North Central Health Care
Person centered. Outcome focused.

OFFICIAL NOTICE AND AGENDA

of a meeting of the **Quality Committee** to be held at **North Central Health Care, 1100 Lake View Drive, Wausau, WI 54403, Board Room** at **12:00 Noon** on **Friday, December 16th, 2016**

In addition to attendance in person at the location described above, Board members and the public are invited to attend by telephone conference. Persons wishing to attend the meeting by phone should contact Debbie Osowski at 715-848-4405 24 hours prior to the start time of the meeting for further instructions. Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the Administrative Office at 715-848-4405.
For TDD telephone service call 715-845-4928.

1. Call to Order
2. Public Comment for Matters Appearing on the Agenda
3. Consent Agenda
    a. ACTION: Approval of 9/15/16 Quality Committee Meeting Minutes
    b. Outcomes Review
        - Organizational Outcomes
        - Program-Specific Outcomes
        - Adverse Event Data
4. Process Improvement Team Reports
    a. Crisis Improvement Team – L. Scudiere/B. Schultz
5. ACTION: Approval of Safety Plans
    a. Summary of Plans:
        ii. Emergency Management Plan
        iii. Hazardous Materials and Waste Management Plan
        iv. Life Safety Management Plan
        v. Resource Management Plan
        vi. Safety and Security Management Plan
6. CLOSED SESSION - pursuant to Section 19.85(1) (c) and (f) Wis. Stats. for the purpose of considering employment and performance evaluation of any public employee over which the governmental body exercises responsibility, and preliminary consideration of specific personnel problems, which if discussed in public, would likely have a substantial adverse effect upon the reputation of any person referred to in such problems, including specific review of performance of employees and providers of service and review of procedures for providing services by Agency.
    a. Report of Investigations:
        i. Corporate Compliance and Ethics
        ii. Significant Events
7. ACTION: Motion to Come Out of Closed Session
8. Possible Announcements Regarding Issues Discussed in Closed Session – B. Bliven
9. Quality Moving Forward Discussion
10. Discussion of Future Agenda Items
11. Adjourn

Presiding Officer or Designee

NOTICE POSTED AT: North Central Health Care
COPY OF NOTICE DISTRIBUTED TO: Wausau Daily Herald, Antigo Daily Journal, Tomahawk Leader, Merrill Foto News, Langlade, Lincoln & Marathon County Clerks Offices
DATE: 12/09/16 TIME: 4:00 p.m. BY: D. Osowski

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
QUALITY COMMITTEE MEETING MINUTES – OPEN SESSION

September 15, 2016 **10:30 a.m.** **NCHC – Wausau Campus**

Present:	X	Steve Benson	X	Darren Bienvenue	X	Ben Bliven
	X	Heidi Keleske	EXC	Joanne Kelly	EXC	Holly Matucheski
	X	Jeannine Nosko				

Others Present: Becky Schultz, Michael Loy, Kim Gochanour, Laura Scudiere

The meeting was called to order at 10:40 a.m.; roll call noted; a quorum declared.

Public Comment for Matters Appearing on the Agenda
There were none.

Consent Agenda

- **Motion**/second, Bienvenue/Nosko, to approve the consent agenda which includes the 8/19/16 Quality Committee Meeting Minutes. Motion carried.

Outcomes Review

- Organizational Outcomes
    - We are working diligently on the challenges in the nursing home as it relates to turnover and particularly CNA turnover. An Action Group has been established which is looking at the staffing model, scheduling, and retention. Wisconsin is experiencing a shortage of CNA's and area nursing homes have even closed units. We are lobbying the State legislature to improve the reimbursement model as Wisconsin is currently 50th in the nation for reimbursement for Medicaid.
    - Patient experience is also a top priority as the score has remained relatively flat. On average we receive 190 surveys; 67.8% are rating us with a 9 or 10 which still places us in the 40-50th percentile. Of the remaining services 25% rate us at a 7 or 8 and just a handful score us less than a 7.
        - Staff will explore the following: In comparison to other organizations, what percent of those have scores below 7? It was felt that it is important to help staff understand that the majority of individuals are ranking NCHC with 7-10 and the reason the percentile ranking is lower than we would like it is because the parameters are very tight.
        - The Executive Team has discussed possibly changing the target to the percent 9 and 10 ratings rather than percentile rank to provide for better understanding by employees. Various options were discussed. Staff may be recommending changes for 2017.
        - Feedback is also received from families of our patients. Patient Experience Team is working on obtaining more input.

        - A trend that has been identified through comments received has been that the patient didn't feel as involved in the decision-making process as they would like. This information is being used to guide action plans.
    - Tracking fairly well in all other measures. Will be following up with Laura Yarie, Marathon County, to see how we can expand OWI recidivism data to a community-wide goal.
    - Access to behavioral health services has dropped primarily due to the pool being closed for two weeks for cleaning/maintenance.
- Program-Specific Outcomes
    - Committee would like to invite program leaders to attend and review their data for their program.
    - Committee would like to change the format of the agenda to have standard reports in the Consent Agenda to provide for more program-specific review.
    - **Motion**/second, Bienvenue/Nosko, to approve the Organizational and Program-Specific Outcomes including the Organizational Dashboard. Motion carried.

Occurrence Process Review

- Distributed and reviewed summary of the occurrence process.
- Staff is encouraged to report all occurrences no matter how small.
- Significant/reportable events are reviewed in closed session.
- Extensive process is in place to protect patients/clients/residents.
- Occurrence data is collated and presented to the appropriate committees.
- Any significant trends are reported to the Quality Committee.

CLOSED SESSION

- **Motion**/second, Benson/Nosko, to move into closed session pursuant to Section 19.85(1)(c) and (f) Wis. Stats. for the purpose of considering employment and performance evaluation of any public employee over which the governmental body exercises responsibility, and preliminary consideration of specific personnel problems, which if discussed in public, would likely have a substantial adverse effect upon the reputation of any person referred to in such problems, including specific review of performance of employees and providers of service and review of procedures for providing services by Agency. Roll call taken: Yes=5, No=0 Motion carried and moved into closed session at 11:26 a.m.
- **Motion**/second, Benson/Bienvenue, to come out of closed session. Motion carried unanimously.

Possible Announcements Regarding Issues Discussed in Closed Session

- Committee advised staff to inform the full board in a closed session of one of the Adverse Event items that occurred including all actions taken, and to prepare a media action plan in the event the media is informed.

Quality Measures Education

- Will hold for the next meeting.

Process Improvement Project – Crisis Services

- Transportation program had a slight interruption while repairs were needed on the van.
- Data is being gathered and will be presented soon.
- Crisis PI Team will be discussing how to make improvements.
- Another team was created to address crisis needs for youth i.e. being proactive with youth in schools due to an increase in youth crisis assessments. Will be working first with DC Everest; working with students with more frequent crisis needs, continuing discussion on key problem areas such as information sharing and HIPAA. Team has been working with community providers on medical clearance. Team has become very collaborative is working smoothly. The group will be visiting Winnebago to see how we can work together better on medical clearance.
- Dr. Benson recommended utilizing the Medical College for community-wide training on collaboration, etc.

Annual Review of Confidentiality Statements

- Distributed Confidentiality Statements asking each member of the committee to sign and return.

Future agenda items

- No new items noted.

Motion/second, Bienvenue/Keleske, to adjourn the meeting at 11:57 a.m. Motion carried.

dko

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QUALITY OUTCOME DASHBOARD

DEPARTMENT: NORTH CENTRAL HEALTH CARE FISCAL YEAR: 2016

PRIMARY OUTCOME GOAL	Continuous Improvement Target	Benchmark	⇧⇩	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD	2015
PEOPLE																	
Vacancy Rate	6-8%	N/A	⇩	8.0%	5.8%	4.8%	5.2%	3.9%	6.2%	4.7%	7.0%	8.1%	9.2%	11.6%		6.8%	7.6%
Employee Turnover Rate*	20-23%	17%	⇩	19.6%	29.2%	29.3%	28.4%	26.3%	27.6%	28.2%	30.2%	31.0%	30.2%	30.0%		30.0%	28.9%
SERVICE																	
Patient Experience: Satisfaction Percentile Ranking	70-84th Percentile	N/A	⇧	53rd	48th	45th	46th	53rd	48th	42nd	40th	37th	64th	42nd		45th	51st
Community Partner Satisfaction	75-80%	N/A	⇧	\	\	77%	\	\	72%	\	\	70%	\	\		75%	76%
CLINICAL																	
Nursing Home Readmission Rate	11-13%	18.2%	⇩	13.8%	6.7%	12.0%	10.7%	14.8%	21.1%	12.5%	3.2%	8.7%	15.0%	7.7%		11.2%	13.7%
Psychiatric Hospital Readmission Rate	9-11%	16.1%	⇩	12.8%	11.1%	3.2%	5.0%	7.2%	11.4%	11.7%	21.4%	11.5%	10.2%	10.0%		10.5%	10.8%
AODA Relapse Rate	18-21%	40-60%	⇩	30.0%	33.3%	20.7%	25.0%	24.3%	27.3%	36.1%	28.6%	31.8%	0.0%	0.0%		26.7%	20.7%
COMMUNITY																	
Crisis Treatment: Collaborative Outcome Rate	90-97%	N/A	⇧	\	\	\	\	100.0%	97.9%	100.0%	93.6%	83.3%	96.2%			93.7%	N/A
Access to Behavioral Health Services	90-95%	NA	⇧	58%	65%	87%	86%	92%	93%	80%	84%	75%	79%			80%	73%
Recidivism Rate for OWI	27-32%	44.7%	⇩	22.6%	20.5%	29.2%	28.2%	18.2%	7.7%	28.6%	19.4%	20.0%	48.3%			24.4%	26.4%
FINANCE																	
*Direct Expense/Gross Patient Revenue	58-62%	N/A	⇩	71%	65%	66%	64%	65%	67%	67%	60%	60%	62%			65%	63%
Days in Account Receivable	60-65	54	⇩	70	65	64	64	58	53	64	54	53	49			49	68

KEY: ⇧ Higher rates are positive
⇩ Lower rates are positive

*** Monthly Rates are Annualized**

Target is based on a 10%-25% improvement from previous year performance or industry benchmarks.

NCHC OUTCOME DEFINITIONS

PEOPLE	
Vacancy Rate	Total number of vacant positions as of month end divided by total number of authorized positions as of month end.
Employee Turnover Rate	Percent of employee terminations (voluntary and involuntary) of the total workforce. Monthly figures represent an annualized rate. *Benchmark: Society of Human Resource Management (SHRM) for the north central region of the U.S.*
SERVICE	
Patient Experience: Satisfaction Percentile Ranking	Comparison rate (to other organizations in the Health Stream database) of the percent of level 9 and 10 responses to the Overall rating question on the survey. *Benchmark: HealthStream 2015 Top Box Percentile*
Community Partner Satisfaction Percent	Percentage of "Good and Excellent" responses to the Overall Satisfaction question on the survey.
CLINICAL	
Nursing Home Readmission Rate	Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. *Benchmark: American Health Care Association/National Center for Assistive Living (AHCA/NCAL) Quality Initiative*
Psychiatric Hospital Readmission Rate	Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnosis. *Benchmark: Medicare Psychiatric Patients & Readmissions in Impatient Psychiatric Facility Prospective Payment System, May, 2013, The Moran Company*
AODA Relapse Rate	Percent for patients admitted to Ambulatory Detoxification or the Behavioral Health hospital for detoxification then readmitted within 30 days of discharge for repeat detoxification. *Benchmark: National Institute of Drug Abuse: Drugs, Brains, and Behavior: The Science of Addiction*
COMMUNITY	
Crisis Treatment: Collaborative Decision Outcome Rate	Total number of positive responses(4 or 5 response on a 5 point scale) on the collaboration survey distributed to referring partners in each encounter in which a referral occurs.
NCHC Access	% of clients obtaining services within the Best Practice timeframes in NCHC programs. • Adult Day Services - within 2 weeks of receiving required enrollment documents • Aquatic Services - within 2 weeks of referral or client phone requests • Birth to 3 - within 45 days of referral • Community Corner Clubhouse - within 2 weeks • Community Treatment - within 60 days of referral • Outpatient Services - within 14 days of referral • Prevocational Services - within 2 weeks of receiving required enrollment documents • Residential Services - within 1 month of referral
Recidivism Rate for OWI	Percentage of people who receive there OWI services from NCHC and then reoffend. *Benchmark: 2012-OWI Related Convictions by Violation County and Repeat Offender Status, State of Wisconsin DOT, Bureau of Driver Service, Alcohol & Drug Review Unit*
FINANCE	
Direct Expense/Gross Patient Revenue	Percentage of total direct expense compared to gross revenue.
Days in Account Receivable	Average number of days for collection of accounts. *Benchmark: WIPFLI, sources 2015 Almanac of Hospital Financial and Operating Indicators published by Optum-Psychiatric Hospitals, 2013 data.*

2016 - Primary Dashboard Measure List

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
NORTH CENTRAL HEALTH CARE OVERALL	People	Vacancy Rate	⇩	6-8%	**6.8%**	N/A
		Employee Turnover Rate*	⇩	20-23%	**30.0%**	**28.9%**
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	**45th**	51st
		Community Partner Satisfaction	⇧	75-80%	**75.0%**	76%
	Clinical	Nursing Home Readmission Rate	⇩	11-13%	**11.2%**	13.7%
		Psychiatric Hospital Readmission Rate	⇩	9-11%	**10.5%**	10.8%
		AODA Relapse Rate	⇩	18-21%	**26.7%**	20.7%
	Community	Crisis Treatment: Collaborative Outcome Rate	⇧	90-97%	**93.7%**	N/A
		Access to Behavioral Health Services	⇧	90-95%	**80%**	73%
		Recidivism Rate for OWI	⇩	27-32%	**24.4%**	**26.4%**
	Finance	Direct Expense/Gross Patient Revenue	⇩	58-62%	**65.0%**	**63%**
		Days in Account Receivable	⇩	60-65	**49**	**68**

HUMAN SERVICES OPERATIONS

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ADULT DAY/ PREVOCATIONAL/RESIDENTIAL SERVICES	People	Employee Engagement Adult Day/Prevocational/ Residential Percentile Rank	⇧	75-80th Percentile	\	64.5
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	**45th**	51st
		ADS/Prevocational/Residential Services Patient Experience % 9/10 Responses	⇧		**87.2% (177/203)**	86.3%
	Clinical	Community Living Employee's job competency proficiency Rate	⇧	75%-80%	\	N/A
	Community					
	Finance	ADS/Prevocational Direct Expense/Gross Patient Revenue	⇩	51-55%	**50.77%**	66.19%
		Residential Direct Expense/Gross Patient Revenue	⇩	74-78%	**69.35%**	76.33%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
AQUATIC SERVICES	People	Employee Engagement Aquatic Services Percentile Rank	⇧	75-80th Percentile	\	65.2
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	**45th**	51st
		Aquatic Services Patient Experience Percent 9/10 Responses	⇧		**93.7% (178/190)**	94.4%
	Clinical					
	Community	Access to Aquatic Services	⇧	90-95%	**98.7%**	92%
	Finance	Direct Expense/Gross Patient Revenue	⇩	38-42%	**41.19%**	40.61%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
BIRTH TO 3	People	Employee Engagement Birth to 3 Percentile Rank	⇧	75-80th Percentile	\	69.7
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	**45th**	51st
		Birth to 3 Patient Experience Percent 9/10 Responses	⇧		**90.7% (98/108)**	91.6%
	Clinical					
	Community	Access- From time of referral to time of treatment plan development. (45 days)	⇧	90-95%	**99%**	100%
	Finance	Direct Expense/Gross Patient Revenue	⇩	116-122%	**132.5%**	136.73%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
COMMUNITY CORNER CLUBHOUSE	People	Employee Engagement Community Corner Clubhouse Percentile Rank	⇧	75-80th Percentile	\	0.0
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Community Corner Clubhouse Patient Experience Percent 9/10 Responses	⇧		69.8% (81/116)	60.4%
	Clinical	Active Membership Daily Attendance	⇧	25-30%	29.0%	N/A
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	124-130%	68.8%	82.89%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
COMMUNITY TREATMENT	People	Employee Engagement Community Treatment Percentile Rank	⇧	75-80th Percentile	\	67.1
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Community Treatment Patient Experience Percent 9/10 Responses	⇧		81.2% (190/234)	72.9%
	Clinical					
	Community	Access to Community Treatment Services	⇧	90-95%	55%	80%
	Finance	Direct Expense/Gross Patient Revenue	⇩	88-92%	75.4%	83.34%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
CRISIS CBRF/ LAKESIDE RECOVERY (MMT)	People	Employee Engagement Adult Day/Prevocational/ Residential Percentile Rank	⇧	75-80th Percentile	\	56.6
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Crisis CBRF/Lakeside Recovery Patient Experience Percent 9/10 Responses	⇧		77.9% (123/158)	62.1%
	Clinical	At 7 day survey- patient kept their outpatient appointment	⇧	75%	62.70%	N/A
	Community					
	Finance	CBRF Direct Expense/Gross Patient Revenue	⇩	14-18%	16.28%	8.86%
		Lakeside Recovery Direct Expense/Gross Patient Revenue	⇩	287-293%	17.63%	N/A

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
CRISIS SERVICES	People	Employee Engagement Crisis Services Percentile Rank	⇧	75-80th Percentile	\	56.6
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Crisis Services Patient Experience Percent 9/10 Responses	⇧		77.9% (53/68)	78.9%
	Clinical					
	Community	Community Partner Survey	⇧	80-85%	56%	63%
	Finance	Direct Expense/Gross Patient Revenue	⇩	362-368%	242.50%	339.22%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
INPATIENT BEHAVIORAL HEALTH	People	Employee Engagement Inpatient Behavioral Health Percentile Rank	⇧	75-80th Percentile	\	57.3
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Inpatient BH Patient Experience Percent 9/10 Responses	⇧		44.1% (252/571)	46.6%
	Clinical	Medication Errors / Patient Days	⇩	0.15-0.3%	1.77%	N/A
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	47-51%	53.97%	60.66%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
OUTPATIENT SERVICES	People	Employee Engagement Outpatient Services Percentile Rank	⇧	75-80th Percentile	\	64.1
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Outpatient Services Patient Experience Percent 9/10 Responses	⇧		64.5% (367/569)	64.4%
	Clinical					
	Community	Outpatient Services Access	⇧	90-95%	74%	64%
	Finance	Direct Expense/Gross Patient Revenue	⇩	68-72%	87.56%	75.34%

2016 NURSING HOME OPERATIONS

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
MOUNT VIEW CARE CENTER OVERALL	People	Employee Engagement MV Overall Percentile Rank	⇧	75-80th Percentile	\	71.5
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		MVCC Overall Patient Experience Percent 9/10 Responses	⇧		683% (192/281)	72.3%
	Clinical	Fall Rate	⇩	5.5-5.8	5.0	5.80
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	47-51%	61.31%	57.88%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
POST-ACUTE CARE	People	Employee Engagement Post-Acute Care Percentile Rank	⇧	75-80th Percentile	\	66.2
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Post-Acute Care Patient Experience Percent 9/10 Responses	⇧		66.7% (54/81)	71.2%
	Clinical	Fall Rate	⇩	4.2 - 4.5	4.3	4.5
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	65-69%	71.1%	66.39%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
LONG TERM CARE	People	Employee Engagement Long Term Care Percentile Rank	⇧	75-80th Percentile	\	63.6
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Long Term Care Patient Experience Percent 9/10 Responses			53.3% (49/92)	55.9%
	Clinical	Fall Data	⇩	4.5 - 4.8	2.8	4.8
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	47-51%	58.72%	59.27%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
LEGACIES BY THE LAKE	People	Employee Engagement Gardenside - Evergreen Care Percentile Rank	⇧	75-80th Percentile	\	72.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Legacies by the Lake Patient Experience Percent 9/10 Responses	⇧		82.4% (89/108)	88.2%
	Clinical	Fall Rate	⇩	4.4 - 4.7	6.7	4.7
	Community					
	Finance	Legacies Overall Direct Expense/Gross Patient Revenue	⇩	34-38%	51.69%	51.11%

2016 SUPPORT SERVICES

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ADULT PROTECTIVE SERVICES	People	Employee Engagement Adult Protective Services Percentile Rank	⇧	75-80th Percentile	\	85.1
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Adult Protective Services Patient Experience Percent 9/10 Responses	⇧		88.5% (154/174)	89.4%
	Clinical	% Of At Risk Investigations closed within 30 days.	⇧	70-80%	71% (331/468)	68%
	Community					
	Finance	Expense Budget	⇩	$432607 - $458564	$446,544	$442,711

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
COMMUNICATION & MARKETING	People	Employee Engagement Administrative Support/ HR/Communication Percentile Rank	⇧	75-80th Percentile	\	78.4
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community	Facebook Ad Campaign Likes Total	⇧	50-75% Increase	187%	N/A
	Finance	Expense Budget	⇩	$177120 - $187747	$191,210	$187,945

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ESS- HOUSEKEEPING	People	Employee Engagement ESS-Housekeeping Percentile Rank	⇧	75-80th Percentile	\	78.7
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Housekeeping Patient Experience Percent Excellent Responses	⇧		60.1% (172/286)	68.4%
		Weekly room checks	⇧	70-80%	87%	N/A
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$1143725 - $1203922	$1,052,070	$130,342

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ESS - LAUNDRY	People	Employee Engagement ESS -Laundry Percentile Rank	⇧	75-80th Percentile	\	68.3
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Laundry Patient Experience Percent Excellent Responses			42.0% (91/218)	39.9%
		Reduce linen shortages (YTD Average calls)	⇩	10-12 calls	5	N/A
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$392803- $413477	$232,711	$358,188

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ESS - MAINTENANCE - GROUNDS	People	Employee Engagement ESS-Maintenance Percentile Rank	⇧	75-80th Percentile	\	83.4
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Maintenance/Grounds Patient Experience Percent Excellent Responses			55.6% (153/275)	56.4%
		Preventative Maintenance Monthly Service	⇧	80-90%	100%	NA
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$1755207 - $1847587	$1,521,865	$1,530,078

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ESS - TRANSPORTATION	People	Employee Engagement ESS- Transportation Percentile Rank	⇧	75-80th Percentile	\	72.5
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$70818 - $74546	$0	$41,125

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
ENVIRONMENTAL SERVICES OVERALL	People	Employee Engagement ESS Overall Percentile Rank	⇧	75-80th Percentile	\	77.9
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Environmental Services Overall Patient Experience Percent Excellent Responses			53.4% (416/779)	49.0%
		Environmental rounds complete campus monthly	⇧	80-90%	93%	N/A
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$3497290- $3707128	$3,037,483	$3,001,938

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
HEALTH INFORMATION	People	Employee Engagement Health Information Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical	Timeliness of chart completion (BHS/NH records within 25 days post discharge)	⇧	70-75%	90.4%	N/A
	Community					
	Finance	Expense Budget	⇩	$352483 - $373632	$332,933	

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
HUMAN RESOURCES	People	Employee Engagement Administrative Support/HR/Quality Percentile Rank	⇧	75-80th Percentile	\	78.4
		Employee Vacancy Rate	⇩	6-8%	6.3%	N/A
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$935007- $991107	$934,446	$980,778

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
NUTRITIONAL SERVICES	People	Employee Engagement Nutritional Services Percentile Rank	⇧	75-80th Percentile	\	58.5
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		Nutritional Services Patient Experience Percent Excellent Responses	⇧		46.1% (124/269)	45.5%
		Nutritional Services External Customer Satisfaction Survey (HealthStream)	⇧	90-95%	48.8%	45.5%
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$2510068 - $2660673	$2,675,555	$2,673,728

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
PHARMACY	People	Employee Engagement Pharmacy Percentile Rank	⇧	75-80th Percentile	\	68.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical	Pharmacy Medication Error Rate	⇩	0.081%- 0.090%	0.02%	0.050%
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	34-38%	42.27%	41.58%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
QUALITY	People	Employee Engagement Administrative Support/HR/Quality/ Volunteer Percentile Rank	⇧	75-80th Percentile	\	78.4
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical	Percent Significant Events	⇩	2.25-2.5%	2.6%	N/A
	Community					
	Finance	Expense Budget	⇩	$690785 - $732232	$736,840	$569,842

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
Volunteer Services	People	Employee Engagement Administrative Support/HR/Quality/ Volunteer Percentile Rank	⇧	75-80th Percentile	\	78.4
		Net New Volunteers	⇧	24-37	31	N/A
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Direct Expense Budget	⇩	$89,215- $94,568	$96,394	$89,520

2016 - FINANCIAL DIVISION

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
BUSINESS OPERATIONS	People	Employee Engagement Financial & Information Division Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Expense Budget (Annualized)	⇩	$763782 - $809609	$780,598	$706,943.0
		Days in Accounts Receivable	⇩	60-65	49	68

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
DEMAND TRANSPORTATION	People	Employee Engagement Financial & Information Division Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical	Double Occupancy Pick-up (YTD Average)	⇧	11-13	8	10/month Average
	Community					
	Finance	Direct Expense/Gross Patient Revenue	⇩	355-361%	225.81%	205.83%

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
INFORMATION SERVICES	People	Employee Engagement Financial & Information Division Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$2232150 - $2366080	$2,333,608	$2,308,637
		Days in Account Receivable	⇩	60-65	49	68

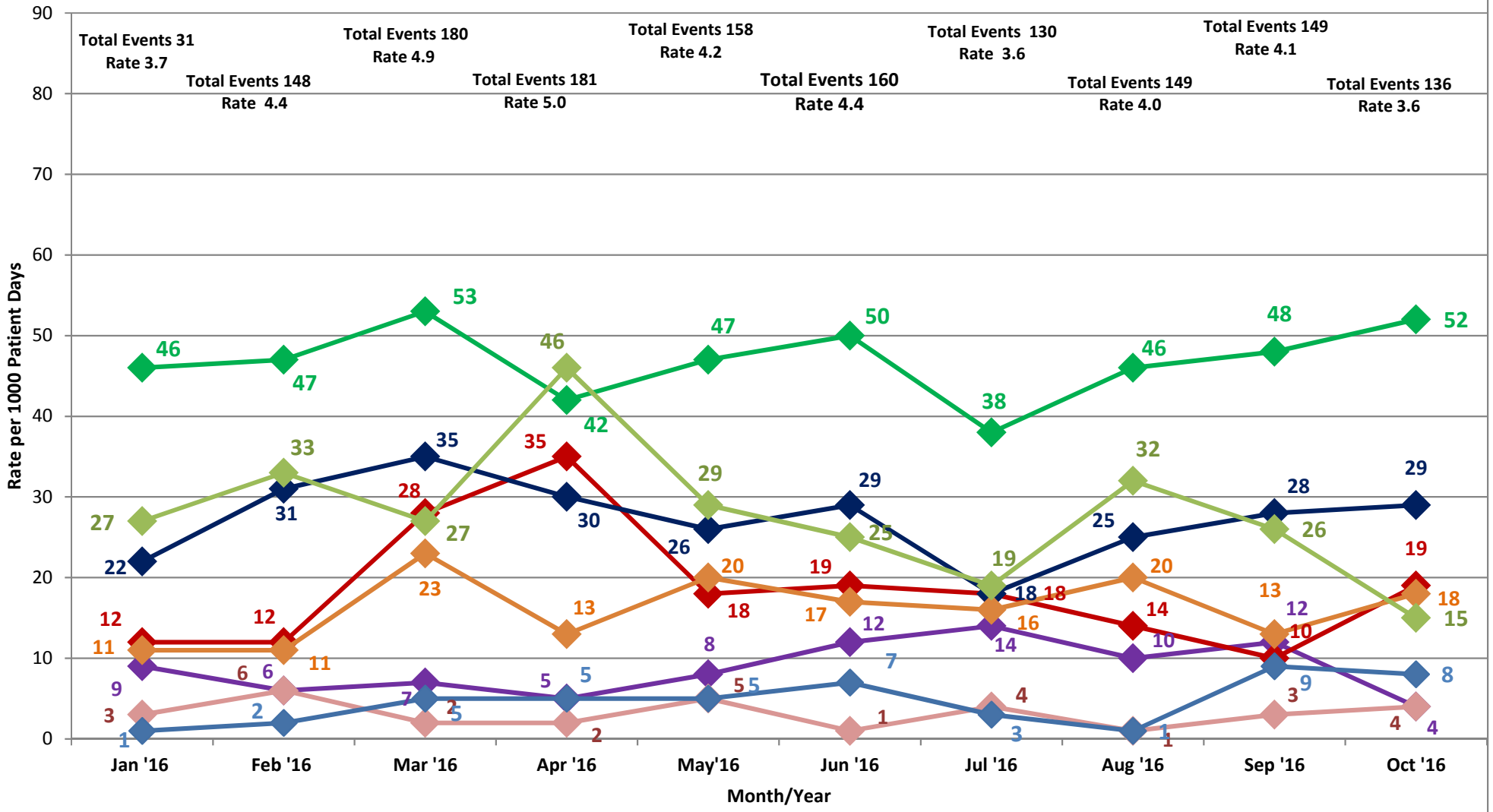
Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
PATIENT ACCOUNTS and ENROLLMENT SERVICES	People	Employee Engagement Financial & Information Division Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$830109 - $879916	$803,123	$798,791
		Days in Account Receivable	⇩	60-65	49	68

Department	Domain	Outcome Measure		Target Level	2016 YTD	2015 Year End
PURCHASING	People	Employee Engagement Financial & Information Division Percentile Rank	⇧	75-80th Percentile	\	69.8
	Service	Patient Experience: Satisfaction Percentile Ranking	⇧	70-84th Percentile	45th	51st
		All Packages are delivered the same day as they arrive	⇧	97-99%	98%	96%
	Clinical					
	Community					
	Finance	Expense Budget	⇩	$212536 - $225289	$226,111	$222,456

2014 Cummulative Rate 4.1
Altercation Rate 0.23
Behavior Rate 0.18
Fall Rate 1.49
Infection Rate 1.13
Injury (Unknown) Rate 0.51
Medication Errors 0.45
Other Safety/Medical 0.13

NORTH CENTRAL HEALTH CARE
CLIENT/PATIENT/RESIDENTS ADVERSE EVENT DATA

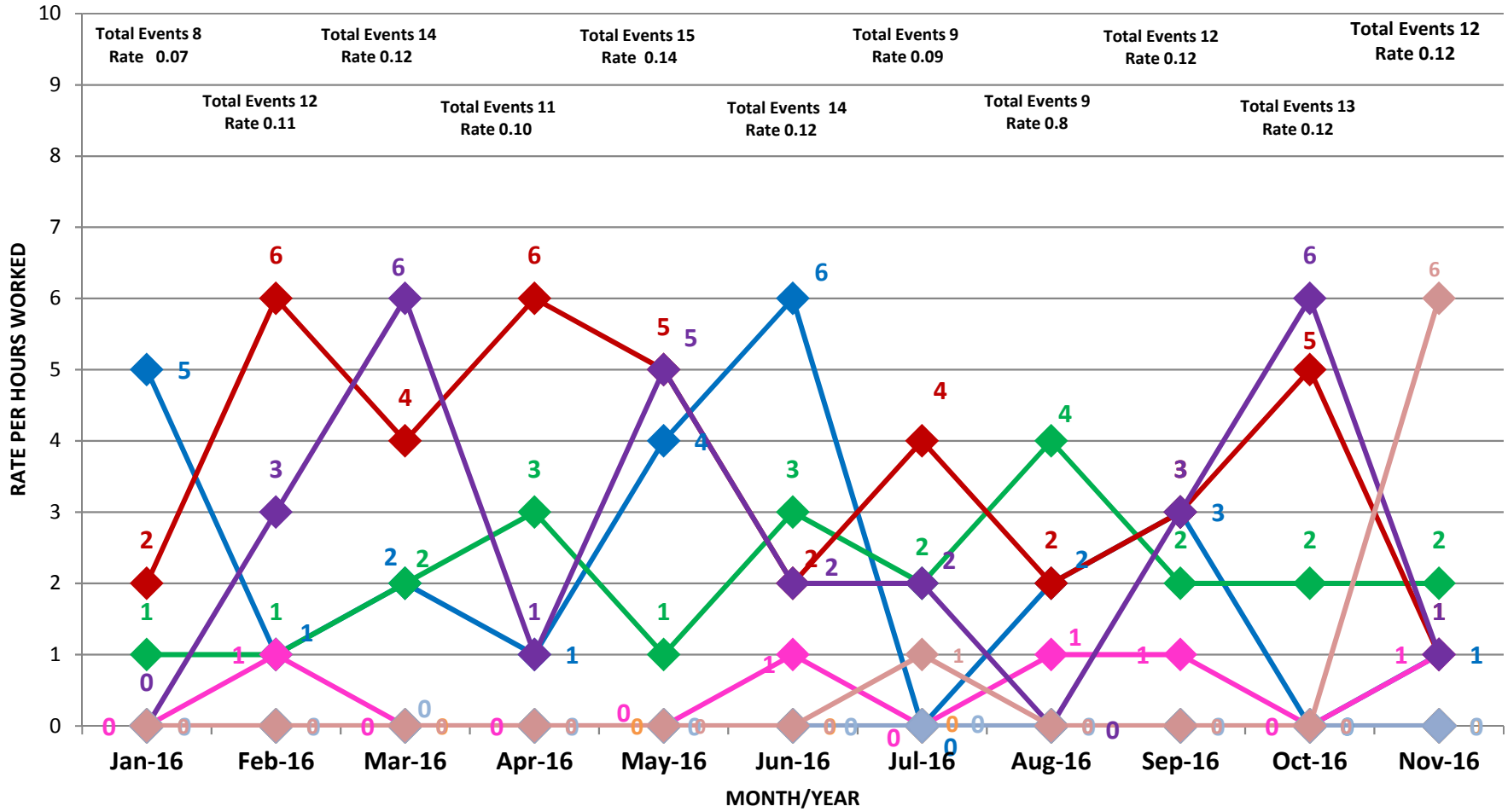
2016 Cummulative Rate 4.2
Altercation Rate 0.2
Behavior Rate 0.5
Fall Rate 1.3
Infection Rate 0.8
Injury Rate 0.4
Medication Errors 0.8
Medical Emergencies 0.1
Miscellaneous Other 0.1



NCHC EMPLOYEE ADVERSE EVENTS

2015 Cummulative Rates
Overall Cummulative Rate **0.08**
Altercation 0.012
Fall 0.009
Direct Patient Care 0.25
Other Work Activities 0.025
Struck by/Against/Between 0.004
Lost/Theft Damage 0.002
Motor Vehicle 0.00
Other 0.001

2016 Cummulative Rates
Overall Cummulative Rate **0.11**
Altercation 0.025
Fall 0.020
Direct Patient Care 0.035
Other Work Activities 0.023
Struck by/Against/Between 0.004
Lost/Theft Damage 0.00
Motor Vehicle 0.00



Crisis Process Improvement Team

Progress Matrix- 12/8/16

IDEAL STATE ELEMENT	PROGRESS RATING*	RATING RATIONALE/RECOMMENDED ACTION
Access for all those in need of services	2,2,5,3,3,2,2,3,3,2,1,.5,3,2	*the thought process is punitive and would like to see us respond as a society *How do we deliver the service when we do not have the capacity to do this *Improved on gaining access to outpatient counseling. Access to local services and capacity to access services *Progress in getting services to BCHC clients *Youth Needs: -Resource officers spending time with same kids. -Counseling services in the schools is needed, -Keeping the kids local and level of care that kids need. -Elementary school children having increased needs. -Early intervention is critical -Services to kids early -Teachers with lack of education regarding for the mental health needs -Continuum of care when the kids present back in the community. -Increased number of youth due to incompetency, Themes: - Overall care facility capacity issue in our counties. -Youth Capacity and youth access to services.

Clearer definition of Crisis process & Consistent Understanding Of Guidelines and Services Evidenced-based and consistent process for Crisis cases	1,3,2,3,3.5,3,4,3,3,3,4,3	*there is better understanding of services and the process of crisis services. *more knowledge and More involvement with law enforcement and *feeling better to have more informed decisions with my players. *a better definition and a better process flow. *Improvement of definition of process *need to educate the community more yet *difficult to draw and algorithm or create a flow chart as each case is different but we need to have consistency in process *moved to an understanding of a clear definition of crisis services. *Continue to educate the community *July 1, 2016 changes …how to communicate this to partners *Youth: potential for this to improve yet. This has occurred with regular meetings with Laure and Pat. But we haven't gotten to clear process for youth crisis *moving in the right direction and involving CIT training was excellent. *high level of need with young children, need to develop the process of how to assist the students and families in need. *Youth is a piece that will need some significant attention. Themes: -Youth element is still not well defined -Evidence-Based & consistent Process for crisis cases has improved Trust and great communication W community partner: Convenient and efficient system for law enforcement Crisis Walk in/Urgent care
Trust and great communication between community partners	3,3,4,4,2,3,2,3,2	Way to go with trust, work to do yet, some feel that better understanding of the complications of patients, and feel that we can communicate. Building blocks are being built, and will jump when it gets done. Politics gets in the way. Lots of need to educate and create awareness. Different measurement for trust in process, but has more trust in individuals. (Dawn working with Laure on very difficult cases, and they are responsive.) We need to trust the process. Would have given a zero this time last year. Having conversation is great. Trust takes a long time to build. Still partners that aren't at the table and there are partners that just joined.

		Shouldn't be an expectation that it's a 4 or 5. Politics create a situation where the HCC has to defend themselves to exist. This is a 3 or 4 year process. We get an A for effort. Group had discussion about how 2 or 3's aren't bad because many of us began as a zero. It's an evolving process. Lee would have put it at a -3 last year. Community has been having more positive experience. People have had bad experience 10 years ago. Communication is much improved, and trust the intent of the group. Trust of the process. Robin wants to trust that similar situations would be handled the same way in similar situations. Way better than a year and a half ago. Her staff is expecting fixed overnight.
Share decision making/more collaboration between partners	3,3,3,2,4,3,3,2,3	The data that we collect at NCHC says that the majority of these cases is being measured as going well. Process is the difficult thing. Depends on the situation. It's becoming more collaborative at times. Pat discussed the CW at WPD. We started doing the ride along. Chuck was able to intervene with a situation and expedite the situation. One big step of something that changed. Collaboration occurs, plans are formulated, where Dawn is concerned is follow through. Vicki has worked with NCHC for years, and has had years of experience of plans not coming to fruition. We need to keep plans on the front of our minds. Feel like the connections are more than it ever was before. Never had a connection before to the crisis center. All about judgement and assumptions. This meeting has created communication which generated other communication. Lots of collaboration and shared decision making. Matt doesn't look at this as be NCHC. These grades are grades for group. Effort that was given to this has been outstanding. We're halfway through the race. We need to complete our ideas. Lee said the clinic has much better experience with shared decision making. Robin said front line staff would not say that they were engaged every time, or have a huddle about the patient. They don't feel as involved as they could be. Some LE is better than others. Barrier with Winnebago. Staff associate issues with Winnebago about NCHC. Ongoing education needed, and ongoing explanation of the process.

		Pat explained the consistency is inconsistency. We all want consistency. We don't have good processes in place. Past experiences have been hard to let go. Heidi wants to see more of a shared decision making model, we moved, but we only have pieces and parts of the model.
Convenient and efficient system for law enforcement	2,2,2,3,2,2,2,3,3	Mary Jo- wants to see more wrap around services-2. Pat-dependent on what law enforcement agency you are talking to. A big piece is transportation 2 CIT training is a good step. Robin-not sure that convenient is the goal. Efficiency is the goal. Dawn P-Based on the feedback we hear. The juvenile justice pop, we don't have anywhere to go with them. There is no program for them in the moment. "This kid has to go somewhere." This is a system issue. Lots of youth on court orders without sufficient monitoring—this is a NCHC piece. The ability to respond to court order piece is a community issue. Lee said no counselor would want to report on commitments, but therapist will report to case manager. She trains her therapists to report. Jen—resource officers at schools are amazing, school has come a long way, associated with 3 different LE agencies, rural schools the time to get LE there is a problem Matt—we're never going to be a 4 or 5. Even if we are super successful, officers would still say it sucks. 95% of their training has nothing to do with this. We're asking a plumber to do electricians work. We're chasing something that doesn't exist. The whole system would have to change dramatically. Mary Jo- we hear similar things from teachers. Teachers are trained to be teachers not MH counselors. Dawn-These are system issues, but we can't just let it stop there. This group needs to work on this. Lee-based on feedback from LE on this team. LE is to protect and serve, is there an emphasis on serve part? Matt-720 of academy, 8 hours on MH stuff. There's only so much more we can add. We can't expect officers to be MH profs. Dawn- do we need to clarify expectations? Clarify that LE is first responder and ensure safety. And MH provider will do service. Laura-We need to make sure not to fall into trap of thinking MH is silver bullet-will cure people. Heidi and Dawn gives the system a zero

Crisis Walk-In/Urgent Care (expanded model of care, including immediate counseling if needed)	1,1,	Plan is being formulated. Laura-NCHC is a little like a child in a divorce situation, and we're waiting to see what happens to us. Pat-Explained some ideas about the plan. More providers on hand to handle situation. We can do medical clearance testing.
Improved Competency and volume of Crisis Staff	4,3,4,3,4,1, 4,-,3,3	-increased capacity of staff was achieved -all staff have received additional training, some staff are new -this staffing level has been budgeted -education requirements increased -CIT training -policy and procedures are still being refined -still completing competency validation -changes and improvement have been made -volumes continue to grow so this may challenge the staffing levels -youth crisis stabilization areas continues to be inconsistent/not available (still recruiting staff) -appreciate the ability to address issue with leaders -there are days that youth crisis stabilization area is not being used-need to make sure partners are aware -still need youth crisis CBRF -too many youth are going to Winnebago (25% of youth at Winnebago are from Marathon County), what is the cost to the tax payers -great work being done at NCHC, competency is always in progress -can't rank because new to process and don't know what the issues were/are, communication is important and is improving -on the right track, still need to work on crisis planning element
Clear Medical Clearance Protocol	5,4,5,4,4,3,3,-,-,-	-this is one of the biggest wins for the team, rarely an issue any more -we are not going to change Winnebago's requirements right now but locally we are collaborating well -rarely have issues -not directly involved but reports from the Team are possible -transportation has helped -still a bit of frustration from Crisis Staff when physicians are not familiar with -protocol is still cumbersome for patients -some expectations of other law enforcement groups of the local law enforcement and partners may not be realistic -medical staff take this process more seriously -unable to rank as not familiar with the process

Mobile Crisis “ambulance”		-Group did not feel this is necessarily still part of the plan- on hold
Physically welcoming environment in Crisis Center	2,-,2,-,2,2,-,1,1,4	-new furnishings but still need improvements -added an interview room, has been helpful in reducing the number of times that people are sitting in the waiting room -more inviting then it was -didn’t rate because haven’t seen it lately -staff is utilizing strategies to help them feel more welcomed (greeting, offering assistance….) -should be better in a couple months -could there be a family waiting room -need to keep working towards a trauma-informed area -staff has been friendly -not tranquil -outdated -institutional like -staff are always really nice -safe and calm
Communities are educated on mental illness and the services available	3, 1, 2, 3, 2, 2, 2, 2, 2, 2, 3	-still working on this -did some good work with partners who work with Crisis -general public is still lacking greatly -action plan was originally directed at crisis partners, have made great progress -sees good effort over the last couple of years (example Life Report) -from school perspective, we are having more conversations with parents regarding services available -awareness is better but we have gotten to action level as a Community -NCHC has done a great job of educating people that interface with the system but general public and partners who don’t interface with the system are not aware -There are still a lot of people who do not want service
Mobile Crisis within 30 minutes	-,4,3,-,4,0,-,2,2	-on average 30 min. , challenged to meet this in Lincoln/Langlade/rural Marathon due to travel time required -schools: fee and permission is required in schools and these are barriers -some feel this should be 100% levy funded -mobile crisis will not go without law enforcement, social services has found that mobile crisis staff will not go to a home without a police officer

		-trialing crisis worker to be dispatched out of police department to help -there are times that staff are not available to get to locations
Satellite crisis "offices"/safe place Replicated in all 3 counties	Group did not rate specifically but discussed it as it relates to access and capacity (items above)	-preliminary discussions with Langlade Aspirus to potentially have a crisis area -this specifically directed a rural/other counties -Crisis CBRF settings would help to meet this need but there is shortage of these facilities -Social Services Group home will provide this environment for those clients with social services
Less stigma related to receiving Crisis Services	2, 2, 2, 2, 2, 2, 2,2, 2, 2	-don't know how to measure is very difficult -discussion regarding this is a chronic illness and needs ongoing care -media is starting to address this more (eg: veteran commercials) -stigma around youth criminal justice -this is not a behavior this is a mental illness -when clients come in that we have worked with are "afraid" of it related to past experiences (hand cuffs) -officers are often involved -people don't understand that any one in Crisis is going to hurt themselves or others -observing people seeking Crisis services seem more at ease -CIT training has helped to change approach and perception -payers contribute to the stigma as a diagnosis -looking at it historically to today, we have come a long ways to go as it is societal issue -Crisis services doesn't always mean that a person has a mental illness they

***Progress Rating: Rank each with a rating 0, 1, 2, 3, 4, or 5**

0: no improvement/movement, we have a lot of work to do yet

5: excellent improvement/movement, need to sustain it now

EVALUATION OF EOC PERFORMANCE STANDARDS AND PROGRAM

As part of Joint Commission and CMS requires the institution to create programs and goals related to the Environment of Care and focuses on 7 areas: Safety, Security, Life Safety (Fire), Emergency Operations, Hazardous Materials & Waste, and Utility Systems.

This year NCHC was able to attain 10 of the 15 goals set forth in the 6 management plans. The goals that we were unable to be attained will be rolled into the 2017 goals.

2016 Goals

Safety & Security Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
Staff who go to clients homes will receive an educational program "Visiting clients homes – Safety Education" delivered by local law enforcement.	All staff who go into client homes will be required to attend. 23 people attended.	Goal Met
Develop an Active Shooter plan in conjunction with Wausau P.D.	Plans have been created and ended up with a false alarm in May.	Goal Met
50% reduction of breeches in HIPPA compared to 2015 (goal: less than 10)	Did not meet the goal. 21 Breeches this year.	Not met
Conduct a Covey's Risk Assessment for Behavioral Health.	Completed December 12, 2016. Working on action plan.	Goal Met
Complete 5 tasks on the Ligature Risk Reduction plan in inpatient psych.	BHS has completed 5 items. 1. Security searches all items that visitors bring on the unit to reduce the risk of ligature. 2. Bathroom in Interview 1 3. Using string free scrubs 4. General disinfectant is a new product that is environmentally friendly. While I don't encourage drinking, there is no negative side effects if they do drink. 5. Removed razors from the unit and replaced with electric razors	Goal Met
Life Safety Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
Enhance Reporting of Life Safety Compliance activities to Safety Committee	Created EOC document and brought data to the meeting.	Met Goal
Focus on CBRF education and compliance with Life Safety Goals	Created EOC document and brought data to the meeting. Continuing to work on improving.	Met Goal
Improve dusting on life safety devices, i.e. sprinklers, fire extinguishers	Received a CMS citation for dust sprinklers	Not met

Emergency Operations Objectives/Goals	Actions/Conclusion	Goal Met Yes/No
To introduce the Safety Committee and Senior Executive Team to NIMS by learning the following modules: ICS 100 & 200	Contracted with state representative to hold education to staff in November for introduction. Due to scheduling conflicts ICS 100 & 200 will be bumped to 2017	Not met
To introduce all of NCHC to NIMS by learning the following modules: 100 by quarter 4 2016.	Introduction scheduled for November 16th.	Goal Met
To conduct a Utility failure drill to test our 96 hour plan.	The test was delayed due to the change in contract with facilities. Will reschedule for next year.	Not Met
Hazardous Materials & Waste Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
Have less than 100 lbs. of hazardous waste a month.	Performed an in-service on what should go into hazardous waste. Average weight was	Goal Met
Reduce the number of cleaning chemical used in Environmental Services on the Wausau Campus.	Went from 11 chemicals to 3 chemicals. The new chemical is also environmentally friendly.	Goal Met
Utility Systems Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
Test the 96 hour drill via a table top exercise.	The test was delayed due to the change in contract with facilities. Will reschedule for next year.	Not met.
Evaluate Oxygen Capacity for expansion of ventilator patients.	Each 230 Liter tank can produce 188.73 Liters of flow per minute. Average Resident uses 4 liters per min. 14 residents are on oxygen dependent on Northern Winds. Thus can sustain independently for 96 hours with current volumes.	Goal met.

2017 Goals

Safety & Security Objectives/Goals	Actions/Conclusion	Goal Met Yes/No
Inpatient BHS will use no more than 1 physical restraint on an individual stay.	Goal is with new skills attained in MOAB that this can be met.	
Measure compliance identified during environmental tour inspections. The goal for 2017 is 90% compliance on environmental rounds audit.		
Measure compliance for annual safety education for employees and staff. The goal for compliance will be 90%.		
Employee ability to hear audible alarms during testing. Threshold 100% Achieved 93%		
50% reduction of breeches in HIPPA compared to 2016 (goal: less than 10)		
Life Safety Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
Fire Drill response will have 80% of the department responding within first 60 seconds of drill being announced.		
Employee knowledge of RACE. Threshold 90% Achieved. 94%		
Fire drills/emergency drills will be conducted within regulatory standards. Threshold 100% Achieved. 100%		
Emergency Operations Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
To introduce the Safety Committee and Senior Executive Team to NIMS by learning the following modules: ICS 100 & 200	Rolled out February 4.	
Conduct a full scale drill using incident command.	Drill slated for February 28.	
Participate in a community drill not related to tornados.	Drill slated for January 14.	
Hazardous Materials & Waste Objectives/Goals	**Actions/Conclusion**	**Goal Met Yes/No**
All Staff knowledge of proper medical waste disposal – annual review	Update the annual training to be more effective. Q2 2017	
Cost of Bio hazardous Waste Disposal Per Adjusted Patient Day	Continue to reduce poundage. Q4 2014	
Standardize and reduce amount of chemical used in the building for housekeeping and front line staff, excludes maintenance.	Reduction from 8 chemicals to 5 by Q3 2017.	

Utility Systems Objectives/Goals	Actions/Conclusion	Goal Met Yes/No
Test the 96 hour drill via a table top exercise.		
PM Completion Rate on Utility Components or Systems. Compliance will be monitored monthly. The numerator is the number of inspections (PMs) completed by maintenance per month. Monthly results will be reported to the EOC. Compliance Goals are as follows: • Life Support (Critical direct Patient Impact)Utility Systems – 100% • Non-Critical Utility Systems – 90%		

Name of Policy: **EMERGENCY OPERATIONS PLAN**	North Central Health Care Person centered. Outcome focused.
Policy #: EM-0001	
Primary Approving Body: Safety Officer/Safety Committee	Committee Approvals: Quality Committee of the Board

I. Policy Statement

The objective of the Emergency Operations Plan is to provide an organized process to initiate, manage, and recover from a variety of emergencies, both external and internal, which confront our Organization.

The Emergency Operations Plan addresses six (6) critical areas of emergency response shall be managed in order to assess the organization's needs and prepare employees to respond to incidents. The six critical areas are:

- Communication
- Resources and assets
- Security and safety
- Management of employees
- Utilities management
- Management of patients/clients/residents

II. Purpose

The purpose of North Central Health Care's Emergency Operations is to provide for effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The organization has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies and/or disasters regardless of the cause.

Goals

The goals of North Central Health Care's Emergency Operations Plan include the following:

a. Identifying mitigation activities
b. Identifying procedures to prepare and respond to potential internal and external disasters or emergencies including:
    1. internal
    2. external
    3. patient surge
    4. facility surge

c. Providing education to employees on the elements of the Emergency Operations Plan
d. Establishing and implementing procedures in response to internal and external disasters and emergencies
e. Identifying alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements which may include, but are not limited to neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire departments; local police departments; area pharmacies; medical supply vendors
f. Identifying recovery strategies and actions to be activated in the event of a disaster or emergency

III. Definitions

Emergency: An unexpected or sudden event that disrupts North Central Health Care's ability to provide care, or the environment of care itself, or results in a sudden, significantly changed or increased demand for the organization's services. Emergencies include, but are not limited to:

- Medical Emergencies (Dr. Blue)
- Bomb Threat (Dr. Yellow)
- Fire (Dr. Red)
- Behavioral Emergency (Dr. Green)
- Dangerous Person with a Weapon (Dr. Black)
- Severe Weather

Emergencies can be either human-made or natural, or a combination of both, and they exist on a continuum of severity.

Disaster: A type of emergency that, due to its complexity, scope or duration, threatens North Central Health Care's service capabilities and requires outside assistance to sustain patient/client/resident care, safety or security functions.

Four (4) Phases of Emergency operations:

Mitigation Activities - Activities that are developed to reduce the risk of and potential damage from an emergency/disaster. Activity occurs before an emergency and/or disaster.

Preparedness - Activities that occur before an emergency and/or disaster.

Response - Activities that occur during and after an emergency/disaster**.**

Recovery - Activities that occur during and after an emergency/disaster.

Internal Emergency/Disaster: an internal event involving an incident within the organization that disrupts normal operations. These may include, but are not limited

to, bomb threats, utility failures, hostage situations, and situations involving weapons (e.g.: active shooter).

External Emergency/Disaster: an external event involving an incident beyond the immediate boundaries of the organization. Such an incident can result in the arrival of a large number of individuals needing services that are within the scope of services at NCHC. Other types of external emergencies include, but are not limited to, such incidents as severe snowstorms, utility outages, and tornados.

Facility Surge: An incident that creates an overload situation on the organization that may necessitate the use of the emergency procedures. These include events such as an approaching severe weather situation in which travel to and from the facility is restricted.

Patient Surge: An incident that results in the arrival of a large number of individuals needing services that are within the scope of services at NCHC.

IV. General Procedure

A. Preparation and Mitigation

It is understood that the On-site Maintenance Manager, and Safety and Risk Manager will:

a. have a working knowledge of emergency operations, daily and emergency organizational operations, as well as Incident Command Center operations,
b. stay abreast of changes in regulations and standards as they pertain to emergency operations, and
c. be knowledgeable of local, state and federal emergency operations agencies and their principle staff.

Senior Executives, leaders, and medical staff, shall actively participate in the development and review of the organization's Emergency Operations Plan.

1. Inventory of Assets and Resources:

The organization will strive to maintain an adequate supply of resources to respond effectively to an emergency and/or disaster. The inventory of assets and resources shall be evaluated, at a minimum, on an annual basis and methods shall be in place for the monitoring of the inventory of assets and resources during an emergency/disaster.

A documented inventory of assets and resources on-site that are needed during the emergency/disaster, at a minimum will include:

- Personal Protective Equipment
- Water
- Fuel

- Staffing
- First Aid Resources
- Pharmaceutical resources

2. Community Involvement:
   a. The Emergency Operations Plan shall be developed in coordination with community partners. Community partners may include, but are not limited to law enforcement, fire departments, public transportation system, public health department, utilities, public safety and security agencies, hazardous materials response, telecommunications, mental health providers, other healthcare facilities, and other government agencies as appropriate. In instances when the community partners are unable or unwilling to participate in the emergency planning efforts, documentation will be maintain to support attempts to involve these partners in NCHC planning process.

   b. The Incident Planning Guides and Incident Response Guides (HICS) shall be used as a resource when reviewing North Central Health Care's Emergency Operations Plan or when the development of new annexes occurs.

   c. North Central Health Care shall regularly participate in community preparedness meetings, training and activities to ensure:
      - Mutual understanding of roles and responsibilities
      - Incident management principles
      - Resource allocations
      - Effective communication, the use of common language, information sharing practices

   d. The Safety and Risk Manager or designee shall meet with specific organizations in the community on a regular basis to define roles and responsibilities, discuss response needs, and to develop plans and procedures to keep North Central Health Care operating in the event of an emergency and/or disaster. The following organizations serve the immediate area with which cooperative planning has been established:

      - Aspirus Wausau Hospital
      - Ministry Health Care
      - Pine Crest Nursing Home
      - Norwood Health Center
      - Marathon County Public Health
      - Marathon County Emergency Management Department

   Meetings with said organizations will include discussions on:
      - Elements of each organization's incident command structures
      - List of names, responsibilities and phone numbers of individuals in each organization's command structure
      - List of resources that can be pooled and/or shared for response to emergency and/or disaster situations

- Sharing of resources
- Credentialing
- Patient/Client/Resident transfer logistics
- Mechanisms to send information on patients/clients/residents and deceased individuals to cooperating organizations to help facilitate identification and location of victims of the emergency and/or disaster.

e. A Memorandum of Understanding shall be developed and maintained with facilities that will be utilized in evacuation situations and/or to support internal needs during emergency/disaster event addressing:

f. The Public Health Department may provide oversight of the Medical Reserve Corp (MRC) which encompasses volunteer healthcare providers who can give medical assistance during an emergency/disaster. These volunteers may be used in shelters, alternative care sites, medication distribution sites, hospitals, other healthcare organizations.

3. Hazard Vulnerability Analysis (HVA):
NCHC will perform a Hazard Vulnerability Analysis 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 North Central Health Care. This analysis will be completed on an annual basis at a minimum. The organization will develop and/or revise specific policies and procedures in response to potential emergencies and/or disasters identified by the Hazard Vulnerability Analysis.

North Central Health Care will communicate its needs and vulnerabilities to community emergency response agencies, and identify the capabilities of the community in meeting the needs of the organization. This communication will take place at the time of North Central Health Care's annual evaluation of the Emergency Operations Plan and when the needs or vulnerabilities of the organization change.

For each emergency and/or disaster identified in the organization's Hazard Vulnerability Analysis, the following shall be defined:

- Mitigation activities that are designed to reduce the risk of and potential damage due to an emergency and/or disaster.

- Preparedness activities that organize and mobilize essential resources.

- Response strategies and actions to be activated during the emergency and/or disaster.

- Recovery strategies and/or actions that will help to restore the systems critical to resuming normal operations of the organization.

- List the potential disasters and emergencies that are specific to your location.

4. Communication:
   North Central Health Care shall maintain a system to ensure communication during and emergency or disaster. Two-way radio equipment and cell phones shall be available in the event of an emergency and/or disaster. In the event that cell phones are not working, portable 800 MHz radios should be available and may be used.

5. Employee Training:
   Employees will be provided with following emergency and disaster education:
   - at the time of hire (orientation),
   - annual NCHC Core Competency training and validation,
   - department-specific trainings and meetings reviewing their specific roles and responsibilities,
   - as needed with changes to Emergency Operation Plan and/or related policies and procedures, and
   - when opportunities for improvement are identified.

B. Response

1. **Activation:** North Central Health Care's Emergency Operations Plan and procedures defined in the Emergency and Disaster Operations Manual and related Emergency Procedures will be activated when it has been determined that an emergency has occurred or has the potential for occurring.

2. **Employee Responsibility:** When North Central Health Care is notified of an emergency and/or disaster, all employees will follow the responsibilities outlined in the Emergency and Disaster Operations Manual and related Emergency Procedures. In the event of a disaster:
   a. all employees, regardless of position, are expected to report to North Central Health Care for duty as soon as it is feasible to travel. In an emergency and/or disaster,
   b. employees may not be assigned to their regular duties and potentially will be asked to perform various jobs, which will be considered vital to the effective operation of North Central Health Care
   c. employees will be assigned duties based on organizational needs. If employees are not needed in their usual program areas, they will be sent to the Labor Pool for assignment,
   d. employees on duty during activation of the Emergency operations Plan will be identified by an employee photo identification badge, which is to be worn at all times by all employees while on duty.

   North Central Health Care will provide for employee support activities in the event of an emergency and/or disaster, which may include, but are not limited to:

   - Housing/lodging needs
   - Transportation needs
   - Family support needs, as necessary

- Incident stress debriefing and counseling

3. **Communication:** In the event of an emergency or disaster, all employees will utilize the communication procedures defined in the Emergency and Disaster Operations Manual and related Emergency Procedures. The NCHC Crisis Center has been designated as the primary communication center in these events.

4. **Response Procedures:** NCHC will develop and maintain an Emergency and Disaster Operations Manual and related Emergency Procedures that will define the response procedures for the following:

    - Specific Emergency Response Procedures
    - Care Triage
    - Incident Command Center
    - Evacuation
    - Facility Management
    - Food Services
    - Medications and Pharmacy Services
    - Transportation Assistance
    - Information Systems
    - Telephone Services
    - Payroll

C. Recovery

North Central Health Care has mechanisms in place to restore the operational capabilities of the organization to pre-emergency levels. Once the emergency/disaster is over, Senior Executives, On-site Maintenance Manager, Maintenance and Grounds Manager, Safety and Risk Manager, and other designees as necessary will begin assessing the damage to the organization and the environmental concerns to determine whether the organization can safely provide health care to the community and provide a safe environment for patients, clients, residents, employees, and visitors. The Incident Command Officer will declare an "All Clear" at this time. The Emergency and Disaster Manual will define the procedures to be followed to complete this phase.

D. Evaluation of the Emergency Operations Plan

The Emergency Operations Plan defines and integrates North Central Health Care's role with the community-wide emergency operations efforts to promote collaborative operations between the organization and the community.

1. Exercises shall be developed based on North Central Health Care's hazard vulnerability analysis (HVA), testing the most threatening hazard(s) and shall evaluate the organization's ability to handle communications, resources and

assets, security, employees, utilities, and patients/residents/clients. Exercises should validate the effectiveness of the Emergency Operations Plan and identify opportunities to improve.

- At North Central Health Care locations providing 24 hour services, the Emergency Operations Plan will be activated twice a year.

- At North Central Health Care locations providing non-24 hour services, the Emergency operations Plan will be activated once a year.

- If the Emergency Operations Plan is activated in response to an actual emergency, this can serve in place of the emergency response exercise.

- Emergency response exercises will incorporate likely disaster scenarios.

- North Central Health Care shall designate individual(s) to monitor the performance of the emergency response exercises and document opportunities for improvement.

2. The Safety Officer and Safety and Risk Manager, with support from the Safety Committee, shall modify North Central Health Care's Emergency operations Plan based on the evaluations of the emergency response exercises and responses to actual emergencies/disasters. These improvements shall be communicated to employees as appropriate.

3. The Emergency Operations Plan shall be evaluated based on information gathered from priorities set from the Hazard Vulnerability Analysis, emergency response exercises, actual emergency/disaster, changes in the mission or capability of North Central Health Care, changes within the community, and/or the Plan's objectives, goals, and performance.

4. Performance Measures to evaluate the effectiveness of the Plan will be established. This will be a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization-wide safety. The following will be included:

   - The 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 are 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, shall monitor performance regarding actual or potential risks related to one or more of the following:

- Staff knowledge and skills

- Level of staff 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 Officer, Safety and Risk Manager, and 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 Officer.

To identify opportunities for improvement/corrective action, the Safety Committee will follow the organization's process 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 an alternate team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Committee will follow the organization's performance improvement guidelines for selection. Determination of necessity will be based on those priority issues listed (high risk, volume, challenging situations, and sentinel event occurrence).

The Safety Committee will review the necessity of development, requesting additional internal or external party 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 said development be deemed necessary, internal and/or external parties will be selected on the basis of their knowledge of 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 and/or Safety and Risk Manager with assistance from the Performance Excellence Specialist at least on a quarterly basis, with a report of performance outcomes forwarded to the Inpatient Quality Improvement Committee, Outpatient Quality Improvement Committee, and Quality Committee of North Central Health Care's Board of Directors.

The following performance measures are recommended:

- Percentage of employees able to demonstrate knowledge and skill of their role and expected participation in the Emergency operations Plan

- Percentage of employees able to demonstrate knowledge of their responsibilities during an exercise

- Number of emergency operations exercises conducted within a specified time span

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

The annual evaluation of North Central Health Care's Emergency operations Plan will include a review of:

- the scope and objectives according to any current accrediting body standards,
- the hazard vulnerability analysis (HVA), and
- the National Incident Management System (NIMS) guidelines, to evaluate the degree in which the Plan meets accreditation standards and assesses any current emergency operations risks at North Central Health Care.

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 and objectives for the following year will be determined.

North Central Health Care's Emergency operations Plan shall be revised and updated based on the annual evaluation of the Emergency operations Plan, including the Hazard Vulnerability Analysis.

The performance and effectiveness of the Emergency operations Plan shall be reviewed by the Safety Committee, Senior Executive Team, and Quality Committee of North Central Health Care's Board of Directors.

Program-Specific Requirements:

N/A

References:

The Joint Commission
National Incident Management System (NIMS)

Name of Policy: **HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN**	North Central Health Care Person centered. Outcome focused.
Policy #: EOC-0003	
Primary Approving Body:	Committee Approvals: Safety Committee

I. POLICY STATEMENT

North Central Health Care (NCHC) will provide a clean, safe, sanitary environment for patients/clients/residents, as well as visitors and staff.

We will promote the appropriate handling and disposal of all solid waste, medical waste, and pharmaceutical waste. We are committed to environmental soundness and cost effectiveness of all waste management and to stay within state and federal regulations at all times.

SCOPE:

- The scope of the Hazardous Materials and Waste Management Plan defines the processes which North Central Health Care utilizes to provide a safely controlled environment where hazardous materials are used in the facility by proactive risk assessments to reduce the risk of injury.

- Hazardous materials and waste risks are continually assessed and reviewed during Safety rounds, occurrence reports, product management and review by the Safety Committee. Risks levels are determined by the level of potential consequences that are associated with the types, quantities, inherent physical and chemical properties of the hazardous materials utilized by the facility.

OBJECTIVE:

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

GOALS:

- The goals of the Hazardous Materials and Waste Management Plan include the following:

    - To provide education to staff on the elements of the Hazardous Materials and Waste Management Program.

    - To assure staff training in the Hazardous Materials and Waste Management Program is effective.

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- To identify, evaluate and inventory hazardous materials and waste generated or used consistent with applicable regulations and laws.

- To provide adequate space and equipment for the safe handling and storage of hazardous materials and waste.

- To establish emergency procedures to use during hazardous materials and waste spills or exposures.

RESPONSIBILITY:

North Central Health Care's Governing Body has ultimate authority and responsibility for the Hazardous Materials and Waste Management Plan. The Governing Body shall delegate the authority to develop, implement, monitor and manage the processes and activities described herein to the Safety/Risk Manager, Materials Manager, Supervisor of Housekeeping and Safety Committee.

HAZARDOUS MATERIALS AND WASTE SELECTING, HANDLING, STORING, TRANSPORTING, USING AND DISPOSING FROM RECEIPT OR GENERATION THROUGH USE OR FINAL DISPOSAL:

- A system has been developed that addresses the identification of hazardous materials and waste from selection to the point of final disposal. Policies and procedures related to various hazardous materials and wastes are reviewed, revised and approved by the Safety Committee

- A review of the use of hazardous materials through the facility will be completed annually the findings reviewed by the Safety Committee.

- In an effort to reduce the use of hazardous materials, the Safety Committee shall review any literature referencing the reduction of toxic materials and make recommendations regarding less hazardous products to the Safety/Risk Manager.

WRITTEN CRITERIA WHICH IS CONSISTENT WITH LOCAL, STATE AND FEDERAL LAW TO IDENTIFY, EVALUATE AND INVENTORY HAZARDOUS MATERIALS USED OR GENERATED IS ESTABLISHED:

- NCHC will keep a list of materials classified by state and federal standards, i.e., OSHA, EPA, as being hazardous material or waste. A copy of the list will be kept in the Safety Office and Materials Management for reference.

- Materials Management shall develop guidelines for receiving, identifying and delivering these materials to their destination in accordance with local, state and federal law. Materials Management will notify Environmental Services support staff of all potentially hazardous material received. In addition, each department manager is responsible for notifying the Environmental Services support staff of any potentially hazardous materials

acquired/being used in the department that was not acquired through Materials Management.

- A Safety Data Sheet is to be obtained for every chemical used in NCHC and identified as hazardous. A master file of all Safety Data Sheets will be kept electronically for all employees to access. A paper copy of the Safety Data Sheets will be available for reference in the event of an electronic system failure.

THE MANAGEMENT OF CHEMICAL WASTE, CHEMOTHERAPEUTIC WASTE, RADIOACTIVE WASTE AND REGULATED MEDICAL WASTE (I.E., SHARPS):

- Policies and procedures relating to chemical and physical hazards shall be reviewed by the Safety Committee and the Infection/Prevention Control Committee for infectious hazards on a yearly/annual basis.

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

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

ADEQUATE AND APPROPRIATE SPACE AND EQUIPMENT IS PROVIDED FOR THE SAFE HANDLING AND STORING OF HAZARDOUS MATERIALS AND WASTE:

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

- Exposure to hazardous materials shall be minimized through primary prevention measures, such as engineering controls, administrative controls and personal protective equipment (PPE).

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

- Highly flammable materials will be kept in an area separate from oxidizing agents (material susceptible to spontaneous heating, explosives, etc.).

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

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

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

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

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

- Personal protective clothing and equipment will be available for use when handling these materials. ~~Staff are~~Staff is trained in the appropriate use of personal protective clothing and equipment.

HAZARDOUS GAS AND VAPORS MONITORING AND DISPOSING:

- Staff involved in the use and transport of compressed gas shall be trained in the proper handling of cylinders, cylinder trucks and supports and cylinder valve protection caps. All cylinder storage areas, outside and inside, shall be protected from extremes of heat and cold and from access by unauthorized individuals.

- Regular visual inspections of compressed gas cylinders are performed to ensure cylinders are in safe condition.

- All pressure relief safety devices meet the Compressed Gas Association (CGA) requirements.

- Oxygen equipment must not come in contact with any form of grease or oil.

ALL HAZARDOUS MATERIALS OR WASTE SPILLS, EXPOSURES AND OTHER OCCURENCES ARE REPORTED AND INVESTIGATED:

- An occurrence report form will be completed on all hazardous materials and waste spills and exposures. The Safety/Risk Manager and Supervisor of Housekeeping shall investigate all hazardous materials and waste spills and exposure. The occurrence report will be reviewed and studied by the Safety/Risk Manager and Supervisor of Housekeeping to determine the cause of the incident. The Safety/Risk Manager will make recommendations to the Safety Committee to prevent the reoccurrence of related incidents.

THE EMERGENCY PROCEDURES FOR THE SPECIFIC PRECAUTIONS, PROCEDURES AND PROTECTIVE EQUIPMENT USED DURING HAZARDOUS MATERIAL AND WASTE SPILLS OR EXPOSURES ARE DESCRIBED:

- If a leak or spill is found, the following actions shall be taken:
    - Identify the chemical before attempting to clean up any hazardous chemical spill or splash.
    - Obtain SDS on chemical. Follow the directions according to the established procedures for cleaning up that kind of chemical spill or leak.

      Notify people in the immediate area, supervisor and Safety/Risk Manager. Call for emergency assistance as needed.
    - Evacuate all staff from the area and close all doors.
    - Ensure adequate ventilation.
    - If a fire occurs, set off the fire alarm and extinguish flames.
    - Wait by the spill area, well out of danger, until help arrives. Avoid tracking through the spill.
    - Obtain appropriate personal protective equipment. (see SDS)
    - Complete occurrence report on spill or leak.

PERMITS, LICENSES AND ADHERENCE TO OTHER REGULATIONS ARE MAINTAINED:

- North Central Health Care is a small quantity generator of hazardous waste. Hazardous/medical waste generated does not exceed 200 pounds per month. Hazardous waste generation will be tracked, controlled and managed according to OSHA, DOT, EPA and state regulations.

- North Central Health Care's medical waste is picked-up once per week by a licensed medical waste hauler and is taken to a certified off-site medical waste treatment facility for treatment and disposal in accordance with federal and state laws.

- Hazardous waste generated by the hospital is removed once per week by a licensed hazardous waste hauler for disposal in accordance with state and federal laws.

REQUIRED MANIFESTS FOR HAZARDOUS MATERIALS AND WASTE ARE MAINTAINED:

- A component of the management and disposition of hazardous wastes is the removal of these materials from the point of generation to a specified treatment, storage or disposal facility.

- Records will be maintained identifying the generator, quantity, ~~type~~and type and disposal action of the hazardous material or waste.

    - A signature is required from the generating facility on each tracking record at the time of pick-up.

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

- Hazardous waste manifests will be maintained by Housekeeping Coordinator. The Housekeeping Coordinator is also responsible for maintaining all documents, including tracking records, shipping documents and the certificate of treatment or disposal for all hazardous materials removed from the facility for a minimum ~~of 3~~of 3 years.

- The Housekeeping Department is responsible for maintaining documentation including tracking records, shipping documents and certificate of treatment for all medical waste removed from the facility.

- Both hazardous and medical waste records will be retained on file according to law for a period of 3 years, at a minimum, by the Housekeeping Coordinator.

- Licensed Medical Waste Hauler:

    Name: LB ~~Medwaste~~Med waste Services

    Address: 8850 Development Ct., Wausau, WI 54402

    Phone Number: 715-842-2048

HAZARDOUS MATERIALS AND WASTE ARE PROPERLY LABELED:

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

- Identity of the hazardous chemical(s) as it appears on the SDS and chemical list
- Appropriate hazard warning in English
- Name and address of the chemical manufacturer, importer or other responsible party

- Labels must be legible and prominently displayed on the container.
- Labels and other forms of warnings are legible in English and predominate second language of staff, if applicable.
- See Hazardous Materials Identification and Labeling Policy.

HAZARDOUS MATERIALS AND WASTE STORAGE AND PROCESSING AREAS ARE SEPARATED FROM OTHER AREAS OF THE FACILITY:

- All medical and hazardous waste will be segregated and contained separately from other waste at the point of generation. The department manager is responsible for ensuring there is appropriate separation and the waste is placed in properly constructed and labeled containers.
- Trained Environmental Services staff will utilize rigid containers to transport biohazardous waste bags from the various departments. All biohazard waste containers will be labeled with the universal biohazard symbol. Environmental Services staff will wear the appropriate personal protective equipment when handling and transporting biohazardous waste.
- Biohazardous wastes will be stored in a designated locked and secured holding area located by the loading dock on the facility property. Warning signs will be posted.
- Medical waste holding areas will be inspected on a daily basis by the Housekeeping Department. Any deficiencies found will be documented and prompt action will be taken to address any handling, segregation, ~~containment~~and containment or storage issues. Monthly rounds will be made by the Housekeeping Coordinator to ensure compliance.

AN ORIENTATION AND EDUCATION PROGRAM FOR EMPLOYEES WHO MANAGE OR HAVE CONTACT WITH HAZARDOUS MATERIALS AND WASTES IS IN PLACE:

- All persons required ~~to manage or handle~~managing or handling hazardous chemicals, materials or waste will be provided with appropriate orientation, personal protective equipment and job training. Each department is responsible for training each individual handling hazardous materials and waste. A master file of the training records will be kept in the employee's automated education transcript.
- Employee orientation and education shall include the following:
  - Information about the hazard communication program

- Identification of the hazardous materials in their workplace and the health hazards associated with mishandling these materials

- The employee will be ~~inserviced~~in-service on the location of the following:
  - Written hazard evaluation procedures
  - Written description of Hazardous Communication Program
  - List of hazardous materials
  - SDS
  - How to detect the presence of hazardous materials
  - Specific measures that have been implemented to protect the employee
  - How to read and interpret information on labels and SDS
  - Emergency procedures to use in the event of an exposure or spill
  - Reporting procedures for incidents, including spills and exposures
  - Where to get more information

- Retraining will be done annually and whenever the hazard changes or a new hazard is introduced to the work environment.

- The effectiveness of all staff training will be evaluated by the Safety Committee, and additional training will be supplied to the employee if he/she does not meet the required level of competence.

PERFORMANCE STANDARDS:

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization-wide hazardous materials and waste management. 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 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 are 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:
  - Staff knowledge and skills
  - Level of staff 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, the Safety Committee will follow the organization's improvement methodology, the PDCA model. 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 (outside of the 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 /Risk Manager at least on a quarterly basis, with a report of performance outcome forwarded to the Quality Improvement Committee and the Board of Director's Quality Committee quarterly.

- The following performance measures are recommended:

  - Percent of staff able to demonstrate their knowledge and skill of their role and expected participation in the hazardous materials and waste program

  - Percent of staff ~~inserviced~~in serviced within 30 days of scheduled ~~inservice~~in-service or hire

  - Percent of hazardous waste disposable units per department containing inappropriate items

  - Number of hazardous materials incident reports

  - Hazardous waste disposal area inspection requiring corrective action

ANNUAL EVALUATION OF THE HAZARDOUS MATERIALS AND WASTE PLAN'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Hazardous Materials and Waste Management Program will include a review of the scope according to the current Joint Commission (TJC) standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital.

- A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations where met.

- The performance and effectiveness of the Hazardous Materials and Waste Management Program shall be reviewed by the Safety Committee and administration.

- Changes in the plan will be incorporated into an updated Hazardous Materials and Waste Management Plan by the Safety/Risk Manager, with approval from the Safety Committee.

Name of Policy: **LIFE SAFETY MANAGEMENT PLAN**	North Central Health Care Person centered. Outcome focused.
Policy #: LS-0017	
Primary Approving Body: Safety Officer/Safety Committee	Committee Approvals: Quality Committee of the Board

I. Policy Statement

The objective of the Life Safety Management Program is to design proactive processes to prevent fires and protect patients/clients/residents, staff, visitors and property in the event of a fire.

II. Purpose

Servicing the community through specialized care in a safe environment that protects patients/clients/residents, staff and visitors as well as protecting property from fire, smoke and products of combustion.

Scope

The scope of the Life Safety Management Plan defines the processes which North Central Health Care utilizes to provide an environment that protects patients/clients/residents, staff and visitors, as well as protecting property from fire, smoke and products of combustion.

Goals

- The goals of North Central Health Care Life Safety Management Plan includes the following:

  - To assure that the building is in compliance with applicable NFPA standards for hospitals as well as local fire regulations.

  - To provide education to staff on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire.

  - To assure that staff training in the Life Safety Management Program is effective.

  - To test and maintain the fire alarm, detection systems and suppression systems.

  - To ensure proper maintenance of life safety features, such as fire and smoke walls and fire doors.

  - To provide and maintain portable fire extinguishers.

  - To investigate and implement actions to correct deficiencies, failures and user errors.

  - To establish processes for identifying deficiencies, performing an investigation and correcting those deficiencies.

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

- To maintain the Statement of Conditions as a living document.

Responsibility
The Safety Officer and the On-site Maintenance Manager share joint responsibility for the Life Safety Program and maintaining compliance with the Life Safety Code. Each department manager/supervisor is responsible for orienting new staff members to the department and job specific fire safety procedures. All employees of North Central Health Care are responsible for learning the hospitalwide and departmental fire safety plans.

III. Definitions
None

IV. General Procedure

THE PROTECTION OF PATIENTS/CLIENTS/RESIDENTS, EMPLOYEES, VISITORS AND PROPERTY FROM FIRE, SMOKE AND OTHER PRODUCTS OF COMBUSTION

- It is the responsibility of Chief Executive Officer, On-site Maintenance Manager and the Safety Risk Manager to manage the Life Safety Management Program that protects its patients/clients/residents, employees, visitors and property by providing appropriate fire protection equipment, employee training and interim life safety measures. North Central Health Care is equipped with a fire detection system that is inspected quarterly.

- Hospital buildings undergo inspections and approval by state or local fire control agencies. Inspections and approvals are documented.

- Employees are inserviced on the organizational protocols in response to fire, general fire safety instructions for their departments and/or worksites, where fire extinguishers are located along with the oxygen shut-offs and evacuation routes. Employees are also provided with education regarding aspects of response during a fire that is unique to the individual’s duties.

- North Central Health Care is equipped with general-purpose portable fire extinguishers. The fire extinguishers are located throughout the hospital. It is each employee's responsibility to know the location and how to use these extinguishers.

- Fire Emergency Pre-Plan:

  - Know the location of the nearest fire alarm.

  - Know the how to alert there is a fire by pulling the fire alarm, activating the emergency notification button or callingx 4599.

- Know the location of fire extinguishers and how to use them.
- Know the location of all exits.
- Know proper evacuation procedures and routes.
- See Use of a Fire Extinguisher and Departmental Fire Plans.

MAINTAINING BUILDING STRUCTURAL REQUIREMENTS FOR FIRE PROTECTION

- North Central Health Care and all buildings, which serve to treat patients /clients/residents and are under the ownership or control of the Governing Body, will maintain compliance with the appropriate provisions of the 2000 edition of the Life Safety Code of NFPA. Documentation of all life safety requirements will be maintained on an ongoing visible basis. The On-site Maintenance Manager is responsible for maintaining and managing all structural elements of life safety.
- Life Safety Code deficiencies shall be resolved as soon as they are identified, whenever possible.
- See Risk Assessment Program Policy, Life Safety Code Compliance Policy, Interim Life Safety Measures (ISLMs) Policy, Life Safety - New Construction Policy, Life Safety - Construction Suitability Policy.

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

- The following fire alarm and detection equipment is tested as required by NFPA:
  - Initiating devices are tested:
    - All supervisory signal devices (except valve tamper switches):
      - At least quarterly
    - All valve tamper switches and water flow devices:
      - Every six (6) months
    - All duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes and smoke detectors.
      - Every 12 months
    - Visual and audible fire alarms, occupant alarm notification devices are tested every 12 months, including all speakers.

- All automatic extinguishing equipment shall be inspected and tested as follows:
    - Main drain tests at all system risers or at system low point - every 12 months
    - Fire department connections - inspected every quarter
    - Kitchen automatic fire extinguishing systems - every six (6) months - (discharge of fire extinguishing system not required)
    - Carbon dioxide and other gaseous automatic fire extinguishing systems - every 12 months - (discharge of fire extinguishing system not required)
    - Portable fire extinguishers inspected - at least monthly - maintained every 12 months
- Stand pipes: At this time NCHC does not have any stand pipes.
- Fire protection equipment:
    - Fire and smoke dampers - one (1) year after installation, and at least every six (6) years to verify they fully close
        - The initial testing applies only to those dampers installed on or after January 1, 2008.
    - Automatic smoke detection shutdown devices for air handling equipment - every 12 months
- System monitoring and transmission of signal every quarter:
    - Simplex monitors and automatically transmits the fire alarm signal to the Wausau Fire Department.
    - Crisis Center monitors the fire alarm system in order to identify the location of alarm, reset and other internal functions.

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

- All fire equipment failures or user errors shall be immediately reported to 4488, Administrator on Call.
    - Fire equipment failures shall be investigated and action taken to correct the problem.
    - Retraining shall be conducted when user errors occur.

- A comprehensive plan to correct any Life Safety deficiencies, which occur or are identified will be developed immediately in writing and will address:
    - All Life Safety Code deficiencies
    - Corrective actions (plan for improvement)
    - Total cost of actions and specific funding information
    - reasonable schedule for completion
    - Coordination with available funding
    - All interim life safety measures have been implemented and are currently enforced
- All fire protection equipment failures or user errors shall be reported immediately and appropriate action taken. When a user error occurs, retraining will be conducted.
- See Life Safety Code Compliance Policy and Interim Life Safety Measures (ISLMs) Policy.

REVIEW OF PURPOSED ACQUISITIONS OF FURNISHINGS AND EQUIPMENT FOR FIRE SAFETY:

- All purchases of hospital furnishings and equipment will be reviewed to determine if they meet fire retardant characteristics and flame spread necessary for continued fire safety. All materials must meet the requirements of the NFPA.
- The Safety Officer, On-site Maintenance Manager and the Materials Management Director are responsible for reviewing new products to verify that the products meet code requirements. The On-site Maintenance Manager is responsible for the installation of fire rated products during construction. The On-site Maintenance Manager will maintain records on all products installed during construction projects. The Materials Management Director maintains records on all replacement products that are fire rated.
- .

FIRE DRILLS:

- Fire drills shall be conducted once per shift per quarter in each building defined as a healthcare occupancy by the Life Safety Code.
    - At least 50% of drills are unannounced.
- Fire drills shall be conducted quarterly in each building defined as an ambulatory healthcare occupancy.

- At least 50% of drills are unannounced.

- Fire drills shall be conducted every 12 months from the date of the last fire drill in all free-standing buildings classified as business occupancy and in which patients/clients/residents are seen or treated.

- All fire drills shall be critiqued to evaluate:

  - Fire equipment

  - Fire safety building features

  - Staff response

- The evaluation of drill drills shall be documented and maintained in System Manager's Office.

ORIENTATION AND EDUCATION TO LIFE SAFETY PROGRAM:

- All staff (including physicians and other licensed independent practitioners) will have knowledge of:

  - Specific fire protocols in addition to their specific roles and responsibilities at the point of origin of a fire and away from the point of origin

  - Use and functioning of fire alarm systems

  - Containing smoke/fire with building compartmentalization

  - Preparing for building evacuation

  - Location and proper use of equipment to evacuate or transport patients/clients/residents to a safe area

- Volunteers, students and physicians will be trained in their specific role and responsibilities in the fire plan.

- All new employees will receive general fire safety information at the hospitalwide orientation program.

- In addition to the initial hospital orientation, all employees will be oriented by their department managers/supervisors on job specific fire safety responsibilities and processes, including location of fire alarms and extinguishers, evacuation routes, department specific fire hazards, measures to avoid fires, etc.

- All employees will be inserviced at least annually in a mandatory continuing education program, which will include the Life Safety Program. Attendance records will be maintained in the employees' file.

- Human Resources will maintain data on the number of employees completing orientation and continuing education and report to the Safety/Environment of Care Committee.

- Effectiveness of the education and training program will be evaluated via ongoing review of fire drill critiques and performance improvement activities conducted related to the critiques.

- An annual evaluation of training effectiveness will be performed annually through aggregated data obtained from fire drill critiques and evaluations, as well as ongoing performance improvement monitoring outcomes.

PERFORMANCE STANDARDS:

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organizationwide 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 are 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 (1) or more of the following:

- Staff knowledge and skills
- Level of staff 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, the Safety Committee will follow the organization's improvement methodology, the PDCA model. 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/Environment of Care 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 and the On-site Maintenance Manager at least on a quarterly basis, with a report of performance outcomes forwarded to the Organizational Performance Improvement Committee, Medical Executive Committee and Governing Body quarterly.

- The following performance measures are recommended:

- Percent of staff able to demonstrate their knowledge, skill and level of participation in the Life Safety Management Program
- Number of fire drills conducted with at least 50% of these on an unannounced basis
- Percent of staff who can describe organizational protocols for fire response
- Percent of staff who can describe evacuation procedures for their unit
- Percent fully operational fire doors
- Percent of tests completed for:
  - Supervisory signal devices - Quarterly
  - Valve tamper switches – Semiannually
  - Duct detectors – Annually
  - Smoke detectors – Annually
  - Heat detectors – Annually
  - Manual fire alarm boxes – Annually
  - Electromechanical releasing devices – Annually
  - Occupant alarm notification devices – Annually
  - Emergency forces notification transmission equipment - Quarterly

- See Safety Committee PI Monitoring and Evaluation Plan.

EMERGENCY MANAGEMENT PROCEDURES:

- Emergency management procedures will be coordinated between the Safety Officer and department managers/supervisors. Each department manager will develop department specific emergency management procedures according to the need of their patient/client/resident population. A copy of department specific fire emergency procedures is located In the Crisis Center. The department manager is responsible for reviewing the content of emergency procedures at least once a year.

- The following emergency procedures will be implemented in the event of a fire:
  - **R** = Rescue patients/clients/residents immediately from fire or smoke area.

- **A** = Pull fire alarm station and call emergency number, give exact location.
- **C** = Contain the smoke or fire by closing all doors to rooms and corridors.
- **E** = Extinguish the fire (when safe to do so).

- General Instructions for All Employees:
  - Keep telephone lines clear for fire control.
  - Do not use elevators.
  - Make sure all fire, corridor and room doors are closed.
  - Clear all corridors and exits of obstructions and unnecessary traffic.
  - All nursing staff shall report to their areas and remain there for instructions.
  - All other staff shall report to their areas and await emergency assignment as needed.
  - Assure patients/clients/residents, if any are aware of the fire. Inform them that the alarm has been turned in, the emergency plan is in effect, and there is an abundance of help to assist as needed.
  - Know evacuation routes.

ANNUAL EVALUATION OF THE LIFE SAFETY PLAN:

- The annual (every 12 months) evaluation of the Life Safety Management Program will include a review of the scope according to the current accrediting organization standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations where met. Included in this evaluation will be an evaluation of the effectiveness of staff training related to the Life Safety Plan and its components.

- The performance and effectiveness of the Life Safety Management Program shall be reviewed by the Safety/Environment of Care Committee, the Performance Improvement Committee and administration.

- See Annual Evaluation of the Effectiveness of the Life Safety/Fire Safety Program.

V. Program-Specific Requirements:

N/A

References:

2016 NCHC Resource Management Plan

The Problem

ThedaCare has identified the need to have as part of its emergency management plan, processes for sustaining and managing resources such as utilities, food and water during an emergency without community support for up to 96 hours.

Aim/Goal

Our goal was to develop a measured sustainability tool for utilities and resources to continue essential services with on-site resources. This tools assist the Incident management Team in outlining conservation and rationing strategies to maintain essential services and establishes trigger times for evacuation when the environment can no longer support care.

The Team

Emergency Management Staff, Facilities, Food services, EVS, Respiratory, Materials Management, Pharmacy

The Interventions

- Development of measured sustainability tool by resourced based on assumed numbers of patients, staff and visitors
- Collected data on amounts kept on hand or stockpiled at any given time at the Medical Center
- Fed amounts into tool; added conservation techniques and calculated sustainability time.

The Results

- Resources: Based on daily census of 117 patients and 175 staff members

Categories	24 hours	48 hours	72 hours	96 Hours
PPE	Yes	Yes	Yes	Yes
Water – Potable	Maybe	No	No	No
Water – Non-potable	Yes	Yes	Yes	Yes
Fuel	Yes	Yes – with conservation	Yes – with conservation	Yes – with conservation
Medical supplies	Not available			
Oxygen	Possibly	No	No	No
Medication	Yes – with conservation	Yes – with conservation	Yes – with conservation	Yes – with conservation
Food	Yes	Yes	Yes	Yes
Utility	Yes	Yes – with conservation	Yes – with conservation	Yes – with conservation
Communication	Yes	Yes	Yes – with conservation	Yes – with conservation
Security	Yes	Yes	Yes	Yes
Staffing	Yes	Yes	Yes	Yes

Lessons Learned

To develop a complex plan to address this need to took significant time to bring all stakeholders to the table and encage the participants in the process improvement.

Next Steps/What Should Happen Next:

- Exercising the tools and plan via a senior leadership tabletop, leading to a functional exercise involving critical infrastructure interruption where the Medical Center must maintain services for a period of time without local support.

Name of Policy: **SAFETY AND SECURITY MANAGEMENT PLAN**	North Central Health Care Person centered. Outcome focused.
Policy #: EOC-0002	
Primary Approving Body: Safety Officer/Safety Committee	Committee Approvals: Quality Committee of the Board

I. Policy Statement

The Safety and Security Management Plan defines how North Central Health Care as an organization maintains the safety and security of the established environment, equipment, supplies, and information at all organizational locations. Oversight of medical information security is a function of the HIPAA Officer and Corporate Compliance Committee. This management plan also describes the process North Central Health Care implements to effectively minimize the inherent safety risks associated with providing services, and the performance of daily activities by employees, contractors, clinicians, medical staff, and volunteers, as well as the environment in which services occur.

II. Purpose

There are inherent safety risks in the healthcare environment to which patients, residents, clients, employees, contractors, clinicians, medical staff, volunteers, and visitors are exposed. North Central Health Care proactively works to identify these risks in an attempt to prevent or mitigate associated effects. General Principles:

- Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or from situations beyond the organization's control such as weather. Safety incidents are most often accidental.
- Security risks are often intentional, caused by individuals within or outside the organization. The security program is designed to protect individuals and property against harm or loss.

III. Definitions

Credible External Sources - External sources which include, but are not limited to, manufacturer recalls, Federal Drug Administration (FDA) notices, Environmental Protection Agency (EPA), The Joint Commission Sentinel Event Alerts, Stayalert notifications from MCN Healthcare, State of Wisconsin Department of Health notices, security alerts from Aspirus Wausau Hospital, Saint Clare Hospital-Weston, City of Wausau Police Department, Marathon, Lincoln, and Langlade County Sheriff's departments, Wausau Chamber of Commerce, COAD and the Wisconsin Hospital Emergency Preparedness Program's WI Trac. These sources are monitored for applicable risks to the North Central Health Care organization. News articles and literature reviews are completed by the Inpatient and Outpatient Service

Line leaders for their assigned programs. Concerns identified are addressed through informational sessions, as well as organizational policies and procedures.

IV. General Procedure

A. North Central Health Care manages risks by identifying qualified individual(s) to manage risk reduction activities in the environment of care, collect information on deficiencies and disseminate summaries of actions and results.

This information is disseminated to individuals with responsibilities for the issues being addressed. These deficiencies include injuries, problems, use, or process errors. These individual(s) oversee the development, implementation, and monitoring of safety management:

- The Senior Executive of Quality and Support Services has been appointed Safety Officer for the organization. The Safety and Risk Manager may intervene in the absence of the Safety Officer.

- The Senior Executive of Quality and Support Services, Safety and Risk Manager, and the Safety Committee oversee the management of the safety and security program.

- The Safety Committee consists of representatives from administration, clinical services, and support services. Safety issues are reviewed and analyzed at the Safety Committee meetings. Report findings and actions are reported to the Quality Sub-Committee of the Board and forwarded to the Board of Directors as appropriate. Key safety and security indicator(s) are selected for performance improvement annually. Oversight of the performance improvement indicators is a function of the Safety Committee.

B. North Central Health Care identifies safety and security risks associated with the environment of care by the following (EP1 EC02.01.01):

- **Ongoing Monitoring (Rounding) of the Environment:**
  Safety and security concerns are proactively identified through safety rounds conducted at least annually in all areas and semi-annually in all patient, resident, or client care areas. Executive rounding, front-line leadership rounding, and environmental tours are completed by the the respective teams.. Employees and contractors are coached to recognize and report any safety or security concerns directly to their reporting supervisor, during department meetings orthrough the occurrence reporting line (#4488).

- **Root Cause Analysis (Cause Effect Analysis):**
  As necessary, and with facilitation from the Quality Data Specialists, the Inpatient and Outpatient Service Line executives, directors, managers, and

supervisors conduct a cause effect analysis of occurrences, designated as sentinel events, in their programs to evaluate processes and prevent recurrence.

A sentinel event, defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof when under North Central Health Care's care or related organizational operations to include: Suicide, suicide attempt, fracture, major injury, unexpected deaths, death from the use of physical restraints, chemical restraints, seclusions, or psychotropic medications, or significant medical outcome as the result of a medication error. The summaries are reported and reviewed by the Safety Committee as requested by the Safety and Risk Manager.

- **Proactive Risk Assessments of High Risk Processes:**
  Risk assessments, when completed, include a review of occurrence reports, the physical environment, practices and policies, a review of codes, standards or literature, and a gap analysis with recommended changes provided to Administration for approval for implementation and/or consideration for potential inclusion into improvement priorities. Such evaluation is also assisted by the use of reports from various resources such as insurance companies and state or county health agencies or regulatory bodies.

  -Potential high risk concerns include threat of workplace violence, consumer suicide, presence of weapons or firearms, orientation of law enforcement personnel, property security, and information security.

  -Pro-active risk assessments include environmental tours, Inpatient and Outpatient Service Line meetings, executive rounding, a comprehensive preventative maintenance program of buildings and equipment, collaborative relationships with law enforcement, and the organization's Hazard Vulnerability Assessment.

C. North Central Health Care takes actions to minimize or eliminate identified safety and security risks in the physical environment by (EP 3 EC02.01.01):

- North Central Health Care conducts environmental tours to assess employee and contractor knowledge and behavior, identify new or altered risks in areas where construction or changes in services have occurred, and identify opportunities to improve the environment. Safety rounds, to identify environment deficiencies, hazards and unsafe practices are conducted at least every six months in all areas where patients, residents, or clients are served and annually in other areas.

- Identifying unsafe conditions or acts by employees, contractors, clinicians, medical staff, volunteers, or visitors which are brought to the attention of the Inpatient and Outpatient Service Line executives, directors, managers, and

supervisors are monitored as appropriate until the issue is resolved. When appropriate, the unsafe condition is reported directly to Executive Team members or through the “4488” occurrence reporting line, which is continually monitored by Executive Team members.

- Establishing and implementing safety and security policies and procedures that are distributed, practiced and reviewed as frequently as necessary, but at least every three years.

- Providing security oversight of patient information by the HIPAA Officer and Corporate Compliance Committee. Administrative policies have been established to address the various security issues concerning patients, residents, clients, visitors, clinicians, medical staff, Electronic Protected Health Information (ePHI) and property identified through the risk assessment process and the review of security occurrences.

- On-site Maintenance Manager, Infection Prevention Specialist, Safety and Risk Manager, maintenance and housekeeping, routinely monitor the building, grounds, construction areas and the parking lot for hazardous conditions. When hazardous conditions are noted, the condition is either rectified immediately or a maintenance work order request is issued. Evaluation of risk and plans of correction relating to significant occurrences are forwarded to the Safety Committee for evaluation of trending, analysis, and action. The Executive Team, in conjunction with assistance from the Performance Improvement Specialist and Safety Committee has developed performance measures (indicators) for each of the functions which are maintained on the organization dashboards. The effectiveness of performance measures is assessed as part of the annual evaluation of the Environment of Care and reported to the Board of Directors as such.

- The Senior Executive of Quality and Support Services has been appointed Safety Officer for the facility. The Safety and Risk Manager may intervene in the absence of the Safety Officer to take actions to minimize or eliminate identified safety and security risks in the physical environment.

- Occurrence analysis is intended to provide an opportunity to identify trends or patterns that can then be used to identify changes to the Safety and Security Management Plan to control or prevent future occurrences. A failure modes and effects analysis (FMEA) is conducted annually by the Safety Officer on a high hazard or high-risk process. The Safety Committee or other process committee, as appropriate, may assist in conducting this review assessment. Sentinel event alerts, near miss opportunities and literature reviews may be evaluated to provide process improvement strategies. A root cause analysis (cause-effect analysis) will be conducted on sentinel events and those deemed significant to provide an action plan to improve the process and prevent recurrence. Information and actions related to occurrences and analysis of such events is reported to the Safety Committee and the Quality Committee of the Board.

D. North Central Health Care maintains the grounds, buildings and equipment (EP 5 EC02.01.01):

- On-site Maintenance Manager supervises and maintains grounds and equipment, clinical, therapeutic, and diagnostic equipment, with the assistance of contracted services from Midwest Biomedical & Scientific Services. Competency of contracted services is confirmed by surveillance and yearly audit of services by designated individuals. Any related grounds, buildings, or equipment related significant occurrences are to be forwarded to the Safety Committee for review. Work orders are developed, assigned, and completed for preventive and corrective maintenance of equipment. The grounds staff conducts visual surveillance of the property on a daily basis, and more frequently in the event of changing conditions such as weather.

E. North Central Health Care identifies individuals entering its facilities by (EP 7 EC02.01.01):

- Human Resources provides new employee photo identification badges, as well as replacement badges as necessary. All employees are required to wear issued identification badge above the waist while on duty, with the name and photograph plainly visible.

- Vendors - All vendors are to report to the front entrance Welcome Center to check in and out of the North Central Health Care property. After checking in, the venders will report to Human Resources where the staff will verify their appointment and provide them with a visitor identification badge.

- Construction workers - All construction workers working inside North Central Health Care will report to the On-site Maintenance Manager or designee, where they will be briefed in safety, infection prevention and control, emergency procedures, and confidentiality. The On-site Maintenance Manager or designee will confirm that the construction worker has appropriate photo identification to be worn whenever inside the facility.

- Residents/Patients – Identification of residents/patients is provided by a photo ID or an identification band provided by a registering party upon their admission. The photo ID or identification band will include the residents/patient’s name, birth date and unique medical record number. The photo ID or identification band is checked by all clinical personnel prior to administration of medications or blood, collection of blood or other samples for clinical testing, or prior to other tests and treatments.

- Staff is encouraged to challenge any individual without proper identification (e.g., no identification badge and/or without apparent reason to be in the area). Such individuals may be detained, questioned and/or escorted from the facility by designated individuals at the discretion of the Safety Officer.

F. ***North Central Health Care controls access to and from areas identified as security sensitive (EP 8 EC02.01.01)***:

- Sensitive areas involving all North Central Health Care locations include but are not limited to: Administration, Pharmacy, Plant Operations, Crisis Emergency Services, Behavioral Health Services, Laboratory Storage, Medical Record Storage, Biohazardous Waste Storage, Information Systems, Electrical and Maintenance rooms, and Hazardous Chemical Waste Storage. Program leaders, with the assistance of the Safety and Risk Manager, are responsible for educating and updating staff on any associated security issues in these areas.

- Environmental Services and/or Security will lock down the facility at specified hours at night until a specified hour in the morning. The Safety Officer or Chief Executive Officer or designee will also lock down the facility during emergencies that require the protection of the facility as outlined in the Emergency Plan (Incident Command Activation) and the Emergency Operations Plan (EM.01.01.01)

- All requests for facility keys are processed through the On-site Maintenance Manager.

G. North Central Health Care implements these following written procedures in the event of a security incident. (EP 9 EC02.01.01):

- An occurrence report is completed for any security incident that is not consistent with the routine operations of the facility or the routine care of a particular consumer. An occurrence may be any situation or condition which could adversely affect the patient, resident, client, visitor, employee, physician, volunteer, student, or the facility. Events involving property damage are reviewed and investigated by Inpatient and Outpatient Service line leaders, the Safety Officer, Safety and Risk Manager, On-site Maintenance Manager, and Safety Committee as necessary. Occupational illness and employee occurrence reports are reviewed and investigated by Inpatient and Outpatient Service Line leaders, Human Resources, the Safety Officer, Quality and Performance Excellence including the Performance Improvement Specialist, Safety and Risk Manager, Employee Health Specialist, Infection Prevention Specialist, and On-site Maintenance Manager as necessary.

- Patient, resident, client, and visitor occurrence reports are reviewed and investigated by Inpatient and Outpatient Service Line leaders, the Performance Improvement Specialist, Safety Officer, Safety and Risk Manager, and Safety Committee.

H. Threats, harassment, aggressive or violent behavior to employees, patients, residents, clients, volunteers, medical staff, visitors or others will not be tolerated. See associated organizational policies for specifics.

Security Occurrences:

- North Central Health Care employees will call the immediate notification line (#4488), which is continually monitored and responded to by the Executive team, and complete an occurrence report for any environmental emergency, including but not limited to fire, weapon presence, bomb threat, computer outage, utility failure, or property damage which could result in a related security event. Such occurrences will be forwarded to the On-site Maintenance Manager or designee, Safety Officer, Safety and Risk Manager, and Safety Committee as appropriate.

- Security occurrences requiring action plans will be reported to the Safety Committee via the On-site Maintenance Manager, Safety Officer, Safety and Risk Manager, or designated representative.

- In the event that any person becomes aware of any suspicious individuals or activities in the facility, the person shall immediately notify the Human Resources Director, Safety Officer, Safety and Risk Manager or any Executive leader, giving the location of the individual and/or activity warranting further investigation.

- The provision of additional staff to control human and vehicle traffic in and around the environment during disasters is outlined in the Emergency Management Plan (EM 01.01.01) and the Internal/External Emergency Plan (Incident Command Activation).

I. NCHC controls access to health information

The Information Services Director is designated as the Health Insurance Portability and Accountability Act (HIPAA) security officer. The HIPAA security officer will be responsible for developing, implementing and overseeing security policies and procedures to ensure information management compliance for North Central Health Care. The ePHI (electronic protected health information) systems are managed to ensure effective, safe and reliable operation essential to the proper operation of the environment of care. These systems will significantly contribute to effective, safe and reliable provisions of care to patients by:

- Ensuring operational reliability of computer systems that contain ePHI.

- Reducing the potential of system outages.

- Providing a process for the continuation of care in the event any of the computer systems are unavailable.

These objectives are met by:

- The design and implementation of computer systems which will meet all HIPAA requirements to provide privacy, confidentiality, and security of patient information.

- Establishing backup, recovery, and emergency modes of operation in the event that computer systems are not available to system users.

J. North Central Health Care responds timely and appropriately to product recalls and notices for the health and safety of patients, residents, clients, employees, and visitors as required. (EP 11 EC02.01.01)

- **Medical Equipment**
  Therapeutic diagnostic equipment hazard notices are received from a variety of external resources. All such notices are referred to Inpatient and Outpatient Service Line leaders, the Safety Officer, Safety and Risk Manager, and/or On-site Maintenance Manager and designees. The select facility personnel (as determined by the device/product affected) investigate the pertinence at North Central Health Care and if applicable, for action following procedures as outlined.

- **Supplies**
  Product safety alerts, product recall notices, and hazard notices are received from a variety of external resources. All such notices are referred to the Purchasing Manager and select facility personnel (as determined by the device/product affected) who each investigate the pertinence at North Central Health Care and if applicable, for action following procedures as outlined. The results of each alert, notice, or hazard or any notices that require action are forwarded to the Safety Officer and/or Safety Committee for review.

- **Medications**
  Product safety alerts, product recall notices, hazard notices are received from a variety of external resources. All such notices are referred to the Pharmacy Director. The Pharmacy Director investigates the pertinence at North Central Health Care and if applicable, for action following procedures outlined.

- **Product Recalls**
  Product safety recall information and follow-up are the responsibility of the Safety Officer, Purchasing Manager, Pharmacy Director, On-site Maintenance Manager, Safety and Risk Manager, as well as designees in the involved departments. A monthly report is provided to the Safety Committee on any hazard notices or recalls and associated follow-up activities affecting the facility.

K. For the health and safety of the patients, residents, clients, visitors, staff, and physicians, smoking is prohibited in any of the hospital's buildings or on hospital grounds. (EP 1 EC02.01.03)

North Central Health Care promotes a smoke free campus; however recognize that some of our residents may have a need to smoke and are permitted to smoke in designated areas.

The Employee Health Specialist in conjunction with the Wellness Committee provides educational literature and guidance regarding the availability of smoking cessation programs. All staff are responsible for the enforcement of the smoking policy. Employees are encouraged to report violations to their immediate supervisor.

ADDITIONAL FOCUS

North Central Health Care Program Directors are responsible for implementation of the safety program within their respective departments. The directors conduct frequent rounding and address safety and security concerns at the time of identification. The Safety Committee will oversee the department implementation and monitoring of the Safety and Security Management Plan.

The Safety Officer, Safety and Risk Manager, On-site Maintenance Manager and designees are responsible for daily security activities and functions, as well as over-all implementation of the Safety and Security Management Plan. Safety and security evaluation occurs daily, with security staff accessibility available as necessary through an external security resource.

Evaluation of the Environment of Care-Safety and Security Management Plan will be formally evaluated by the Safety Officer, Safety and Risk Manager, On-site Maintenance Manager and designees, and Safety Committee annually and findings to the Board of Directors provided through a performance improvement structure.

V. Program-Specific Requirements:

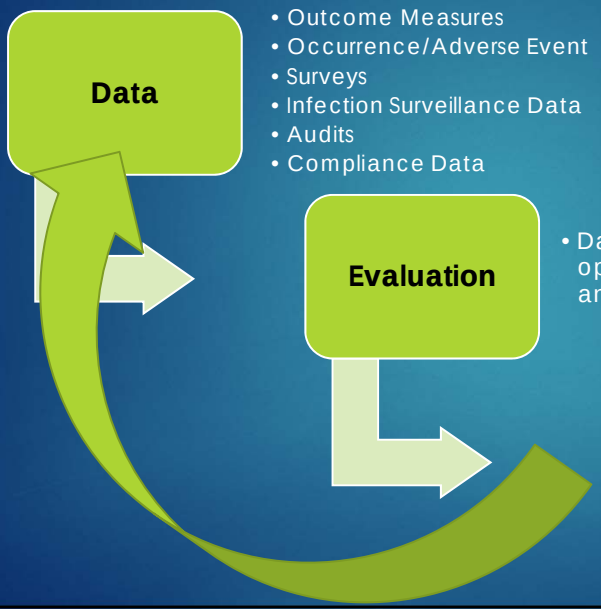
References:

Quality Moving Forward

A DISCUSSION TO PREPARE FOR 2017

North Central Health Care
Person centered. Outcome focused.

Quality Structures and Process



- Outcome Measures
- Occurrence/Adverse Event
- Surveys
- Infection Surveillance Data
- Audits
- Compliance Data

- Data is evaluated by operational leaders and committees

- 90 day action plans
- Process Improvement Teams

Quality Committee Structure

Discussion Questions

When assessing the Quality process at NCHC:

- What is working well that we should continue to strengthen and grow?
- What opportunities should we focus on moving forward?
- Are there changes that should be made to the Quality structures and/or reporting process that should be considered?