



**AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS**

Wednesday, December 6, 2023 – 5:30 pm

Hyatt Centric Mountain View - Room: Cloud 2 (409 San Antonio Rd, Mountain View, CA 94040)

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 928 3318 8782# No participant code. Just press #.**

To watch the meeting, please visit: [ECH Board Meeting Link](#)

Please note that the link is for **meeting viewing only**, and there is a slight delay; to provide public comment, please use the phone number listed above.

MISSION: To heal, relieve suffering, and advance wellness.

VALUE PROPOSITION STATEMENT: Setting the Standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	CALL TO ORDER/ROLL CALL	Bob Rebitzer, Board Chair	Information	5:30 – 5:31 pm
2	POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Bob Rebitzer, Board Chair	Information	5:31 – 5:32
3	PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.</i> b. Written Public Comments <i>Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.</i>	Bob Rebitzer, Board Chair	Information	5:32 – 5:35
4	RECEIVE QUALITY COMMITTEE REPORT	Carol Somersille, MD Quality Committee Chair; Holly Beeman, MD Chief Quality Officer	Motion Required	5:35 – 5:40
5	RECESS TO CLOSED SESSION	Bob Rebitzer, Board Chair	Motion Required	5:40 – 5:41
6	<i>Health and Safety Code Section 32106(b)</i> Report on health facility trade secrets regarding new services or programs: PHYSICIAN CONTRACTS a. MV Cardiology Call Panel Renewal b. Urology Medical Group PSA	Mark Adams, MD, Chief Medical Officer Shahab Dadjou, President ECHMN Omar Chughtai, Chief Growth Officer	Discussion	5:41 – 5:50
7	<i>Health and Safety Code Section 32106(b)</i> Report on health facility trade secrets regarding new services or programs: MV CAMPUS COMPLETION PHASE 3	Dan Woods, Chief Executive Officer Ken King, CAO	Discussion	5:50 – 5:55

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-3218 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
8	Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: APPROVE CREDENTIALING AND PRIVILEGING REPORT	Mark Adams, MD, Chief Medical Officer	Motion Required	5:55 – 6:00
9	Report involving Gov't Code Section 54957(b) for discussion and information on personnel performance matters – Senior Management: CEO AMENDED MOTION FOR CEO BASE SALARY	Bob Rebitzer, Board Chair	Discussion	6:00 – 6:05
10	RECONVENE TO OPEN SESSION	Bob Rebitzer, Board Chair	Motion Required	6:05 – 6:06
11	CLOSED SESSION REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	6:06 – 6:07
12	CONSENT CALENDAR ITEMS: <i>Items removed from the Consent Calendar will be considered at the end of the regular agenda. .</i> a. Approve Hospital Board Open Session Minutes (11/08/23) b. Approve Minutes of the Closed Session of the Hospital Board (11/08/2023) c. Approve Annual Safety Report for the Environment of Care as Reviewed and Recommended for Approval by the Quality Committee d. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee e. Approve delegation to Chief Executive Officer to execute Physician Contract – MV Cardiology Call Panel Renewal f. Approve delegation to Chief Executive Officer to execute Physician Contract – Urology Medical Group PSA g. Approve delegation to Chief Executive Officer to execute Capital Projects – MV Campus Completion Phase 3 h. Approve Physician Wellness Policy i. Receive Director Somersille Report on Educational Activity j. Receive CEO Report	Bob Rebitzer, Board Chair	Motion Required	6:07– 6:13
13	APPROVE AMENDED MOTION TO CLARIFY CEO BASE SALARY	Bob Rebitzer, Board Chair	Motion Required	6:13 – 6:14
14	DIRECTOR MILLER ECH FOUNDATION LIASION REPORT	Julia Miller, Director	Information	6:14 – 6:18
15	BOARD ANNOUNCEMENTS	Bob Rebitzer, Board Chair	Information	6:18 – 6:25
16	ADJOURNMENT APPENDIX	Bob Rebitzer, Board Chair	Motion Required	6:25

Next ECHB Regular Meetings: February 7, 2024; March 13, 2024; April 17, 2024; May 8, 2024; June 12, 2024

**EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Ken King, CAO
Date: December 6, 2023
Subject: FY-23 Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommends that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management for FY-23.

Summary:

1. **Situation:** The management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results in FY-23. Highlights include:
 - a) **Employee Safety:** The rate of OSHA Recordable Injuries decreased 15% from the previous year and the lost work time rate decreased 50% from the previous year.
 - b) **Security:** The number of OSHA reportable Workplace Violence incidents decreased 6% from the prior year. The decrease in incidents is attributed to enhanced Nonviolent
 - c) **Hazardous Materials:** There were no Reportable Hazardous Material Incidents or Waste Water Discharge violations.
 - d) **Fire Safety:** There were no Fire Incidents at any El Camino Health facilities in FY-23.
 - e) **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 99.23% completion rates, a slight improvement over the prior year.
 - f) **Utilities:** There were nine PG&E electrical power outages during FY-23, three in Los Gatos and six in Mountain View. All emergency power systems functioned as designed and there were no negative outcomes.
 - g) **Emergency Management:** There were three incidents during FY-23 that prompted the activation of the Command Center and activation of the HICS (Hospital Incident Command System) protocols. These actual events were in addition to various table top drills that we conducted throughout the organization.

Additionally, we conducted extensive active shooter drills and training events with outside experts that was available to all staff. The training modules have been updated and risk assessments in all high-risk areas have been completed.

Overall, a positive outcome for the year.

Annual Report – Evaluation of the Environment of Care and Emergency Management
December 6, 2023

1. Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.
2. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.
3. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement.
4. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.
5. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-23.

List of Attachments:

1. Full Report – FY-23 Evaluation of the Environment of Care & Emergency Management



Fiscal Year 2023 Evaluation of the Environment of Care And Emergency Management

Prepared by:

Matt Scannell

Director, Safety and Security

Bryan Plett

Manager, Environmental Health and
Safety

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Program Overview

The Joint Commission standards provide the framework for the Safety Program for managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety / Security and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends. The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for the Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2023. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

Safety Management

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-23. This includes data from both the Mountain View and Los Gatos campuses.

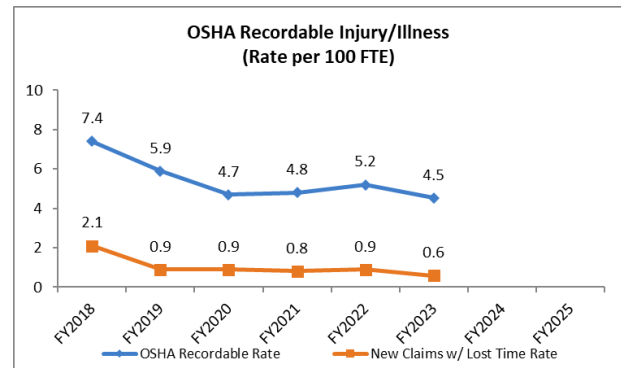
[See [Attachment 1](#) for a definition of terms and formulas used to calculate in this report.]

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE slightly decreased in FY-23 to 4.5 as compared to 5.2 in FY-22.

The total number of recordable incidents decreased to 132 compared to 145 in FY-22.

The rate of lost workdays for all open claims (per 100 FTEs) decreased to 0.6 in FY-23 compared to 0.9 in FY-22.



Analysis

- In FY-23, the rate of OSHA recordable injuries decreased 15% compared to FY-22 and the loss time rate decreased by 50% compared to FY-22.
- Injury Rates: The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disorders (MSD)-not related to patient handling at 26%, blood and bodily fluid exposures at 21%, and slips/trips/falls at 13%.
- In FY-23 blood borne pathogen exposures due to needle sticks remained consistent at 22 injuries compared to 21 injuries in FY-22. An increase in sharp injuries was noted. Improvement strategies will be explained in the blood borne pathogens exposures section below.

Effectiveness

Key indicators were identified to establish goals for FY-23 with opportunities to improve Safety Management within the Environment of Care.

FY 23 Goals

- 1) Reduce employee musculoskeletal disease injuries

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce MSD (musculoskeletal disorder) OSHA recordable employee injuries NOT related to patient handling by 15% over FY22	EWHS /EH&S	15% reduction over FY 22

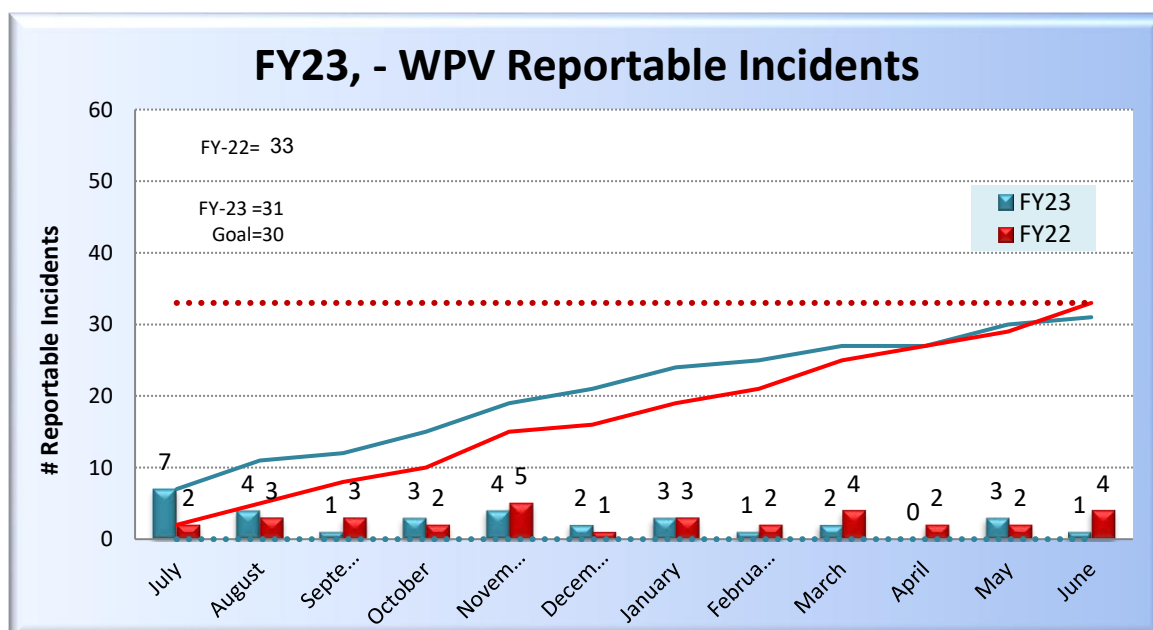
- Measurement of success:** The goal was not accomplished. In FY22, there were 35 MSD OSHA recordable employee injuries not related to patient handling. The goal was a 15% reduction. In FY-23 there were 33 MSD OSHA recordable injuries not related to patient handling. Although the goal was not met, there was a net decrease.

Security Management

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the “Trends Report”. The following performance criteria monitor Security Management for FY23. The data includes activity from both campuses.

There were a total of 522 reported security incidents for FY23 requiring a security response. This is a slight increase from the FY22 of 510.

Review of the FY23 WPV incidents showed:



- There were 31 Workplace Violence (WPV) incidents reported to CA-OSHA in FY 23. This is a 6% decrease from FY22. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
 - More focus on the root causes of workplace violence events in the WPV committee.
 - Better communication and preparedness between clinical departments on patients that have already been combative during their Hospitalization.
 - A renewed focus on strategies to deal with behavioral health or substance abuse patients in FY23.
 - More proactive use of the combative patient flagging tool in Epic.
 - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.
 - The pilot of the “CALM Team” (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a workplace violence event

Note - The number of events decreased slightly but the events increased in their combative or violent nature.

Effectiveness

Key performance indicators were identified in FY23 to improve Security Management within the Environment of Care.

FY23 Goals

- 1) 10% reduction in number of reportable workplace violence incidents- In FY23 there was a 6% decrease in the number of Workplace Violence reports submitted to CAL-OSHA in FY 23.
 - a) **This goal was not met.**
- 2) Security Officer (non- recordable) injury rate of <5% per 100 employees for FY 23. Reduce the number of non- recordable security officer injuries compared to FY 22.
 - a) **This goal was met.**

Hazardous Material Management

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER¹ training course.

¹ HAZWOPER: Hazardous Waste Operations and Emergency Response

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve hazardous materials & waste management.

FY-23 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
 - **Measurement of success** :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
 - **Measurement of Success:** >95%. **This goal was accomplished.**

Fire Safety Management

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY23.

Fire Incidents:

There were no fire incidents in Mountain View or Los Gatos in FY23.

Effectiveness:

Based on opportunities for improvement identified in FY22 annual EOC evaluation the FY23 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY24 due to staff performance in FY23.

Medical Equipment

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-23.

A. Reports to the FDA –

There were 8 reports through the Medwatch² system in FY-23. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 87% for FY-23. A 13% improvement from FY-22. The year-end completion rate is 91.26%, a 4% increase from FY-22. The team averaged 95% since the beginning of the calendar year. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 96%.
- All high risk, life safety equipment was maintained at 99.23% completion rate. A 1.2% improvement from FY-22. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.84%.

FY23 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

1. Raise the asset confidence level currently at 96.8% to 98%. This will confirm that 98% of all medical devices received a completed maintenance.

Goal was not met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 97.28%

2. Network visibility through the ORDR tool of all networked medical devices. Current visibility is 86.5%, the goal would be 100%.

Goal not met. We were able to raise the ORDR visibility to 91.6%. We continue to strive for 100%. Most of those assets not seen by ORDR are on a separate segmented network and therefore protected from main network vulnerabilities and issues.

² The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

Utility Systems

A. Utility Reportable Incidents

There were nine reportable incidents in FY-23. All were electrical outages or voltage fluctuations.

- Los Gatos had 3 reportable incidents. On January 10, 2023, Los Gatos had loss of electrical utility (PG&E) campus wide for 2 ½ hours that started up the Emergency Generators. On March 14 and June 5, 2023, there were momentary power fluctuations of the electric utility (PG&E) that started up the Emergency Generators.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates, emergency generators ran and functioned as designed: 10/24/22, 1/5/23, 2/21/23, 3/14/23, 3/15/23, 3/17/23.

Effectiveness

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	88% Goal was not met
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	93%- Goal was met

Note: Data is collected through fire drills and environment of care rounds.

Emergency Management

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY23.

A. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY23 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. The Mountain View campus experienced a power fluctuation on October 24, 2022 that resulted in the activation of the Hospital Command Center from 12:38 to 14:00.

2. The Mountain View campus experienced a weather related power outage on January 4th from 17:38 to 19:31 that resulted in the partial activation of the Hospital Command Center.
3. Both the Los Gatos and Mountain View campuses experienced a complete network outage on April 11th 2023 from 09:20 to 17:50 that shut off all internal phone lines and computer/network connectivity for approximately nine hours.

FY23 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY22)
 - **Measurement of Success**
 - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
 - Evaluate and set up logical groups and rules for notifications.
 - Train key staff to be able to use/send alerts
 - ***This goal was accomplished.***
 - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
 - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
 - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
 - ***This goal was accomplished.*** All exercises have been expanded to include all pavilions in planning and participation including active shooter tabletops and drills.
3. Revise Hospital Surge Plan.
 - ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

EC 1.0 - Safety Management

Work Group Chair: **Michael Rea**

Scope

Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

- Employee Wellness & Health Services
 - Education Services
 - Quality and Patient Safety
 - Infection Prevention
 - Security Management
 - Environmental Services
 - Facilities Services
 - Patient Care Services
 - Human Resources
 - Radiation Safety

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-23. This includes data from both the Mountain View and Los Gatos campuses.

[See [Attachment 1](#) for a definition of terms and formulas used to calculate in this report.]

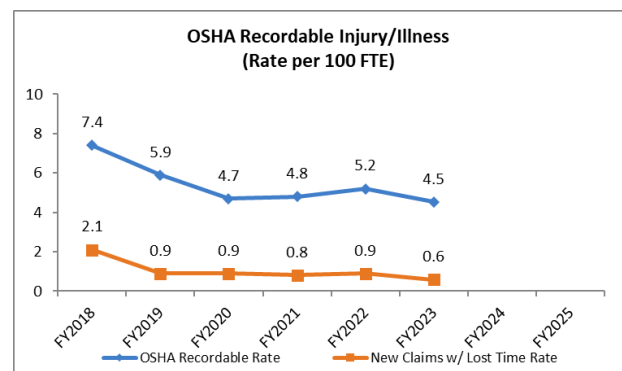
B. OSHA Recordable Injury & Illness

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The rate of lost workdays for all open claims (per 100 FTEs) decreased to 0.6 in FY-23 compared to 0.9 in FY-22.

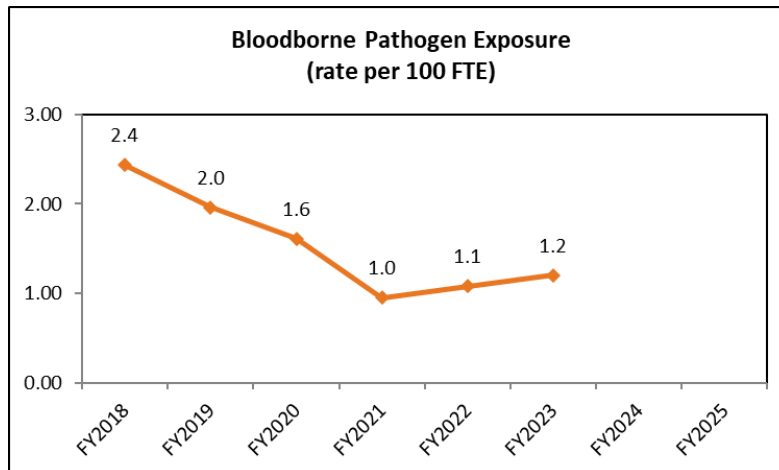
Analysis



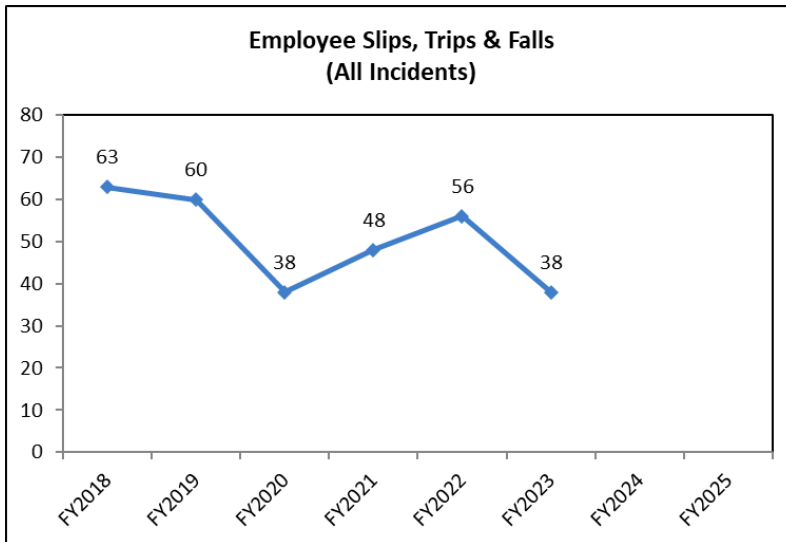
- In FY-23, the rate of OSHA recordable injuries decreased 15% compared to FY-22 and the loss time rate decreased by 50% compared to FY-22.
- Injury Rates: The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disorders (MSD)-not related to patient handling at 26%, blood and bodily fluid exposures at 21%, and slips/trips/falls at 13%.
- In FY-23 blood borne pathogen exposures due to needle sticks remained consistent at 22 injuries compared to 21 injuries in FY-22. An increase in sharp injuries was noted. Improvement strategies will be explained in the blood borne pathogens exposures section below.

Improvement Strategies:

The OSHA recordable rate of blood borne pathogen exposures is slightly increasing. More information is contained in the blood borne pathogen exposure section below.

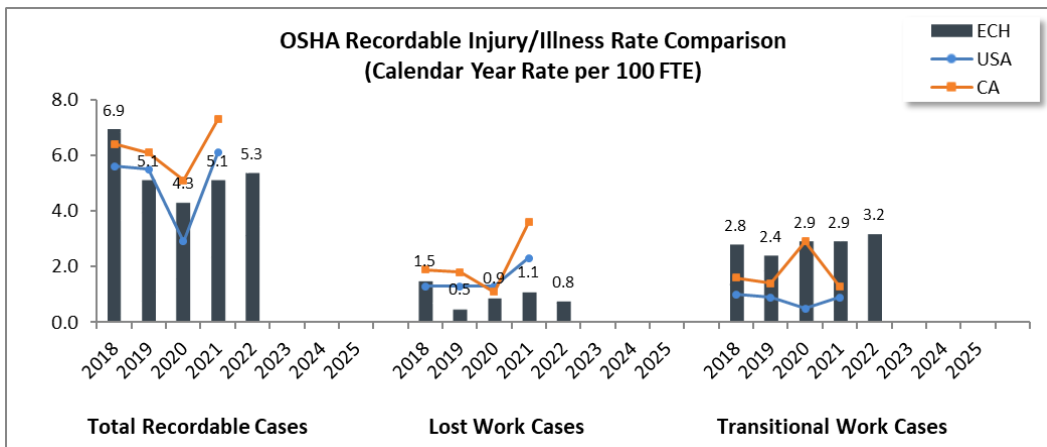


Slips, trips, and falls among employees decreased after a three year trend of increasing OSHA recordable injuries. More information is contained in the Slips, trips, and falls section below.



C. OSHA Recordable Injury/Illness Rates as Compared to U.S. & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California³.



The ECH injury/illness rate in **calendar year 2022** was 5.3, which is comparable to the California state and national averages in 2021 (7.3 and 5.1, respectively where 2021 is the most recent year available from the BLS). The ECH lost work cases rate was 0.8, which is below both state and national average. The lower rate in lost time incidents is

³The BLS data is calculated by calendar year. 2021 is the most recent calendar year of injury and illness data available as of September 08, 2023.

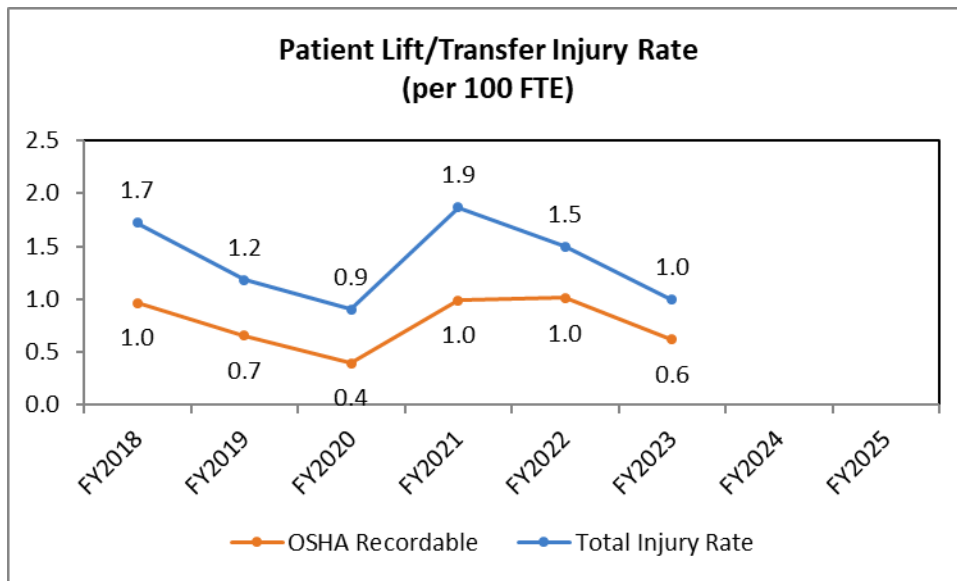
due to prevention efforts in worksite evaluations and outreach to departments along with the Safe Patient Handling & Mobility (SPHM) program.

El Camino Health’s robust Transitional Work Assignment Program shows a commitment to keeping employees safely working and engaged through an injury or illness. This innovative program accounts for the nearly three-fold increase in transitional work cases (3.2) relative to the state and national rates of Cases with job transfer or restriction (1.3 and 0.9, respectively).

D. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- Injury Rates:** The rate of OSHA recordable SPHM injuries per 100 FTEs decreased in FY-23, from 1.0 in FY-22 to 0.6 in FY-23.
- Total Injuries:** The overall number of SPHM injuries (29) and those persistent downward trend in both the total number of SPHM injuries and those that are OSHA-recordable (18) returned to pre-COVID-19 norms as observed in fiscal years 2018, 2019, and 2020.



SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 18-21)

SPHM Injuries	2017	2018	2019	2020	2021	2022	2023
Total Reported	44	41	29	23	50	37	29
OSHA-recordable	29	23	16	10	26	28	18
% OSHA	66%	56%	55%	43%	52%	76%	62%

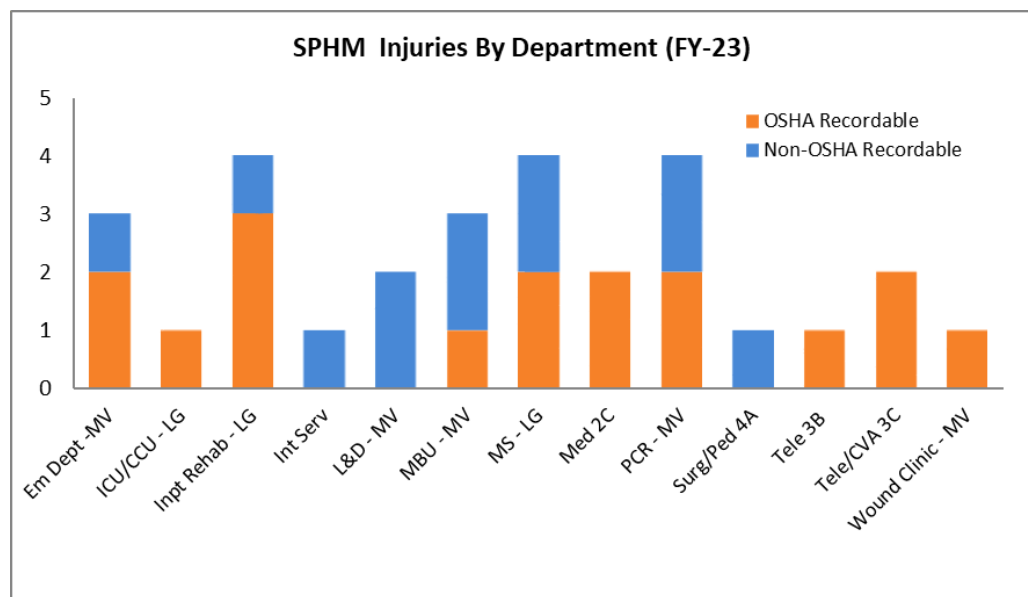
- Lost/Restricted Days due to SPHM Injuries:** Of the 18 OSHA-recordable injuries, one resulted in lost days.

SPHM Injuries by Type, Fiscal Years 17 – 23

Activity	2017	2018	2019	2020	2021	2022	2023
Combined Transfer	6	5	5	2	3	1	4
Cumulative Pt Handling	5	4	0	1	2	5	1
Lateral Transfer	8	1	5	3	9	4	3
Patient fall/prevention	5	9	8	8	10	3	9
Car extraction	0	0	0	1	2	1	0
Pt Holding	2	3	2	1	5	0	1
Turning/Pulling	12	16	5	6	17	11	9
Vertical Transfer	5	3	4	1	2	3	1

- Preventing/assisting patient falls and turning/pulling persist as the top categories of SPHM injuries.

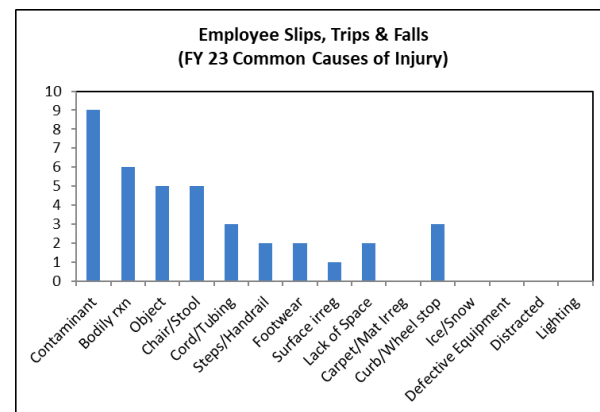
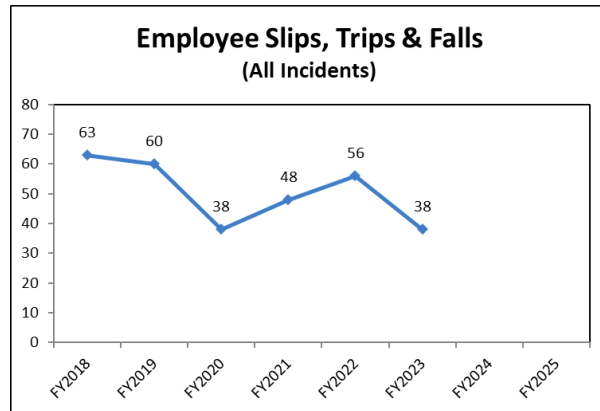
- **Injuries by Department**



E. Slips, Trips, Falls Injuries

Analysis:

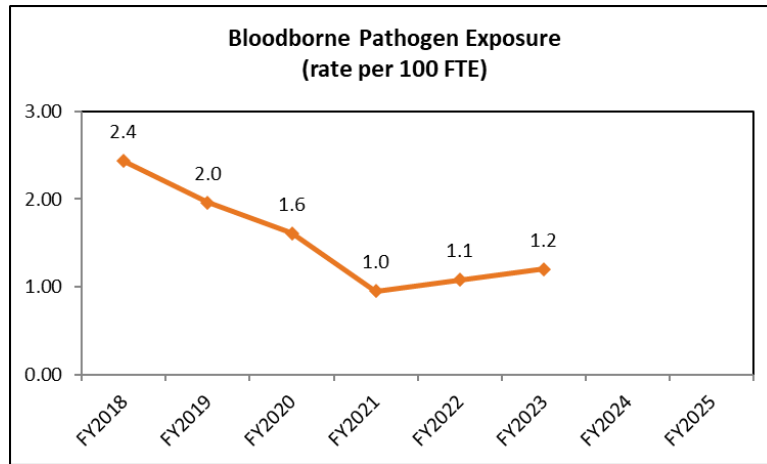
- **Injury Incidence:** Targeted interventions to reduce Slip, Trip, and Fall (STF) injuries were initiated in FY-17 due to the consistently rising incidence. There was a decline in incidents in FY-23 following several years of increase returning to pre-COVID-19 pandemic levels.
- The number of OSHA-recordable STFs was 14.
- **Injury Types:**
 - Contaminants/slippery floor continues to be a leading cause most significant cause of STFs (n=9) but reduced from a high of 20 in FY-22.
 - Bodily reaction, or “I just fell” (n=6) was the second most common cause.

**Improvement Strategies:**

- Task force attendance continues to be robust, with reviews of injuries and collaboration of improvement strategies among managers.
- Partnership with Facilities and annual outside stair maintenance continues to contribute to a reduction in STFs on stairs, down to 2 from a high of 8 in FY-19.
- New landscaping and signage has effectively reduced falls outside. This is the first FY that no falls were reported due to falls in dirt pathways and shortcuts.
- Two falls were attributed to scrub pants dragging under heels. After review of available and feasible options, reusable leg bands are being trialed.
- The introduction of Safety First and HRO training: focusing on the task by using STAR to raise awareness and reduce distractions are targeted techniques to reduce falls due bodily reaction, falls from chairs and on wet or slippery floors.
- *Test Your Tread* was a marketing slogan and process introduced this fiscal year as an additional strategy to maintain shoe traction to prevent falls on wet or slippery conditions.

F. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **increased to 1.2 in FY-23 compared to 1.1 in FY-22**. The total number of exposures for both campuses increased to 35 exposures in FY-23 compared to 30 in FY-22. Of these, 29 were percutaneous exposures and six were body fluid exposures due to splashes.



Analysis:

- The number of sharp injuries increased in FY-23 to 7 compared to two in FY-22:

	FY 22	FY 23
Needlestick	21	22
Blood	4	3
Body Fluids	1	2
Urine	2	0
Saliva	0	1
Scissors	2	5
Scalpel	0	1
Instrument	0	1
TOTAL	30	35

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO.
- Continue to meet one on one with injured employees to identify preventable root causes.
- Continue to analyze potential patterns of injuries for further investigation and action. Specifically, the increase in sharp injuries in FY-23 led to a product change.
- EWHS continues to collaborate with Clinical Education to explore ways to increase awareness and possible education among our nursing new graduates.

G. TB Conversions

There were no known occupational exposure conversions during FY-23.

H. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. All employees complete new employee orientation upon hire. Annual regulatory review courses are required for all employees and provided as on-line modules. The topics including fire, evacuation, hazardous materials, and other safety topics. The compliance rates for FY--23 are:

- New employee orientation: 100% (Target: 100%)
- Annual Regulatory Clinical Review: 91% (Target: 95%)
- Annual Regulatory Non-Clinical Review: 93% (Target: 95%)

Effectiveness

Key indicators were identified to establish goals for FY-23 with opportunities to improve Safety Management within the Environment of Care.

FY 23 Goals

2) Reduce employee musculoskeletal disease injuries

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce MSD (musculoskeletal disorder) OSHA recordable employee injuries NOT related to patient handling by 15% over FY22	EWHS /EH&S	15% reduction over FY 22- Goal not met

- **Measurement of success:** The goal was not accomplished. In FY22, there were 35 MSD OSHA recordable employee injuries not related to patient handling. The goal was a 15% reduction. In FY-23 there were 33 MSD OSHA recordable injuries not related to patient handling. Although the goal was not met, there was a net decrease.

EC 2.0 - Security Management

Work Group Chair: **Matt Scannell**

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime
Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events
Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
 - **AVADE** – Computer based training module assigned annually to most staff.
 - **Nonviolent Crisis Intervention (NCI) training** – module and classroom assigned to employees working in departments considered “High Risk” whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
 - Behavioral Health
 - Emergency Department
 - Charge Nurses/Clinical Managers
 - Assistant Hospital Managers (Hospital Supervisors)
 - Security
 - Course is also available as an option to all staff.

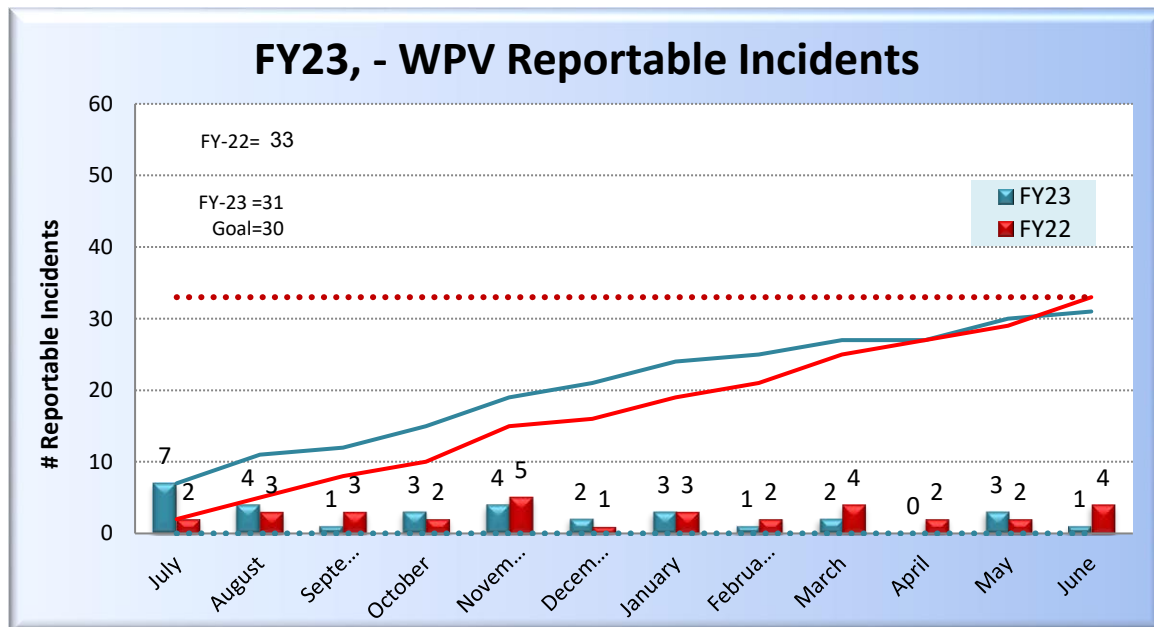
Note- The hands on portion of the class was restarted in February of 2023. This training was revised to include a three-hour mental health component.
4. Reporting: An ongoing WPV reporting team ensures reporting is completed as required.
 - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
 - In FY23, 31 incidents reported to CAL-OSHA WPV website. 65% of the incidents resulted in no injury and 35% of the incidents had bruises or abrasions. There were no major injuries reported to the CAL-OSHA district office.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the “Trends Report”. The following performance criteria monitor Security Management for FY23. The data includes activity from both campuses.

There were a total of 522 reported security incidents for FY23 requiring a security response. This is a slight increase from the FY22 of 510.

Review of the FY23 WPV incidents showed:

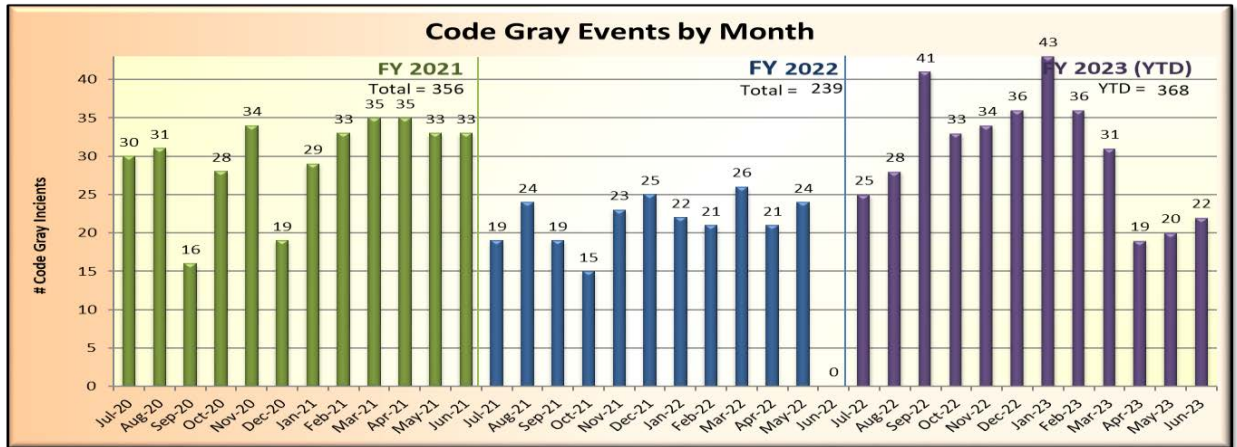


- There were 31 Workplace Violence (WPV) incidents reported to CA-OSHA in FY 23. This is a 6% decrease from FY22. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
 - More focus on the root causes of workplace violence events in the WPV committee.
 - Better communication and preparedness between clinical departments on patients that have already been combative during their Hospitalization.
 - A renewed focus on strategies to deal with behavioral health or substance abuse patients in FY23.
 - More proactive use of the combative patient flagging tool in Epic.
 - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.
 - The pilot of the “CALM Team” (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a workplace violence event

Note - The number of events decreased slightly but the events increased in their combative or violent nature.

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY23 was 368 compared to 255 in FY22. The increase in code greys is largely due to an increase in patients and difficult discharges out of the emergency room in the winter months. Additionally, in FY 23 more visitors were on campus after removing all COVID 19 restrictions.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- MV Emergency Dept. (ED) – 57%
- Medical Unit (3B)- 15%
- MV Medical Unit (2C) – 12%
- Medical Unit (4A)- 12%

Responses are tracked through the Code Gray security shift report form and monitored to help identify possible improvements to the process.

In FY 23 a new program was launched called the “CALM Team” (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a code grey or a workplace violence event. The pilot was launched in June of 2023 on 2 C and 3C.

B. Bulletins, Alerts & Presentations

Security Services issued five personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 6,165 chain-of-custody transactions involving patient’s belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 2,565 patient watches, standbys and restraints. This was an increase over FY22 (2565). Hospital Supervisors or Nurse Managers notify Security of these events, which can last several hours. They primarily occur in the Emergency Department, Mental Health and Addiction Services (MHAS) and on the Medical Units. Patient watches are also handled by ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 104 fire drills and 8 fire watches were performed in FY23.

F. General Assistance

Security Officers performed 44,323 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Badging Services issued 2,591 El Camino Health badges in FY 23, which was an increase of 659 Photo ID Badges. This provides access and barcoding technology to staff, physicians, auxiliary, contractors, and students. Additionally, in FY 23 1,365 temporary badges were issued to staff who forgot or temporality lost their badges.

H. Investigations & Audits

Security Services performed 109 investigations and audits including, but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost and Found

Security Officers performed 473 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 84,423 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 411 incidents involving problematic individuals who required extra time and assistance leaving hospital property. This was an increase of 79 loitering or trespassing responses. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

In addition to daily parking control and ‘space availability’ counts, Security Officers performed 107 vehicle-related services including jump-starts, door unlocks and tows. 904 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 185 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics –Police Department Crime Data

Estimated MVPD Annual Report		
Square Miles:	12	11.25
Population:	83,377 (County of Santa Clara 1,945,940)	30,516
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics UCR data includes attempts and actual crimes		
Part I UCR:	2274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2497	Not Collected
Previous Year	2800	Not Collected
Arrests-Misdemeanor:	1235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2199	Not Collected
Indexes Per 1,000 current year population		
Violent:⁴	2.11	0.35
Previous Year	2.33	0.48
Property:⁵	26.29	15.53
Previous Year	24.46	18.98

⁴ Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery

⁵ Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

Effectiveness

Key performance indicators were identified in FY23 to improve Security Management within the Environment of Care.

FY23 Goals

- 3) 10% reduction in number of reportable workplace violence incidents- In FY23 there was a 6% decrease in the number of Workplace Violence reports submitted to CAL-OSHA in FY 23.
 - a) **This goal was not met.**
- 4) Security Officer (non- recordable) injury rate of <5% per 100 employees for FY 23. Reduce the number of non- recordable security officer injuries compared to FY 22.
 - a) **This goal was met.**

EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: Lorna Koep

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Health. The work group chair serves as the central contact point for the reporting and documentation for the work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents:**

- 1) Oxytocin 5ml spill - MV Mother Baby Unit – roller clamp user error. MBU Nursing Education reviewed roller clamp procedure and safety. Cleanup was handled safely.
- 2) Chemotherapy Taxol 150ml spill – MV Unit 4B Room 4220 – CTSD (Closed System Transfer Device) not secured, loosened due to. Gap identified with incomplete Code Orange Response Team present lack of frontline staff knowledge. Nursing Educator present –Reviewed/Educated staff. Cleanup was handled safely.
- 3) Buffered 10% Formalin 16 oz. spill – LG 2nd Floor OR Pathology Room – contents spilled when RN transferred Buffered 10% Formalin from 5-gallon container spigot into a small container. Gap identified lack of frontline staff knowledge. Reviewed/Educated procedures for Formalin storage/handling and switched to

prefilled containers and 1 gallon container only as needed. Cleanup was handled safely.

- 4) Buffered 10% Formalin 5ml spill- Imaging Nurses station – contents spilled when container failed during collection of a biopsy. Spill contained in secondary container. Gap identified with incomplete Code Orange Response Team present. Reviewed/Educated procedures for Formalin storage/handling with Imaging Staff. Reviewed procedures for Formalin storage/handling. Cleanup was handled safely.
 - 5) Fentanyl 250cc spill – MV Labor and Delivery room 9 - contents spilled when RN transferring bag slipped and fell to floor. Gap identified in incomplete Code Orange Response Team present & lack of frontline staff knowledge. Reviewed/Educated safe handling procedures for Fentanyl storage/handling with staff. Cleanup was handled safely.
 - 6) Chemotherapy Methotrexate Spill <1ml spill – MV ED Fast Track. Contents spilled when new RN attempted to draw up methotrexate with the transfer device but was unsure how to use. Gap identified in incomplete Code Orange Response Team present & lack of frontline staff knowledge. ED Educator Reviewed/Educated procedures on transfer device and location of spill kits. Cleanup was handled safely.
- **Reportable Hazardous Material Incidents** – There were no reportable spills in FY 23.

B. Waste Water Discharge Violations:

- **There were no wastewater discharge violations in FY 23.**

C. Monitoring and Inspections

- **Hazardous Waste Inspections** – There were no hazardous materials and or waste inspections in FY 23.
- **Santa Clara County Annual Medical Waste Inspections** – There were no medical waste inspections in FY 23.
 - **In FY 23 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation compliance:**
 - Annual Waste Management education for staff
 - Daily rounds by EVS supervisors
 - Monthly Safety Rounds that include observation of waste segregation practices
 - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly at the Central Safety Committee. .

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER⁶ training course.

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve hazardous materials & waste management.

FY-23 Goals:

3. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
 - **Measurement of success** :> 95%. **This goal was accomplished.**
4. Staff can describe the process for accessing a safety data sheet.
 - **Measurement of Success:** >95%. **This goal was accomplished.**

EC 4.0 - Fire Safety Management

Work Group Chair: John Folk

Scope

The Fire Safety Management Plan is designed to assure appropriate, effective response to a fire emergency situation that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY23.

A. Fire Incidents

There were no fire incidents in Mountain View or Los Gatos in FY23.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated for potential opportunities for improvement.

The total number of events in FY23 (49) was slightly higher than FY22 (45). There were 45 events in Mountain View and 4 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY23.

C. Fire Drills Completed / Scheduled

⁶ HAZWOPER: Hazardous Waste Operations and Emergency Response

All required fire drills were completed in FY23. For all drills, there are 24 required actions by staff. All issues corrected either on the spot or with further education by the dept. Manager.

D. Effectiveness

Based on opportunities for improvement identified in FY22 annual EOC evaluation the FY23 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY24 due to staff performance in FY23.

EC 5.0 - Medical Equipment Management

Work Group Chair: Jeff Hayes

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-23.

C. Reports to the FDA –

There were 8 reports through the Medwatch⁷ system in FY-23. There were no patient deaths associated with any of the reports.

D. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 87% for FY-23. A 13% improvement from FY-22. The year-end completion rate is 91.26%, a 4% increase from FY-22. The team averaged 95% since the beginning of the calendar year. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 96%.
- All high risk, life safety equipment was maintained at 99.23% completion rate. A 1.2% improvement from FY-22. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.84%.

E. Product Recalls Percentage Closed / Received

For FY-23, there were 73 recorded equipment recalls; 10 still open.

Effectiveness

FY23 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

3. Raise the asset confidence level currently at 96.8% to 98%. This will confirm that 98% of all medical devices received a completed maintenance.
Goal was not met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 97.28%
4. Network visibility through the ORDR tool of all networked medical devices. Current visibility is 86.5%, the goal would be 100%.
Goal not met. We were able to raise the ORDR visibility to 91.6%. We continue to strive for 100%. Most of those assets not seen by ORDR are on a separate segmented network and therefore protected from main network vulnerabilities and issues.

⁷ The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

EC 6.0 - Utilities Management

Work Group Chair: John Thompson

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-23.

B. Utility Reportable Incidents

There were nine reportable incidents in FY-23. All were electrical outages or voltage fluctuations.

- Los Gatos had 3 reportable incidents. On January 10, 2023, Los Gatos had loss of electrical utility (PG&E) campus wide for 2 ½ hours that started up the Emergency Generators. On March 14 and June 5, 2023, there were momentary power fluctuations of the electric utility (PG&E) that started up the Emergency Generators.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates, emergency generators ran and functioned as designed: 10/24/22, 1/5/23, 2/21/23, 3/14/23, 3/15/23, 3/17/23.

C. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **95%**, meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

D. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	88% Goal was not met
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	93%- Goal was met

Note: Data is collected through fire drills and environment of care rounds.

EM – Emergency Management

Committee Chair: Matt Scannell/Bryan Plett

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies affecting the El Camino Health environment of care. The Emergency Management Committee ensures an effective response to these events. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however, the annual reporting is being combined with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY23.

B. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY23 requiring activation of HICS and opening of the Hospital Command Center (HCC).

4. The Mountain View campus experienced a power fluctuation on October 24, 2022 that resulted in the activation of the Hospital Command Center from 12:38 to 14:00.
5. The Mountain View campus experienced a weather related power outage on January 4th from 17:38 to 19:31 that resulted in the partial activation of the Hospital Command Center.

6. Both the Los Gatos and Mountain View campuses experienced a complete network outage on April 11th 2023 from 09:20 to 17:50 that shut off all internal phone lines and computer/network connectivity for approximately nine hours.

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY23, this was met through separate planned exercises at both campuses (see below) and the continuing COVID-19 pandemic response. The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

Note, during most years, the hospitals participate in a statewide medical and health exercise in November. Due to COVID-19 pandemic, the statewide event was cancelled.

- a. Active Shooter tabletop drills were held in Los Gatos on February 10th 2023 and in Mountain View on February 17th 2023. In total approximately 560 staff members' participated either in person or on zoom.
- b. During the months of March and April, department specific active shooter drills were held in both Mountain View and Los Gatos. A total 365 staff members' participated in those department specific active shooter drills.

D. Emergency Management Training

- New hire and new manager emergency management training was presented to the new staff members.
- Safety coordinator meetings- Safety Coordinator meetings are presented in-person and on Zoom. Recordings of the meetings are also available for staff unable to attend live.
- CHA Disaster Preparedness Conference – the CHA hosts an in-depth conference related to disaster response and preparedness each year in September. The hospital has always sent a contingent to this conference. This year, the conference was held in Anaheim and was well attended by El Camino Health.

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The emphasis is creating a collaborative county-wide emergency response and disaster plan. The group also organizes and facilitates county-wide disaster exercises in which the hospital actively participates.

The EPHC expands many of the same elements of the SCCHEPP to all healthcare facilities in the county including clinics, skilled-nursing facilities and dialysis clinics. This group meets quarterly and shares information and provides training to help all healthcare facilities prepare for emergencies.

The Hospital conducts an annual Hazard Vulnerability Assessment (HVA). The HVA is an assessment of each facilities risk for various emergency situations. The HVA is reviewed and revised annually. Separate HVA's are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities. Efforts are then focused on attempting to minimize the highest risks during the fiscal year.

- There were no changes to the top five HVAs at both campuses in FY23 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Pandemic	(2) Pandemic
(3) Infectious Disease Outbreak	(3) Infectious Disease Outbreak
(4) Patient Surge	(4) Patient Surge
(5) Cyberattack	(5) Power Outage

F. Effectiveness

Key indicators were targeted to establish goals for FY23. The following goals presented opportunities to improve emergency management.

FY23 Goals

4. Expand the use of mass notification system (Everbridge) to all employees (continued from FY22)
 - **Measurement of Success**
 - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
 - Evaluate and set up logical groups and rules for notifications.
 - Train key staff to be able to use/send alerts
 - **This goal was accomplished.**
 - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
 - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
 - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
5. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
 - **This goal was accomplished.** All exercises have been expanded to include all pavilions in planning and participation including active shooter tabletops and drills.
6. Revise Hospital Surge Plan.

- ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

Department	Policy Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
PCU	1. Scope of Service – Progressive Care Unit (PCU)	Revised	Scope of Svc	1. Updated Sections: Types and Ages of Patients Served, Scope and Complexity of Services Offered, Staffing/Skill Mix	<ul style="list-style-type: none"> • Med Dir • Med Dept Exec • ePolicy • MEC
Emergency Mgmt	1. Emergency Operations Plan	Revised	Plan	1. Updated Sections: Coverage, Statement, Responsibilities, Planning, Security & Safety Management	<ul style="list-style-type: none"> • Emergency Mgmt Committee • ePolicy • MEC
Pharmacy	1. Drug Supply Chain Security Act (DSCSA) 2. MERP – Medication Error Reduction Plan	Revised None	Policy Plan	1. Updated Sections: Policy Statement, Procedure 2. None	#1: <ul style="list-style-type: none"> • P&T • ePolicy • MEC <hr style="width: 10%; margin: 5px auto;"/> #2: <ul style="list-style-type: none"> • Med Safety Cmte • P&T • ePolicy • MEC

EL CAMINO HOSPITAL BOARD OF DIRECTORS

To: El Camino Hospital Board of Directors
From: Diane Wigglesworth, Compliance/ Privacy Officer
Date: December 6, 2023
Subject: Physician Wellness Program Policy

Recommendation(s):

To approve a new Physician Wellness Program Policy as recommended by the Compliance and Audit Committee.

Summary:

1. **Situation:** Physician wellness programs are now permitted under the Stark Law exceptions and the federal anti-kickback safe harbor included in the Consolidated Appropriations Act, 2023 (CAA). The hospital is prepared to offer an annual mental and behavioral health improvement program to Medical Professionals practicing within the community for the primary purpose of preventing suicide and improving mental health and resiliency of providers.
2. **Authority:** Under the Stark Law exception and as required by title 22 and Joint Commission the Hospital's governing body must approve before the hospital can implement this program.
3. **Background:** ECH will offer the program through its affiliate, Concern: Employee Assistance Program (EAP). Program services will be provided by qualified counselors and other behavioral health professional who demonstrate an understating of the unique stressors associated with being a medical professional.
4. **Assessment:** ECH evaluated a need to offer a program to medical professionals practicing within the community.
5. **Other Reviews:** The Compliance and Audit Committee recommended the policy for approval at the November 29, 2023 meeting.

List of Attachments:

1. Physician Wellness Program Policy

Status **Pending** PolicyStat ID **14737372**



Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	3 years after approval

Owner	Melissa Guerrero: Manager Corporate Compliance
Area	Corporate Compliance

Physician Wellness Program Policy

COVERAGE:

El Camino Hospital referred to as "ECH".

PURPOSE:

To establish a Physician Wellness Program as permitted under the Stark Law exception and federal anti-kickback safe harbor included in the Consolidated Appropriations Act, 2023 (CAA), which is available to all physicians and clinicians who practice within the geographic service area served by ECH.

POLICY STATEMENT:

El Camino Health will offer and provide, without regard to the volume or value of referrals, or the value of other business generated, an annual mental and behavioral health improvement or maintenance program to Medical Professionals practicing within the community for the primary purpose of preventing suicide and improving mental health and resiliency of providers ("Program").

DEFINITIONS:

Physician: A Doctor of Medicine or osteopathy, a Doctor of Dental Surgery or dental medicine, a Doctor of Podiatric Medicine, a Doctor of Optometry, or a chiropractor.

Clinician: A healthcare professional qualified in the clinical practice of medicine, including advanced practice providers (APP), such as a nurse practitioner or a physician assistant. Clinicians are those who provide principal care for a patient where there is no planned endpoint of the relationship; expertise needed for the ongoing management of a chronic disease or condition; care during a

defined period and circumstance, such as hospitalization; or care as ordered by another clinician.

Medical Professionals: Includes Physicians and Clinicians.

Geographic Service Area: The hospital's geographic area is defined as the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients.

REFERENCES:

Physician Wellness Exception Under the Stark Law (42 U.S.C. § 1395nn(e)(9))

Physician Wellness Safe Harbor Under the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)(3)(L))

The Consolidated Appropriations Act (CAA) of 2023- Physician Wellness Program Exception (CAA, §4126)

PROCEDURE:

ECH will offer the Program through its affiliate, Concern: Employee Assistance Program (EAP) referred to as "Concern". Program services will be provided by qualified counselors and other behavioral health professionals who demonstrate an understanding of the unique stressors associated with being a Medical Professional in today's challenging healthcare environment, and will consider the Medical Professional's values, beliefs, and norms when providing care. The Program services that will be offered include:

- **Confidential Counseling**- Up to 10 sessions (in-person, virtual) per person, per issue, per 12-month period. Counseling provided by Concern's Provider Network and the BetterHelp Provider Network with experienced, licensed, culturally competent providers.
- **Coaching**- Up to four 30-minute phone sessions with a certified coach. Coaching is ideally suited for work-life balance. Through a collaborative process, the coach helps individuals establish a plan to address competing demands and find resources to support them. Examples include setting boundaries to reduce overload, or commitment to healthy habits, like eating well and taking breaks when possible.
- **In-the-Moment Support**- Clinicians who work with Medical Professionals and understand their unique work demands help them manage the stress of their personal and professional lives. Clinicians provide immediate emotional support and help them plan a positive next step.
- **Crisis Support**- A clinician helps address stress and other outcomes associated with a traumatic event. Events can include unanticipated death of a patient, aggression, and violence towards Medical Professionals, or death of a colleague. Concern will connect the Medical Professional to a clinician for ongoing care as needed.
- **Peer Support**- Concern will help develop a peer support team and train medical professional team members. Peer teams support colleagues when they are feeling over-extended, overwhelmed, or have had an upsetting patient interaction, and ensure they are emotionally supported after exposure to traumatic events. Because team members themselves often deal

with feelings of exhaustion, overwhelm, and other emotional reactions, an experienced clinician will be available to offer empathy, guidance, and help set boundaries.

Medical Professionals will also have access to all other Concern services including: 24/7 access (clinical first intake center or self-service digital platform), parent coaching, work-life resources, round the clock crisis support, live and on-demand guided mindfulness options, curated self-help library, and an assigned Account Executive.

Description of Evidence-Based Support Program Design

Concern's 2023 Physician Burnout and Well-Being Report was sourced from valid, highly reliable sources, organizations, and research studies.

Overview revealed that physicians are acculturated to take care of others first and are reluctant to seek help for themselves. The stigma that still exists around mental health issues also makes them less likely to seek counseling and emotional support. Without intervention, they are more likely to suffer from mental and emotional problems associated with their work environment and their unique work demands, including staffing shortages, operational inefficiencies, and work overload. This can lead to high levels of stress and burnout, including increased incidence of depression. More than half of US physicians report at least one symptom of burnout – nearly twice the rate of the general population.

In addition to organization-level resources that address operational inefficiencies, and access to peer support, studies in this review also suggest that physicians who proactively address their mental health are better equipped to care for patients and sustain their own resilience in the face of distress. Physicians are encouraged to combine healthy self-care strategies with effective professional treatment for mental health conditions, such as depression, anxiety, and suicidal ideation.

Personnel Conducting the Program

The Program will be facilitated and conducted by Concern EAP's staff and contracted providers meeting the following qualifications:

- Licensed Marriage and Family Therapists (LMFT)
- Clinical Social Workers
- Counselors – Concern's Provider Network and the BetterHelp Provider Network with experienced, licensed, culturally competent providers
- Certified Coaches
- Behavioral Health Professionals

Participant Privacy and Confidentiality

All Program services provided are confidential and designed to safeguard the participant's privacy and rights. Medical information and treatment records are maintained by the individual counselor or other behavioral health professional providing services and may only be released by such provider to other individuals if authorized by the participant in writing. All counselors are guided by a professional code of ethics and applicable state and federal privacy laws. Limited individual

participant information is maintained by Concern in a confidential manner and does not include treatment records.


Program Cost and Evaluation

The estimated total cost of the Program is \$49k annually and is limited to max amount of sessions for each participant based on the type of Program service provided. The Program costs, utilization and client satisfaction data will be evaluated annually to measure the success of the Program. Substantial changes to the Program shall require an amendment to this policy and Board approval.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
Director of Corporate Compliance	Diane Wigglesworth: Compliance and Privacy Officer	Pending
	Melissa Guerrero: Manager Corporate Compliance	11/2023



**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Carol Somersille, M.D., Board Member
Date: December 6, 2023
Subject: Report on Educational Activity

Purpose: For information.

Summary:

Conference Title: HQI and Hospital Council Annual Conference, October 15-16, 2023

Sponsoring Organization: Hospital Quality Institute

1. Key Educational Points, Lessons Learned: (Please use as much space as necessary)

Stephen Shedletzky, of author Simon Sinek's The Optimism Company, delivered the Keynote address entitled "The Infinite Game".

Mr. Shedletzky spoke on leading with an infinite mindset instead of a finite mindset. In a finite mindset there are known players, fixed rules, a finish line, winners and losers. This leads to a decline in trust and cooperation over time. In an infinite mindset there are known and unknown players, new players can join anytime, no fixed rules, no end game, no standard definition of what it means to be number one. The goal is to stay in the game, contribute and thrive.

Leaders with an infinite mindset:

- Advance a just cause
- Build trusting teams
- Study worthy rivals. The finite mindset prioritizes the outcome while the infinite "worthy rival" mindset prioritizes the process.
- Prepare to pivot
- Demonstrate the courage to lead

California Maternal Quality Care Collaborative (CMQCC) Updates and Strategies.

El Camino Health already uses the CMQCC data to analyze our population and effect change. Our work regarding evaluating outcomes is ahead of the curve and should be published. It was acknowledged that the standing toolkits regarding equity work are not sufficient. Our work regarding integrating the advancement of quality care and health equity is groundbreaking.

Jeremy Waiser of Voyce spoke on Using On-Demand Language Interpretation Services to Improve Patient Outcomes.

El Camino Health uses the Voyce system. Strengths are accessibility, speed, cost, compliance, medically qualified and critically integrated. Challenges are discussions in highly sensitive cases such as end of life discussions and hands on training. This discussion reinforced the need to have a diversified workforce who are certified in interpretation and can be called upon to translate for our major languages other than English.

Report on Educational Activity – Director Somersille
December 6, 2023

Mr. Waiser stated that Voyce can be automatically accessed through our EPIC system. However, our computers in each room do not have voice and video capability. Perhaps when we upgrade the computers in the rooms, we should have that capability instead of using a roaming cart.

Patients are surveyed by asking five questions. At the conclusion of the call, the patient taps the screen to rate the service or be connected to another interpreter to ask the questions in their language. Providers should encourage participation in the survey.

2. Has the conference improved your ability to fulfill your obligations as a member of the ECH Board? If so, how?

The conference has improved my ability to fulfill my obligations as a member of the ECH board by helping me to approach problems with an infinite mindset instead of a finite mindset. It has also reinforced my findings that El Camino Healthcare district is leading the pack regarding assessment and improvement of quality.

3. Were there speakers that ECH should consider inviting? Yes No

Stephen Shedletsy

4. Do you recommend this conference to other members of the Board? Yes No

**CEO Report
December 6, 2023
Dan Woods, Chief Executive Officer**

Finance

The month ending October 31, 2023, produced strong operating revenue of \$132.6 million which was favorable to budget by \$2.0 million / 1.5% and 11.6% higher than the same period last year. Income from operations of \$13.5 million was favorable to budget by \$1.7 million / 14.1%. Net income of \$12.6 million was unfavorable to budget by \$1.8 million / 12.2% mainly attributed to lower than budgeted investment income.

YTD FY2024 total operating revenue of \$500.1 million is unfavorable to budget by \$8.0 million / 1.6% and \$30.6 million / 6.5% higher than same period last year. Operating EBIDA of \$75.8 million is unfavorable to budget by \$1.6 million / 2.0% and lower than the same period last year by \$3.4 million / 4.3%. Initiatives to reduce denials / increase cash collections resulted in a month-over-month decrease in Net Days in A/R of 4.2 days.

Operations

The Orchard Pavilion welcome two new patient care departments - private neonatology suites a new lobby to welcome our patients and their loved ones. The neonatology suites include latest in care and equipment for newborns, space for visitors and a family lounge. Enhancements and investments into The Orchard Pavilion are ongoing and we will continue to provide updates as new spaces are completed and ready for patient care.

In early November, the Peter C. Fung, M.D. Stroke Center, the cath lab, and the emergency department set a new ECH all-time record for fastest brain intervention for an acute stroke patient. The neuroIR physician pulled the clot from the patient at **72 minutes** from their arrival to the Emergency Department for this walk-in patient. This timely teamwork included ED triage, CT scans, radiology report, tele-neurology consultation in CT, and cath lab response. Work groups meets every month to develop faster activation protocols.

Information Services

ECHMN continues to increase the percent of active patients enrolled in MyChart reaching 74% this month placing ECH Clinics in the top 10% percentile of all Epic organizations.

To address increasing imaging volume impacting patient through-put, the Mountain View CT department has installed a third CT. The new CT obtains sharp and rich-in-contrast images at high speed and low dose while minimizing sedation requirements and facilitating low-dose scans for children.

Corporate Health Services

Concern received a foundation grant to provide mental health services to over 750 El Camino Health positions. The program will launch January 2024 with a focus on counseling and coaching sessions.

The Chinese Health Initiative launched the new bilingual Emotional Well-being Resource Hub to provide resources and tips on maintaining emotional well-being.

Foundation

In October, El Camino Health Foundation secured \$3,241,374 in donations. The Foundation has raised a total of \$4,793,533 in the first four periods of RY 2024, which is 48% of the fiscal year fundraising goal.

Foundation staff members are delivering holiday gifts of locally sourced dried fruit to major donors, which is a wonderful chance to visit with them. We hosted a major donor stewardship reception at Los Altos Golf & Country Club at the end of November, with a focus on innovation at El Camino Health.

Government Relations & Community Partnerships

Government Relations

The California Assembly Select Committee on California's Mental Health Crisis will be holding a field hearing in Los Gatos. The Committee's Vice Chair, Assemblymember Gail Pellerin, represents El Camino Health and invited us to have a panelist participate. Dr. Nicole Tarui, Medical Director of the Maternal Outreach Mood Services (MOMS) Program at El Camino Health, will be speaking on a panel focused on the gaps in the current ability to serve people with behavioral health needs.

Community Partnerships

The annual Community Benefit grant application is scheduled to go live no later than December 15, 2023, and applications will be due by February 23, 2024. As in previous years, there will be Community Benefit Grant Application Information Sessions held via Zoom. During these sessions, the Community Partnerships staff will provide an overview of the Community Health Needs Assessment, Implementation Strategy Report and Community Benefit Plan, and FY25 application highlights and logistics.

Auxiliary

The Auxiliary donated 4,250 volunteer hours for the month of October. Since the inception of the Auxiliary in 1958 through the end of October the total volunteer hours is 6,134,002.

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Julia E. Miller, Board Member and Foundation Liaison
Date: December 6, 2023
Subject: Foundation Liaison Report

Summary:

- 1. Policy Change:** I would like to share a reminder regarding the Foundation's generous change in policy allowing board members to attend Foundation events with one complimentary ticket. The recent annual Fall Golf Tournament dinner had two board members in attendance. We are doing a trial to track if this will change attendance and will allow more Board members to interact with donors.
- 2. Orchard Pavilion Donor Wall:** Flyers for donor plaques are included at the end of my report and in the appendix as part of the materials packet again this month. Please pass the word to your friends, potential donors or people you know whose children were born at ECH. Plaques come in two sizes, \$2,500 or \$5,000 for two-tiered tiles. There will be flyers in the room during the meeting if you would like to take some to share.
- 3. Donation Update:** As the liaison I secured an additional \$25K donation from a personal friend who will receive a donor name plaque on one of the NICU patient rooms in Orchard Pavilion.
- 4. Service Update:** I also actively serve on the Orchard Pavilion Renovation Philanthropy Council.



Planting Philanthropic Seeds

El Camino Health has always provided superb maternal-child healthcare. The remodeled, modernized, and expanded Orchard Pavilion will support continued excellence but in a welcoming, healing environment that better launches more of our community's young families on the path to a healthy future. Your gift to support this project is an investment in our families, our community, and a new generation.

Apricot orchards once blossomed where the Orchard Pavilion now stands. A beautiful, back-lit mosaic outside the state-of-the-art building will evoke this past and acknowledge donors who contribute to provide the best possible care for women, newborns and families inside. Your family can donate and inscribe a tile.

Orchard Pavilion
A New Vision for Mother, Baby, and Family Care

El Camino Health is renovating and expanding the Orchard Pavilion for Women's and Newborn Services. When construction is complete, our community will have a best-in-class center of excellence that provides the highest quality, most personalized care in an environment that promotes healing and wellness for women, newborns, and families.

- 52 private mother-baby rooms large enough for a partner to comfortably stay overnight.
- More labor and delivery rooms.
- Obstetrics emergency department.
- Dedicated antepartum rooms for women with high-risk pregnancies.
- Enlarged neonatal intensive care unit designed for family-centered care.
- Double pane windows, LED lighting, and other energy efficiency upgrades to make the building eligible for LEED Gold status.

Payment Information

Name _____

Address _____

City/State/Zip _____

Home Phone _____

Mobile Phone _____

Email _____

My check payable to El Camino Health Foundation is enclosed.

I will pay this gift through my donor advised fund.

I will pay this gift through stock. Please send instructions.

I prefer to pay by credit card.

American Express Discover MC Visa

Total contribution \$ _____

Acct # _____

Expiration Date _____ CVV _____

Signature _____

My company has a matching gift program. I will contact them to match my gift. Company name _____

Please clip and mail to:
 El Camino Health Foundation
 Dept. No. 05868
 P.O. Box 885868
 Los Angeles, CA 90088-5868

Or donate online at:
donate.elcaminohealth.org/apricot



elcaminohealth.org/foundation

I would like to inscribe a tile on the apricot blossom donor wall outside the Orchard Pavilion

Customize your tile

(Include spaces in character count)

4" x 8" - \$2,500 each

112 tiles

Maximum 3 lines

Acknowledgment,

Line 1 – $\frac{3}{8}$ " (italic), maximum 26 characters

Donor Names, Lines 2,3

$\frac{1}{2}$ ", maximum 21 characters per line



A Gift of
Abcdefghijklmnopqrstu
Associates

8" x 8" - \$5,000 each

32 tiles

Maximum 5 lines

Acknowledgment,

Line 1 – $\frac{3}{8}$ " (italic),
maximum 26 characters

Donor Names, Lines 2-5

$\frac{1}{2}$ ", maximum 21 characters per line



Abcdefghijklmnopqrstuvwxyz
Donor Name Family
Name, Name, Name
Line 4
Line 5

A12a. DRAFT 2023-11-08 ECHB Minutes (Open)

**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, November 8, 2023**

El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

Board Members Present

Bob Rebitzer, Chair
Julia E. Miller,
 Secretary/Treasurer
Jack Po, MD, Ph.D., Vice-Chair
Lanhee Chen, JD, PhD
Wayne Doiguchi
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Board Members Absent

Peter Fung, MD
John Zoglin

Others Present

Dan Woods, CEO
Mark Adams, MD, CMO
Carlos Bohorquez, CFO
Shahab Dadjou, President, ECHMN
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Deanna Dudley, CHRO
Omar Chughtai, Chief Growth
 Officer**
Jeff Cowart, Marketing**
Christine Cunningham, Chief
 Experience and Performance
 Improvement Officer**

Others Present (cont.)

Tracy Fowler, Director,
 Governance Services
Gabriel Fernandez, Governance
 Services Coordinator
Brian Richards, Information
 Technology

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Chen, Doiguchi, Miller, Po, Rebitzer, Ting and Watters were present constituting a quorum. Director Somersille was absent at roll call and joined the meeting at 5:47 pm.	The meeting was called to order at 5:30 p.m.
2. AB2449 REMOTE PARTICIPATION	Chair Rebitzer asked the Board for declarations of AB2449 request for approval. Director Chen participated remotely via Just Cause until he was able to join in person at 6:26 pm.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board for declarations of conflict of interest with any items on the agenda. None were reported.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members of the public were present.	
5. AGENDA ITEM 5: VERBAL MEDICAL STAFF REPORT	Dr. Adams provided the medical staff report as Drs. Legha and Ho were still engaged with patients. The report covered improvements and plans within different departments of the medical staff, with notable progress in anesthesia, pathology, and radiology services.	
6. AGENDA ITEM 6: APPROVE ECHB CODE OF CONDUCT	Director Chen shared the updates on the Code of Conduct taken since the prior meeting as urged the Board to approve the document. Discussion from the Board commended the working team for striking a good balance and offering a structured process. Motion: To approve the ECHB Code of Conduct.	ECHB Code of Conduct was approved.

	<p>Movant: Miller Second: Watters Ayes: Chen, Doiguchi, Miller, Po, Rebitzer, Ting, Watters Noes: None Abstentions: None Absent: Fung, Somersille, Zoglin Recused: None</p>	
<p>7. AGENDA ITEM 7: RECESS TO CLOSED SESSION</p>	<p>Motion to adjourn to closed session at 5:42 p.m. pursuant to <i>Health and Safety Code Section 32106(b)</i> for reports and discussion involving healthcare facility trade secrets for discussion of the strategic environment; and <i>Gov't Code Section 54957</i>; and deliberations concerning reports on Medical Staff quality assurance matters.</p> <p>Motion: to adjourn to closed session at 5:42 p.m.</p> <p>Movant: Miller Second: Doiguchi Ayes: Chen, Doiguchi, Miller, Po, Rebitzer, Ting, Watters Noes: None Abstentions: None Absent: Fung, Somersille, Zoglin Recused: None</p>	<p><i>Adjourned to closed session at 5:42 p.m.</i></p>
<p>8. AGENDA ITEM 17: CLOSED SESSION REPORT OUT</p>	<p>The open session was reconvened at 7:21 p.m. by Chair Rebitzer. Agenda Items 8-15 were addressed in closed session.</p> <p>During the closed session, the Credentialing and Privileges Report by a unanimous vote of all Directors present (Directors Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, and Watters).</p>	<p><i>Reconvened Open Session at 7:21 p.m.</i></p>
<p>9. AGENDA ITEM 18: CONSENT CALENDAR</p>	<p>Chair Rebitzer asked if any member of the Board wished to raise an item from the consent calendar for discussion. No items were removed. Director Somersille recused herself from voting on items (e) Delegation to Chief Executive Officer to execute OB/GYN Call Panel Agreements and (f) Resolution 2023-02 Regarding OB/GYN Call Panel Agreement with Dr. Somersille</p> <p>Motion: To approve the consent calendar.</p> <p>Movant: Po Second: Miller Ayes: Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters Noes: None Abstentions: None Absent: Fung, Zoglin Recused: Somersille for items (e) and (f)</p>	<p><i>The consent calendar was approved</i></p>
<p>10. AGENDA ITEM 19: CEO REPORT</p>	<p>Mr. Woods provided a report that focused on recent accolades and events.</p>	

11. AGENDA ITEM 20: BOARD ANNOUNCEMENTS	Chair Rebitzer recounted the action items posed by the Board during the meeting.	
12. AGENDA ITEM 21: ADJOURNMENT	Motion: To adjourn at 7:30 p.m. Movant: Chen Second: Doiguchi Ayes: Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters Noes: None Abstentions: None Absent: Fung, Zoglin Recused: None	<i>The meeting adjourned at 7:30 p.m.</i>

Attest as to the approval of the preceding minutes by the Board of Directors of El Camino Hospital:

Julia Miller, Secretary/Treasurer

DRAFT

A12d2. Scope of Service - Progressive Care Unit -PCU- History-Changes



Origination	09/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2023
Next Review	3 years after approval

Owner	David Michael Gabriel: Clinical Manager
Area	Scopes of Service

Scope of Service - Progressive Care Unit (PCU)

Types and Ages of Patients Served

The Progressive Care Unit (PCU) is a 16 bed step-down unit to the Critical Care Unit (CCU). The PCU serves all patients ~~(children weighing 80 pounds or greater to geriatric)~~ who meet the admission criteria. Medical-surgical patients who are deemed stable enough not to require CCU, but require frequent, comprehensive clinical intervention(s) and/or hemodynamic/respiratory monitoring are served in the PCU.

Assessment Methods

Nursing care is provided by registered nurses (RNs) who assess, document, and evaluate patient progress toward expected outcomes and daily goals. Registered nurses provide direct supervision to clinical support staff/certified nursing assistants (CNAs) in the provision of patient care.

Staff nurses participate in continuous quality improvement efforts related to patient care delivery.

Scope and Complexity of Services Offered

The department provides total nursing care, as directed and prescribed by the physician. Besides the physical care of the patient, psychosocial needs are also addressed. Patients are cared for in a compassionate manner, utilizing a multidisciplinary approach. The privacy of the patient is always considered while caring for the patient in (PCU). ~~Multidisciplinary rounds are conducted weekly which includes plan of care review, daily goals and necessary revisions by the team members. Monday – Friday, daily rounds are made by the Medical Director, Charge RN, Clinical Pharmacist and other healthcare team members as deemed appropriate.~~

Non-nursing orders are communicated to appropriate departments. Nursing staff communicate specific patient needs and coordinate treatments with ancillary departments.

Discharge planning is initiated on admission in collaboration with physician(s), care coordinators, social services, patients and families/Significant Others. Family participation in overall goals is encouraged

Arrangements are made for transfer to another facility or to a higher level of care if the scope of services provided by the Progressive Care Unit does not meet the patient's clinical requirements.

Appropriateness, Necessity, and Timeliness of Services

The Clinical Manager, in collaboration with the Medical Director, RN Clinical Staff and Charge Nurses assesses the appropriateness, necessity, and timeliness of service. The appropriateness of services is addressed in hospital and department specific policies and procedures which are established in coordination with the medical staff.

A continuous quality improvement process is in place to identify opportunities for improvement in patient care processes and to measure on-going performance. The patient's progress is evaluated by physician(s), nurses, members of other health disciplines and by patient and family satisfaction measures/surveys.

Staffing/ Skill Mix

The Clinical Manager oversees the 24-hour operation of the unit and reports to the Director, ~~Critical Care of Cardiovascular~~ Services. PCU staffing includes a skill mix of RNs, CNAs, and administrative support staff to provide patient care and services. Staffing is based on budgeted hours of care, patient census and ~~nursing intensity measures~~ Workload Acuity Score (NIMSWAS). ~~Patient specific NIM levels, which are assessed each shift and~~ factored into the staffing guidelines by the charge nurse ~~for determination of staffing~~ when making patient assignments for the next shift.

The competency of the staff is evaluated through observation of performance and by skill competency validation. Staff orientation, education and training are provided to assist in the achievement of performance expectations and standards.

Levels of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department is designed to meet the level of care required and acuity of the patient.

Performance assessment and improvement processes are evaluated through performance improvement activities in conjunction with the multidisciplinary health care professionals who provide services to the unit.

Standards of Practice

The PCU is governed by state regulations as outlined in Title 22 and standards established by the Joint Commission on Accreditation of Healthcare Organizations. Additional practices are described in the Patient Care Policies and Procedures; Unit Description, Policies, Procedures; Admission Discharge and Transfer Criteria for PCU, and Clinical Practice Standards. PCU Clinical Care is based upon the standards described and recommended by the American Association of Critical Care Nurses (AACN).

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
Medicine Department Executive Committee	David Michael Gabriel: Clinical Manager	09/2023
Medical Director	David Michael Gabriel: Clinical Manager	07/2023
	David Michael Gabriel: Clinical Manager [PS]	05/2023

History

Draft saved by Gabriel, David Michael: Clinical Manager on 2/17/2023, 2:34PM EST

Edited by Gabriel, David Michael: Clinical Manager on 2/17/2023, 2:42PM EST

Under "Types and Ages of Patients Served," language removed which previously stated that children weighing 80 pounds or greater are admitted to PCU. It is inappropriate for pediatric patients to be admitted to PCU as frontline PCU nursing staff are not PALS certified and lack

competence in caring for this patient population.

Under "Scope and Complexity of Services Offered," language removed which previously stated multidisciplinary rounds are done weekly. Multidisciplinary rounds are only done in CCU and are not done in PCU.

Under "Staffing/Skill Mix," "Director of Critical Care Services" changed to "Director of Cardiovascular Services." Language also changed which previously stated that staffing "is based on...nursing intensity measures (NIMS)" removed and replaced with "Workload Acuity Score" as NIMS will be sunset and replaced enterprise-wide with Workload Acuity Score.

Last Approved by Gabriel, David Michael: Clinical Manager on 2/17/2023, 2:42PM EST

Last Approved by Gabriel, David Michael: Clinical Manager on 2/17/2023, 2:42PM EST

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 3/3/2023, 12:56PM EST

Updated approval workflow to include Med Dept for review, per Franz E.

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/3/2023, 12:56PM EST

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/13/2023, 3:37PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/30/2023, 4:26PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/3/2023, 3:42PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/20/2023, 12:25PM EDT

Last Approved by Gabriel, David Michael: Clinical Manager on 4/20/2023, 12:34PM EDT

Approved by PCU Manager 4/20/23

Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator on 5/4/2023, 1:09PM EDT

This has not been reviewed at Medicine Dept.; restarting.

Last Approved by Gabriel, David Michael: Clinical Manager on 5/4/2023, 1:09PM EDT

PCU 4/20/23

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/28/2023, 2:22PM EDT

Last Approved by Gabriel, David Michael: Clinical Manager on 7/17/2023, 7:05PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 7/21/2023, 12:41PM EDT

Comment by Santos, Patrick: Policy and Procedure Coordinator on 7/21/2023, 3:48PM EDT

Per email from David that Dr. Ganesh Krishna reviewed/approved on 2/10/23.

Last Approved by Gabriel, David Michael: Clinical Manager on 9/22/2023, 12:57PM EDT

approved at Med Exec Committee

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/16/2023, 9:50AM EDT

ePolicy 10/13/23

Last Approved by Coston, Michael: Interim Regulatory Accreditation and Licensing Con on 11/6/2023, 4:26PM EST

MEC 10/26/23

A12d3. Emergency Operations Plan-History-Changes

Status **Pending** PolicyStat ID **14472776**



Origination 03/2018
 Last Approved N/A
 Effective Upon Approval
 Last Revised 10/2023
 Next Review 1 year after approval

Owner Bryan Plett: Mgr Environmental Hlth&Safety
 Area Emergency Management
 Document Type Plan

Emergency Operations Plan

COVERAGE:

This Emergency Operations Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics as listed below.

Mountain View	Los Gatos
<ul style="list-style-type: none"> • Main Hospital • Old Main Hospital • Advanced Radiotherapy & CyberKnife Radiosurgery Center (125 South Dr.) • Cedar Pavilion (2660 Grant Road) • Melchor Pavilion (Lab - 1st Floor; Concern, Community Benefits, Chinese Health Initiative, and South Asian Heart Center - 3rd Floor) • Oak Pavilion • Orchard Pavilion (Women's Hospital) • Park Pavilion (excludes YMCA) • Sobrato Pavilion (Ground, 1st, 2nd and ECH-occupied offices on other floors) • Taube Pavilion (MHAS Services) • Willow Pavilion 	<ul style="list-style-type: none"> • Main Hospital • Cancer/Infusion Center • Rehabilitation Center (355 Dardanelli Ln.) • PPI (555 Knowles Dr., Suite 100) • OATS/Aspire (825 Pollard Rd.) • Men's Clinic (825 Pollard Rd.)

PURPOSE:

This Emergency Operations Plan at El Camino Health describes how the organization ensures effective response to disasters or emergencies affecting the safe operation of the hospital. The Emergency Management Committee implements processes for developing, implementing and monitoring the Plan.

STATEMENT:

The El Camino Health Emergency Operations Plan is an "All Hazards" approach to the facilitation and coordination of incidents and emergencies that directly affect the hospital or have been determined to have a high likelihood of affecting hospital operations. The plan directly addresses the following six (6) critical areas identified by The Joint Commission:

- A. Communications (EM.12.02.01)
- B. Staffing (EM.12.02.03)
- C. Patient Clinical and Support Activities (EM.12.02.05)
- D. Safety and security (EM.12.02.07)
- E. Resources and assets (EM.12.02.09)
- E. Utilities (EM.12.02.11)

~~The Plan describes a comprehensive "all hazards" command system for coordinating the six critical areas: communications, resources and assets, safety and security, staffing, utilities, and clinical activities. The overall response procedures include~~ El Camino Health is prepared to respond to single emergencies that can temporarily affect demand for services, along with multiple emergencies (that can occur concurrently or sequentially) that ~~can~~ adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time.

Necessary policies and procedures have been adopted to ensure the hospital adequately addresses response efforts in each of the following four (4) phases of the Emergency Management program:

- A. Mitigation
- B. Preparedness
- C. Response
- D. Recovery

~~El Camino Health has established the necessary policies~~ These current plans and procedures ~~to achieve preparedness and respond to and recover from an incident. These current plans and procedures~~ are exercised and reviewed to determine and measure functional capability. The Emergency Operations Plan complies with the National Incident Management System (NIMS) components.

RESPONSIBILITIES:

- A. Leadership

The hospital's leaders are involved in the planning activities and the development of the Emergency Operations Plan. The administrators, and department heads are represented in the Emergency Management Committee. Executive sponsors of the program include the Chief Administrative Services Officer and the Chief Medical Officer.

B. Emergency Management Program

The Manager of Environmental Health and Safety and Emergency Management

The Hospital Safety Officer provides overall support to the hospital's preparedness efforts, including developing needed procedures, coordinating production or revision of the Emergency Operations Plan, planning and executing training and exercises, and coordinating the critiquing of the events and preparing the After Action Reports (AAR).

C. The Emergency Management Committee

The Emergency Management Committee is a group of multidisciplinary hospital representatives, including. The committee meets regularly and includes representatives from senior leadership, clinical and non-clinical representatives from key departments nursing services, medical staff, pharmacy services, infection prevention and control, facilities engineering, security, and information technology.

The committee meets regularly. The chairperson sets each meeting's agenda and facilitates the committee's work to achieve an annually established set of objectives. Subcommittees or task groups are appointed to accomplish identified projects or to plan training and exercises. Minutes of each meeting are published and available ~~to~~ for review by hospital.

D. Hospital Incident Command System

The hospital utilizes the Hospital Incident Command System (HICS) to manage and direct hospital operations during incidents that could impact hospital operations. Information on HICS and its utilization are available in the Emergency Management Policies and Procedures located online (Electronic Policy Database: Emergency Management)

PLANNING

A. Hazard Vulnerability Analysis

Hazard Vulnerability Assessments (HVAs) are conducted annually at each hospital campus to identify the potential emergencies that could affect the ability of the organization to provide normal services. This assessment identifies the likelihood of those events occurring and the consequences of those events. The assessment provides a realistic understanding of the vulnerabilities and ~~to help~~ helps focus the resources and planning efforts.

The HVA's of other area hospitals and health-care agencies are shared and summarized to help develop a list of priorities on a county-wide basis. This summary is updated annually.

B. Community Involvement

A strong relationship has been established between other hospitals and agencies within Santa

Clara County. The combined group meets regularly to share information and resources and to work together to identify and meet the needs and vulnerabilities of each facility.

C. Mitigation & Preparedness

Specific emergency response plans have been established to address needs based on priorities from the HVA. Each plan addresses the four phases of emergency management activities:

1. Mitigation: Activities designed to reduce the risk of and potential damage due to an emergency (i.e., the installation of stand-by or redundant equipment, training).
2. Preparedness: Activities that organize and mobilize essential resources (i.e., plan-writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies).
3. Response: Activities the hospital undertakes to respond to disruptive events. The actions are designed with strategies and actions to be activated during the emergency (i.e., control, warnings, and evacuations).
4. Recovery: Activities the hospital undertakes to return the facility to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating standards. The long-term focus should be on returning all hospital operations back to normal or an improved state of affairs.

D. Hospital Command Center

~~The Hospital Command Center (HCC) will be established according to procedures designated in HICS. See the following documents for additional information:~~

- ~~• [Hospital Command Center \(HCC\)](#)~~
- ~~• [HICS Chart](#)~~
- ~~• [HICS Roles Information Guide](#)~~

Hospital Command Center

El Camino Health responds to incidents and/or emergencies by activating the Hospital Command Center (HCC) in accordance with the Hospital Incident Command System (HICS) and the National Incident Management System (NIMS). The incident command structure is flexible and scalable in order to respond to varying types and degrees of emergencies or disaster incidents. The El Camino Health Incident Command Staff includes an Incident Commander, Medical / Technical Specialists, Safety Officer, Public Information Officer, and Liaison Officer as dictated by the complexity of a given incident. A representative from Environmental Health and Safety / Emergency Management shall serve as the Hospital Command Center (HCC) Manager.

The Incident Commander shall determine incident specific objectives in the addition to the following standing objectives:

Protect Life

Protect the Facilities, Critical Utilities, and Network Infrastructure

Continue Mission Critical Operations

The Hospital Command Center (HCC) will be established according to procedures designated in HICS and NIMS. See the following documents for additional information:

- [Hospital Command Center \(HCC\)](#)
- [HICS Chart \(See attachment\)](#)
- [HICS Roles Information Guide \(See attachment\)](#)

E. Inventory & Monitoring of Assets & Resources

The resources and assets that are available on-site and/or elsewhere to respond to an emergency are maintained and inventoried. This includes, but is not limited to the following assets and resources:

- Food
- Fuel
- Medical supplies
- Medications
- Personal protective equipment (PPE)
- Water

The current equipment inventory can be found in the [Emergency Supply and Equipment Plan](#)

The organization will establish a threshold for resource quantities that trigger a resupply actions. These levels will be the Par Levels, a quantity at a midpoint between extremes on a scale of normal availability.

Emergency Operations Plans

A. Response

A response procedure to an emergency can include the following:

- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation.
- [HICS shall be activated as outlined in: Activation and Termination of Hospital Incident Command System -HICS](#)

- [Staff respond to the emergency as outlined in: Code Triage](#)
- 1. ~~HICS shall be activated as outlined in: [Activation and Termination of Hospital Incident Command System -HICS](#)~~
- 2. ~~Staff respond to the emergency as outlined in: [Code Triage](#)~~

B. Sustainability

A process has been developed for determining the sustainability of the organization during an emergency. The end-point in planning for sustaining an emergency is 96-hours without the support of the local community. The planning on sustainability is coordinated with the Emergency Management Committee and the appropriate departments. The organization will continually monitor the availability and consumption rate of resources and assets to determine the length of time the organization can provide services. When necessary, the organization will adjust the consumption of the resources to extend the sustainability period. When it is determined the organization cannot provide services at an acceptable level of services, safety, and protection, a partial or total evacuation will be considered.

C. Recovery Procedures

The return to normal operations from an emergency will utilize the procedures outlined in [Activation and Termination of Hospital Incident Command System \(HICS\)](#).

D. Incident Levels and Phases

1. **Emergency Response Level 1:** Potential Emergency - An unusual event or potential emergency affecting a single department of a single building area. The situation is an isolated incident. Life safety is not threatened and patients are not adversely affected.
2. **Emergency Response Level 2:** Localized Emergency - An emergency situation affecting multiple departments or buildings. Patients may be affected and life safety may be threatened.
3. **Emergency Response Level 3:** Major Disaster – A major disaster affecting buildings, utilities and patient care. Life safety may be threatened. Code Triage is in effect. Multiple Casualty Incident (MCI) patients are arriving at the hospital Emergency Department at a time when buildings and utilities are damaged or disrupted and personnel are affected.

An "All Clear" may be called while the recovery efforts continue until the hospital is back to normal operations.

Details on the levels of incidents and phases are outlined in [Activation and Termination of HICS](#).

E. Alternate Care Site

In a major emergency situation, there is a possibility that the buildings or spaces in which patient care is normally provided will be rendered unusable. In this event, an alternate care site will be designated as a location on the facility grounds or within the community. More

information on the selection of Alternate Care Sites is available in [Emergency Management - Hospital Surge Capacity Plan – Alternate Care Sites](#).

- 1135 Waiver
When the President declares an emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency, the Secretary may temporarily waive certain EMTALA sanctions during the emergency period. The hospital may request the waiver after implementing a disaster protocol. Refer to procedure [HICS - Alternate Care Sites - Requesting 1135 Waiver](#) for details.

Communication Management

A. Internal Communication & Staff Notification

1. Staff shall be notified of an incident utilizing overhead pages through the Fire Alarm System (FAS) or through other methods as outlined in EM - Internal Communications Plan. This plan also includes back-up communications systems within the hospital.

B. Notification & Communication with External Authorities

When an emergency plan is initiated, the appropriate external authorities and community resources will be notified. Contact information can be found in: [HICS - Communication with Hospitals, City, County and State](#).

C. Communication with Patients & Family

1. A family support center may be established to coordinate the needs and information to family members of patients, to coordinate the information on the location of patients, and to provide critical incident stress debriefings.
2. These activities will be managed by the Logistics Section with the Support Branch and the Family Unit Leader.
3. There will be direct communication with the Patient Tracking Manager for tracking of patients.
4. If the emergency contact family member is not present with the patient, they will be contacted with the location of the patient once they are moved or evacuated.
5. Additional information on communications with family in the event of a patient discharge or transfer is available in [Patient Discharge - Transfer Plan](#).

D. Communication with Media

1. The Public Information Officer (PIO) is responsible for interacting with media and public information.
 - a. For internal events, the PIO will develop communications to staff and community with the authorization of the Incident Commander in the HCC.
 - b. If the event is external to the hospital, the county Joint Information Center (JIC) will coordinate with the PIO to develop a unified message.

E. Communication with Suppliers

A list of suppliers, including vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event is available in the Command Center. The list will be maintained by the individual that normally interacts with the purveyor. Where appropriate, Memoranda of Understandings (MOUs) are developed as needed to help facilitate services during the time of a community event.

F. Communication with other health care organizations

1. A working relationship has been established with other health care organizations within Santa Clara County. A Memorandum of Understanding (MOU) is in place to share resources as needed and available.
2. Key information to share with the other health care organizations includes:
 - a. Command systems & other command center information
 - b. Names & roles of command center system
 - c. Resources & assets to be potentially shared
 - d. Process for the dissemination of patient & deceased individual names for tracking purposes
 - e. Communication with third parties
3. Inter-agency communications is maintained through several channels:
 - Telephone
 - 2-Way Command Radio
 - EM-Resources – on-line hospital status reporting in real-time
 - ~~WebEOC – web-based system for sharing status and requesting resources~~
 - Amateur Radio - volunteer radio operator system
4. Patient information that must be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency will be transmitted in accordance with applicable laws and regulations.

G. Alternate Care Site Communications

The Command Center will maintain communications with the Alternate Care Site (ACS). Once an ACS has been established, the site will initiate contact with the HCC and may establish an Alternate Care Command Center (ACCC).

RESOURCE & ASSET MANAGEMENT

A. Obtaining & Replenishing Medical, Non-Medical & Medication Supplies

The amounts, locations and processes for obtaining and replenishing ~~of~~ medical and non-medical pharmaceutical supplies, are evaluated to determine how many hours the facility can sustain before replenishing. The inventory of resources and assets is the starting point of par levels.

Mutual Aid Agreements have been developed to expedite receipt of items when needed. The MOU Agreements references the agreement with the other health care organizations on response of assets.

B. Monitoring Resources and Assets

During the emergency, the Logistics Chief will monitor the overall quantities of assets and resources. This information will be communicated to the HCC and to those in the community.

SECURITY & SAFETY MANAGEMENT

A. Security

El Camino Health has a Security Plan for Code Triage or Disaster. The plan describes the roles that internal security will have in the event of an emergency and how the hospital will coordinate security activities with outside law enforcement.

The Director of Safety and Security shall have primary responsibility for security during emergencies and shall participate in the Hospital Incident Command System / Hospital Command Center whenever it is activated in support of a security related incident.

B. Access & Egress Control

The facility "lock down" procedures will be implemented when deemed appropriate by the Incident Commander (IC) to provide the proper control of access and egress to the facility.

C. Traffic Control

The Incident Commander will initiate a Traffic Control Plan to manage the movement of personnel, vehicles, and patients both inside and on the grounds of the facility if deemed appropriate.

1. Security staff will assist in the movement of vehicles, including cars, and emergency and commercial vehicles, on the grounds.
2. When appropriate, local law enforcement will be contacted for assistance in the management of traffic on the grounds of facility.

D. Managing Hazardous Waste

The hazardous waste generated after decontamination and during isolation procedures, including biological, chemical, and radioactive waste will be stored in the appropriate location and with sufficient security. This would also include the waste that would accumulate during an emergency, but not removed because of vendor issues. A list of alternate vendors will be maintained.

E. Biological, Radiological & Chemical Isolation & Decontamination

For contagious patients in need of isolation, consult the Infection Control guidelines located in the Infection Control Manual for isolation and standard precautions. For contaminated patients, Decontamination Procedures would be implemented.

F. Access & Egress Control

The facility "lock down" procedures will be implemented when deemed appropriate by the Incident Commander (IC) to provide the proper control of access and egress to the facility.

G. Traffic Control

The IC will initiate a Traffic Control Plan to manage the movement of personnel, vehicles, and patients both inside and on the grounds of the facility if deemed appropriate.

1. Security staff will assist in the movement of vehicles, including cars, and emergency and commercial vehicles, on the grounds.
2. When appropriate, local law enforcement will be contacted for assistance in the management of traffic on the grounds of facility.

STAFF MANAGEMENT

A. Roles and Responsibilities

When HICS is established, the HICS Chart and Job Action Sheets are used to assure critical task positions are filled first Staffing Plan

El Camino Health maintains a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. As other staff members become available, they are assigned to the most critical jobs remaining.

If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments or, if none are available, from the labor pool.

As staff is called in, they will replace personnel on tasks they are better qualified to perform. If questions arise, the Section Leaders will determine who will perform the task. The tasks are evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems are identified, and staff members in these jobs are rotated as soon as possible.

1. Bringing in Staff / Managing Staff and Volunteers During an Emergency

El Camino Health maintains a staffing plan (Disaster Staffing Needs: Off Duty Employees, Volunteers and Physician Staffing) and (Independent Contractor / Outside Labor Plan) to ensure there is adequate staff to care for patients during an emergency or disaster event. The plan specifically addresses the emergency or disaster situations which require additional off duty staff to be called in to assist with hospital operations as well as the use of external staffing agencies.

2. Granting Disaster Privileges to Volunteer Physicians and Other Licensed Practitioners

El Camino Health maintains a plan for Privileging Licensed Independent Practitioners During Disaster Events. In addition to the Privileging Licensed

Independent Practitioners During Disaster Events plan, the hospital has a HICS – Volunteer Credentialing Plan. These plans ensure that physicians and allied health practitioners that do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated.

3. Hospital Command Center Staffing

When the Hospital Command Center is activated, the HICS Chart and Job Action Sheets are used to assure critical task positions are filled first. As other staff members become available, they are assigned to the most critical jobs remaining.

If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments. If no staff is available, staff will be drawn from the labor pool.

As staff is called in, they will replace personnel on tasks they are better qualified to perform. If questions arise, the Section Leaders will determine who will perform the task. The tasks are evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems are identified, and staff members in these jobs are rotated as soon as possible.

B. Managing Staff Support Activities

During activations of the Emergency Operation Plan (EOP), the following accommodations are authorized:

1. Where necessary because of conditions, the hospital will accommodate staff that need to sleep, eat, and/or other services in order to be at the hospital to provide needed services.
2. The Logistics Chief with the Service Branch Staff Food and Water Leader will handle the needs of staff during the emergency. The Logistics Chief is authorized to modify the normal use of hospital space and to work with local hotels and motels to provide accommodations for staff. Meal service for staff is authorized where approved by the Logistics Chief.
3. Preparation is made for incident stress debriefings. These areas will be staffed by Concern, the hospitals EAP and/or staff from community mental health services, clergy, and others trained in incident stress debriefing.
4. Communication ~~to~~with staff family members will also be arranged through the Staff Family Support Leader.

C. Managing Staff Family Support Activities

During activations of the EOP, the IC will determine if various accommodations may be made for staff's families to assist staff availability for providing their services.

D. Training and Identification of Staff

1. Training: The staff identified in the critical areas will receive the appropriate training

in HICS and NIMS prior to an event.

2. Identification:

- a. HICS identification apparel is issued to the appropriate roles in the HICS.
- b. Employees will wear their hospital identification badges at all times during the emergency.
- c. Additional identification will be distributed, as needed to all serving in specific roles during the emergency.

MANAGING UTILITIES

During an emergency, alternate means will be provided for essential utility systems as identified in the plan. These utility systems are identified as well as alternate means for providing the services. The organization will assess the requirements needed to support these systems such as fuel, water, and supplies for a period of time identified. This assessment includes the requirements for 96 hours without community support.

The alternative utility systems and supplies networks shall include, but not be limited to the following:

- Emergency power supply system
- Water supplies for consumption and essential care activities
- Water supplies for equipment and sanitary usage
- Fuel supplies for building operations, generators, and essential transportation services
- Medical gas systems
- Ventilation systems, Vacuum systems and Steam
- Other essential utilities

Refer to [Utility Systems - Equipment Inventory](#) and [Utilities Systems or Equipment Failure Response](#) for more information

MANAGING PATIENT CLINICAL & SUPPORT ACTIVITIES

A. Clinical Activities

Clinical activities for the treatment of patients during an emergency include triage, scheduling, assessment, treatment, and discharge. Whenever possible, the routine policies for patient services will be utilized.

B. Evacuation Activities

An evacuation of the hospital for a situation which renders the facility no longer capable of providing the necessary support for patient care, treatment and services, will be directed by the IC. The evacuation will be handled in cooperation with local police, fire departments and county EMS agency.

C. Vulnerable Patients

The policy on the clinical services includes providing for treatment of special patients during an emergency includes pediatrics, geriatrics, and disabled. This may also include patients with serious chronic conditions such as mental health or addiction.

D. Personal Hygiene and Sanitation Requirements

The HCC will determine appropriate ~~alternative~~alternatives for personal hygiene. This can include baby wipes, personal wipes, or alcohol-based rubs. Family members can also assist ~~to clean~~in cleaning the patient during an event. If toilets are inoperable, bags in toilet, bucket brigade, other appropriate alternatives can be used.

E. Mental Health Services

During an emergency, mental health services will be provided to the patients when deemed necessary. Mental Health and Addiction Services (MHAS) will track these patients receiving these services during the emergency.

F. Mortuary Services

In the event of deceased patients, the local medical examiner will be contacted for the appropriate clearance and procedures.

G. Patient Tracking: Internal & External

Patients will be tracked using current policies of the department. This includes discharge or ~~patient~~transfer ~~patient~~. That information will be given to the Patient Tracking Manager who will track all the patients within the facility during disaster. The form to use for patient tracking will be the [HICS 254 – Disaster Victim Patient Tracking Form](#). Staff shall follow internal procedures for tracking patients and notifying patient families.

If patients are evacuated, the following HICS forms should be utilized:

- [HICS 260 – Patient Evacuation Tracking Form](#), for individual patients.
- [HICS 255 – Master Patient Evacuation Tracking Form](#) should be used to gain a master copy of all those that were evacuated.

DISASTER PRIVILEGES

A. Volunteer Licensed Independent Practitioners (LIP)

Disaster privileges may be granted to volunteer licensed independent practitioners (LIP) when the EOP has been activated and the hospital is unable to meet immediate patient needs.

The Medical Staffing Office is responsible for granting disaster privileges to volunteer LIP and will distinguish volunteer LIP from other LIP's. Refer to Policy/Procedure: [Medical Staff-Privileging Licensed Independent Practitioners During Disaster Events](#).

B. Other Licensed Volunteers (non-LIP)

Disaster responsibilities may be assigned to volunteers that are licensed, certified and/or registered in a skilled healthcare position when the EOP has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

The hospital identifies the individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not a LIP and will distinguish volunteer practitioners who are not LIP's from its staff. The hospital will oversee the performance of volunteer practitioners who are not LIPs who are assigned disaster responsibilities by direct observation, mentoring, or medical record review. Refer to [HICS - Volunteer Credentialing](#).

EMERGENCY RESPONSE PLANS

Emergency Plans for the incident types listed below can be found in the Emergency Management section of the [Safety Tab](#) on the Toolbox.

- [Closed Point of Dispensing \(POD\)](#)
 - This plan coordinates the hospital planning and response actions during a public health emergency requiring medical countermeasures given to a group of people at risk of exposure to a disease in accordance with public health guidelines or recommendations.
- [Earthquake](#)
 - This plan is to ensure safety of patients, staff and visitors in the event of a major earthquake
- [Hospital Evacuation / Shelter in Place](#)
 - This plan provides a framework for sheltering-in-place and evacuation when hazardous conditions develop to the degree that the facility and/or first responders must take action to protect patients, visitors and staff.
- [Hospital Surge](#)
 - This plan is intended to assist the hospital in thinking through critical issues related to healthcare surge in emergency situations
- [Mass Fatality](#)
 - This plan is designed to outline the management and disposition of large numbers of human remains as a result of a natural disaster, epidemic, pandemic or other catastrophic event
- [Pandemic](#)
 - This plan is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic influenza event
- Post-Disaster Business Continuity Plan
 - This plan ensures the continuity of mission essential services after a wide range of emergencies and incidents.

Additional plans and procedures are available through Facilities, Nutrition Services and Material

Management.

PLAN EVALUATION AND PERFORMANCE IMPROVEMENT

- A. The following events will be reviewed and critiqued to determine the effectiveness of the Emergency Management Plans.
 - 1. Planned exercises
 - 2. Actual events impacting or having the potential to impact hospital operations.
- B. Assessment is conducted through the analysis of the information and reports that create an overall critique of the disaster event or exercise to determine:
 - 1. If plans and job actions are appropriately designed.
 - 2. The level of performance of systems and individuals.
 - 3. The level of improvement from prior events.
 - 4. The effectiveness of redesigned plans and job actions.
- C. Opportunities for improvement are continuously evaluated and implemented through the Emergency Management Committee.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Attachments

[HICS Chart.pdf](#)

[HICS Roles Information Guide.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023

ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
Emergency Management Committee	Bryan Plett: Mgr Environmental Hlth&Safety	10/2023
	Bryan Plett: Mgr Environmental Hlth&Safety	10/2023

History

Draft saved by Plett, Bryan: Mgr Environmental Hlth&Safety on 9/18/2023, 3:22PM EDT

Draft discarded by Plett, Bryan: Mgr Environmental Hlth&Safety on 9/18/2023, 3:29PM EDT

Draft saved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/2/2023, 9:47AM EDT

Edited by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/2/2023, 9:49AM EDT

Clarity around staffing has been added. Other minor grammatical changes have been made.

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/2/2023, 9:49AM EDT

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/2/2023, 9:50AM EDT

Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator on 10/5/2023, 3:04PM EDT

Not ready for ePolicy; restarting process.

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 10/5/2023, 3:06PM EDT

Draft saved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/5/2023, 3:26PM EDT

Edited by Santos, Patrick: Policy and Procedure Coordinator on 10/6/2023, 6:06PM EDT

Pushing draft version for review

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/8/2023, 3:39PM EDT

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 10/8/2023, 3:39PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/16/2023, 10:45AM EDT

ePolicy 10/13/23

Last Approved by Coston, Michael: Interim Regulatory Accreditation and Licensing Con on 11/6/2023, 4:25PM EST

COPY

A12d4. Drug Supply Chain Security Act -DSCSA-History- Changes

Status **Pending** PolicyStat ID **14336846**



Origination 07/2017
Last Approved N/A
Effective Upon Approval
Last Revised 10/2023
Next Review 3 years after approval

Owner Poopak Barirani:
Asst Director
Pharmacy
Area Pharmacy
Document Policy
Types

Drug Supply Chain Security Act (DSCSA)

COVERAGE:

All El Camino Hospital Pharmacy staff

PURPOSE:

- To ensure that pedigree requirements regarding drug supply transfers are protected
- To aid trading partners in identifying a suspect pharmaceutical product
- To initiate notifications regarding illegitimate product

POLICY STATEMENT:

Starting January 1, 2015, section 582 of the [Federal Food, Drug, and Cosmetic \(FD&C\)](#) Act requires trading partners, upon determining that a product in their possession or control is illegitimate, to notify [Food and Drug Administration \(FDA\)](#) and all immediate trading partners (that they have reason to believe may have received the illegitimate product) not later than 24 hours after making the determination.

On 7/1/15, dispensers are required to receive [Transaction History \(TH\)](#) / [Transaction Information \(TI\)](#) / [Transaction Statement \(TS\)](#) and must capture information and maintain documentation for 6 years. In addition, dispensers must respond to requests for information regarding suspect or illegitimate product within two business days.

DEFINITIONS:

Dispenser:

A retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor, or any other person authorized by law to dispense or administer prescription drugs, and the affiliated warehouses or distribution centers of such entities under common ownership and control that do not act as a wholesale distributor, and does not include a person who dispenses only products to be used in animals in accordance with section 512(a)(5).

EXCEPTION: *The dispenser requirements for product tracing and verification shall not apply to **licensed health care practitioners** authorized to prescribe or administer medication under State law or **other licensed individuals under the supervision or direction of such practitioners who dispense or administer product in the usual course of professional practice.***

Suspect/Illegitimate product: A product for which there are several reason to believe that such product is potentially counterfeit, diverted, or stolen; intentionally adulterated such that the product would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the product would result in serious adverse health consequences or death to humans.

Trading Partners: Trading partners are manufacturers, repackagers, wholesale distributors, or dispensers including physician offices.

PROCEDURE:

- A. On November 27, 2013, the Drug Quality and Security Act (DQSA) was signed into law, and Title II of the DQSA, the Drug Supply Chain Security Act (DSCSA) sets forth new definitions and requirements related to product tracing.
- B. Beginning in 7/1/2015, trading partners (defined as manufacturers, wholesale distributors, repackagers, and dispensers) are required to provide the subsequent purchaser with product tracing information when engaging in transactions involving certain prescription drugs. Trading partners are also required to capture the product tracing information and maintain that data for not less than six years after the transaction occurs.
- C. DSCSA Traceability requirements:
 1. Apply to Products = Prescription drugs in finished dosage form that are for human use. No **Over the Counter (OTC)**, medical devices, **Active Pharmaceutical Ingredient (API)**, or drugs indicated for animal use.
 2. A number of prescription drugs are exempted from the definition of product, including:
 - a. Blood and blood components intended for transfusion
 - b. Radioactive drugs and radioactive biologics
 - c. Imaging drugs
 - d. Intravenous products
 - e. Medical gases
 - f. Homeopathic drugs
 - g. Compounded drugs.

3. Transaction is the transfer of product in which a change of ownership occurs.
 4. A number of transfers are exempted from the definition of transaction, including:
 - a. Dispensing of prescription drugs to patients
 - b. Intercompany distribution between members of an affiliate
 - c. Distributions of product among hospitals or health care entities under common control
 - d. Distribution of minimal quantities of products by a license retail pharmacy to a licensed practitioner for office use.
 - e. Distribution of combination products (device+ drug/device/biologic)
 - f. Distribution for emergency medical reasons
 - g. Distribution of medical convenience kits
- D. Trading partners must have systems in place that enable them, upon determining that a product in their possession or control is suspect or upon receiving a request for verification from the FDA, to quarantine suspect product and promptly conduct an investigation, in coordination with other trading partners, as applicable, to determine whether a suspect product is illegitimate.
- E. Starting on January 1, 2015 manufacturers, repackagers, wholesale distributor ("trading partner") are required to provide the subsequent purchaser with product tracing information each time the drug is sold in the U.S market. This transaction document has three required pieces:
1. **TRANSACTION HISTORY (TH)**—The term "transaction history" means a statement, in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.
 2. **TRANSACTION INFORMATION (TI)**—The term "transaction information" means the:
 - A. proprietary or established name or names of the product;
 - B. strength and dosage form of the product;
 - C. National Drug Code number of the product;
 - D. container size;
 - E. number of containers;
 - F. lot number of the product;
 - G. date of the transaction;
 - H. date of the shipment, if more than 24 hours after the date of the transaction;
 - I. business name and address of the person from whom ownership is being transferred; and
 - J. business name and address of the person to whom ownership is being transferred.
 3. **TRANSACTION STATEMENT (TS)**—The "transaction statement" is a statement, in

paper or electronic form, that the entity transferring ownership in a transaction:

- A. is authorized as required under the Drug Supply Chain Security Act;
- B. received the product from a person that is authorized as required under the Drug Supply Chain Security Act;
- C. received transaction information and a transaction statement from the prior owner of the product, as required under section 582;
- D. did not knowingly ship a suspect or illegitimate product;
- E. had systems and processes in place to comply with verification requirements under section 582;
- F. did not knowingly provide false transaction information.

REFERENCES:

1. Guidance for Industry Drug Supply Chain Security Act Implementation: Identification of Suspect Product and Notification Guidance for the Drug Industry.pdf
2. Drug Quality and Security Act – Overview and Implementation DQSA - Drug Quality and Security Act Title II Track and Trace.ppt.pdf
3. Draft Guidance for Industry DSCSA Implementation: Identification of Suspect Product and Notification Drug Quality and Security Act - Identification of Suspicious Products and Notification Guidance FDA July 1, 2014.pdf
4. Drug Supply Chain Security Act (DSCSA) – Updates and Actions for Health System Pharmacy GAD.SPPM DSCSA_Final-1.pdf
5. Following Pharmaceutical Products Through the Supply Chain Following-Pharmaceutical-Product Through Supply Chails.pdf
6. Impact of the Drug Supply Chain Security Act on Pharmacy Management: 2015 to 2023 (ASHP) DSCSA-Compliance(ASHP).pdf
7. DSCSA Implementation: Product Tracing Requirements – Compliance Policy Guidance for Industry DSCSA_ Product_Tracing_Requirements_Compliance_Policy.pdf
8. Impact of the Drug Supply Chain Security Act on Pharmacy Management: 2015 to 2023 DSCSA-Compliance(ASHP).pdf

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
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Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
P&T	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	09/2023
	Poopak Barirani: Asst Director Pharmacy	09/2023

History

Comment by Barirani, Poopak: Asst Director Pharmacy on 9/7/2023, 6:19PM EDT

@Hoang, Ngan: Manager Pharmacy Operations; @Huang, Jen: Director Pharmacy--proposing to send through with no change. tx

Comment by Huang, Jen: Director Pharmacy on 9/7/2023, 7:33PM EDT

Agree to move forward Agree to move frowrad. Thanks.

Sent for re-approval by Barirani, Poopak: Asst Director Pharmacy on 9/8/2023, 2:03PM EDT

no changes, triannual review

Last Approved by Barirani, Poopak: Asst Director Pharmacy on 9/8/2023, 2:03PM EDT

Last Approved by Nodoushani, Mojgan: Senior Manager-Clinical Pharmacy on 9/28/2023, 5:50PM EDT

Approved by P&T on 9/28/2023

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 10/13/2023, 11:32AM EDT

Spelled out acronyms

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/16/2023, 12:05PM EDT

ePolicy 10/13/23

Last Approved by Coston, Michael: Interim Regulatory Accreditation and Licensing Con on 11/6/2023, 4:23PM EST

MEC 10/26/23

COPY

A12d5. MERP - Medication Error Reduction Plan-History

Status **Pending** PolicyStat ID **14222266**



Origination 11/2020
Last Approved N/A
Effective Upon Approval
Last Revised 06/2023
Next Review 1 year after approval

Owner Poopak Barirani:
Asst Director
Pharmacy
Area Pharmacy
Document Plan
Types

MERP - Medication Error Reduction Plan

COVERAGE:

El Camino Hospital Mountain View & Los Gatos

MERP (Medication Error Reduction Plan) OVERVIEW:

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce medication-related errors. Ensuring that our patient population receives quality health care is and always has been of utmost importance to El Camino Hospitals.

Medication error reduction is one of our key areas of focus. This plan is an opportunity to evaluate our strategies for safe medical practices related to professional practice, or health care product, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

This plan outlines multiple methods for reducing medication errors and will address each of the following strategies:

- A. Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.

- B. Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
- C. Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
- D. Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
- E. Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
- F. Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.
- G. Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

REFERENCE:

- SB1875 & HSC 1339.63(g)

OBJECTIVES:

- A. Create a common understanding of the current state of medication errors in the healthcare industry and to create a non-punitive system of reporting errors.
- B. Define medication processes that support medication safety throughout the 11 elements.
- C. Improve the clinical decision making process related to medication use.
- D. Improve communication among the health professionals and patients.
- E. Monitor Medication error events.
- F. Enterprise Medication Safety Committee, RN-RX Council MV and RN-RX Council LG and Pharmacy & Therapeutics Committee (P&T) review and evaluate various components of medication management: practices, processes, and usage, compliance and safety concerns.

STRUCTURE:

- A. A collaborative multidisciplinary approach has been organized to ensure adequate participation of hospital personnel. Each of the following participate in the medication safety improvement process:
 1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-RX reviews ISMP newsletters as part of the agenda. RN-RX is also the approving body for Automated

Dispensing Machines (ADM) override requests.

2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.
5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use; medication errors.

B. Medication Error Reporting process:

1. Errors, near misses, safety and system issues are reported by hospital staff using the electronic system for reporting of unusual occurrence and patient safety issues.
2. The reports are reviewed by risk management and clinical leadership. Trends for medication errors will be identified and analyzed by Med Safety and MERP committee on a regular basis and takes actions as appropriate.
3. Medication error trends and MERP plans are reported to P&T for review and approval.
4. P&T refers physician specific issues to appropriate Medical Staff committees and process issues to Hospital Quality Committee as needed.

C. Communication of Medication Safety Information:

1. Staff and Department Meetings
2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter

3. Resources provided include computer based drug information programs (e.g., UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet “Tool Box”)
4. Policies and Procedures: Policies and procedures are available online on the hospital’s intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

MEDICATION ERROR REPORTING AND MONITORING:

- A. Definition: A “medication-related error” means any preventable medication-related event that adversely affects a patient and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:
1. Prescribing
 2. Prescription order communications
 3. Product labeling
 4. Packaging and nomenclature
 5. Compounding
 6. Dispensing
 7. Distribution
 8. Administration
 9. Education
 10. Monitoring
 11. Use
- B. Proactive identification of actual and potential medication related errors:
1. Medication Safety Committee: Continuous performance improvement review mechanism for medication errors both potential and actual. Reviews medication errors, performs regular assessments, and conducts ongoing evaluation of the medication systems and procedures.
 2. Identification of the potential medication-related errors are done by reviewing a variety of patient safety related publications such as ISMP Medication Safety Newsletter, FDA MedWatch, The Joint Commission Sentinel Event Alerts, ASHP Patient Safety List-Serve and California Board of Pharmacy e-mail alerts, identifying

any issues that are pertinent at the facility and then implementing suggested changes.

C. Voluntary Non-Punitive Reporting System:

1. Potential or actual medication-related errors are primarily identified via non-punitive unusual occurrence reporting system by hospital staff, which can be submitted anonymously.
2. Actual or potential (near miss) medication-related errors are identified by all staff and physicians.
3. Adverse Drug Reaction (ADR) reports may be done via unusual occurrence system, telephone hot-line or by pharmacy generating reports on reversal agents.

PROCESS:

A. Plan Development Process:

1. Multidisciplinary MERP subcommittee members evaluate the current plan and facilitate the assessment of MERP. Potential or actual medication errors and adverse medication events are discussed at Medication Safety Committee and then reported to Pharmacy & Therapeutics.
2. Analysis of Medication Errors: MERP sub-committee reviews medication errors to identify trends, categorize, and identified the opportunities for reductions of errors.
3. MERP Subcommittee is responsible for identifying annual goals for MERP.

B. Assessment:

1. Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

C. Requirements for Assessing the Effectiveness of MERP:

1. Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications.
2. Categorize and focus on evaluating 11 elements of the MERP implementation for ongoing improvement.

Refer to ECH detailed Fiscal Year MERP Crosswalk (Medication Safety Committee)

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Attachments

[Final-FY2023-Medication Safety and MERP Annual Report.pdf](#)

[MERP FY2021 Annual and FY22 Plan.pdf](#)

[MERP Trends and Accomplishments FY2020.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
P & T Committee	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	09/2023
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	09/2023
	Poopak Barirani: Asst Director Pharmacy	08/2023

History

Comment by Barirani, Poopak: Asst Director Pharmacy on 8/18/2023, 3:10PM EDT

Annual review of MERP. The body of the policy remains the same. The MERP FY2023 will be attached to the policy.

Sent for re-approval by Barirani, Poopak: Asst Director Pharmacy on 8/18/2023, 3:11PM EDT

none to the body of the report. Just attach the updated FY2023 to the policy.

Last Approved by Barirani, Poopak: Asst Director Pharmacy on 8/18/2023, 3:11PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 8/18/2023, 3:15PM EDT

Updating attachment for Annual Report 2024.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 8/18/2023, 3:25PM EDT

Removed outdated attachments; latest attachment is current.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 8/18/2023, 3:27PM EDT

Per email from Poopak to re-attachment documents.

Last Approved by Barirani, Poopak: Asst Director Pharmacy on 9/5/2023, 3:58PM EDT

Last Approved by Nodoushani, Mojgan: Senior Manager-Clinical Pharmacy on 9/28/2023, 5:51PM EDT

Approved by P&T on 9/28/2023

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/16/2023, 12:08PM EDT

ePolicy 10/13/23

Last Approved by Coston, Michael: Interim Regulatory Accreditation and Licensing Con on 11/6/2023, 4:21PM EST

MEC 10/26/23

A14b. OP Donor Wall Brochures



Orchard Pavilion

Apricot Blossom Donor Wall

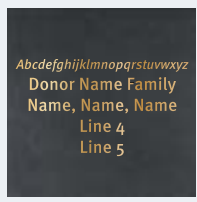
El Camino Health is renovating and expanding the Orchard Pavilion for Women’s and Newborn Services. When construction is complete, our community will have a best-in-class center of excellence that provides the highest quality, most personalized care in an environment that promotes healing and wellness for women, newborns, and families.



- 52 private mother-baby rooms large enough for a partner to comfortably stay overnight.
- More labor and delivery rooms.
- Obstetrics emergency department.
- Dedicated antepartum rooms for women with high-risk pregnancies.
- Enlarged neonatal intensive care unit designed for family-centered care.
- Double pane windows, LED lighting, and other energy efficiency upgrades to make the building eligible for LEED Gold status.

El Camino Health has always provided superb maternal-child healthcare. The remodeled, modernized, and expanded Orchard Pavilion will support continued excellence but in a welcoming, healing environment that better launches more of our community’s young families on the path to a healthy future.

Apricot orchards once blossomed where the Orchard Pavilion now stands. A beautiful, back-lit mosaic outside the state-of-the-art building will evoke this past and acknowledge donors who contribute to provide the best possible care inside. Your family can donate and inscribe a tile. Two sizes are available: 4”x8” tile (\$2,500 donation, 112 tiles available) and 8”x8” tile (\$5,000 donation, 32 tiles available).



Donate and personalize your tile at donate.elcaminohealth.org/apricot
Your gift is an investment in our families, our community, and a new generation.



I would like to inscribe a tile on the apricot blossom donor wall outside the Orchard Pavilion

Customize your tile

(Include spaces in character count)

4" x 8" - \$2,500 each

112 tiles

Maximum 3 lines

Acknowledgment,
Line 1 – 3/8" (italic), maximum 26 characters

Donor Names, Lines 2,3
1/2", maximum 21 characters per line



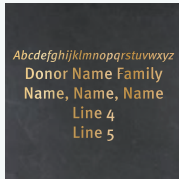
8" x 8" - \$5,000 each

32 tiles

Maximum 5 lines

Acknowledgment,
Line 1 – 3/8" (italic), maximum 26 characters

Donor Names, Lines 2-5
1/2", maximum 21 characters per line



Contact Information

650-940-7154

foundation@elcaminohealth.org

elcaminohealth.org/foundation

donate.elcaminohealth.org/apricot



Orchard Pavilion

Apricot Blossom Donor Wall



Orchard Pavilion

A New Vision for Mother, Baby, and Family Care

El Camino Health is renovating and expanding the Orchard Pavilion for Women’s and Newborn Services. When construction is complete, our community will have a best-in-class center of excellence that provides the highest quality, most personalized care in an environment that promotes healing and wellness for women, newborns, and families.

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Planting Philanthropic Seeds

El Camino Health has always provided superb maternal-child healthcare. The remodeled, modernized, and expanded Orchard Pavilion will support continued excellence but in a welcoming, healing environment that better launches more of our community’s young families on the path to a healthy future. Your gift to support this project is an investment in our families, our community, and a new generation.

Apricot orchards once blossomed where the Orchard Pavilion now stands. A beautiful, back-lit mosaic outside the state-of-the-art building will evoke this past and acknowledge donors who contribute to provide the best possible care for women, newborns and families inside. Your family can donate and inscribe a tile.



Name _____

Address _____

City/State/Zip _____

Home Phone _____

Mobile Phone _____

Email _____

- My check payable to El Camino Health Foundation is enclosed.
- I will pay this gift through my donor advised fund.
- I will pay this gift through stock. Please send instructions.
- I prefer to pay by credit card.
 - American Express Discover
 - MC Visa

Total contribution \$ _____

Acct # _____

Expiration Date _____ CVV _____

Signature _____

- My company has a matching gift program. I will contact them to match my gift. Company name _____

Please clip and mail to:
 El Camino Health Foundation
 Dept. No. 05868
 P.O. Box 885868
 Los Angeles, CA 90088-5868

Or donate online at:
donate.elcaminohealth.org/apricot

A14c. Orchard Pavilion Donor Wall Email Flyer v5



Orchard Pavilion

Apricot Blossom Donor Wall

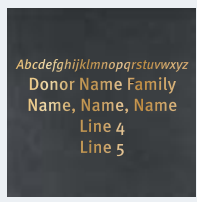
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