

Chapter: Environment of Care (EC)

Section 1: Hospital Safety and Violence Prevention Plan

Scope

This plan is developed as a hospital-wide safety plan that encourages the recognition of risks to patient, staff, and visitor safety. This plan also encourages the initiation of actions to reduce risks and provides mechanisms for reporting and resolving risks.

Goal

The goal of the safety management plan is for all employees to understand and participate in safety management.

Policy

1. DESIGNATION OF INDIVIDUAL TO MANAGE THE HOSPITAL-WIDE SAFETY PLAN
 - 1.1. The Utah State Hospital designates the Assistant Superintendent as the individual to manage the hospital-wide safety plan.
 - 1.2. The Assistant Superintendent collaborates with Executive Staff for additional assistance when needed.
 - 1.3. The Hospital Superintendent or designee intervenes as needed whenever conditions immediately threaten life or health or threaten damage to equipment or buildings.
2. TYPES OF OCCURRENCES TO BE ADDRESSED
 - 2.1. The Utah State Hospital has identified the following types of occurrences to be addressed:
 - 2.1.1. Patient Incidents (patient aggression, accidents, elopements, injury, and, seclusion and restraint.)
 - 2.1.2. Adverse Drug Reactions
 - 2.1.3. CPS/APS referrals
 - 2.1.4. Staff incidents (injuries, needle stick, and accidents)
 - 2.1.5. Environment of Care Issues (Life Safety, Emergency Management, Medical Equipment, Hazardous Materials, Security, Utilities Systems, Safety)
 - 2.1.6. Infection Control
 - 2.1.7. Sentinel Events and Near Misses

2.2. The Utah State Hospital, through its performance improvement activities may add other occurrences as they warrant.

3. MECHANISMS TO ENSURE ALL COMPONENTS ARE INTEGRATED INTO AND PARTICIPATE IN THE ORGANIZATION WIDE PROGRAM

3.1. The Utah State Hospital has identified the following committees and departments as having safety responsibilities. These committees or departments report their safety issues/concerns/actions directly to Risk Management. Risk Management reports aggregate data to the Performance Improvement Committee.

3.1.1. Environment of Care Committee (includes: Life Safety, Emergency Management, Medical Equipment, Hazardous Materials, Security, Utilities Systems, Safety)

3.1.2. Infection Control Committee

3.1.3. Pharmacy and Therapeutics Committee

3.1.4. Suggestion / Concern Committee

3.1.5. Safety Inspection Committee

3.1.6. Campus Safety

3.1.7. Risk Management

3.1.8. Unit Service Management Teams

3.1.9. Executive Staff

3.2. Risk Management is responsible to: (1) set measurable objectives for improving safety; (2) gather information to assess their effectiveness in improving patient safety; (3) use pre-established, objective process criteria to assess their effectiveness in improving safety; (4) draw conclusions based on their findings and implement improvement in their activities; and (5) evaluate their performance to support sustained improvement. All documentation is provided to the Performance Improvement Committee.

3.3. In an effort to promote safety awareness and education, the Utah State Hospital also provides safety training to all employees through:

3.3.1. New Employee Orientation

3.3.2. Annual Employee Mandatory Training (including safety intervention techniques and verbal intervention)

3.3.3. Annual Nursing Mandatory Training

3.3.4. Periodic In-service activities

3.3.5. Periodic fire and emergency management drills

3.3.6. All training is monitored by the Human Resource Department.

4. Proactive Risk Assessment (PRA)
 - 4.1. Patient care processes are reviewed each year to identify a project that utilizes PRA principles on an indicator determined by Executive Staff and Risk Management. This improves safety by evaluating areas for potential weakness and failure before they occur through a proactive process. Risk Management has the responsibility to see that these analyses are carried out and improvements are made.
5. PROCEDURES FOR IMMEDIATE RESPONSE TO MEDICAL/HEALTH CARE ERRORS (The arrows indicate the next step in the procedure)
 - 5.1. Patient Incidents: PIRS entry initiated by physician or nurse → Direct staff (nurse, physician, psychiatric technician, etc) debriefing → Unit Administrative Review → Hospital executive staff review (weekly) → Action(s) to appropriate Committee → Documentation to Risk Management.
 - 5.1.1. Patient Clinical Risk Manager is part of the Hospital-wide Clinical Director's Morning Report
 - 5.2. Adverse Drug Reaction: Unit reports adverse drug reaction to Pharmacy → Pharmacy reports adverse drug reaction and action(s) taken to Pharmacy and Therapeutics Committee → P & T Committee reports reaction with documentation to Medical Staff → Action(s), if any, are assigned → Outcome with appropriate information is reported to Performance Improvement Committee.
 - 5.3. CPS/APS referrals: Report to Risk Management → Report to CPS/APS and Executive Staff → Investigation or action(s) initiated → Resolution → Report to Performance Improvement Committee.
 - 5.4. Staff incidents: Staff report incident to immediate supervisor → Appropriate action(s), if needed, are taken → Incident is reported to Human Resources for follow up and Workers Compensation initiation, if needed → Report to Risk Management → Report to Performance Improvement Committee.
 - 5.5. Environment of Care Issues: Risk Management is notified of issue → Risk Management notifies Executive Staff → Actions assigned by Risk Management and/or Executive Staff → Risk Management monitors for resolution → Risk Management Report to Performance Improvement Committee.
 - 5.6. Infection Control Issues: Infection Control Manager reviews every patient's lab work → If infection control issues arises, infection control manager contacts staff for medical assessment → the County Health Department is notified of reportable diseases → Infection Control monitors for resolution → Information reported to monthly Infection Control Committee → Recommendations, if any, are taken to Medical Services → Director of Medical Services reports back to Infection Control Committee → Data to Performance Improvement Committee.
 - 5.7. Sentinel Events and Near Misses: Unit/Department report to PIRS → Clinical Director determines if incident meets definition of "sentinel event" → If sentinel event, root cause analysis is assigned → Director of Quality Resources reports event to The Joint Commission within 5 working days → Root cause analysis findings and recommendations are reported to Performance Improvement Committee and Administrative Services Meeting → Action(s) are assigned → Action plan is forwarded to

The Joint Commission within 45 days → Performance Improvement Committee monitors implementation of action plan.

- 5.8. Emergency Management: Report to hospital by staff, employee, or outside agency → Hospital determines command center location → Disaster is announced → Action(s) assigned → Resolution → Documentation with outcomes reported to Emergency Management Committee, Environment of Care and Performance Improvement Committee.
- 5.9. Other occurrences that require immediate response outside the normal procedure are handled by Risk Management and/or the Executive Staff. Critical issues are reported to the Performance Improvement Committee.

6. SYSTEMS FOR INTERNAL AND EXTERNAL REPORTING OF INFORMATION

- 6.1. The Utah State Hospital utilizes several systems for internal and external reporting of information relating to medical/health care errors. These systems include
 - 6.1.1. Patient Incident Reporting System (PIRS)
 - 6.1.2. Adverse Drug Reaction Reporting
 - 6.1.3. CPS/APS and Law Enforcement Referral Protocol
 - 6.1.4. Staff Incidents
 - 6.1.5. Environment of Care Reporting Systems (7)
 - 6.1.6. Infection Control Reporting System
 - 6.1.7. Sentinel Event or Near Misses Reporting

7. DEFINED MECHANISMS FOR RESPONDING TO THE VARIOUS TYPES OF OCCURRENCES

- 7.1. Patient Incidents: PIRS, Debriefing, Risk Management, Administrative Review, and Clinical Director' Morning Report
 - 7.2. Adverse Drug Reactions: PIRS, Clinical Director' Morning Report, Medical Staff, and Pharmacy and Therapeutics Committee
 - 7.3. CPS/APS referrals: Risk Management, PIRS, Executive Staff, and Campus Safety
 - 7.4. Staff incidents: Campus Safety, Risk Management, Human Resources, Employee Advocates, Suggestion/Concern Committee, Executive Staff, and Workers Compensation
 - 7.5. Environment of Care Issues: Monthly Inspection Committee, Risk Management, Work Order System, Command Center, Suggestion/Concern Committee, and Executive Staff
 - 7.6. Infection Control: Infection Control Committee, Nursing Administration, Medical Staff, Pharmacy and Therapeutics Committee, Health Department, Human Resources, and Risk Management
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7.7. Sentinel Events and Near Misses: Root Cause Analysis, Clinical Director' Morning Report, Executive Staff, Risk Management, and Quality Resources

8. MECHANISMS FOR SUPPORT STAFF WHO HAVE BEEN INVOLVED IN A SENTINEL EVENT

8.1. The Utah State Hospital provides the following support, as needed, for staff who have been involved in a sentinel event:

8.1.1. Immediate supervisor meeting

8.1.2. Unit debriefing

8.1.3. Service Management Team debriefing

8.1.4. Executive Staff debriefing

8.1.5. Crisis Teams

8.1.6. Human Resources

8.1.7. Employee Advocates

8.1.8. Workers Compensation Referral

8.1.9. Supportive phone check-ins

9. REPORTING TO THE GOVERNING BODY ON THE OCCURRENCE OF MEDICAL/HEALTH CARE ERRORS AND ACTIONS TAKEN TO IMPROVE SAFETY

9.1. The Utah State Hospital's Performance Improvement Committee reports to the Governing Body on a quarterly basis information related to the occurrence of medical/health care errors and actions taken to improve safety. The PI Committee also reports on proactive measures utilized to improve safety.

9.2. The Utah State Hospital Safety Plan is reviewed annually by the Director of Risk Management, Executive Staff, and the Governing Body.

10. VIOLENCE PREVENTION

10.1. The Utah State Hospital is committed to the prevention of violence. In accordance with the Department of Human Resources "Workplace Violence" policy, the Utah State Hospital does not tolerate any workplace violence committed by or against employees, clients, the general public, and/or property.

10.2. Adoption of Norm of Non-Violence Environment

10.2.1. Although violence may occur, we challenge the notion that violence is to be expected in a state hospital setting. The Norm of Non-Violence pervades all interactions involving patients and staff and between patients. Hospital safety and security is derived from the therapeutic relationships between staff and patients. All members of the USH community, patients, and staff alike, are personally responsible for the safety and security of the hospital environment.

10.3. Violence Prevention Education

- 10.3.1. Employees: Each newly hired employee is trained in violence prevention and reporting systems through New Employee Orientation and Safety Intervention Training. Employees are required to attend annual mandatory training related to violence prevention and Units/departments, review courses throughout the year.
- 10.3.2. Patients: Patients are educated in the hospital's norm of non-violence for violent behavior at admission and throughout their hospital stay.

10.4. Assessing Violence in Patients

- 10.4.1. The Utah State Hospital strives to provide a safe work environment for its employees. Patients are assessed for violence upon admission as part of the integrated assessment process. A de-escalation form is completed by nursing staff which identifies risk factors and intervention techniques. Administrative Risk assessments are completed on all Forensic patients. These are reviewed periodically as treatment plans are developed.

10.5. Responses to Violence

- 10.5.1. Patient Violence: Patient violence requires assessment before staff intervention. All direct care employees are trained in verbal intervention and safety techniques and are expected to utilize these tools when intervening with patient violence. The patient's clinical team determines what interventions should be utilized for the safety of patients and staff.
 - 10.5.1.1. Patients who are violent or irrational are attended by sufficient staff as warranted by their behavior, history, and unpredictability, as per nursing decision during emergency behavioral or medical procedures or during transfer to a general hospital.
 - 10.5.1.2. Patients who are violent and are transferred to a general hospital via USH transportation are accompanied by at least two staff members, one of which is the same sex as the patient.
 - 10.5.1.3. When a violent situation is resolved, a unit debriefing with employees and patients occurs to assess 1) factors leading to the violence, 2) prevention techniques that could have been initiated, 3) appropriateness of interventions utilized, 4) future improvements and preventative measures.
 - 10.5.1.4. Patient violence / aggression is tracked through the Patient Incident Reporting System (PIRS). The data is analyzed by the SMT and Executive Staff who makes recommendations for treatment interventions, training needs, and policy revision.
 - 10.5.2. Employee Violence: Employee violence may require administrative leave for investigative purposes. Employee violence is reported immediately to Campus Safety for intervention. Non-immediate threats of violence are reported to Campus Safety, Administration, and Risk Management. Administrative actions may need to be taken which may include termination. Other actions are initiated as needed.
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10.6. Reporting of Violence

10.6.1. Employees reporting violence: Employees may report violence utilizing one or more of the following systems:

10.6.1.1. Immediate supervisor

10.6.1.2. Initiating the Patient Incident Reporting System (when involving a patient)

10.6.1.3. Reporting to management team member(s)

10.6.1.4. Filing a Statement of Concern with the hospital

10.6.1.5. E-mail to appropriate staff

10.6.1.6. Reporting to Risk Management

10.6.1.7. Reporting to Campus Safety

10.6.1.8. Reporting violence or safety concerns to the Safety Inspection Committee member in their unit/department

10.6.1.9. Reporting to Employee Advocate(s)

10.6.1.10. Reporting to the Department of Human Services Risk Management Office or Director

10.6.1.11. Filing statement with local police

10.6.2. Patients reporting violence: Patients may report violence utilizing one or more of the following systems:

10.6.2.1. Reporting to clinical team members (RN, Psychiatric Technician, Social Worker, etc)

10.6.2.2. Reporting to patient advocate

10.6.2.3. Filing a Statement of Concern with the hospital

10.6.2.4. Reporting to hospital risk management

10.6.2.5. Reporting to contract patient attorney or the DLC

10.6.2.6. Reporting to Campus Safety

10.6.2.7. Reporting to the Department of Human Services Risk Management Office or Director

10.6.2.8. Filing statement with local police

10.6.3. Visitors reporting violence: visitors may report violence utilizing one or more of the following systems:

- 10.6.3.1. Any staff member
 - 10.6.3.2. Filing a Statement of Concern with the hospital
 - 10.6.3.3. E-mail to appropriate staff
 - 10.6.3.4. Reporting to Risk Management
 - 10.6.3.5. Reporting to Campus Safety
 - 10.6.3.6. Reporting to the Department of Human Services Risk Management Office or Director
 - 10.6.3.7. Filing statement with local police
- 10.7. Assistance available to employees who are involved or witness violence (employees may utilize one or all of the following):
- 10.7.1. Immediate supervisor meeting
 - 10.7.2. Unit debriefing
 - 10.7.3. Service Management Team debriefing
 - 10.7.4. Executive Staff debriefing
 - 10.7.5. Campus Safety
 - 10.7.6. Risk Management
 - 10.7.7. Local Police
 - 10.7.8. Employee Advocates
 - 10.7.9. Workers Compensation Referral
- 10.8. Data Collection and Analysis
- 10.8.1. Utah State Hospital monitors violence through incident reporting, data analysis, and outcome measures to make recommendations or changes to reduce violence in the workplace. All persons/departments/committees who have violence reported to them forward the data to the Risk Management Office for analysis. Risk Management reports its findings to the Performance Improvement Committee.

Implemented: 10-02

Revised: 5-04

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Chapter: Environment of Care (EC)

Section 2: Emergency Management Plan

Policy

Utah State Hospital (USH) establishes and maintains an Emergency Management Plan to ensure effective response to disasters or emergencies affecting the environment of care. It is based on a Hazard Vulnerability Analysis performed by the Emergency Management Committee. The plan addresses four phases of emergency management activities: mitigation, preparedness, response, and recovery. The Emergency Preparedness Manual, which is available on each unit/service, and the Command Center Plan supplement this Emergency Management Plan.

Procedure

1. The Emergency Management Committee meets at least quarterly and includes representatives from Executive Staff, Medical Services, Facilities, Nursing, Infection Control, Risk Management and others as assigned.
2. Emergency Management Committee conducts a Hazard Vulnerability Analysis.
 - 2.1. The analysis identifies potential disaster hazards to Utah State Hospital.
 - 2.2. The analysis identifies the potential effects of the hazards on Utah State Hospital.
 - 2.3. The analysis is evaluated annually.
3. Utah State Hospital communicates identified needs and vulnerabilities to emergency response agencies, identifies the community's capability to meet those needs, and established the following with the community:
 - 3.1. Utah State Hospital participates in mitigation planning with Provo City, as appropriate.
 - 3.2. Utah State Hospital is an active member of the Local Emergency Planning Committee.
 - 3.2.1. Local emergency planners designate Utah State Hospital for housing and/or a staging area, as needed.
 - 3.3. Utah State Hospital is an active member of the Utah Disaster Advisory Committee and Utah Hospital Association.
 - 3.4. Utah state Hospital is an active member of the Healthcare Preparedness Coalition of Utah/Wasatch Counties
 - 3.4.1. USH actively participates in planning and executing disaster plans through the training and exercise committee.
 - 3.5. Utah State Hospital is a member of the National Disaster Medical System.
 - 3.6. Utah State Hospital participates in planning with FEMA region 8.

- 3.6.1. Utah State Hospital provides 15 psychiatric beds, as needed, in the event of a national emergency.
- 3.7. The "all hazards" Command Center structure at Utah State Hospital links with the community command structure.
- 4. The Emergency Management Plan addresses mitigation activities to lessen the severity and impact of a potential emergency, to help restore systems critical to providing care, treatment, and services after an emergency. Utah State Hospital has:
 - 4.1. An alternative source of essential utilities.
 - 4.1.1. There is an emergency electrical back-up system for each building that is occupied 24 hours per day.
 - 4.1.2. Facilities maintain an emergency supply of fuel.
 - 4.1.3. The hospital maintains access to several water sources.
 - 4.1.3.1. The hospital maintains an independent potable water system including Slate Canyon and the well.
 - 4.1.3.1.1. The hospital water system is attached to Provo City water for back up.
 - 4.1.3.2. The hospital has access to four sources of water that require filtration including the water tank, fish pond, pool, and heating plant basement ground water. The hospital also has a water filtration system with a reservoir to contain the filtered water.
 - 4.1.3.3. A limited amount of bottled water is stored in the warehouse.
 - 4.1.3.4. Portable camp toilets are stored in the warehouse. Portable toilets are also stored in the emergency shipping containers on south side of campus.
 - 4.1.4. Emergency generators maintain ventilation in all patient housing occupied 24 hours per day.
 - 4.1.4.1. Four large portable AC units and one heating unit can be used as needed.
 - 4.1.5. Alternative sources for medical gas are stored by central supply in the form of O₂ emergency tanks and oxygen concentrators. These supplies are maintained, inspected and serviced by contracted vendors.
 - 4.1.6. Resources are evaluated as drills are held or incidents occur. Levels of preparedness are reported to Environment of Care Committee.
 - 4.2. A backup communication system in the event of failure during disasters and emergencies.
 - 4.2.1. 800 MHz radios are on every unit, support services, and administration.

- 4.2.2. Trunk lines are available for incoming and outgoing calls.
 - 4.2.3. Sheriff's Communication Auxiliary Team (SCAT) radio operators implement a community support radio system.
 - 4.2.4. Portable HAM radio kits, Cellular phones, satellite phones and HAM radios are available.
 - 4.2.5. Utah State Hospital has radios and is connected to UCAN (Utah Communication Agency Network), a statewide emergency network, and hospital commons network.
 - 4.2.6. UHRMS bed reporting drill is completed monthly.
 - 4.2.7. Two-way radios are utilized by CERT members.
 - 4.2.8. The emergency calling tree is initiated through the Utah Notification and Information System (UNIS).
 - 4.2.9. Outside agency contact information is maintained in Command Center boxes.
 - 4.3. Provision for emergency housing of patients, staff, and limited numbers of persons from the community.
 - 4.3.1. USH has extra beds, cots, and bedding, triage cots with IV poles, emergency triage tents, etc., which could be set up in the gymnasium or other areas as needed.
 - 4.3.2. The Recreation Therapy Department has tents, including a large military tent, sleeping bags, stoves, a mobile kitchen and other camping equipment that can be utilized if necessary.
 - 4.3.3. The Command Center initiates the provision of daycare for children of employees who are on grounds.
 - 4.4. Utah State Hospital keeps a documented inventory of the assets and resources it has on site that would be needed during an emergency for hospital and community needs (at minimum, personal protective equipment, water, fuel, staffing, medical, and pharmaceuticals resources and assets).
 - 4.4.1. Hospital Incident Command System (HICS) forms are used to track quantities of assets and resources used during an emergency.
 - 4.4.1.1. HICS forms are maintained in command center boxes.
 - 4.5. USH maintains a supply of emergency food, and supplies.
 - 4.5.1. Food Services maintain at least a seven day supply of food.
 - 4.5.2. Food Services maintain a supply of extra canned goods.
 - 4.5.3. USH has a mobile kitchen.
 - 4.6. USH maintains at least a week's supply of medication.
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- 4.6.1. The hospital maintains a minimum of a 96 hour supply of medication for the hospital.
 - 4.6.2. Medications may be obtained from an outside provider if not available at Utah State Hospital Pharmacy.
 - 4.7. USH maintains a supply of linens.
 - 4.7.1. A supply of new linens of all types is maintained in the hospital warehouse.
 - 4.7.2. USH laundry has a large industrial washer and dryer that can be utilized to wash linens on campus.
 - 4.7.3. Each unit has smaller washers and dryers that can be utilized for patients' clothing and, to some extent, hospital linens.
 - 4.7.4. Emergency trailers hold a large inventory of linens.
 - 4.8. CERT (Community Emergency Response Team) personnel are trained in fire suppression, search and rescue, triage and emergency care, etc., and are able to manage a disaster situation until professional help from the community arrives.
 - 4.8.1. CERT trailer is equipped with generator, lights, stretchers, and all types of first aid equipment.
 - 4.9. Access to facilities for radioactive, biological, or chemical isolation and decontamination.
 - 4.10. Provisions for mass fatalities are determined by the Command Center. USH has a walk-in cooler in the warehouse as well as vendors on contract to obtain refrigerated trucks.
 - 4.10.1. See Chapter: Environment of Care (EOC), Section: Emergency Management Plan, Appendix A: Utah State Hospital Mass Fatality Management Plan.
 - 5. The Emergency Management Plan addresses preparedness activities to build capacity and identify resources that may be used if an emergency occurs.
 - 5.1. The plan establishes
 - 5.1.1. an orientation and education program for personnel who participate in implementing the emergency preparedness plan,
 - 5.1.1.1. New employee orientation,
 - 5.1.1.2. Mandatory annual in-service,
 - 5.1.1.3. Specific training as needed.
 - 5.1.1.4. Incident Command System (ICS) training for command center personnel and leaders.
 - 5.1.2. the information and skills required to perform duties during emergencies,
 - 5.1.3. the backup communication system used during disasters and emergencies, and
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- 5.1.4. How supplies and equipment are obtained during disasters or emergencies.
- 5.2. The plan establishes performance standards that address the following:
 - 5.2.1. Emergency preparedness knowledge and skills for staff
 - 5.2.1.1. Employees are expected to know the information and skills taught in New Employee Orientation.
 - 5.2.1.2. Employees are expected to know how to access and use emergency preparedness information in the Emergency Management Manual located on their unit/service and on the computer and flip charts.
 - 5.2.1.3. Staff knowledge of emergency management procedures and skills is tested at the conclusion of training, and quarterly.
 - 5.2.1.4. Staff achieves the threshold set for testing.
 - 5.2.1.5. Areas of weakness identified with testing are addressed with further training as necessary.
 - 5.2.1.6. Effectiveness of training is monitored with ongoing tracking. Outcomes are reported to the Emergency Management Committee and Environment of Care Committee quarterly.
 - 5.2.1.7. Tracers are performed at random.
 - 5.2.2. The level of staff participation in emergency preparedness management.
 - 5.2.2.1. Drills monitor staff participation for each level of staff involved.
 - 5.2.2.2. A threshold is set for staff performance during drills.
 - 5.2.2.3. A hot wash / debriefing session is held at the conclusion of emergency events or exercises to critique performance and identify areas for improvement.
 - 5.2.2.3.1. After action report is completed.
 - 5.2.2.3.2. All hazards Joint Commission Report is completed.
 - 5.2.2.3.3. Reports are reviewed and tracked through the Emergency Management Committee and the Environment of Care Committee.
 - 5.2.2.3.4. A plan of correction is developed for areas of concern.
- 5.3. The Emergency Management Plan is evaluated annually in terms of its

- 5.3.1. Objectives
 - 5.3.1.1. The Emergency Management Plan ensures effective response to disasters or emergencies affecting the environment of care.
 - 5.3.2. Scope
 - 5.3.2.1. The scope of the Emergency Management Plan encompasses all facilities and grounds of the USH campus.
 - 5.3.3. Performance
 - 5.3.3.1. Staff involved in each emergency preparedness activity function according to specific directions in the Emergency Management Plan.
 - 5.3.4. Effectiveness
 - 5.3.4.1. Problems identified in executing the Emergency Management Plan are corrected by revising the plan and/or providing education to identified employees.
 - 5.3.4.2. Subsequent emergency management activities demonstrate staff competency in areas that were previously problematic.
 - 5.4. Drills are regularly conducted to test emergency preparedness.
 - 5.4.1. The emergency preparedness plan is executed at least twice a year, either in response to an emergency or in planned drills.
 - 5.5. Utah State Hospital has a plan to maintain charting activities when E-chart is not available.
 - 5.5.1. Each patient unit has packets containing forms for hard-copy charting.
 - 5.5.2. Instructions for maintaining charting, writing orders, etc., are found in USHOPP.
 - 6. The Emergency Management Plan addresses Utah State Hospital's response to an emergency or disaster event.
 - 6.1. Utah State Hospital maintains an Emergency Preparedness Manual on each unit/service, and on the computer, which identifies:
 - 6.1.1. USH Incident Command structure
 - 6.1.2. General Disaster Instructions
 - 6.1.3. Unit/Service Plans
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- 6.1.4. Specific Disaster Situations
 - 6.1.4.1. Violence
 - 6.1.4.2. Bomb Threat
 - 6.1.4.3. Earthquake
 - 6.1.4.4. Hostage
 - 6.1.4.5. Electrical Power Outage
 - 6.1.4.6. Loss of Communication
 - 6.1.4.7. Toxic Cloud
 - 6.1.4.8. Anthrax and Other Biological Agents
 - 6.1.4.9. Flood
 - 6.1.4.10. Medical Emergency
 - 6.1.4.11. Active Shooter
 - 6.1.4.12. Elopement
 - 6.1.5. Hospital Emergency Preparedness Codes
 - 6.1.5.1. Disaster: CODE D
 - 6.1.5.2. Fire: CODE RED
 - 6.1.5.3. Medical: CODE BLUE
 - 6.1.5.4. Violence Control: CODE 10
 - 6.1.5.5. Active Shooter: CODE SILVER
 - 6.1.5.6. Elopement: CODE PURPLE
 - 6.2. Utah State Hospital has a Command Center Plan which identifies:
 - 6.2.1. How, when and by whom the Emergency Management plan is activated.
 - 6.2.2. Who is in charge of what activities during an emergency situation?
 - 6.2.3. How and by whom external authorities are notified.
 - 6.2.4. How personnel are notified when emergency response measures are initiated.
 - 6.2.4.1. Utah State Hospital utilizes the overhead paging system, telephones, radios and/or runners.
 - 6.2.4.2. Utah State Hospital has an Emergency Call System to contact personnel that may not be at the hospital.
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- 6.2.5. How personnel are identified during emergencies.
 - 6.2.5.1. USH Employees wear identification badges at all times.
 - 6.2.5.2. Command Center positions wear clearly identifiable vests.
 - 6.2.5.3. CERT members wear CERT attire when mobilized.
 - 6.2.5.4. Volunteer resources, identified as outlined in 8.2.
 - 6.2.6. How available personnel are assigned during emergencies to cover all necessary staff positions. Employee pool staff reports to Classroom 21 during an emergency. In the event that Classroom 21 is unavailable due to an emergency, the Incident Commander identifies an alternative location for employee pool staff to convene.
 - 6.2.7. Alternate roles and responsibilities of personnel during emergencies, including who they report to within the Command Center, which is consistent with that used by the local community.
 - 6.2.8. How supplies and equipment are obtained during emergencies.
 - 6.2.9. How the Command Center interacts with community security agencies.
 - 6.2.10. Security, including access, crowd control and traffic control.
 - 6.2.11. Interaction with the news media.
 - 6.2.11.1. Utah State Hospital Public Information Officer (PIO) coordinates with State of Utah Human Services PIO who can be reached 24-hours at 1-801-520-2777.
 - 6.2.11.1.1. PIO contact information is maintained in command center boxes.
 - 6.2.12. Evacuating specific buildings or the entire facility both horizontally and when applicable, vertically when the environment cannot support adequate patient care and treatment.
 - 6.2.13. Managing patients' activities including scheduling, modifying, or discontinuing services, control of patient information, and patient transportation.
 - 6.2.14. Staff and visitors activities including housing, transportation and incident stress debriefing.
 - 6.2.15. Coordination/communication with the community regarding any patients or other persons who may be brought to Utah State Hospital for housing or care, and their status.
 - 6.2.16. The process for terminating the hospital's response and recovery phase.
 - 6.3. Utah State Hospital participates in community emergency preparedness activities which include the following:
 - 6.3.1. Emergency plans and drills. This may include coordination with:
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- 6.3.1.1. Salt Lake Area / National Disaster Medical System (NDMS)
 - 6.3.1.2. Utah County/ Local Emergency Planning Committee (LEPC).
 - 6.3.1.3. Provo City and/or other local emergency plans and exercises.
 - 6.3.1.4. Healthcare Preparedness Coalition of Utah/Wasatch Counties.
 - 6.3.1.5. FEMA Region 8
 - 6.3.1.6. Utah Hospital Association
 - 6.3.1.7. Utah county Health Department.
 - 6.3.2. Receiving assistance from Utah County, Provo City, community hospitals, school shelters, and the Red Cross based on the type of disaster and the impact on the community.
 - 6.3.3. Providing assistance to the community based on the type of disaster and the impact on USH.
 - 6.4. Infection Control monitors infectious disease processes and other health concerns at USH.
 - 6.4.1. Infection Control notes patterns and trends and communicates with the Utah County Health Department as needed.
 - 6.5. External authorities during emergencies may include:
 - 6.5.1. State agencies including, but not limited to Division of Substance Abuse and Mental Health / Department of Human Services / Office of Administrative Support
 - 6.5.2. Provo City / Utah County
 - 6.5.3. Western Psychiatric State Hospitals Association (Idaho South and Wyoming)
 - 7. The Emergency Management Plan addresses Utah State Hospital's recovery to continue or re-establish operations following an emergency or disaster event, which is coordinated or directed by the Command Center.
 - 7.1. An assessment of damage is performed:
 - 7.1.1. USH personnel and/or the CERT Team make a preliminary assessment of damage.
 - 7.1.2. The State Division of Facilities and Construction Management (DFCM), in conjunction with USH personnel and the local fire department, make a professional assessment of damage.
-

- 7.2. The Command Center establishes alternative care site(s) that have the capabilities to meet the clinical needs of patients when the environment cannot support adequate patient care; The command center is responsible for the following:
 - 7.2.1. Management of patient necessities including medications and medical records to and from the alternative care site.
 - 7.2.2. Patient tracking to and from the alternative care site.
 - 7.2.3. Communication between the organization and the alternative care site.
 - 7.2.4. Transportation of patients, staff, and equipment to the alternative care site.
 - 7.2.5. Other agencies, such as the Red Cross and the Local Emergency Planning Committee, assist the command center in providing alternative care which includes assistance in assigning space for short-term occupation. The State DFCM assists in finding alternative space for longer term occupation.
 - 7.2.5.1. Civil patients: Buildings at Utah State Developmental Center (USDC).
 - 7.2.5.2. Forensic patients: Slate Canyon Youth Center.
 - 7.3. Clean up:
 - 7.3.1. USH personnel provide initial/immediate clean up.
 - 7.3.2. DFCM provides/coordinates resources for clean up beyond the capacity of USH.
 - 7.4. Water damage/records recovery
 - 7.4.1. USH personnel provide initial recovery.
 - 7.4.2. The State Archives office provides professional assistance beyond the capacity of USH personnel.
 - 7.5. Information Technology / Electronic Records / Telephone Services:
 - 7.5.1. USH personnel provide initial recovery.
 - 7.5.2. State Information Technology Services provides assistance with information technology and telephone services beyond the capacity of USH personnel.
 - 7.5.3. A back-up copy of charting done electronically with e-chart program is maintained off-campus by Department of Technology Services (DTS).
 - 7.6. Utilities:
 - 7.6.1. USH personnel coordinate with Utah Power and Light in the restoration of electrical service.
 - 7.6.2. USH personnel coordinate with Questar in the restoration of natural gas services.
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- 7.6.3. USH Personnel coordinate with Provo City in the restoration of sewer and supplementary water services.
- 7.7. Staff-family support activities:
 - 7.7.1. USH staff, including psychiatrists and social workers, provide incident stress debriefings.
 - 7.7.2. The State Employee Assistance Program provides assistance as needed.
- 7.8. Maintenance / replacement of supplies:
 - 7.8.1. Unit / service managers assess their needs and communicate them to the Command Center.
 - 7.8.2. Warehouse and other supply offices work through regular contracted sources of supply.
 - 7.8.3. Warehouse and other supply offices maintain a list of, and utilize alternate sources for supplies as needed.
- 8. The emergency management plan includes disaster privileges that may be granted to volunteer non licensed individual practitioners (LIP) by the Superintendent or Hospital Clinical Director or his or her designee(s) on a case by case basis, and at the discretion of the responsible individuals.
 - 8.1. Responsibilities and Oversight:
 - 8.1.1. Disaster responsibilities are assigned to volunteer non LIP's (e.g., RNs, LPNs, and Social Workers) only when the following two conditions are present:
 - 8.1.1.1. The emergency management plan has been activated.
 - 8.1.1.2. The facility is unable to meet immediate patient care needs.
 - 8.1.2. The superintendent or hospital clinical director or his or her designee(s) may grant disaster privileges upon presentation of acceptable identification.
 - 8.1.3. Applicants for, or individuals with disaster privileges report to the Incident Commander or his or her designee(s), indicate their licensed profession and upon approval are assigned duties.
 - 8.1.4. Supervision of the volunteer is assigned by the Incident Commander or designee.
 - 8.1.5. Any volunteer(s) granted disaster privileges may have privileges revoked at any time and be required to immediately dismiss themselves from service upon request from, and at the discretion of the Superintendent, Hospital Clinical Director, or Incident Commander, or his or her designee(s).
 - 8.1.6. Privileges end when the disaster is deactivated.
 - 8.2. Identification:

- 8.2.1. Volunteer Non LIP must at minimum present a valid government issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - 8.2.1.1. A current hospital picture identification that clearly identifies professional designation.
 - 8.2.1.2. A current license, certification, or registration.
 - 8.2.1.3. Primary source verification of licensure, certification, or registration (If required by law and regulation to practice a profession).
 - 8.2.1.4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health professionals (ESAR-VHP), or other recognized state or federal facilities or groups.
 - 8.2.1.5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority being granted by a federal, state, or municipal entity).
 - 8.2.1.6. Presentation by current facility member(s) who possess personal knowledge regarding the volunteer non LIP's qualifications.
 - 8.2.2. If the facility has the capability (e.g., electricity, computer, printers), the volunteer is issued a formal identification badge including the person's photo, name, licensed profession, and volunteer status.
 - 8.2.3. If a formal identification badge cannot be accomplished, a visible identifier (e.g., index card with permanent marker) is placed on the volunteer including name, licensed profession, and volunteer status. The visible identifier is signed and dated by the facility staff issuing the identification.
 - 8.2.4. Volunteers are required to visibly wear issued identification on their persons at all times while on the Utah State Hospital premises.
 - 8.3. Primary source verification of licensure, certification, or registration:
 - 8.3.1. Verification of licensure begins as soon as the immediate situation is under control and is managed by the Logistics Branch Director, or his/her designee(s) who then works with each individual volunteer non LIP to verify current licensure in good standing from the primary source.
 - 8.3.2. In the extraordinary circumstance that primary source verification can not be completed until situation is under control (e.g., no means of communication and/or lack of resources), it is expected to be done as soon as possible.
 - 8.3.3. If primary source verification of licensure can not be verified, with the exception to extraordinary circumstances, the volunteer is restricted from performing care, treatment, and/or services of a licensed practitioner.
-

- 8.3.4. If primary source verification can not be verified due to extraordinary circumstance, an individual may then be restricted from performing care, treatment, and/or services of a licensed practitioner unless the following conditions are documented and met:
- 8.3.4.1. Reason why primary source verification could not be performed.
 - 8.3.4.2. Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services.
 - 8.3.4.3. An attempt to rectify the situation as soon as possible.
- 8.3.5. Primary source verification is not required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.

Implemented: 12-97

Revised: 2-98

Revised: 7-98

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Revised: 5-06

Revised: 2-07

Revised: 2-08

Revised: 2-09

Reviewed: 2-10

Revised: 2-11

Revised: 7-11

Revised: 8-12

Revised: 1-13

Revised: 2-14

Chapter: Environment of Care (EC)

Appendix A: Utah State Hospital Mass Fatality Management Procedure

Purpose

A mass casualty event, whether man-made, a natural disaster or a pandemic disease, may potentially cause an overwhelming number of fatalities. In these situations, Utah State Hospital may find it necessary to provide short term storage of the deceased at the facility until such time that local funeral directors or the Office of the Medical Examiner can take possession of the bodies. The purpose of this document is to insure the safety of employees and that bodies are taken care of in a manner that maintains both the sanitary conditions of the remains as well as the dignity they rightfully deserve.

This document relates only to those victims dying at the facility. It is not intended that this facility become a temporary morgue site for the entire community.

Planning

Mass fatalities may occur as the result of a variety of events, including natural disasters, disease outbreaks, transportation accidents, or as the result of the intentional use of a chemical, biological, radiological, or explosive agent. Since a Mass Fatalities Incident (MFI) is likely to result from a major incident, responsibility for managing the incident response and recovery requires a UNIFIED effort by all agencies, jurisdictions and entities involved. This plan has been developed in conjunction with the following local partners:

Utah County Health Department

Utah County Emergency Manager

Office of Medical Examiner

Utah County Sheriff's Department

BERG MORTUARY

185 East Center Street P.O. Box 1468) Provo, UT 84603-1468

(PH) 801-373-1841 (Fax) 801-371-0110

E-mail: bmort@fiber.net

Website: www.bergmortuary.com

J. Todd Jenkins

Dennis Bubash

Matt Dobson

BRANCH—WALKER MORTUARY--PROVO

85 East 300 South

Provo, UT 84606

(Ph) 801-373-6668 (Fax) 801-374-2151

Email: provo@walkerfamilymortuary.com

Website: www.walkerfamilymortuary.com

Determinations:

The Warehouse walk-in refrigerator has been chosen as Utah State Hospital's short term morgue. The Utah State Hospital Command Center works with Purchasing Agents and the Utah County Emergency Manager to obtain refrigerated trucks for temporary rental as a short term morgue. The Utah State Hospital Disaster Liaison acts as the Liaison upon activation of the emergency command center:

- A mortality tracking/documentation system for those remains not immediately removed from the facility has been developed and is available in Command Center Files.

Plan Activation:

Once a disaster has occurred and decedents are not able to be removed from the facility, activation of the mass fatality plan becomes operational.

The Liaison Officer notifies the Incident Commander of the situation:

- A briefing of the events takes place
- The Nursing Supervisors work with the funeral homes to have the decedent removed from the facility as soon as possible unless the event requires approval from state or federal agencies, due to the cause of the mass fatality.
- Temporary storage of decedents is in the pre-determined cool-dry location that is locked and secure.

Documentation of the patient's death:

Medical Facility personnel are required to maintain appropriate documentation of the patient's death.

Deceased Patient Identification:

Time of Death _____ A.M. _____ P.M.

Patient's Home Address _____

Relative Responsible _____

Relative's Address _____

Relative's Telephone No. _____

Procedure:

The Medical Facility is required, at the time of death to:

- Certify the death via the State Electronic Death Entry Network (EDEN).
 - Utilize mortality tracking/documentation system for those remains not immediately removed from the facility.
 - Notify Family in an appropriate manner.
 - Release remains only to a licensed Funeral Director or other authorized official.
-

- Maintain documentation of decedent's temporary/staging location and obtain signature of release to Funeral Director/Authority.

Procedures for Electronic Death Entry – Facility medical records director is in charge

Electronic Death Entry Network (EDEN)

- Death Certificate must be filed with local registrar within 5 days of death.
- By statute, funeral directors are responsible for death registration.
- Certifying physician or ME completes medical section within 72 hours from time of death.
- Physicians or Medical Services Practitioners can sign onto EDEN to provide information for the death certificate. All USH practitioners sign up to use this service. The URL is <http://vr.health.utah.gov/eden> (you must be using Internet Explorer and Windows 2000 or XP – Contact Margaret Bowen at 801-538-6012 or Lisa Finch at 801-538-9326 for assistance).

Location of Body bags and Personal Protective Equipment (PPE) Supplies

- During a disaster, body bags are located in large disaster trailer east of the Heninger Building.
- PPE is located in Central Supply, OSHA cabinets throughout the facility, large disaster trailer east of the Heninger Building.
- Other supplies (ie. ID tags, gloves) are located in large disaster trailer east of the Heninger Building and in OSHA cabinets throughout the facility.

Proper care of the Decedent:

Some Mass Fatality Incidents may actually be classified as **Crime Scenes** (such as a bomb explosion). In accordance with UCA 26-4-7, Hospital Security immediately notifies the Provo Police of the death (379-6210) and follows Utah State Hospital Policy regarding Patient Death/Immediate Actions.

During normal operations, our facility provides care services to the decedent's remains. These services maintain both the sanitary conditions of the remains as well as the dignity they rightfully deserve. This may include, but not be limited to: washing and cleaning of the remains, the dressing or removing of hospital clothing, wrapping them in clean sheets and/or placing the remains in a body pouch.

Pan Flu Body Preparation:

During a Pan Flu, there may not be the personnel or resources available to provide this care nor would it be prudent to unnecessarily expose staff.

Process:

Upon declaration of a Pan Flu emergency by the Utah Department of Health, this facility provides only the following care for remains:

1. Leave remains in existing clothing. Do not remove clothing or re-dress them.
2. Do not remove wrist band, toe tag, or other medical apparatus or appliances (i.e. IV's, trach tubes, monitor patches, etc.)

3. Do not clean or bathe the decedent.
4. Wrap the remains in the existing bedding (sheets) upon which they are lying, if any. Do not wrap them in a clean sheet.
5. Carefully place the remains in a zippered body pouch. This includes their existing clothing and their bedding that they are wrapped in. Contact local public health or emergency management for additional body pouches if necessary.
6. Identify the remains on the outside of the pouch so that the body can be easily identified without having to open the pouch. This is critical. It is imperative that no confusing of the remains take place. At this point, the facility is responsible for proper identification of the deceased. Funeral Directors only open the pouch slightly in order to read the wrist band or toe tag to verify identity.
7. Caregivers use appropriate PPE while taking care of the body.
8. Remains and the decedent's personal effects are then taken to an appropriate location to await arrival of the Funeral Home Director. The location of the decedent and personal effects are to be documented carefully on the facility's mortality tracking documents.
9. It is the facility's option to allow family visitation immediately following the death of the patient. This is discouraged however, due to the need of social distancing and infection control measures. This is only to be allowed in the patient care room and is not to be allowed in the storage area.
10. Proper verification and documentation of the decedent in the storage area is critical. It is imperative that no confusion as to the decedents' identity take place.

Temporary Care of the decedents – storage while awaiting the funeral home.

1. The incident commander utilizes the identified location for temporary holding.
 - 1.1. Temporary storage should be no longer than 24-48 hours
2. If unable to secure a location on site, a call is made to the Utah County's Emergency Manager to assist in procuring a refrigerated trailer for use at the facility.
3. If unable to secure a trailer, the Utah County Emergency Manager assists in transportation and storage of remains.

Transfer of remains to a funeral home

1. Verification of decedent must be documented by the funeral home.
2. Upon arrival of the funeral home personnel at the medical facility, hospital security or designee identifies the location of the decedent in the temporary storage area. Hospital staff don proper PPE and accompany the funeral home personnel to verify the identity of the decedent.
3. The funeral home personnel signs the facility's mortality tracking documents before decedent removal.

Psychosocial Considerations

This type of event is very stressful for staff. A close watch on staff should be conducted by managers, supervisors and administrators. As needed, arrangements for critical stress debriefing for staff are made by contacting the Utah State Hospital Employee Advocates or the Life Assistance Counseling program at 801-262-9619 or the Utah Critical Incident Stress team at 1-866-364-8824.

Contact List

Disaster Hotline

(Surge Capacity and Resources) 1-866-DOH-UTAH (364-8824)

State of Utah Division of Epidemiology and Laboratory Services

288 North 1460 West
Salt Lake City, UT
24-Hour Hotline – 1-888-374-8824 (EPI UTAH)
24-Hour Hotline – 801-538-6191 (local)

Utah County's EOC – 801-851-4150

Utah County Emergency Manager – Peter Quitner, 801-404-6050

Medical Examiner - Utah Department of Health 48 North Medical Drive, Salt Lake City, UT 84113 801-584-8410; Fax 801-584-8435

EDEN - Jeff Duncan, 801-538-7023, <http://health.utah.gov/vitalrecords>

Implemented: 3-10
Reviewed: 7-12
Reviewed: 4-02-2013
Reviewed: 4-11-2013
Revised: 2-14

Chapter: Environment of Care (EC)

Section 3: Hazardous Materials & Waste Plan

Policy

Utah State Hospital maintains a program to safely control hazardous materials and waste.

Procedure

1. USH implements the hazardous materials and waste plan by:
 - 1.1. Maintaining oversight through the Office of Risk Management.
 - 1.1.1. Service Areas may only use approved materials.
 - 1.2. Maintaining documentation of incidents and Process Improvement measures.
 - 1.3. Reviewing protocols for hazardous materials and waste.
2. Service areas which may handle, store, use and dispose of hazardous materials maintain an inventory that identifies hazardous materials used, stored or generated in their respective service area. Service areas; Nursing Services, Environmental Services, Facilities Services, Recreational Therapy, Occupational Therapy and Pharmacy, develop protocols to control hazardous materials and maintain a printed copy of Material Safety Data Sheets (MSDS) for the top ten most commonly used chemicals in their area.
3. Nursing Services, Environmental Services, Facilities Services, Recreational Therapy, Occupational Therapy and Pharmacy, maintain and review an inventory and protocols for handling, labeling, storing and disposing of any hazardous waste, stored or generated in their area, including medical and infectious waste.
4. Service Areas which handle hazardous materials and waste provide adequate space for safe handling and storing of hazardous materials and waste. These areas are designated in each area (such as environmental services custodial closets, service area nursing stations and soiled linen closets, designated workshop areas, etc.). Protocols will also describe the proper procedures for separating hazardous materials when indicated.
5. Service Areas which handle hazardous materials and waste provide equipment for the safe handling of hazardous materials and waste (i.e., gloves, aprons, masks, and shields). These areas are storage cabinets labeled for staff to easily identify the contents within the cabinet.
6. The Office of Risk Management:
 - 6.1. Reviews all hazardous materials and waste incidents, actions taken by staff in response to incidents, employee injuries related to incidents, critical occurrences, and patterns and trends.
 - 6.2. Reviews any corrective action taken by service areas administration or assesses the need for corrective action. This assessment is based on a review of staff competency in response to hazardous waste incidents, need for education, or need for policy review.
 - 6.3. Reports hazardous materials incidents to the Environment of Care committee monthly along with corrective action measures.

7. The Environment of Care Committee:
 - 7.1. Establishes safety thresholds and is proactive in making improvements through Process Improvement Measures.
 - 7.2. Reports Process Improvement Measures and other pertinent information to the Process Improvement Council.
8. The staff has knowledge and skill necessary to perform their role in managing hazardous materials and waste.
 - 8.1. Education includes: precautions for selecting, handling, storing, using, and disposing of hazardous materials and waste; emergency procedures for hazardous materials and waste spill or exposures; health hazards of mishandling hazardous materials; and reporting procedures for incidents involving hazardous materials, including spills or exposure.
 - 8.2. Compliance will be established and monitored by the Environment of Care Committee.
9. The Environment of Care Committee completes an annual evaluation of the hazardous materials and waste management plan.

Implemented: 12-98

Revised: 3-02

Revised: 10-02

Revised: 6-04

Revised: 12-05

Revised 1-08

Revised 9-09

Revised: 9-10

Reviewed: 2-12

Revised: 1-13

Chapter: Environment of Care (EC)

Section 4: Life Safety/Fire Management Plan

Policy

USH maintains a life safety management program to provide a fire safe environment. USH protects patients, personnel, visitors, and property from fire, smoke and other products of combustion. The Environmental Risk Manager is responsible for implementation of the Life Safety Management Plan.

Procedure

1. USH maintains compliance with the appropriate provisions from 2000 Life Safety Code (LSC) of the National Fire Protection Association (NFPA) that has been adopted by the State of Utah.
2. USH Support Services is responsible for maintaining designated exhaust fans and electrical fire dampers in air-handling systems.
 - 2.1. A vendor on contract with USH inspects, tests, and maintains all fire alarm or detection systems, including annual testing of all circuits and preventive maintenance of all components.
 - 2.1.1. All fire and smoke dampers are operated at least every four years to verify that they close.
 - 2.2. A UL approved company on contract with USH, receives all alarms and contacts local Fire Department for dispatch to USH.
 - 2.3. Exit signs are inspected quarterly by USH support service department.
 - 2.3.1. Exit signs are inspected during each fire drill.
3. The Environmental Risk Manager and contracted vendor inspect, test, and maintain all fire extinguishing systems, which includes sprinkling and automatic commercial cooking suppression systems.
 - 3.1. The Environmental Risk Manager completes a quarterly test on all wet fire sprinkling systems (excluding anti-freeze systems).
 - 3.1.1. The Environmental Risk Manager does a main drain and an inspectors test on each wet fire sprinkling system quarterly.
 - 3.1.2. Fire Department connections are inspected quarterly.
 - 3.1.3. All supervisory signal devices are tested at least quarterly.
 - 3.1.4. All valve tamper switches and water flow devices are tested at least semiannually.
 - 3.1.5. All fire sprinkler risers are inspected quarterly.

- 3.1.6. All standpipes and fire hoses are visually inspected quarterly and tested annually.
 - 3.1.7. Thresholds are established and corrective action taken when results do not meet prescribed outcomes. A report is given to the Environment of Care committee quarterly.
 - 3.2. The contracted vendor performs an annual fire sprinkler inspection on all wet fire sprinkling systems.
 - 3.2.1. The contracted vendor performs a semi-annual test on all automatic commercial cooking suppression systems.
 - 3.2.1.1. The contracted vendor replaces all fusible links on automatic commercial cooking suppression systems every six months.
 - 3.2.2. Thresholds are established and corrective action taken when results do not meet prescribed outcomes. A report is given to the Environment of Care committee semi-annually.
 - 3.3. The Campus Fire Marshall and contracted vendor inspects and tests fire hydrants annually.
 - 3.3.1. Any deficiencies are evaluated and repaired by USH support services.
 - 4. The contracted vendor provides inspection, testing, and maintenance as required by 2000 NFPA 101 and 2002 NFPA 10.
 - 4.1. Fire extinguishers which are out of compliance either by date or by use are replaced by the Environmental Risk Manager.
 - 4.1.1. The Environmental Risk Manager and USH environmentalists inspect fire extinguishers in their designated areas monthly and report any deficiencies or concerns and actions to the Environmental Risk Manager or designee.
 - 4.2. The Environmental Risk Manager and contracted vendor complete an annual inspection of all fire extinguishers throughout the hospital. This information is reported to Environment of Care Committee annually.
 - 5. The USH Purchasing Office reviews all requests for bedding, window drapes or other curtains, furnishings, decorations to ensure they meet acceptable fire safety standards.
 - 5.1. Unit environmentalists conduct a semiannual inspection of their units to ensure drapes, curtains, furnishings, decorations, and bedding have an acceptable fire safety rating.
 - 6. The Environmental Risk Manager and contracted vendor inspect, test and maintain all smoke detectors.
 - 6.1. Smoke detectors monitor compliance with No Smoking policies, i.e. no smoking in any buildings.
 - 6.2. All smoke detectors are inspected annually.
 - 6.3. If a yellow or red alarm occurs, the Environmental Risk Manager or Security investigates the cause of the alarm.
-

- 6.3.1. If the cause of the alarm is a dirty or faulty smoke detector, the smoke detector is cleaned and/or replaced.
 - 6.4. The USH Fire Marshall maintains No Smoking signs in all buildings to prohibit smoking within the buildings in accordance with Utah State Law.
 7. Fire protection deficiencies, failures, or user errors are reported and investigated by the Environmental Risk Manager or designee.
 - 7.1. USH Security staff notifies the Environmental Risk Manager or designee.
 - 7.2. A contracted vendor reports any deficiencies or failures to the Environmental Risk Manager.
 - 7.3. A Life Safety / Fire Management log is kept by the Environmental Risk Manger which identifies failures and deficiencies which are reported. This information is reported to the Environment of Care Committee quarterly.
 - 7.3.1. The Environmental Risk Manager documents a resolution for each failure or deficiency which is reported.
 8. The Life Safety / Fire Management Education Program addresses employee, volunteer and students roles and responsibilities.
 - 8.1. The Life Safety / Fire Management Education Program provides training in the following areas:
 - 8.1.1. At a fire's point of origin,
 - 8.1.2. Away from a fire's point of origin,
 - 8.1.3. Use and functioning of fire alarm systems,
 - 8.1.4. Special roles and responsibilities in preparing for evacuation,
 - 8.1.5. Location and proper use of equipment for evacuating or transporting patients to area of refuge, and
 - 8.1.6. Building compartmentalization for containing smoke and fire.
 9. The Life Safety / Fire Management Plan performance standards focus on knowledge and skill of staff, and level of staff participation.
 - 9.1. Employee life safety / fire management knowledge and skill is assessed through:
 - 9.1.1. Employees are expected to know the information and skills taught in New Employee Orientation and information gained by participation in fire drills.
 - 9.1.2. Staff knowledge of life safety procedures and skills are tested at the conclusion of New Employee Orientation, annual mandatory in-services, and during fire drills.
 - 9.1.3. Performance on the job.
-

- 9.2. The Environment of Care committee establishes training thresholds which demonstrate staff competency.
 - 9.2.1. Performance Improvement measures are developed to address deficiencies and ensure staff meet competency level.
10. Emergency procedures, which are addressed in the Emergency Preparedness Manual and Fire Safety Plan, include:
 - 10.1. Facility-wide response needs,
 - 10.2. Unit/service specific needs and fire evacuation routes,
 - 10.3. Specific roles and responsibilities of personnel at the fire's point of origin,
 - 10.4. Specific roles and responsibilities of personnel away from the fire's point of origin,
 - 10.5. Specific roles and responsibilities of personnel in preparing for building evacuation.
11. The Interim Life Safety Measures (ILSM) consist of the following actions:
 - 11.1. Interim Life Safety Measures can be implemented to temporarily compensate for hazards posed by:
 - 11.1.1. Construction activities (in or adjacent to all construction areas).
 - 11.1.1.1. Procedures for ILSM due to construction activities:
 - 11.1.1.2. The Service Management Team (SMT) /or contractor is responsible to provide the following for remodeling construction: free and unobstructed exits and additional training for personnel when alternative exits are designated.
 - 11.1.1.3. The contractor inspects construction exits daily.
 - 11.1.1.4. The SMT and/or contractor, as appropriate, ensure free and unobstructed access to emergency services and for fire, police, and other emergency forces.
 - 11.1.1.5. The USH Fire Marshall or contractor ensures that fire alarm, detection, and suppression systems are in good working order.
 - 11.1.1.6. A temporary but equivalent system is provided by the contractor when any fire system is impaired. Temporary systems are inspected and tested monthly.
 - 11.1.1.7. The USH Fire Marshall or contractor ensures temporary construction partitions are smoke tight and built of noncombustible materials that will not contribute to the development or spread of fire.
 - 11.1.1.8. The USH Fire Marshall or contractor increases hazard surveillance of buildings, grounds and equipment, with special attention to excavations, construction areas, construction storage, and field offices.

- 11.1.1.9. The USH Fire Marshall or contractor trains personnel to compensate for impaired structural or compartmentalization features of fire safety.
 - 11.1.2. Buildings with existing Life Safety Code deficiencies (throughout building).
 - 11.1.3. Emergency loss of utilities that directly affect the fire safety equipment.
 - 11.1.3.1. The USH Fire Marshall or designee notifies Provo Fire Department and Central Station whenever an approved fire alarm or automatic sprinkler system is out of service for more than four hours in an occupied building.
 - 11.1.3.2. A fire watch is instituted by the USH Fire Marshall or Security whenever an approved fire alarm or automatic sprinkler system is out of service for more than four hours in a 24 hour period in an occupied building. A fire watch is defined as a physical walk through of each room in the affected building at least every hour. It is documented on the Fire Watch form.
 - 11.1.3.3. Fire Watches are completed by Security Officers in all areas of the affected building(s) except for the patient living areas. Fire Watches are provided by Nursing Staff in the affected building(s) in the patient living areas.
 - 11.1.3.4. In the event that the fire watch includes several buildings, the Security officers may have the CERT prepared employees assist in the fire watch.
 - 11.2. When significant life safety deficiencies are identified on the hospital campus or in buildings, the Hospital Fire Marshal/Environmental Risk Manager (or his designee in his absence) is notified immediately to make an assessment.
 - 11.2.1. Once the Fire Marshal has assessed the deficiency it is his responsibility to make recommendations on appropriate compensatory actions.
 - 11.3. The Interim Life Safety Measures (ILSM) Guidelines is used as a screening system to assess the need to institute compensatory measures when life safety deficiencies exist.
 - 11.3.1. Interim Life Safety Screening Tools are a series of eleven (11) administrative actions that could be taken to temporarily compensate for hazards posed by existing *Life Safety Code* deficiencies or construction activities (see the following table).
-

Interim Life Safety Assessment Form

Project Title: _____

Estimated Project Start Date: _____

Estimated Project Completion Date: _____

		YES	NO
A.	Will any exits become blocked or obstructed as a result of the construction boundary? (Do not forget internal, horizontal exits) If yes, do 1,2 & 3		
B.	Will access to any building access point (including ED) or hydrant or FDC become blocked or obstructed? If yes, do 4 & 10		
C.	Will part of any fire alarm, detection, and/or suppression system be impaired or shut down for more than four hours? If yes, do 7, 8, 9, & 11		
D.	Will a temporary fire alarm system be required? If yes, do 3 & 5		
E.	Will smoke or fire walls be breached where a temporary seal can not maintain barrier integrity? If yes, do 4, 7 & 9		
F.	Will it be necessary to erect any temporary construction partitions? If yes, do 6		
G.	Will the project result in the unacceptable accumulation of debris or construction materials? If yes, do 2, & 7		
H.	Will construction effect exterior ground's safety (pits, storage, equipment, etc.)? If yes, do 2, 4 & 10		
I.	Will construction present other safety hazards? If yes do 9		

1. Document personnel training for alternative means of egress.
2. Adopt and document daily inspections of construction areas either by Fire Marshal's Office or by the job foreman.
3. Conduct and document 2 fire drills per shift per quarter.
4. Develop alternate systems, policies (i.e. - covering smoke heads during welding operations, uncovering at end of shift, lay hose to an accessible point, temporary seal penetrations)
5. Test and document temporary systems monthly.
6. Document fire resistive rating of partition material/structure.
7. Access storage, housekeeping and debris removal so its maintained at its lowest level.
8. Provide and document fire fighting equipment and use training.
9. Provide training related to other safety hazards.
10. Meet with ED staff, EMS and/or Fire Department as appropriate to develop plans; document.
11. The municipal Fire Department is notified and the fire watch is notified whenever an approved fire alarm or automatic sprinkler system is out of service of > 4 hours in 24 hour time-frame in an occupied building.

This is a planning guide only. For each item from the "DO" list a separate action plan may need to be developed to assign responsibility and schedule. This hospital is smoke free and additional policies related to smoking are not required.

- 11.4. The USH Fire Marshall or contractor implements, documents, and enforces appropriate interim life safety (fire management) measures (ILSM) based upon the above assessment.
 - 11.4.1. During the design review process for new construction the Hospital Fire Marshal performs an Interim Life Safety Assessment Screening to assess the appropriate compensatory measures that might be required during the construction phase.
 - 11.4.2. The Hospital Fire Marshal inspects the job site at the beginning of the project and approximately once per week.
 - 11.4.2.1. This frequency can be altered as directed by the inspector as indicated by his findings, confidence and previous dealings with various contractors.
- 11.5. The ILSM apply to all personnel, including remodeling construction workers, and are implemented on project development and are continuously enforced through project completion.
- 11.6. The USH Fire Marshall / SMT or contractor posts and maintains No Smoking signs to prohibit smoking in USH buildings, on the hospital campus, and in and next to construction areas.
- 11.7. The USH Fire Marshall / SMT or contractor directs housekeeping and debris removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.
- 11.8. The USH Fire Marshall / SMT or contractor conducts a minimum of one fire drill per shift per quarter.
- 11.9. The USH Fire Marshall or SMT conducts organization-wide safety education programs to promote awareness of LSC deficiencies, construction hazards, and ILSM.
- 12. A contracted vendor tests the USH Fire Notification system each night, to verify system is working properly.
- 13. The Environment of Care committee reviews the Life Safety Management plan annually.

Implemented: 1-98

Revised: 11-98

Revised: 4-99

Revised: 4-00

Revised: 1-01

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Reviewed: 2-10

Revised: 6-11

Reviewed: 7-12

Revised: 7-13

Chapter: Environment of Care (EC)

Section 5: Medical Equipment Management Plan

Policy

Utah State Hospital establishes and maintains a program to ensure safe and effective use of medical equipment. The medical equipment management plan describes how this will occur. All medical equipment at Utah State Hospital is inventoried annually.

Procedure

1. SELECTING AND ACQUIRING MEDICAL EQUIPMENT:
 - 1.1. A Medical Product Review Committee evaluates all medical equipment for possible purchase.
 - 1.1.1. The committee is comprised of the following personnel:
 - 1.1.1.1. The Medical Equipment Purchasing Agent
 - 1.1.1.2. The Central Supply Manager
 - 1.1.1.3. The Infection Control Coordinator
 - 1.1.1.4. On Unit Nursing Staff
 - 1.1.1.5. Other personnel as pertinent
 - 1.1.2. The Infection Control Coordinator manages the committee.
 - 1.2. Medical equipment is evaluated based on:
 - 1.2.1. need (including frequency of use and population served)
 - 1.2.2. the equipment's function;
 - 1.2.3. the physical/clinical risks associated with use or potential for injury;
 - 1.2.4. maintenance requirements of the equipment;
 - 1.2.5. performance history (reliability, accuracy, incidents);
 - 1.2.6. cost;
 - 1.2.7. maintenance/monitoring requirements;

1.2.8. user friendly/ability to maintain user competency;

1.2.9. servicing vs. replacement costs.

1.3. Once medical equipment has been selected, a request stating the specifications and other pertinent information of the equipment needed is completed by the Medical Equipment Purchasing Agent. The Medical Equipment Purchasing Agent completes the necessary paperwork and purchases the equipment.

2. INVENTORY OF MEDICAL EQUIPMENT:

2.1. The Medical Equipment Purchasing Agent maintains a file documenting the evaluation criteria for medical equipment used in the hospital.

2.2. The documentation includes the dates of completed evaluations.

2.3. Criteria for evaluation are based on manufacturer's recommendation.

2.3.1. The criteria include the equipment function and maintenance requirements.

3. INSPECTION, TESTING, AND MAINTENANCE:

3.1. The hospital vendor inspects and tests all new equipment before

3.1.1. first use and inspects and tests all other equipment according to manufacturer's recommendations.

3.1.2. A contract is in place with a vendor to perform medical equipment management services which includes semi-annual inspections of Oxygen Concentrators and annual inspections of all hospital equipment, reporting, and technical consultation. (See contract in Business Office)

3.1.2.1. When a patient brings in their own medical equipment to use i.e. CPAP machines or other electrical equipment for medical use, the item is taken to the Clinics Manager for inspection prior to the patient using it.

3.1.3. Any noted defects in medical equipment are reported to the Clinics Manager and the equipment is returned to the Clinics Manager for the defect to be addressed and corrected.

3.1.3.1. Essential back-up equipment is obtained through vendors or other resources. (See Accessing Medical Supplies and Pumps in the Nursing Policy and Procedure Manual).

3.2. Medical equipment management problems, failures and user errors are reported to the Clinics Manager for investigation and repairs.

3.2.1. Medical equipment that malfunctions or fails is removed from the patient care area.

- 3.2.1.1. Malfunctioning or failed medical equipment is returned to the Clinics Manager.
 - 3.2.1.2. Replacement equipment is obtained at the time the failed equipment is returned.
 - 3.2.2. A vendor is available to provide technical consultation 24 hours per day, 7 days per week.
 - 3.2.2.1. The Clinics Manager contacts the vendor to pick up the item, repair it, and return it to the hospital.
 - 3.2.2.2. Equipment that is repaired by a vendor is returned to the Clinics Manager.
 - 3.2.3. Medical equipment inspected by the vendor which is found to be defective is reported to the Clinics Manager.
 - 3.2.3.1. The Clinics Manager notifies Nursing Administration and also notifies the unit or service area that the defective item must be sent for repair.
 - 3.3. Any product recall is reported to the Assistant Nursing Director
 - 3.3.1. If the hospital owns any recalled equipment, the unit is notified to return the equipment to the Clinics Manager, who returns the equipment to the manufacturer.
 - 3.4. The Risk Management Office investigates and files a report on any incident in which a medical device is connected to an injury, illness, or death of an individual (as required by the Safe Medical Devices Act of 1990).
 - 3.5. Inspection and test results, equipment failures, and product recall information is reported quarterly to Environment of Care Committee. Process improvement measures are developed to address deficiencies to ensure safety with all medical equipment.
4. ORIENTATION AND EDUCATION:
- 4.1. Prior to a medical device being used, all pertinent staff are required attend an orientation and training session regarding the equipment.
 - 4.1.1. The training includes capabilities, limitations, and special application of equipment, basic operating and safety procedures, emergency procedures in the event of equipment failure, maintenance responsibilities for the equipment, and the processes for reporting medical equipment management problems, failures, and user errors.
 - 4.2. The medical equipment is used only within the specifications delineated by the manufacturer.
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4.3. The employees' competency in operation and care of the specific item of equipment is determined annually through each employee's demonstration of operation of the equipment and documented in the Human Resource system.

4.3.1. All employees who are required to use the equipment are required to demonstrate competency.

5. QUALITY CONTROL:

5.1. Glucometers are monitored for accuracy on a daily basis on each unit (See "Use of Glucometer" in Patient Management under Nursing Policies and Procedures).

5.2. The accuracy checks are stored in each unit's glucometer and are downloaded every month by Nursing Administration.

5.3. The Assistant Nursing Director reviews the information printed out from the glucometers and records the results and reports information to Nursing Administration and Environment of Care Committee quarterly.

5.3.1. If a glucometer has been out of compliance with the control tests, the reason and corrective action are indicated on the monthly download information and noted by the Assistant Nursing Director.

6. IMPLEMENTATION AND EVALUATION:

6.1. The medical equipment management plan includes how it is evaluated annually in terms of its:

6.2. Objective:

6.2.1. The medical equipment management plan ensures effective operation and safety of medical equipment.

6.2.1.1. All staff that use specific medical equipment are trained in operation and safety of the equipment as evidenced by training rolls.

6.3. Scope:

6.3.1. The scope of the medical equipment management plan encompasses all staff who use medical equipment at Utah State Hospital.

6.4. Performance:

6.4.1. All staff who use medical equipment demonstrate appropriate operation and safe use of the medical equipment. The verification of use is documented in the Human Resource system.

6.5. Effectiveness:

- 6.5.1. Problems identified in executing the medical equipment management plan are corrected by revising the plan and/or providing in-service to identified employees.
- 6.6. Implementation:
 - 6.6.1. The Environment of Care Committee is responsible for the implementation of the medical equipment management plan.
 - 6.6.1.1. The Environment of Care Committee reviews the medical equipment management plan annually.

Implemented: 5-98

Revised: 1-01

Revised: 7-01

Revised: 10-02

Revised: 12-04

Revised: 10-05

Revised: 12-05

Revised: 10-08

Revised: 1-10

Reviewed: 1-11

Revised: 2-12

Reviewed: 5-12

Revised: 4-13

Chapter: Environment of Care (EC)

Section 6: Physical Environment Safety Management Plan

Policy

Utah State Hospital provides a safe, accessible physical environment free of hazards and manages staff and patient activities to reduce the risk of injuries.

Procedure

1. The Assistant Superintendent oversees development, implementation, and monitoring of Safety Management and intervenes whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings.
 - 1.1. USH Risk Management Office works closely with the DHS / Utah State Office of Risk Management to report findings on a regular basis and identify immediate needs for resources to address safety concerns.
 2. The Risk Management Office conducts semi-annual safety inspections that evaluate the condition of buildings, grounds, equipment, and internal physical systems.
 - 2.1. USH Risk Management Office aggregates data from inspections and follows up to ensure identified problem areas are resolved. These reports including the identified problem and the action are reviewed during the Risk Management Meeting.
 - 2.2. Hazard Surveillance is completed as part of periodic campus walk-through's and documented in minutes of monthly Risk Management meetings as well as during the semi-annual inspections.
 - 2.2.1. Any immediate life safety concern or general safety issue is reported directly to Risk Management by memo, e-mail, phone, etc.
 - 2.2.2. Risk Management forwards the information to the appropriate department for resolution.
 3. Each Service Area conducts monthly safety inspections.
 - 3.1. The Risk Management Office meets monthly with the Safety and Inspection Committee to review Service Area safety inspection reports.
 - 3.2. Corrective Action is taken by the Safety Inspection Committee when safety concerns are identified.
 - 3.3. Performance Improvement measures are identified by the Safety Inspection Committee to address ongoing safety problems.
 4. The Risk Management Office reviews all incidents of employee, patient and visitor injuries, and property damage.
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- 4.1. Incident reports are reviewed on a weekly basis by Human Resources and the Risk Management Office.
 - 4.1.1. Risk Management coordinates follow up and reviews when indicated with the appropriate service area administration to identify critical needs for safety.
 - 4.2. Patient Injuries and property damage are reported via the Patient Incident Reporting System (PIRS) and reviewed weekly by the SMT and Executive Staff.
 - 4.3. Employee Injuries are reported via an employee incident form.
 - 4.3.1. This form is filled out by the employee and the employee's supervisor and submitted to the Human Resources Department before the end of the employee's shift.
 - 4.3.2. Human Resources submit copy to Risk Management.
 - 4.4. Reported occupational Illness information is confidential and is maintained by the Infection Control Office.
 - 4.5. Visitor Injury report forms are completed by the visitor and submitted to the Human Resource Department and Risk Management Office.
 - 4.5.1. Risk Management submits report of incident to Utah State Risk when needed.
 - 4.5.2. Human Resources Department completes follow up reports by contacting visitors after an incident and then gives Risk Management a copy.
 5. USH Support Services inspects and maintains all grounds and facility service equipment on a regular basis.
 - 5.1. Records are maintained of all inspections and repairs.
 - 5.2. Staff are trained in proper use and safety of equipment.
 - 5.3. Safety concerns or incidents are reported to the Risk Management Office.
 6. USH Risk Management follows appropriate State rules and regulations including the Guidelines for Design and Construction of Hospitals and Health Care Facilities (2002 edition), or equivalent design criteria, in renovation and construction of Facilities for guidelines in design and construction.
 - 6.1. When planning demolition, construction, or renovation, Risk Management does the following:
 - 6.1.1. Conducts a risk assessment on any possible hazards that may compromise care, treatment, and services in occupied areas of the hospital buildings. The scope and nature of the activities in the area determines the extent of the risk assessment.
 - 6.1.2. Conducts an assessment on air quality requirements, infection control, utility requirements, noise, vibration, and emergency procedures.
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- 6.2. The USH selects and implements proper controls, as required, to reduce risk and minimize impact of these activities.
7. The Purchasing Office / Warehouse and Central Supply / Assistant Director of Nursing are responsible to respond to all concerns of product safety recall and report information to the Risk Management Office.
 - 7.1. Recall information is reviewed in monthly Risk Management meeting to ensure all procedures are followed to correct problem equipment.
 - 7.2. A record log for medications that have been recalled is reviewed on a monthly basis by the Risk Management and Pharmacy Departments.
8. The Pharmacy is responsible to respond to all concerns of medication recall and report information to the Risk Management Office and Medical Staff.
9. Monthly reports of aggregate incident data is reviewed and reported to the Risk Management Meeting. The Risk Management Department aggregates the data and reports to the Environment of Care Committee.
10. Environment of Care Committee establishes thresholds and Performance Improvement Measures to correct identified areas of concern.
 - 10.1. Environment of Care Committee representative reports PI processes quarterly to the PI Council.
11. The Safety Plan is evaluated annually by the Environment of Care Committee.

Implemented: 1-98

Revised: 11-98

Revised: 1-01

Revised: 10-02

Revised: 6-03

Revised: 5-04

Revised: 12-05

Revised: 6-09

Reviewed: 6-10

Revised: 1-13

Revised: 2-14

Chapter: Environment of Care (EC)

Section 7: Security Management Plan

Policy

The Utah State Hospital Security Department establishes and maintains a program to protect employees, patients, and visitors from harm.

Procedure

1. The plan provides a process for:
 - 1.1. Designation of employees responsible for developing, implementing, and monitoring the security management plan.
 - 1.1.1. Chief of Security is responsible for managing the security management plan.
 - 1.2. Security issues concerning patients, visitors, employees and USH grounds.
 - 1.2.1. Refer to USH Manuals, Security, Unit Walk-Through Procedures: 1, 1.1 - 1.5; Campus Patrol Procedure 1, 1.1 - 1.5.2; and Controlling Public Access definitions and procedure.
 - 1.3. Identification for patients, employees, and visitors.
 - 1.3.1. Security reminds patients and staff to wear their identification badges while on grounds. If the patient is on their unit, the pass does not have to be worn. Employees are required to wear badges at all times when on USH grounds.
 - 1.3.2. Visitors on campus visiting patients are required to obtain a pass from the switchboard operator, unless approved through the unit. The visitor must present this pass to security upon request.
 - 1.3.3. Visitors to the Castle Park are required to obtain a pass from the switchboard operator to have access to this area. If they do not have a pass, they will be asked to obtain one or leave the premises.
 - 1.4. Controlled access to emergency red zoned areas, as determined by the organization.
 - 1.4.1. Refer to USH Manuals, Security, Parking Ticket Issuance and Vehicle Booting and Towing, Procedures: 1, 2, and 3.
 - 1.5. Providing vehicle access to the emergency red zone areas.
 - 1.5.1. Refer to USH Manuals, Security, Traffic and Parking regulations, Procedures: 10, 10.1-10.7, 11, 12, and 13.
 - 1.6. Prevention of pediatric or adult patient abductions.
 - 1.6.1. Refer to USH Manual, Security, Child Abductions

2. Minimizing risk for personnel in security sensitive areas.
 - 2.1. USH Security officers complete walk-through's of all units while on duty. They document the time they completed the walk through and their findings in the Officers Daily Activity Log.
 - 2.2. While completing unit walk-through's, the officer, if needed, points out possible safety and security risks associated with the unit so that in the event of crisis the employees are aware of the risk and what they may need to do in a disaster.
 - 2.3. In the event that an officer is called upon by a specific unit requesting assistance, the officer(s) immediately report to the RN and ask where assistance is needed. If the incident is in direct view of the officer, then they offer assistance to the employees involved.
 - 2.4. If a crime has occurred, the officer(s) gathers any pertinent information, such as, witness statements, photographs of injuries or property damage, weapons, etc. The officer then fills out a criminal report and hand it into the Chief of Security for review.
 - 2.5. All reports of assault or property damage showing sufficient evidence are sent to the City or County attorney except for the following:
 - 2.5.1. The assault report is considered frivolous, erroneous, or false.
 - 2.5.2. There is no clear victimization or evidence of trauma or injury
 - 2.5.3. There is no clear aggressor and victim identified.
 - 2.5.4. If the event had occurred in a setting it would be reasonable to expect that law enforcement would not be involved (unless a staff member specifically requests the hospital make the report).
 - 2.5.5. Property Damage is estimated to be very minimal in cost.
 - 2.6. If the suspect is a juvenile and a crime has been committed, the Chief of Security contacts the Administrative Director of the unit where the juvenile is housed to determine if charges should be filed with the Juvenile Court.
 3. The Utah State Hospital Security Department monitors security incidents involving patients, visitors, employees and property.
 - 3.1. Refer to USH Manuals, Security, Filing Criminal Charges, and Procedures: 1-5; Lost and Found Items, Procedures: 1-4, Disposal 1-2.
 - 3.2. All written reports are completed and turned in by the end of the work shift in which the incident(S) occurred. The Chief of Security collects and reviews all reports for error.
 - 3.3. All Security Officers complete an Officers Daily Activity log. The Officers Daily Activity log is an internal document recorded for the purpose of officer accountability and to document the number of dispatched calls the officer(s) responds to each shift.
 - 3.4. The officers responding to the scene complete an Incident, Criminal, or Vehicle Accident Report. These reports are documented in the USH computer system.
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- 3.5. Information regarding dispatched calls, and Criminal Reports are reported to the Environment of Care Committee quarterly.
 4. The Utah State Hospital Security Department provides emergency protocols for:
 - 4.1. Incidents involving civil disturbances.
 - 4.1.1. Security officers offer assistance as needed.
 - 4.1.2. Request backup from Provo City Police if necessary.
 - 4.2. Additional staff to control traffic during disasters.
 - 4.2.1. The Chief of Security contacts the off-duty Security Officers for assistance, in the event that there is a disaster at the hospital.
 - 4.3. Incidents involving High Profile Patients or media.
 - 4.3.1. Refer to USH Manuals, Security, Chapter 6, ADT/New Patients/High Profile Patients Procedures: 4. - 4.6.3.
 - 4.3.2. Any requests for information from the media are forwarded to the USH or DHS Public Information Officer.
 5. The Chief of Security is responsible for the instruction of the Safety Intervention Training (SIT Training) to all hospital employees who work directly with patients.
 - 5.1. All employees pass a competency which is recorded in the Human Resources System.
 - 5.2. Chief of Security works with education department to provide physical SIT training and show competency.
 6. USH Security officers receive a standard curriculum and successful completion of initial training including:
 - 6.1. USH New Employee Orientation
 - 6.2. USH Psychiatric Technician Training
 - 6.3. POST Special Functions Officer Training
 - 6.4. Comprehensive Safety Intervention Training
 - 6.5. Maintain POST certification which includes 40 hours of annual in-service training in compliance with POST standards which is recorded in the human resources system.
 7. The Chief of Security collaborates with the Director of Risk Management to conduct daily proactive risk assessments of safety and security related concerns involving patients, employees and/or visitors.
 - 7.1. The information from the risk assessments is utilized in developing and implementing procedures to decrease the identified safety and security risks.
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- 7.2. The Officer conducting the Risk Assessment insures that when a safety concern is identified during the Risk Assessment that a work order is sent to the USH Facilities Department during that same shift.
8. Quarterly reports of aggregate incident data are reviewed and reported to the Environment of Care Committee
9. Environment of Care Committee establishes thresholds and performance improvement measures to correct identified areas of concern.
 - 9.1. Environment of Care Committee reports PI processes quarterly to the PI Council.
10. Security Management Plan is reviewed annually by the Environment of Care Committee.

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Revised: 12-05

Revised: 3-07

Revised: 1-10

Reviewed: 1-11

Reviewed: 5-12

Revised: 4-13

Chapter: Environment of Care (EC)

Section 8: Utilities Systems Management Plan

Policy

Utah State Hospital provides processes for establishing and maintaining a Utility Systems Management program. This is detailed in the Utility Systems Management Manual.

Objective

1. The Utility Systems Management Plan is intended to provide processes for:
 - 1.1. Assessing and minimizing the risks associated with utility systems.
 - 1.2. Ensuring the operational reliability of utility systems through:
 - 1.2.1. Inspection, testing, and maintenance of critical operating components of utility systems.
 - 1.2.2. The education and in-service training of maintenance workers of utility systems.

Responsibility

1. The utility system is maintained by the Facilities Management Department.
2. The utility system program is established, supported, and monitored by the Facilities Management Department. Reports are given in Environment of Care Committee meeting quarterly.

Procedure

1. The management plan establishes and maintains a utility systems management program to:
 - 1.1. promote a safe, controlled, comfortable environment of care;
 - 1.2. assess and minimize risks of utility failures; and
 - 1.3. ensure operational reliability of utility systems.
2. Protocols are established by Facilities Management Department to identify criteria in evaluating and taking inventory of critical operating components of systems to be included in the utility management program.
 - 2.1. These protocols address the impact of utility systems on:
 - 2.1.1. infection control systems,

- 2.1.2. environmental support systems
 - 2.1.3. equipment-support systems, and
 - 2.1.4. communication systems.
 - 2.2. Facilities Management monitors the effectiveness of the protocols by:
 - 2.2.1. Inspecting, testing, and maintaining critical operating components on a regular basis as outlined in protocols in Facilities policy and procedure manual.
 - 2.2.1.1. The emergency generators are inspected and tested at load capacity monthly.
 - 2.2.1.2. The alarm systems, exit signs, medical suction and oxygen operate on the emergency generators.
 - 2.2.2. Developing and maintaining current utility system operational plans to help ensure reliability, minimize risks and reduce failures.
 - 2.2.3. Mapping the distribution of utility systems and labeling controls for a partial or complete emergency shutdown.
 - 2.2.4. Investigating utility systems management problems, failures, or user errors and reporting incidents and corrective actions.
 - 3. Protocols are established which address emergency procedures for utility system disruptions or failures:
 - 3.1. specific procedures in the event of utility systems malfunction;
 - 3.2. identification of an alternative source of essential utilities;
 - 3.3. shutoff of malfunctioning systems and notification of staff in affected areas;
 - 3.4. obtaining repair services; and
 - 3.5. how and when to perform emergency clinical interventions when utility systems fail.
 - 4. Environment of Care Committee establishes thresholds and performance improvement measures to correct identified areas of concern.
 - 4.1. Environment of Care Committee reports PI processes quarterly to the PI Council.
 - 5. Facilities staff are trained and oriented in:
 - 5.1. utility systems' capabilities, limitations, and special applications;
 - 5.2. emergency procedures in the event of system failure;
 - 5.3. information and skills necessary to perform assigned maintenance responsibilities;
-

- 5.4. location and instructions for use of emergency shutoff controls; and
 - 5.5. processes for reporting utility system management problems, failures, and user errors.
 - 5.6. Training for Facilities staff is recorded in the human resources system.
6. Utilities System Management Plan is reviewed annually by the Environment of Care Committee.

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