

# **Chapter: Committees (CM)**

## **Section 1: Selection of Standing Committee Members**

### ***Policy***

Committees are composed of a chairperson, manager, and members.

### ***Procedures***

1. The Executive Staff appoints chairpersons and managers to each of the standing committees.
2. The discipline directors, medical staff and unit administrative directors are consulted regarding the makeup of committee membership.
3. Executive Staff appoints individuals to serve on a given committee with review of assignment periodically.
4. A list of committee chairpersons, managers, and members is distributed following each revision.
5. Performance Improvement (PI) Council monitors the status of committees and reports any concerns to executive staff.
  - 5.1. Committees report general information of operational status to PI Council.

---

*Implemented: 10-23-85*

*Revised: 3-17-88*

*Reviewed: 12-90*

*Reviewed: 3-92*

*Reviewed: 2-93*

*Revised: 8-95*

*Revised: 12-98*

*Reviewed: 3-02*

*Revised: 1-05*

*Reviewed: 9-07*

*Revised: 4-09*

*Reviewed: 8-12*

---

# **Chapter: Committees (CM)**

## **Section 2: CME Committee Guidelines**

### ***Mission***

The Utah State Hospital CME Committee's mission is to provide Utah State Hospital psychiatrists and other physicians with strategies / tools to bring about needed change in competence, performance, or patient outcomes.

### ***Functions/Objectives***

1. Identify educational needs / practice gaps by reviewing:
    - 1.1. PI Council minutes;
    - 1.2. topics suggested on CME evaluation forms via a quarterly review of summary evaluations;
    - 1.3. suggestions / observations from physicians or other staff.
    - 1.4. observations / recommendations / requirements of outside regulatory bodies;
    - 1.5. recommendations from death reviews;
    - 1.6. recommendations from root-cause analyses of sentinel events.
  2. Screen suggested CME topics; establish expected results that will provide participants with strategies / tools to bring about needed change in competence, performance, or patient outcomes; establish course objectives; select presenters; and communicate course objectives to presenters.
  3. Establish methods to determine if expected results were achieved.
  4. Engage in ongoing and formal annual program evaluation and take action as necessary in order to bring about improvement.
  5. Ensure that all CME activities meet the Accreditation Council for Continuing Medical Education (ACCME) standards for commercial support and Utah State Hospital CME Committee policy on commercial support, including obtaining a letter of agreement between the hospital and any commercial supporters regarding the terms, conditions, and purposes of educational grants; obtaining conflict-of-interest disclosures and CME attestations from presenters regarding significant financial relationships; and disclosing on all CME flyers, brochures, and announcements, and evaluation forms any such relationships and any use of commercial support; and obtaining conflict-of-interest disclosures from CME Committee members annually.
  6. Accept responsibility as per the Utah State Hospital CME Committee Joint Sponsorship Policy, that the essentials and standards of the ACCME are met when educational activities are planned and presented in joint sponsorship with non-accredited sponsors, including ensuring that the activity conforms to the CME mission of the Utah State Hospital.
  7. Make recommendations concerning acquisition of professional journals.
-

## **Structure**

Membership: All members of the CME Committee are physicians. The Administrative Secretary serves as the committee manager.

Meetings: CME Committee business is conducted as needed during the monthly meetings of the Medical Executive Committee Leadership Group.

Minutes: Minutes are recorded and kept on file by the Administrative Secretary. They are approved by the CME Committee Chairman.

---

*Implemented: 12-30-82*

*Revised: 8-12-86*

*Revised: 3-20-89*

*Revised: 12-04-90*

*Revised: 3-92*

*Reviewed: 2-93*

*Reviewed: 4-25-95*

*Revised: 11-98*

*Revised: 3-02*

*Revised: 1-05*

*Revised: 9-07*

*Revised: 4-09*

*Revised: 6-12*

---

# **Chapter: Committees (CM)**

## **Section 3: Ethics Committee Guidelines**

### ***Mission***

The Ethics Committee of the Utah State Hospital reviews ethical and patient rights issues related to important aspects of patient care not able to be satisfactorily resolved at the treatment-unit level or by other established policies and procedures.

### ***Function***

Issues reviewed by the Ethics/Human Rights Committee may include, but are not limited to the following:

1. patient abuse;
2. patient refusing medically indicated treatment (medication, etc.);
3. patient and/or family concerns;
4. medical/surgical requests and/or problems;
5. unusual treatment, including pre-investigational and/or unusual medications;
6. issues surrounding personal life choices of patients;
7. religious issues;
8. language problems;
9. DNR policy and procedure;
10. other ethical and rights concerns.

### ***Structure***

**Leadership:** The Ethics Committee Chairperson is the Hospital Assistant Clinical Director.

**Membership:** The membership includes the following: The Hospital Clinical Director, Program Directors, Nursing Administration, Director of Social Work, President of the Medical Staff, nursing personnel, Hospital Patient Advocate, Clergy, a Family Member / community member, and a physician. Other hospital staff and/or outside consultants may be included when appropriate. Patient's family and friends are invited when appropriate.

**Meetings:** Meetings are held as needed.

---

## ***Role of the Committee***

The committee serves as a consulting body to the Hospital Administration and Clinical Services. The committee assesses ethical issues and makes recommendations as appropriate.

---

*Implemented: 3-24-88*

*Revised: 6-21-89*

*Reviewed: 12-90*

*Revised: 3-92*

*Revised: 2-93*

*Revised: 9-95*

*Revised: 12-98*

*Revised: 2-02*

*Revised: 1-05*

*Reviewed: 9-07*

*Revised: 4-09*

*Revised: 5-12*

---

# **Chapter: Committees (CM)**

## **Section 4: Infection Control Committee Guidelines**

### ***Mission***

The responsibility of monitoring the infection control program is vested in a multi-disciplinary committee.

### ***Functions***

1. Determines the type of surveillance and reporting programs to be used in the hospital.
  2. Reports nosocomial infections; including respiratory, gastro-intestinal, skin/wound, genitourinary, milieu and others. Recording of data includes, at a minimum, the following:
    - 2.1. hospital-wide statistics, including types of infections;
    - 2.2. unit statistics, including most common infections;
    - 2.3. laboratory testing, including Hepatitis panels, HIV, and cultures;
    - 2.4. case evaluation of high-risk or unusual infections; and
    - 2.5. reportable infectious processes.
  3. Recommends actions based on information obtained and infection control principles.
  4. There is a full-time Infection Control Coordinator, a registered nurse, employed to do surveillance. The Infection Control Coordinator, in addition to collecting required data and routinely carrying out surveillance, is also involved in the following:
    - 4.1. identifying and investigating clusters of infections;
    - 4.2. investigating single cases of unusual nosocomial infections;
    - 4.3. developing and implementing methods to improve patient care procedures;
    - 4.4. developing employee health programs and in-service education on infection control;
    - 4.5. reporting required cases to the Public Health Department; and
    - 4.6. identifying nosocomial infections post discharge, when possible.
  5. Infection data originates in the nursing care unit, in one or more of the following ways:
    - 5.1. The physician or nurse practitioner writing the order identifies the infectious process in the written order;
    - 5.2. The registered nurse receiving the order verifies the suspected infectious process in the order;
-

- 5.3. The registered nurse notifies Infection Control via E-mail or phone message of new anti-infectives ordered, or newly identified infectious processes;
  - 5.4. Nursing administration, Medical services staff, shift-supervisors or other interested staff report any patterns, trends or concerns relating to infection control.
  - 5.5. The Infection Control Coordinator identifies areas of concern based on direct observation or informal reports from staff.
  6. The data are evaluated by the Infection Control Coordinator.
    - 6.1. The Infection Control Coordinator consults with the Director of Medical Services when warranted by the situation.
    - 6.2. Authority is delegated by the Director of Medical Services to the Infection Control Coordinator or to unit registered nurse practitioners or unit registered nurses to:
      - 6.2.1. report any actual or suspected infection; and,
      - 6.2.2. initiate appropriate isolation procedures.
    - 6.3. When any of these actions are taken, the appropriate medical staff member responsible for the patient's care is notified.
  7. The Infection Control Committee reviews infections in the hospital with regard to proper management and epidemic potential.
    - 7.1. The Infection Control Committee determines the presence of nosocomial infections and recommends actions to minimize such.
    - 7.2. Review may be directed to surveillance data when available, looking for unusual epidemic, clusters, infections due to unusual pathogens, or any occurrence of nosocomial infections that exceed the acceptable levels.
      - 7.2.1. The Infection Control Committee has determined that a case rate of 8 per 1000 patient days is the maximum acceptable level for the hospital.
  8. The Infection Control Committee reviews the results of any cultures required by any state, federal, or local agency.
    - 8.1. Sampling is usually reserved for specific situations when the outcome can be expected to have a potential beneficial effect on the standards of care or to support change in maintenance or personnel practices.
    - 8.2. Occasional sampling may be used as a quality control mechanism or as an educational exercise.
  9. Proposals and protocols for all special infection control studies conducted and results of such studies are reviewed.
  10. The committee reviews guidelines and recommendations from various sources (i.e. OSHA, CDC, NIH, APIC) and makes recommendations for the hospital.
-

11. Pertinent related findings of other committees are reviewed and discussed.
12. Pertinent findings are incorporated into the in-service education and orientation programs.

### **Structure**

1. Authority of the Infection Control Committee is approved in writing by the hospital administration and the medical staff.
2. Membership includes representation from medical staff, administration, nursing services, pharmacy, risk management, support services, and other representation as needed. An effort is made to include a member of the State Health Department on at least a consultative basis.
3. The Infection Control Coordinator is a registered nurse and serves as Infection Control Committee Manager.
4. The Chairman of the Infection Control Committee is a physician with interest and experience in infection control. The Chairman must be present in Infection Control Committee meetings in order for clinical decisions or policy changes to be made.
5. Meetings are held ten times per year and as necessary.
6. Minutes are recorded of each meeting and are circulated to each member of the committee and the Nursing Administrator.
7. The Infection Control Committee reports its findings and recommendations to medical staff, the Hospital Superintendent, and the Nursing Administrator *via* appropriate committee representatives and through copies of minutes.
8. The Infection Control Committee Manager maintains a file of monthly Infection Control Reports.

---

*Implemented: 3-09-83*

*Revised: 10-23-85*

*Revised: 5-16-89*

*Reviewed: 12-90*

*Reviewed: 2-93*

*Revised: 9-95*

*Revised: 11-98*

*Revised: 12-01*

*Revised: 1-05*

*Revised: 3-09*

*Revised: 9-12*

---

# **Chapter: Committees (CM)**

## **Section 5: Medical Records/Information Management Committee Guidelines**

### **Mission**

The Medical Records/Information Management Committee serves a multi-disciplinary function of reviewing, revising, and recommending changes in policies and procedures for the purpose of enhancing the quality of care through documentation.

### **Functions**

Functions of the Medical Records/Information Management Committee include but are not limited to:

1. Review of forms to be used in documentation and charting of patient information.
2. Review electronic charting processes for additions or changes.
3. Revision of Utah State Hospital policies, procedures, forms, and standards as necessary to comply with standards of the Joint Commission on Accreditation of Health care Organizations and Medicare/Medicaid.
4. Dissemination of information concerning policies, procedures, standards, and forms through hospital channels of communication.
5. Participation in the hospital's overall program for the assessment and improvement of quality.

### **Structure**

Membership:	A psychiatrist serves as chairperson of the Medical Records Committee. The Records manager serves as committee manager. Members of the committee include discipline representatives and Quality Resources staff. Others attend upon request or invitation by the committee chairperson or manager.
Frequency of Meetings:	The Medical Records/Information Management Committee meets quarterly. More frequent meetings are scheduled as needed.
Minutes:	Minutes are kept of each meeting and are distributed to each member and to appropriate hospital staff.

---

*Implemented: 3-83*

*Revised: 8-86*

*Revised: 6-88*

*Reviewed: 12-90*

*Revised: 4-92*

*Reviewed: 2-93*

---

---

*Reviewed: 9-95*

*Reviewed: 7-98*

*Reviewed: 12-01*

*Revised: 1-05*

*Reviewed: 9-07*

*Reviewed: 4-09*

*Revised: 5-12*

---

# **Chapter: Committees (CM)**

## **Section 6: Pharmacy and Therapeutics Committee Guidelines**

### **Mission**

The Pharmacy and Therapeutics Committee of the Integrated Medical Staff of Utah State Hospital is a standing committee which meets quarterly in collaboration with the pharmacy staff, nursing service, and hospital administration to implement activities concerned with the objective evaluation, selection, and use of medications at Utah State Hospital. The committee's mission is to promote rational, cost-effective medication therapy within Utah State Hospital. When indicated, a subcommittee of the P&T Committee composed of physician members of the medical staff, and others as indicated, reviews medication usage at USH and makes recommendations to the P&T Committee based on its findings.

The subcommittee usually consists of not more than four, with at least two physician members of the medical staff. An appeal process is afforded any physician who does not agree with the recommendation of the subcommittee regarding his/her prescribing patterns. Appeal must be filed and heard within fourteen days of receiving the subcommittee's recommendation to allow for a petition to the subcommittee to consider additional information and/or clinical rationale which justify his/her prescribing patterns for specific patients reviewed.

### **Function**

The functions of the Pharmacy and Therapeutics Committee include but are not limited to the following:

1. The development or approval of policies and procedures relating to the acquisition, storage, handling, and distribution of medications and diagnostic testing materials.
  2. The development and maintenance of a drug formulary, including changes to the formulary as appropriate. Utah State Hospital has a drug formulary which is reviewed, revised, and updated at least annually.
  3. The review of all adverse drug reactions. An adverse drug reaction is defined as "a response to a medication that is undesired, unintended, and unexpected, that follows the use of a drug in doses recognized as accepted medical practice." The process for reviewing untoward drug reactions includes, but is not limited to the following:
    - 3.1. A nurse, nurse practitioner, pharmacist, or physician identifies the suspected adverse reaction and informs the medication prescriber of the reaction. A nurse, nurse practitioner, pharmacist, or physician may fill out the *Suspected Adverse Drug Reaction* form. However, the physician is ultimately responsible for the reporting of the suspected adverse reaction.
    - 3.2. Medical staff will have as part of its regular weekly meeting agenda the reporting of adverse drug reactions. Report forms will be available at the meeting to enable members of medical staff to report any adverse drug reactions from their units for the previous week(s) that have not yet been reported.
    - 3.3. The *Suspected Adverse Drug Reaction* form is sent to the pharmacy, where it will be initially reviewed, and taken to Pharmacy and Therapeutics Committee for review.
-

- 3.4. P&T Committee reviews the reports, indicates findings, conclusions, recommendations, actions, and follow-up.
4. The evaluation and/or approval of protocols relating to drug use.
5. Providing advisory and educational resources to the medical, nursing, pharmacy, administrative staffs, and others regarding the appropriate usage of medications in the treatment of patients.
6. Monitoring utilization review results, and when appropriate, implementing recommendations or policies to ensure the proper use of medications; especially those which reflect high volume, high risk, or problem-prone usage.
7. Providing monitoring of specific medications by means of written protocols with ongoing evaluation of usage patterns.

## **Structure**

**Meetings:** Meetings are held quarterly, and follow a written agenda of relevant topics that have been previously submitted. Items for discussion are submitted to the committee manager at least three days prior to the meeting. Topics for review and discussion include, but are not limited to the following:

1. Formulary additions or deletions;
2. Policies and procedures for acquiring, prescribing, ordering, dispensing, and administering of medications and diagnostic testing material;
3. All adverse drug reactions;
4. All medication errors;
5. Results of monitoring prescribing patterns of all medications used at USH; especially those of high volume, high risk, and problem prone potential;
6. New warnings or precautions received from the FDA or drug manufacturers regarding specific medications;
7. Appropriate educational activities.

**Minutes:** Minutes of the meetings are taken and distributed to all members of the committee and others as appropriate. Relevant problems identified, along with recommendations, actions, and follow-up, are reviewed both by the P&T and Medical Executive Committees for their appropriateness and as an on-going part of facility-wide Quality Improvement.

---

*Implemented: 6-88*

*Revised: 11-90*

*Revised: 3-92*

*Revised: 3-93*

*Reviewed: 9-95*

*Revised: 3-02*

---

# **Chapter: Committees (CM)**

## **Section 7: Utilization Review Committee Guidelines**

### **Mission**

The Utilization Review Committee (URC) maintains high quality patient care and promotes the most appropriate, efficient, and effective use of available health services and facilities through the implementation of a written utilization review plan. This plan is approved by the Division of Substance Abuse and Mental Health and USH Executive Staff members.

### **Function**

1. Conduct screens, reviews, and patient record audits to ascertain:
  - 1.1. the hospital is meeting the patients' requirements; and
  - 1.2. that patients are receiving the care they need and for which the facility is receiving funding.
2. Conduct screens on all admissions and continued stays to evaluate adequacy and necessity of continued care.
3. Conduct sample studies on extended duration cases, correlating diagnosis(es) with medications prescribed, psychiatric treatment programs, and discharge plans.
4. Act as an appeals board for decisions on individual patients.
5. Submit reports as required.
6. Other activities as determined by the URC, the Hospital Clinical Director, or the Superintendent.

### **Structure**

**Membership:** The URC is chaired by a member of the medical staff. The Utilization Review Coordinator serves as the committee manager. Membership includes but is not limited to two physicians, a representative from the nursing discipline, and other discipline representatives as appropriate.

**Meetings:** The URC meets at least quarterly.

**Minutes:** Written records of all Utilization Review Committee activities, including meeting minutes, are maintained and made available to committee members, executive staff, medical staff, and administrative staff.

**Reports:** Reports are printed and filed in the committee records; copies are maintained by the Utilization Review Coordinator.

---

---

*Implemented: 12-30-82*

*Revised: 11-14-84*

*Revised: 6-16-88*

*Revised: 11-28-90*

*Revised: 3-92*

*Reviewed: 9-95*

*Revised: 6-98*

*Revised: 3-02*

*Reviewed: 2-05*

*Revised: 5-09*

*Revised: 10-12*

---

# **Chapter: Committees (CM)**

## **Section 8: Suggestion Committee Guidelines**

### ***Mission***

To ensure hospital responsiveness to patient, employee, and visitor suggestions and / or concerns by providing a means of having suggestions listened to and concerns addressed in order to improve the quality of patient care provided at Utah State Hospital.

### ***Function***

The Suggestion Committee reviews the suggestions and / or concerns of patients, employees, and visitors, directs them as necessary to the responsible department and/or staff member, and ensures appropriate follow-up in a timely manner.

### ***Procedure***

1. Regularly scheduled meetings are held to review written Statements of Suggestion/Concern.
2. Statements are submitted through the locked Suggestion Boxes located throughout the patient units and in the Owen P. Heninger Administration Building or are sent through the hospital mail to the Employee Advocate, the Patient Advocate, or any member of the Hospital Suggestion/Concern Committee.
  - 2.1. Verbal suggestions reported in meetings, groups, or from one individual to another may be written on Statement of Suggestion/Concern forms to ensure follow-up.
  - 2.2. Statements of Concern may be anonymous.
3. Responses are sent to identified submitters. The copies are kept for one year at which time they are then destroyed.

### ***Structure***

The Assistant Hospital Superintendent/Designee serves as chairperson. A Patient Advocate serves as Committee Manager. Members include the Clinical Risk Manager, the Director of Social Work, the Risk Management Secretary, and others as assigned.

**Meetings:** Suggestion/Concern Committee meetings are scheduled weekly. More frequent meetings are scheduled as needed.

**Minutes:** Minutes are kept of each Suggestion/Concern Committee meeting. Data from the minutes are compiled monthly, quarterly, and yearly as desired and reported in Performance Improvement Council meeting when requested. Signed minutes are retained for five years and then destroyed.

---

---

*Implemented: 1-91*

*Revised: 3-92*

*Revised: 2-93*

*Revised: 9-95*

*Revised: 6-98*

*Reviewed: 2-02*

*Reviewed: 2-05*

*Revised: 4-09*

*Revised: 2-13*

*Revised: 3-13*

---