

Continue working with Renovo to ensure that the Preventative Maintenance Rate for Non-Life Support Equipment stays at 100%. The current rate is at 98.5% in the Osborne Engineering Benchmarking Database. *Meet with The Safety Officer and Renovo staff to assess and review.*

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment.

The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the EC managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC. 01.01.01 EP8 Joint Commission Resources. Oak Brook, IL

SIERRA VIEW
MEDICAL CENTER

SUBJECT: **SCOPE OF SERVICE - FOOD AND NUTRITION**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The Food and Nutrition Service (FNS) Department demonstrates a consistent endeavor to provide safe, healthy, and acceptable food to patients, staff and visitors and deliver optimal patient care within available resources and consistent with achievable goals.

POLICY:

The FNS Department of Sierra View Medical Center (SVMC) will be open daily from 0500 to 2100 and provide the following services:

1. Patient/Resident Meals – Patients/Residents are provided with three (3) meals a day according to their physician's orders. Patient tray line begins at 0700, 1130 and 1700.

2. Nourishment – Patients/Residents are provided with additional nourishment and snacks as ordered by the doctors or as deemed appropriate for their nutritional care plan by the dietitian. A variety of juices and light snacks (puddings, crackers, soups, etc.) are also available at the unit's nourishment stations. The FNS Department replenishes snacks daily.

3. Cafe Services – Breakfast, lunch, and dinner meals are available for purchase in the cafe for staff and guests.

4. Catered Meals – Catered meals are provided for Board Meetings, Administrative Meetings, Medical Staff Meetings, and other hospital functions noted in the CATERING SERVICES guidelines upon request and approval.

5. Coffee Kiosk – Specialty coffee drinks are available for purchase to staff and guests.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PATIENT CARE AREAS*

PROCEDURE:

1. To serve attractive, satisfying meals prepared under high standards of sanitation and safety.

2. To plan appetizing, well-designed menus that meet the nutritional and therapeutic needs of patients/residents in accordance with physicians' orders.

3. To operate a department that meets and exceeds the standards of federal, state, and local regulatory agencies and The Joint Commission.

4. To foster good interdepartmental relations to enhance the overall quality of patient/resident care.

5. To provide continuing in-service education for all FNS employees to increase their understanding of required job tasks and improve overall skills and performance.

6. To offer nutrition consultation and educational services for patients.

7. To provide nutritional assessments and develop nutrition care plans for those patients/residents requiring nutrition intervention and care.

8. To provide optimum nutrition care while keeping within the prescribed fiscal budget.

Position Corresponding Schedule #	Monday – Friday	Weekend
Director Food & Nutrition Service	0800-1630	On Call
Clinical Nutrition Manager	0800-1630	On Call
Clinical Dietitian	0730-1600	
Clinical Dietitian	0800-1630	0800-1630 /On Call
Clinical Dietitian	0830-1700	
Food Service Lead - #20	1030-2100	1030-2100
Cook #2	0530-1400	0530-1400
Cook #3	0500-1330	0500-1330
Cook #4	1130-2000	1130-2000
Diet Aide #7	0530-1400	0530-1400
Diet Aide #8	0630-1500	0630-1500
Diet Aide #9	1230-2100	1230-2100
Cafe` Cashier #11	0530-1400	0530-1400
Cafe` Cashier #12	0600-1430	0630-1500
Cafe` Cashier #14	1230-2100	1230-2100
Cafe` Coffee Corner #33	0600-1630	
Caterer #10	0700-1530 FLEX	
Food Service Worker #16	0600-1430	0600-1430
Food Service Worker #17	0630-1500	0630-1500
Food Service Worker #18	1230-2100	1230-2100
Food Service Informatics System Specialist	0700-1530	

Scheduled hours may be periodically updated. Current schedules for all food service positions are posted in the kitchen.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. PC.02.02.03, PC.01.02.01, HR.01.06.01. Joint Commission Resources, Oak Brook, IL.

CROSS REFERENCE:

- CATERING SERVICES

SUBJECT: **SECURITY MANAGEMENT PLAN**	SECTION: ***Security*** **Page 1 of 11**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Security Management Program is designed to identify and manage the security risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for a Secure Environment describes the security risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Surgery Clinic, Sierra View Community Health Clinic and Medical Office Building of Sierra View Medical Center. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. Security is a system made up of human assets and technology.

B. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Sierra View Medical Center.

C. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Sierra View Medical Center.

D. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.

E. Staff awareness of security is an essential part of an effective program. Sierra View Medical Center orients and trains all staff to the security program and to techniques for managing security risks related to work areas or daily activities.

III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.

C. Analyze security incidents and occurrences to identify root cause elements of them.

D. Conduct ongoing random security patrols in all areas of the hospital, affiliated medical practices, and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.

E. Present reports of Environment of Care management activities to the Environmental Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Safety/Security Officer coordinates the documentation and presentation of this information.

F. Assure that all departments have current organization-wide and department-specific procedures and controls designed to manage identified security risks.

G. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.

H. Assign qualified individuals to manage the program and to respond to immediate security threats.

I. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.

J. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.

K. Provide timely response to emergencies and requests for assistance.

L. Communicate with law enforcement and other civil authorities as needed.

M. Manage access to the grounds, buildings, and sensitive areas of Sierra View Medical Center.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Security Program from the Environmental Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety/Security Officer.

B. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leadership to assure budget and staffing resources are available to support the Security Program.

C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Security program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address security issues and concerns. The Chief Executive Officer also collaborates with the Safety/Security Officer to develop a budget and operational objectives for the Security Program.

D. The Safety/Security Officer works under the general direction of the Chief Executive Officer or designee. The Safety Officer, in collaboration with the Environment of Care/Safety and Security Manager, is responsible for managing the Security Program. The Safety/Security Officer reports program findings to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.

E. Department Directors are responsible for orienting new staff members to the department and job and to task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department Directors are also responsible for participating in the reporting and investigation of incidents occurring in their departments.

F. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

V. ELEMENTS OF THE SECURITY PLAN

EC.01.01.01 EP1 – Appointment of Security Leadership

The Chief Executive Officer of Sierra View Medical Center appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program.

The Safety Officer coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Safety Officer job is defined by a job description. The Chief Executive Officer or designee evaluates the competence of the Safety/Security Officer annually.

The Safety Officer maintains a current knowledge of laws, regulations, and standards of security. The Safety Officer also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time that any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors, or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

EC.01.01.01 EP5 – Management Plan for a Secure Environment

The Security Management Program is described in this management plan. The Security Management Plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse security event.

EC.02.01.01 EP1 – Proactive Risk Assessment

The Safety Officer of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

The Safety Officer works with Department Directors and Managers, the Patient Safety Officer, Risk Coordinator, the Vice President of Quality and Regulatory Affairs and others as appropriate.

EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified security risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.

LD.04.01.07 EP1 – Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job specific environmental safety procedures and controls.

The organization wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by Department Directors. The Department Directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures and controls. Department Directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Safety Officer coordinates the reviews of procedures with department heads and other appropriate staff.

EC.02.01.01 EP7 – Identification of Patients, Staff, and Others Entering the Facility

The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.

The current systems in place at Sierra View Medical Center include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.

The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems. It also includes functional identification of patients who are fall risks, have allergies to medications or nutritional products, have DNR orders or Advance Directives, who are undergoing surgery, who are receiving blood or blood products, and who are security risks.

The identification of others entering Sierra View Medical Center is managed by the Security and Materials Management Departments. The Safety Officer, in collaboration with the Chief Executive Officer and other appropriate staff, manages the procedures for identification of contractors and visitors. The Director of Materials Management manages the procedures for identification of vendors. The Safety Officer takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to Sierra View Medical Center.

Sierra View Medical Center requires all guests/visitors on Sierra View Medical Center premises to wear authorized colored identification wristbands indicating the date and the area or department they are visiting or rendering services from:

- White – Radiology/Lab
- Orange – Distinct Part Skilled Nursing Facility (DPSNF)
- Purple – Cath Lab
- Yellow – Emergency Department
- Blue – Post Anesthesia Care Unit (PACU)/Surgery
- Red – Intensive Care Unit (ICU)/Telemetry
- Green – Medical Surgical Unit
- Pink – Women's Services

EC.02.01.01 EP8 – Identification and Management of Security Sensitive Areas

The Safety Officer is responsible for identifying security sensitive areas, and controls access to and from the security sensitive areas.

The following areas have been designated as sensitive areas:

- Cashiers Window
- Emergency Department
- Human Resources
- Labor & Delivery
- Women's Services

- Pharmacy
- Information Services
- Health Information Management (HIM)
- Medication Rooms
- OTHERS as deemed necessary

Staff in each sensitive area participates in intensive training addressing the unique risks of the area and the procedures and controls in place to manage them. The Safety Officer assesses the need for reinforcement of department level education on an annual basis.

EC.02.01.01 EP9 – Management of Security Incidents Including an Infant or Pediatric Abduction

The Safety Officer has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Safety Officer or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

The responding officers use appropriate written procedures and techniques, including use of force, to bring security incidents under control and to restore order.

The Safety Officer and the Vice President of Patient Care Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

The Safety Officer and the Clinical Directors of Neonatal and Pediatric Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works

with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Environment of Care Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer and other leaders, including the Board of Directors, as appropriate.

The Safety Officer works with the Security Supervisor and the Safety Committee to collect information about Security deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement/Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule.

The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to the Board of Directors, Senior Leadership and Quality and Patient Safety leadership.

GOAL:

Continue to work on reducing Assaults and Batteries Against Patients, Employees and Visitors to the 50th percentile in the Osborne Engineering Benchmarking database. The current rate is at the 92nd percentile. *Work with Security and staff on appropriate times to call a Code Gray to help minimize harm.*

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, contract staff, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as contract staff, volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses the changes to the policies, procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate

how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.01.01.01 EP5 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- WORKPLACE VIOLENCE PREVENTION PLAN

SUBJECT: **SHELTER-IN-PLACE PLAN**	SECTION: ***Emergency Operations Manual*** **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of this plan is:

- To direct the activities required to implement sheltering-in-place, partial evacuation/internal relocation or full evacuation
- To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation
- To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the Hospital Incident Command System (HICS)

DEFINITIONS:

1. **Shelter in Place**: A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP.
   - When SIP is done in an active shooter or active threat situation, it can be called Defend in Place. Refer to *"Code Silver" Person with Weapon or Active Shooter*.

2. **Evacuation**: The movement of patients, personnel and visitors from a dangerous location to one of relative safety.
   - Partial Evacuation or Relocation: Movement within the facility.
   - Horizontal Evacuation: Evacuation on the same floor, often to the other side of a set of fire barrier doors.
   - Vertical Evacuation: Evacuation to a safe place on another floor, can be upward or downward.
   - Total or Complete Evacuation: The full evacuation of a facility to an outside area which may also require transfer of patients (and possibly personnel) to another healthcare facility or alternate site.

3. **Emergent Evacuation**: An evacuation that is conducted in quick response to an acute emergency.

4. **Planned or Phased Evacuation**: An evacuation that is conducted in a planned or phased manner in response to an impending emergency such as wildfire or flood.

5. **Refuge Area**: A location within a building that is identified as having relative safety. May be used in SIP situations or partial evacuation/relocation.

6. **Assembly Point or Collection Area**: A pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

POLICY:

- Sheltering-in-place, relocation, and evacuation activities:
  - May occur as standalone response or may be implemented in a progression, if necessary, as the incident evolves

- May be implemented in a proactive response to impending hazards
- May be implemented in response to an acute incident

- The following are examples of factors that could lead to activation of the shelter-in- place / relocation / evacuation plan:
    - Loss of environmental support services including heating, water, air conditioning, sterilization, electrical power, and medical gases.
    - Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.
    - External emergencies including natural and man-made disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminated victims/toxic agents, radiation exposure, explosions and police actions.

- The evacuation of the facility shall only be initiated as a last resort in response to disruption of services caused by an internal or external disaster.

- The responsible individual for the activation and implementation of this plan is the Incident Commander or designee.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

EQUIPMENT: *N/A*

REFERENCES:

- Evacuation and Shelter in Place Guidance for Healthcare Facilities (April 17, 2012). Retrieved from https://www.calhospitalprepare.org/sites/main/files/file-attachments/evac_sip_ii_0.pdf.

- The Joint Commission (2023). Hospital accreditation standards. EM.15.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Activation of the Command Center
- "Code Silver" Person with Weapon or Active Shooter

SUBJECT: **UTILITY SYSTEMS MANAGEMENT PLAN**	SECTION: **Page 1 of 11**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria, including risks identified by outside sources such as the Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center (SVMC), Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.

B. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

C. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

III. OBJECTIVES

Design, operate and maintain utility systems serving the buildings that house the healthcare services of Sierra View Medical Center to provide a safe, comfortable, appropriate environment that supports patient care and business operations.

Perform recommended maintenance to maximize system service life and reliability.

Manage the Utility Systems Management program to assure compliance with the Joint Commission requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Facilities Manager assures that an appropriate utility system maintenance program is implemented. The Facilities Manager also collaborates with the Safety Officer to develop reports of Utility Systems Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.

B. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Facilities Manager and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leaders to assure budget and staffing resources are available to support the Utility Systems Management program.

C. The Hospital's Chief Executive Officer receives regular reports of the activities of the Utility Systems Management program. The Chief Executive Officer collaborates with the Facilities Manager and other appropriate staff to address utility system issues and concerns. The Chief Executive Officer collaborates with the Facilities Manager to develop a budget and operational objectives for the program.

D. The facility maintenance technicians, and selected outside service company staff, schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

E. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. PROCESSES OF THE UTILITY SYSTEMS PLAN

EC.01.01.01 EP9 – Plan for the Safe, Reliable, Effective Operation of Utility Systems

The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of Sierra View Medical Center may experience an adverse event while being monitored, diagnosed, or treated

with any type of medical equipment or being housed in an environment supported by the utility systems of Sierra View Medical Center.

EC.02.05.01 EP1 – Design and Installation of Utility Systems

The Facilities Manager works with qualified design professionals, project managers, and the intended end users of the space of Sierra View Medical Center to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of Sierra View Medical Center. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

EC.02.05.01 EP3 –Developing an Inventory of Utility Systems and Equipment

All utility systems' components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

EC.02.05.01 EP4 – Determining System Risk

The Facilities Manager identifies high-risk, operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High-risk, operating components of utility system include life-support equipment.

EC.02.05.01 EP5 & EP6 – Inspection, Testing, and Maintenance Intervals

The Facilities Manager uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Facilities Manager is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

EC.02.05.02 EP1- – Management of Water Systems

The Facilities Manager and the Manager of Infection Control are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.

Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.

The Facilities Manager and the Manager of Infection Control are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.

The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.

EC.02.05.01 EP15 & EP16 – Management of Ventilation Systems

The Facilities Manager and the Manager of Infection Control are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.

Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.

The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum, flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.

Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Facilities Manager and Manager of Infection Control develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

EC.02.05.01 EP17 – Mapping of Utility Systems

The Facilities Manager is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.

Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on disc or on the Intranet server of the hospital.

EC.02.05.01 EP9 – Labeling of Controls for System Shutdown and Recovery

The Facilities Manager is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.

The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

EC.02.05.01 EP9 – 13 – Emergency Procedures

The Facilities Manager and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.

The Facilities Manager and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All utility systems emergency procedures are reviewed annually.

EC.02.05.03 EP1 – 7 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems

The Facilities Manager is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. Sierra View Medical Center uses battery-powered lights, engine-

driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.

Each required battery-powered emergency lighting device is tested for 30 seconds each quarter and for 90 minutes annually.

The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that, if disrupted, would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.

The Facilities Manager is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and the essential electrical system is functional again.

Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by National Fire Protection Association (NFPA) 99, NFPA 101 and NFPA 110.

Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Facilities Manager, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

EC.02.05.05 EP2 - Utility Systems Inventory and Initial Testing

The Facilities Manager establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center and leased or rented equipment.

The Facilities Manager is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

EC.02.05.05 EP4 - Testing of High Risk Equipment

The Facilities Manager assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP5 - Testing of Infection Control Support Equipment

The Facilities Manager assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP6 - Testing of Non-High Risk Equipment

The Facilities Manager assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.09 EP7 - Medical Gas System Testing

All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the 2012 edition of NFPA 99.

UM.EC.02.05.09 EP10 - Modifying / Repairing Medical Gas Systems

When a new medical gas system is installed or an existing system is breached for any reason, the Facilities Manager coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the 2012 edition of NFPA 99. The Facilities Manager maintains a permanent record of all certification testing.

EC.02.05.09 EP11 - Labeling & Accessibility of Medical Gas Controls

The Facilities Manager is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.

In addition, the Facilities Manager is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.

EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Administrative Director of Quality and Care, who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Senior Leaders, and the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities.

The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Environmental Safety/Security Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, the Board of Directors, Department Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership, and Vice President of Quality and Regulatory Affairs concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

Goal:

Work with Engineering to improve the Preventative Maintenance quarterly completion rate to 100%. The current rate is 98% in the Osborne Engineering Benchmarking Database.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC 01.01.01 EP9 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES**	SECTION: *Utilities Management* **Page 1 of 32**

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PURPOSE:

Utility system operational plans are written to help ensure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Written Operational Plans

- *Management of failure*
- *User and operator training*

As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system must be evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturer's recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

The preventive maintenance program consists of training of operating and maintenance personnel to familiarize them with the program and to train them to acquire data useful for analyzing the performance of utility systems. Management of the utility systems must identify key indicators of equipment and personnel performance.

Job training is provided by individuals with appropriate technical and/or educational backgrounds in the organization, along with outside training seminars and educational programs. The training is designed to customize basic technical skills to the medical center's needs. Training is central to maintaining system reliability and to protecting the health and safety of all those affected by the systems

- The Administrative Director of General Services is responsible for the proper and safe functioning of all equipment within the facility and the condition of the facility generally. It is therefore the responsibility of the Engineering Manager to maintain awareness of the activities within the facility.
- Engineering Services requires that written procedures shall be developed that specify the action to be taken during the failure of essential equipment and major utility services. The written procedures shall include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services shall be included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, and humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and medical gas and vacuum systems. Qualified engineering consultative advice should be available as

needed.

- The Administrative Director of General Services should be notified first when a disruption of service occurs, but in the event of his absence, this system gives Administration and other department heads a greater idea of who is best qualified to handle the situation.
- In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then Administration, the Administrative Director of General Services, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

UTILITY FAILURE DEFINITIONS:

Equipment/Utilities Failures Reports should be completed for the following Utilities Failures:

Loss of Electrical Power

- One breaker in a distribution panel which would shutdown a whole area.

Failure of Emergency Generator and/or Emergency Power Distribution System

- Any contamination of fuel source, switch gear malfunction, or power interruption lasting 10 seconds or more. Any failure or shutdown during weekly testing or actual use.

Failure of Fire Alarm System

- Loss or unscheduled shutdown of a zone.

Failure of Fire Protection System

- Loss or unscheduled shutdown of a zone.

Elevator Failure

- When more than two out of four elevators are inoperable for more than eight hours.

Failure of Vertical Lifts

- When a dumbwaiter is inoperable for more than 72 hours.

Failure of Communication System

- PBX and Paging System: Any area loss of overhead paging.
- Telephone System: Failure of any one switch on the telephone system or loss of any card.

Failure of Nurse Call System

- Any zone failure of more than eight rooms.

Failure of Blood, Bone, and Tissue Storage Systems

- Any loss of temperature above 6 degrees C for longer than two hours.

Failure of HVAC System

- Any unscheduled total shutdown of chillers or a major air handling unit.

Failure of Medical Air System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Vacuum System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Oxygen System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Medical Gas Nitrous Oxide System

- Any failed test of the system, contamination of the system, or when an alarm occurs due to other than testing or scheduled maintenance on the system.

Failure of Natural Gas System

- Any unscheduled shutdown of the system.

Failure of Boiler System

- When water temperature falls 15 degrees below steeping or when alarm goes off.

Failure of Water Distribution System

- Contamination of the potable water supply or an unscheduled shutdown of the main riser for more than one hour.

Failure of Plumbing System

- Unscheduled shutdown of the main riser for more than one hour.

SUBJECT: OUTSIDE VENDOR ASSISTANCE

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

OUTSIDE VENDOR ASSISTANCE:

Outside vendor assistance may be used should an emergency occur beyond the scope of the Engineering Department or if assistance is required due to a utility system failure.

PROCEDURE:

During normal working hours (8:00 A.M. - 5:00 P.M.) (Monday through Friday) notify the Administrative Director of General Services and obtain permission to use outside vendor.

If Administrative Director of General Services is unavailable or does not respond within 15 minutes, notify the Administrator On Call and obtain permission to use outside vendor.

SUBJECT: LOSS OF ELECTRICAL POWER

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The normal/emergency/critical systems for the medical center are supplied by Southern California Edison (SCE) through substations which provide the normal (primary) power source and the alternate (secondary) power source. The emergency distribution is supplied by two (2) sources, normal SCE power and emergency generator power.

Warning signs or indicators of loss of power and failure of emergency power include:

- Total loss of power and lights in all areas
- Warning signs or indicators of loss of external power only include:
    - Loss of most lighting and power in all areas

Reasons for loss of electrical power:

- Disruption in all or part of internal electrical distribution system
- Disruption of external power (utility company equipment)

PROCEDURE: (For loss of power to primary and secondary power sources)

Containment:

- A failure of the normal power source will result in the emergency generators automatically starting and emergency loads automatically transferring to the emergency generators. The generator is managed through an automatic paralleling system and all are diesel powered.
- The Engineer on duty will ensure generator is running properly.
- Notify the Administrative Director of General Services and the Administrator On Call.
- Check to ensure that the generator is running and supplying power to essential areas.
- Monitor generator for any load-shedding requirements.

Resolution:

Determine whether loss of power is due to internal or external disruption.

- Check main electrical distribution panel
- Call utility company

If power loss is due to disruption in the external power source, the Administrative Director of General Services or his designee will contact Southern California Edison to determine and estimate how long outage will last.

Administrative Director of General Services or his designee will notify the following:

- Administrator On Call
- Nursing House Supervisor (after normal business hours)

If power loss is due to disruption in the internal electrical distribution system, identify the problem.

- If emergency generator is on line, identify the distribution panel(s) serving the affected area(s).
- Trace and correct the problem.
- If the problem cannot be resolved immediately, notify the following: Administrative Director of

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General Services Administrator On Call, Nursing House Supervisor, Engineering Manager, and the affected areas.

- If repairs are beyond the scope of the Engineering Department, request assistance from the licensed electrical contractor on the call list.
- Request other outside assistance as necessary.
- Distribute emergency extension cords so power can be supplied from one area to another if there is a critical need (determined by Administrative Director of General Services, Nursing House Supervisor, Administrator On Call).
- When normal utility power has been restored, restart and reset all affected equipment in the power plant, mechanical rooms and other parts of the hospital affected by the power outage.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the loss of electrical power include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF EMERGENCY GENERATOR AND/OR EMERGENCY POWER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

A failure of the normal power source will result in the emergency generator automatically starting and emergency loads automatically transferring to the emergency generator.

PROCEDURE:

In the event of failure of the emergency generator, or if emergency power is not supplied to the essential emergency power system during an electrical power outage, the following procedures as outlined below are to be followed:

Containment:

- Call for assistance and notify key personnel.
- Call generator repair service/request immediate dispatch of service tech
- Notify Administrative Director of General Services
- Notify Nursing Supervisor
- Notify Administrator On Call

Determine reason for generator failure:

- If engine failure, attempt to manually start generator.
- If engine does not start, check starter system.
- Check fuel system for fuel in day tank; refuel from main supply if necessary.
- If generator can be started, check transfer switch for tripping.
- If transfer switch is not tripped, check control panel for fault indicators.
- If no fault indicators, attempt to manually throw transfer switch.
- If transfer switch cannot be manually thrown or a fault is indicated on control panel, call an electrician.
- If transfer switch can be thrown, notify Nursing Supervisor and Administration that the medical center is on emergency power.
- If no malfunction of generator or transfer switch, check for fuel contamination.
- If fuel contaminated, call for immediate dispatch of mobile fuel tanker.

Resolution:

- If directed, call generator supplier for portable generator(s), cables and lugs.
- Notify Nursing Supervisor and Administration for estimated length of power outage.
- Assist service technician to resolve and repair problem.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Emergency Generators or the Emergency Power Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF FIRE ALARM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

The fire alarm system provides fire detection services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- Audible alarms
- Visual observance

Reasons for fire alarm systems failure:

- Neglect
- Vandalism
- Computer malfunction

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- Failure in electrical system

PROCEDURE:

Containment:

In the event of fire alarm systems failure, notify all affected areas including:

- Fire Department
- Administrative Director of General Services or his designee
- Alarm service company
- Alarm monitoring company
- If repairs are beyond scope of service of Engineering Service's staff, call the alarm company and request immediate dispatch of service technician.

Resolution:

- Administrative Director of General Services will post fire watch.
- A log of all fire watch activities will be maintained by Engineering Services.
- Notify Administration and all affected departments of estimated time fire alarm system will be out of service.
- Notify Fire Department, Alarm Monitoring Company, Administration, and all affected departments when repairs have been completed.
- Check with alarm monitoring company to ensure alarm signal is being received.
- Discontinue fire watch.
- File fire log watch activities in Engineering Services.

Evaluation:

- Record incident on Utility Disruption Form.
- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the Fire Alarm System include:

- Maintenance Engineers on all shifts

SUBJECT: ELEVATOR FAILURE/PASSENGER EVACUATION

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

Employees of the medical center who become aware of individuals detained in an elevator, due to an elevator failure, should respond immediately by reporting the incident to maintenance and the Nursing House Supervisor. Maintenance staff will respond to meet the needs of the situation caused by the elevator failure.

ELEVATOR FAILURE:

Elevators serve vertical transportation in all areas throughout the medical center. Warning signs of an elevator failure include:

- Audible alarm
- Sounds of passenger(s) yelling or banging on elevator doors
- Elevator not responding to call buttons

Reasons for elevator failure:

- Power failure
- Failure of relay switches to reset

PROCEDURE:

Containment:

In the event of elevator failure with passenger(s) on board, notify the following:

- Maintenance and Administrative Director of General Services
- Maintenance staff will respond immediately to site of elevator failure.
- If no alarms or signals have been received from the disabled elevator(s), determine if passengers are on board by yelling at the approximate level elevator has stopped.
- Assure passengers that help is on the way.
- If patients are in elevator, communicate with escorting staff to determine if patient must be immediately evacuated.

Resolution:

EMERGENCY EVACUATION:

- If unclear to urgency of evacuation, contact Emergency Room Physician on duty. If the patient must be evacuated immediately, refer to the Emergency Evacuation Plan.
- When it is determined that a patient must be evacuated immediately, contact the elevator service company and request immediate dispatch of a service technician. Stress the urgency of the situation. Call the fire department and notify them that an emergency elevator evacuation is needed.
- Instruct passengers on board (if any) to remain calm and inform them not to attempt to restart elevators with reset button.
- Inform passengers that the Elevator Service Company and Fire Department have been notified and that help is on the way.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure and/or Passenger Evacuation of Elevator(s) include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF COMMUNICATION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The communication system provides telephone and paging services to all parts of all areas of the medical center. Warning signs or indicators of failure include:

- No dial tones
- Poor transmission quality

Reasons for communication systems or paging system failure:

- Equipment malfunction
- Broken transmission lines
- Switch malfunction
- Failure in electrical system

PROCEDURE:

In the event of a malfunction and/or failure of the communications system (telephone and/or paging system), the following procedure will be followed:

Containment:

In the event of communication systems failure, notify all affected areas including:

- Information Technology (IT)
- Maintenance

- Telephone company
- Notify Administrative Director of General Services, who will determine amount of down time and inform Administration, Nursing Services, and all affected departments.
- IT staff with the assistance of maintenance staff will try to identify and correct the problem.

Resolution:

- If repairs are beyond scope of service of IT and Maintenance Service's staff, the Administrative Director of General Services will call the telephone company or the paging system service company and request immediate dispatch of service technician.
- Administrative Director of General Services will assign priority departments with 2 way radios for communication.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Communication System or the Paging System include:

- Information Technology staff
- Maintenance Engineers on all shifts

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