Board of Trustees

CLINICAL AFFAIRS COMMITTEE MEETING

April 16, 2018 - 12:30 p.m. - Driscoll Alumni Center, Schmakel Room

Sharon Speyer - Chair, Mary Ellen Pisanelli - Vice Chair

Alfred A. Baker, Pat D'Eramo, Patrick J. Kenney - Trustee Members

Hedyeh Elahinia, Lucas D. Zastrow - Student Trustee Members

Shobha Ratnam - Faculty Representative

Gary P. Thieman - Community Member

THE UNIVERSITY OF TOLEDO
1872

Clinical Affairs Committee Meeting - April 16, 2018

Agenda

12:30 p.m. **1. Call to Order**

2. Action Items

a) Clinical Affairs Committee Meeting Minutes for February 19, 2018

3. Discussion Items

Presentation for a) and b)

a) UT Health Science Campus 2017 Annual Evaluation of Environment of Care Management Plans

b) Emergency Management Annual Performance Evaluation for 2017

4. Education Items

5. Executive Session

Executive Session to discuss privileged information related to the evaluation of medical staff personnel appointments and quality reporting

6. Other Business

a) Approval of April Chief of Staff Report

7. Adjournment

Minutes
The University of Toledo Board of Trustees
Clinical Affairs Committee Meeting
February 19, 2018

ATTENDANCE

Committee Chair Ms. Sharon Speyer was present with Committee members Mr. Alfred A. Baker, Mr. Pat D'Eramo, Mr. Patrick Kenney, and Student Trustee Mr. Lucas D. Zastrow. Trustee Ms. Mary Ellen Pisanelli and Student Trustee Ms. Hedyeh Elahinia were absent. Other Trustees who attended included Mr. Steven M. Cavanaugh, Mr. Jeffrey C. Cole, Mr. Will Lucas, and Mr. Joseph H. Zerbey, IV. Faculty Representative Dr. Shobha Ratnam and Community member Mr. Gary P. Thieman were absent. Others in attendance were Mr. Javonte Anderson, Mr. Daniel Barbee, Ms. Sherri Boyle, Dr. Christopher Cooper, Ms. Meghan Cunningham, Dr. Michael Ellis, Dr. Sharon Gaber, Mr. Rick Gerasimiak, Mr. Michael Haar. Mr. Jared Holt, Ms. Mary Humphrys, Mr. Charles Jake, Dr. Samer Khouri, Ms. Jean Lovejoy, Ms. Diane Miller, Mr. Peter Papadimos, Dr. Jason Schroeder, Mr. Matthew Schroeder, Dr. Tanvir Singh, Ms. Joan Stasa and Dr. Amy Thompson.

CALL TO ORDER

The meeting was called to order at 12:30 p.m. by Trustee Speyer at the Driscoll Alumni Center in the Schmakel room. Ms. Joan Stasa, Secretary to the Board, recorded the minutes.

APPROVAL OF MINUTES

Trustee Speyer requested a motion to waive the reading of the minutes from the December 18 Committee meeting and approve them as written. A motion for approval was provided by Trustee Baker, seconded by Trustee D'Eramo, and approved by the Committee.

U.S. OPIOID CRISIS – UTMC RESPONSE

Dr. Christopher Cooper, EVP Clinical Affairs and Dean College of Medicine and Life Sciences, presented the Committee with information about the opioid crisis in the United States and how UTMC is addressing it. Dr. Cooper stated that abuse and addiction to alcohol and drugs is an enormous problem. Costs amount to $700 billion annually in the U.S. due to health care, crime and lost productivity. The death rate reaches 90,000 Americans annually. In Ohio, overdose deaths rose from 3,050 to 4,050 between 2015 and 2016. There were 266 confirmed overdoses in the UTMC Emergency Department last fiscal year, which equals approximately five patients per week. Dr. Cooper described how addiction can happen. A slide was displayed showing brain recovery with prolonged abstinence. A chart showing the number of unintentional overdose incidents involving selected drugs, by year, in Ohio from 2000-2015, was discussed with the Committee showing the number of deaths and the specific drug. Another chart presented showed a 500% increase in Ohio deaths since 2000. A map of Ohio indicating drug overdoses by county for 2010-2015 prior to the epidemic was displayed and discussed. A bar chart showed Lucas County unintentional drug overdose death rates for 2011-2016. Dr. Cooper provided information about the actions UTMC is taking to help prevent addiction.

A team, led by Linda Lewandowski, Dean College of Nursing, and Amy Thompson, Professor of Public Health, CHHS, is coordinating UT's response by establishing a cross functional, university-wide steering committee. Development of a directory of all faculty-related research, education and clinical practice is underway. Meetings are being held with community leaders to identify opportunities for collaboration and partnerships.

Initial achievements include the following:

- A collaborative proposal submitted to Cardinal Health Foundation from UT Colleges of Nursing and HHS, TPS, Lucas County Health Department for education project on safe prescription drug use.
- Opioid Summit planned for April 2018 to bring state-level funding agency representatives together with UT faculty and regional community leaders to discuss funding opportunities and develop plans
- Developing pamphlet and web page outlining UT's role in combating opioid epidemic
- Developing plan to increase awareness of opioid-related activities through medical outreach/internal stories

The UTMC Detox Unit, which opened in March 2017, plays a key role. It holds ten beds and has provided care to 512 addicted people as of December 31. The Unit has a community partnership with Hazelden-Betty Ford Hospital and is the only hospital-based unit in our community. This unit allows treatment to addicted patients with acute medical problems. Dr. Cooper provided information about further plans and considerations for the Detox Unit. The UTMC Detox advertising campaign was discussed with the Committee. Currently, our communities and region face an epidemic of drug use and unintended drug-related deaths, many from opioids. The Inpatient Detox Unit is exceeding expectations. UTMC will continue to advance addiction treatment to improve the health of the communities and region that they serve.

EXECUTIVE SESSION

Trustee Speyer requested a motion to enter Executive Session to discuss privileged information related to the evaluation of medical staff personnel appointments and quality reporting. The motion was received from Trustee Pisanelli, seconded by Trustee D'Eramo, and a roll call was taken by Ms. Stasa: Mr. Baker, yes; Mr. D'Eramo, yes; Mr. Kenney, yes; and, Ms. Speyer, yes. After discussions, the Committee exited Executive Session.

CHIEF OF STAFF REPORT

Ms. Speyer requested a motion to approve the Chief of Staff Report as presented in Executive Session. A motion for approval of the report was received from Trustee Baker, seconded by Trustee Kenney and approved by the Committee. The Chief of Staff Report is attached.

ADJOURNMENT

With no further business before the Committee, Trustee Speyer adjourned the meeting at 1:30 p.m.

CHIEF OF STAFF SUMMARY REPORT

February 19, 2018

I. Initial Appointments - Physicians/Dentists

Mahfooz, Naeem, MD
Neurology

Nemunaitis, John, MD
Medicine-Hematology/Oncology

Sun, Hongliu, MD
Pathology

II. Initial Appointments - Allied Health Professionals (AHP)

Bellman, Brooke, CNM
Obstetrics/Gynecology

Chambers, Kristen, LISW-S
Psychiatry

Fontaine, Sarah, AuD
Surgery/General Surgery

III. Reappointments - Physicians/Dentists

1.	Afolabi, Akinfemi, MD	Medicine/Nephrology	Courtesy
2.	Alfonso-Jaume, Maria, MD	Medicine/Nephrology	Active
3.	Ariss, Steven, MD	Urology	Membership Only
4.	Basu, Asish, MD	Medicine/Cardiology	Active
5.	Bhatia, Raj, MD	Medicine/Cardiology	Membership Only
6.	Brar, Balhinder, MD	Medicine/Nephrology	Membership Only
7.	Burket, Mark, MD	Medicine/Cardiology	Active
8.	Chaudhry, Foiqa, MD	Medicine/Endocrinology	Active
9.	Collier, Annette, MD	Medicine/Hospice-Palliative Care	Courtesy
10.	Cooper, Christopher, MD	Medicine/Cardiology	Active
11.	Da Rocha, Afodu, David, MD	Medicine/Nephrology	Courtesy
12.	Dworkin, Lance, MD	Medicine/Nephrology	Active
13.	Eltahawy, Ehab, MD	Medicine/Cardiology	Active
14.	Farrell, Steven, MD	PM&R	Active
15.	Goodenday, Lucy, MD	Medicine/Cardiology	Active
16.	Grubb, Blair, MD	Medicine/Cardiology	Active
17.	Gupta, Rajesh, MD	Medicine/Cardiology	Active
18.	Haines, Mary, PhD	PM&R	Active
19.	Jaume, Juan, MD	Medicine/Endocrinology	Active
20.	Johar, Bikram, MD	Medicine/Nephrology	Courtesy
21.	Jun, John, MD, MS	Medicine/Endocrinology	Active
22.	Kabour, Ameer, MD	Medicine/Cardiology	Courtesy

23.	Karamali, Adil, MD	Medicine/Cardiology	Membership Only
24.	Karim, Saima, DO	Medicine/Cardiology	Active
25.	Kaw, Dinkar, MD	Medicine/Nephrology	Active
26.	Khouri, Samer, MD, MBA	Medicine/Cardiology	Active
27.	Kobeissy, Abdallah, MD	Medicine/Gastroenterology	Active
28.	Kosinski, Daniel, MD	Medicine/Cardiology	Active
29.	Kovach, Julie, MD	Medicine/Cardiology	Active
30.	Malhotra, Deepak, MD, PhD	Medicine/Nephrology	Active
31.	Mathew, Anil, MD	Medicine/Cardiology	Active
32.	Moukarbel, George, MD	Medicine/Cardiology	Active
33.	Mowat, Rex, MD	Medicine/Hematology/Oncology	Courtesy
34.	Murphy, Laura, MD	Medicine/Cardiology	Active
35.	Nahhas, Ahed, MD	Medicine/Cardiology	Courtesy
36.	Nawras, Ali, MD	Medicine/Gastroenterology	Active
37.	Ratnam, Shobha, MD, PhD	Medicine/Nephrology	Active
38.	Rizk, Tallat, MD	PM&R	Active
39.	Sarikonda, Kesari, MD	Medicine/Cardiology	Courtesy
40.	Schweitzer, Kellee, MD	PM&R	Active
41.	Shafiq, Qaiser, MD	Medicine/Cardiology	Active
42.	Shapiro, Ronald, MD	Medicine/Nephrology	Membership Only
43.	Sheikh, Mujeeb, MD	Medicine/Cardiology	Active
44.	Skeel, Roland, MD	Medicine/Hematology/Oncology	Active
45.	Smith, Mary R, MD	Pathology	Active
46.	Sodeman, Thomas, MD	Medicine/Gastroenterology	Active
47.	Stockard, Herbert, MD	Medicine/Nephrology	Courtesy
48.	Suico, Sharleen, MD	PM&R	Active
49.	Verghese, Cherian, MD	Medicine/Hematology/Oncology	Active
50.	Wuescher, Christian, MD	PM&R	Active

IV. <u>Reappointments - Allied Health Professionals</u>

1.	Austin, Jared, PharmD, RPH	Medicine/Hematology/Oncology	AHP
2.	Berry, Brittany, FNP-C	Medicine/Hematology/Oncology	AHP
3.	Boes, Melissa, FNP-C	Medicine/Cardiology	AHP
4.	Braddock, Becky, CNS, MSN	Medicine/Cardiology	AHP
5.	Carter, Patricia, CNS, DNP	Medicine/Nephrology	AHP
6.	Doughty, Yana, PharmD, RPH	Medicine/Cardiology	AHP
7.	Elnagar, Noha, PA-C	Medicine/Endocrinology	AHP
8.	Garris, Theresa, CNP, MSN	Medicine/Cardiology	AHP
9.	Harp, Michelle, CAA	Anesthesiology	AHP
10.	Karabin, Beverly, FNP-BC	Medicine/Cardiology	AHP
11.	Lay, Roberta, CNP, MSN	Medicine/Gastroenterology	AHP
12.	Malenfant, Jacqueline, FNP-C	Medicine/Gastroenterology	AHP
13.	Malhotra, Judith, CNP, MSN	Medicine/Nephrology	AHP
14.	McClain, Jodi, CNP, MSN	Medicine/Hematology/Oncology	AHP
15.	Nedley, Amy, PA-C	Medicine/Endocrinology	AHP
16.	Porter, Amanda, PharmD	Medicine/Cardiology	AHP
17.	Shiple, Victoria, CNP, MSN	Medicine/Cardiology	AHP
18.	Shoukair, Sirine, PharmD	Medicine/Cardiology	AHP
19.	Tipton, Janelle, CNS, MSN	Medicine/Hematology/Oncology	AHP

V. Additional/Withdrawal Privileges

1. Ortiz, Jorge, MD - Surgery/General Surgery - Approve additional privileges for Moderate Sedation, Wound Care and Hyperbaric under FPPE.

VI. Change in Staff Category - Physicians

1. Ikezuagu, Mbonu, MD - Medicine/Hospital Medicine- Locum Tenens - Approve request to change from Locum Tenens to Courtesy Staff category.

VII. Change in Staff Category - AHPs

1. Dugan, Amy, CNP - Anesthesiology - AHP - Approve request to change supervising physician from Joseph Atallah, MD to Andrew Casabianca, MD and Jason Schroeder, MD.
2. Maldonado, Henrry, FNP-C - Surgery/CT Surgery - AHP- Approve request to change division from CT Surgery to Vascular Surgery under the supervision of Munier Nazzal, MD.
3. Vasko, Michael, PA-C - Medicine/Hospital Medicine - AHP - Approve request to change from Medicine to Family Medicine under the supervision of Jyothi Pappula, MD.

VIII. Removal from FPPE - Transition to OPPE - Physicians

1.	Amegee, Jean-Paul, MD	Emergency Medicine	Active
2.	Aouthmany, Shaza, MD	Emergency Medicine	Active
3.	Baehren, David, MD	Emergency Medicine	Active
4.	Ekweena, Obinna, MD	Urology	Active
5.	Karim, Saima, MD	Medicine/Cardiology	Active
6.	Kriegel, Svetlana, MD	Medicine/Allergy&Immunology	Active
7.	Moussa, Mohamad, MD	Emergency Medicine	Active
8.	Sheikh, Ajaz, MD	Neurology	Active
9.	Sindhwani, Puneet, MD	Urology	Active
10.	Shahab Ud Din, MD	Medicine/General Internal Medicine	Active
11.	Van Hook, Catherine, MD	Obstetrics/Gynecology	Active

IX. Removal from FPPE - Transition to OPPE - AHPs

1.	Behnfeldt, Sarah, FNP	Surgery/Vascular Surgery	AHP
2.	Doughty, Yana, PharmD	Medicine/Cardiology	AHP
3.	Herrera, Kayla, PA-C	Family Medicine	AHP
4.	Johnson, Stefanie, FNP-C	Neurology	AHP
5.	Mason, Susan, FNP-C	Surgery/Vascular Surgery	AHP
6.	Porter, Amanda, Pharm D	Medicine/Cardiology	AHP
7.	Salyer, Tracie, CNM	Obstetrics/Gynecology	AHP
8.	Wesley-Ayad, Michelle, FNP-C	Family Medicine	AHP

X. Continuation of FPPE due to limited activity

1.	Delos Reyes, Arthur, MD	Surgery/Vascular Surgery	Active

XI. Physician Departures - Informational

1.	Atallah, Joseph, MD - effective 12/15/2017	Anesthesiology	Active
2.	Brown, Laura, MD - effective 12/25/2017	Surgery/General Surgery	Active
3.	Gaudin, Daniel, MD - effective 12/31/2017	Surgery/Neurosurgery	Active
4.	Girgis, Sonia, MD - Appointment and clinical privileges will expire on 3/1/2018 due to failure to submit reappointment application.	PM&R	Courtesy
5.	Lee, Saebom, MD - effective 12/22/2017	Anesthesiology	Active
6.	Salander, Richard, DDS - effective 12/31/2017	Surgery/Dentistry	Courtesy

XII. Allied Health Professional Departures - Informational

1.	Carder, Laura, CNP	Surgery/General Surgery	AHP
2.	Kallay, David, CSA	Surgery	AHP
3.	Petite, Sarah, PharmD	Medicine/General Internal Medicine	AHP

XIII. Proposed Changes to Delineation of Privileges

1. Approve proposed revisions to the Clinical Nurse Specialist and Certified Nurse Practitioner delineation of privileges as requested. (Additions are bolded, italicized and highlighted - deletions are in the strike-through mode).
2. Approve proposed revisions to the Urology delineation of privileges as requested. (Additions are bolded, italicized and highlighted).

UNIVERSITY OF TOLEDO
HEALTH SCIENCE CAMPUS (HSC)
2017 ANNUAL
EVALUATION OF ENVIRONMENT OF CARE MANAGEMENT PLANS

UNIVERSITY OF TOLEDO HEALTH SCIENCE CAMPUS
2017 ANNUAL SAFETY REPORT AND
EVALUATION OF ENVIRONMENT OF CARE MANAGEMENT PLANS

INTRODUCTION

The Joint Commission (JC) requires that an annual evaluation of the "objectives, scope, performance and effectiveness" of the Environment of Care management plans be completed. In addition, it highlights upgrades and improvements to the various areas of the Environment of Care. The sections of the Environment of Care (EofC) are: Safety, Fire/Life Safety, Security, Hazardous Materials and Waste, Utilities Management and Medical Equipment.

SAFETY

OBJECTIVE(S):

To create and sustain a physical environment as free of foreseeable hazards as can be reasonably expected; to proactively anticipate and respond to safety concerns; to investigate accidents and other incidents that need corrective action; to educate new employees in safety and maintain safety readiness in current employees; and to reduce the accident/injury rate through education, surveillance of the physical plant and investigation of accidents that occur, in order to determine the root cause of those accidents, and to implement preventive measures.

SCOPE:

Health Science Campus-wide: all buildings, all persons in those buildings, on the grounds, and at off-campus satellite locations.

PERFORMANCE:

The objectives of the safety management program are achieved through performance of the following activities or initiatives:

- safety education of new employees and refresher training for current employees
- environmental safety rounds
- injury/illness reporting and accident and safety investigations
- meetings of the HSC Safety & Health Committee
- Ad-hoc task forces (i.e. needlestick).

EFFECTIVENESS:

Regulatory Measures

In CY 2017 the OSHA accident/injury rate for the HSC was 3.19. The rate is down from 3.41 in CY 2016. This rate is calculated annually to provide a benchmark for safety concerns, employee injuries, and return-to-work initiatives. The national average rate for "hospitals, state government" will be available in December of 2018; (SOURCE: U.S. Department of Labor Bureau of Labor Statistics). The 2016 national average for the "hospitals, state government" was 8.2. The achievement of a rate of 3.19 shows the effectiveness of new employee safety orientation training, environmental safety rounds, and post-incident accident investigation protocols.

Performance Improvement

The needlestick task force was extremely active in monitoring sharp injuries, eliminating non-safety sharps, and educating staff. There was a decrease in the needlestick incident rate (incidents per 100 Occupied Beds/Year) from CY 2016 (45.7) to CY 2017 (39.4). Injury/illness and needlestick follow-up was completed for all injuries including needlesticks in 2017.

The Environment of Care Task Force, on behalf of the Safety Committee, initiated this PI project at the direction of senior leadership. Weekly Leadership follow-up occurs during Administrative Rounds for items found during environmental rounds and tracers. Reports of items found and closed out are presented in a quarterly report to the Safety Committee. In 2017 an average of 72% of all findings for each quarter were closed out. This PI project will continue to monitor progress of closed out findings. This is a significant increase from 63% in 2016. In addition to the normally scheduled rounds, a multifaceted group including key individuals leading the Environment of Care, participated in a new Tracer program that rounded in inpatient and clinic areas in 2017.

Additional Key Improvements
In addition, the following initiatives were completed:

- Suicide/Ligature Risk Assessments were updated in both the Adolescent and Adult Behavioral Health Kobacker Facility and the Emergency Room to meet the newest guidelines. As a result, several changes were made including the addition of new slanted bathroom doors, removal of unnecessary outlets, and bathroom fixture retrofits in Kobacker. De-escalation and risk awareness training was completed in the Emergency Department.
- Suicide/Ligature Risk Assessments were also performed for the hospital inpatient units and the new Detox unit with the hospital.
- A Fall risk assessment was conducted at Renee's survivor shop in the Dana Cancer Center with resulting in corrective action.

All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Safety Management Plan was reviewed and assessed in CY 2017.

FIRE SAFETY

OBJECTIVE(S):
To establish, monitor and maintain an environment that is fire-safe and compliant with all local, state and national/JC fire standards; and to reduce the number of actual Code Red (fire) incidents.

SCOPE:
Health Science Campus-wide: All buildings and all employees in those buildings, and all off-campus satellite.

PERFORMANCE:

The objectives of the life safety/fire safety management program are achieved through performance of the following activities or initiatives:

- fire drills
- fire alarm notification systems
- fire suppression systems and their regular testing and inspection
- annual inspection of fire extinguisher network by certified outside vendor
- review of items to be purchased for compliance with fire retardancy or resistance standards
- meetings of the HSC Safety and Health Committee to anticipate life safety issues and to review life safety reports
- fire safety/prevention questions on the computerized employee safety test bank that is an annual requirement for all clinical/Hospital employees.

EFFECTIVENESS:

Regulatory Measures

As required by the Joint Commission, the 2012 NFPA 101 Life Safety Code was adopted. This included the implementation of several new initiatives including but not limited to monthly EXIT sign visual checks and annual PM's of all fire doors.

The effectiveness of fire response training is evaluated annually and was found to meet the regulatory requirements. The training is excellent, as evidenced by employees' quick knowledge during fire drills of the R.A.C.E. acronym for fire response, as outlined in the institutional fire response plan; employee knowledge of issues of compartmentalization in patient care areas; their skill in describing what steps they take in preparing patients for transport to areas of refuge away from a fire, the considerations they must make when planning such actions, and the efficient manner in which employees respond during fire drills.

The computerized alert system that was initiated in late 2014 was continued throughout 2017 to ensure annual preventative maintenance is performed on all fire detection systems. All preventative maintenance was completed at 100% per the Joint Commission and Life Safety Code.

UTMC also conducted 138 fire drills campus wide in 2017 in accordance with the Joint Commission Environment of Care Standards. The Hospital and Kobacker drills were conducted quarterly, per shift, +/- 10 days and outside the 2-hour window from the last drill to ensure varying conditions and unexpected times. Business occupancies were conducted annually +/- 30 days and outside the 2-hour window.

Additional Key Improvements

In addition, Facilities upgraded the Fireworks software providing reliability for our fire safety components.

All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Fire Safety Management Plan was reviewed and assessed in CY 2017.

SECURITY

OBJECTIVES:

The Health Science Campus Security Department is charged with the responsibility of serving and protecting students, patients, faculty and staff within our area of responsibility. We do this with a proactive approach of deterring, detecting, denying and delaying the negative influences within the Health Science Campus. The Security Department is funded, trained and equipped to respond, secure and de-conflict incidents that escalate to an unmanageable level within patient care areas.

SCOPE:

Health Science Campus-wide: all buildings and grounds, and some off-campus satellite locations.

PERFORMANCE:

The objectives of the security management program are achieved through the performance of the following activities or initiatives:

- Visible routine patrols of parking lots, clinics and centers
- Quarterly crime analysis review of trends and patterns on campus
- Administrative documentation of events, police reports and supplements
- Investigation of workplace incidents for theft, conflict or violent action
- Risk Assessments highlighting physical security vulnerabilities; lighting, locks & egress
- Weekly Command Staff meeting with HSC Security, UT Police and Environmental Health and Radiation Safety

EFFECTIVENESS:

Regulatory Measures

- UT Police and Hospital Security work in concert to ensure the safety and security of the UT Medical Center and surrounding campus. Effectiveness is evidenced by quick response time. UTPD response time is reduced by posting 1 UTPD Officer on HSC.
- Security risk assessments were completed in all high risk areas including Kobacker, the Emergency Department and all Pharmacy Locations in CY2017.
- Annual crime stats are located at http://www.utoledo.edu/offices/internalaudit/clery-act/docs/security-fire-safety-report-2017.pdf

Performance Improvements

- UTPD and Hospital Security offered 17 A.L.I.C.E. training classes on the Health Science Campus in 2017 training a total of 386 Faculty, Staff and Students. This is a significant decrease from 1,725 trained in 2016, however, the decrease in demand can be contributed to the large numbers of personnel who completed the training in the previous year.

Additional Key Improvements

In addition, the following initiatives were completed:

- A fully functional active shooter exercise was completed in July of 2017 in the UT Emergency Department. The exercise participants were made up of Emergency Department Staff who actively cared for simulated patients during a simulated active shooter events.
- Identified vulnerabilities were eliminated by the addition of cameras in Lots 41 and 42 as well as the Fast Track hallway in the Emergency Department. Mirrors were also added at Kobacker for visibility.
- Non-Abusive Physical and Psychological Intervention (NAPPI) training was instituted in April of 2017. Twelve of 17 Security officers were trained.
- Additionally, the Emergency Department has 50 RN Staff Members NAPPI Qualified.
- Conducted lock down drills to verify proper operation and continued improvement in the functional hardware and software.

All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Security Plan was reviewed and assessed in 2017.

HAZARDOUS MATERIALS & WASTE

OBJECTIVES:

To create and maintain an environment in which hazardous materials are safely handled and disposed of, and to create a systematic process for the ordering, receiving, transportation, use, pickup and safe disposal of hazardous materials/chemicals. Tracking of such products from "cradle to grave" will ensure that use of such materials remains within regulatory parameters established by the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency (EPA), and state and local regulatory bodies.

SCOPE:

Health Science Campus-wide: all buildings, with special emphasis on those areas, units and buildings containing hazardous materials.

PERFORMANCE:

The objectives of the hazardous materials management program are achieved through the performance of the following activities or initiatives:

- managing the hazardous materials spill response program
- monitoring the ordering, handling, use, storage and disposal of hazardous materials, vapors and waste
- IH monitoring
- ensuring institutional compliance with all applicable OSHA, JC, EPA and state and local regulations and standards governing ordering, using, storing, transporting, and disposing of hazardous materials and waste

EFFECTIVENESS:

Regulatory Measures

- Surface wipe sampling was completed in the Dana Cancer Center for commonly used hazardous drugs resulting in levels below the limit of detection. This provides a good indication that the likelihood for incidental exposure/transfer is low.
- All air sampling results for hazardous agents were below occupational exposure limits.
- The University of Toledo had a successful large quantity hazardous waste inspection completed by the Ohio EPA with no finding and full compliance.
- The University of Toledo had a successful ODH inspection for Radioactive Materials and our Pathology lab was re-accredited by the College of American Pathologist (CAP)

Performance Improvement

- A conscience effort was put in place to reduce costs by changing the type of packaging system used in the surgical areas to reduce improper segregation of infectious and non - infectious waste. The HSC generated and disposed of 18,879 lbs. of infectious waste.
- The HSC generated and disposed of 18,226 lbs. of Hazardous Waste.
- There were zero hazardous material spills requiring a response by the Environmental Health and Radiation Safety Department in the clinical areas on HSC in CY2017 compared to two hazardous material spills in 2016.

Additional Key Improvements

In addition, the following initiatives were completed:

- An SDS and Hazardous material inventory audit was completed in all clinical areas.
- A committee was formed to address the changes in the USP 797 Hazardous Drug standards to ensure compliance with the new USP800 standards.
- A review of personal protective equipment was also completed in areas where hazardous drugs are used.

This program continued its smooth and efficient operation in CY 2016. The process for ordering, handling, removal of and disposal of hazardous materials on the HSC ran without any significant deficiencies in CY 2017. In addition, all reports required by regulatory agencies, local, state and federal, were filed as required. All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Hazardous Materials Plan was reviewed and assessed in 2017.

UTILITIES

OBJECTIVES:

To create and maintain a consistent flow of utilities to all segments of the campus community and its buildings, with special emphasis on the provision of safe, reliable utility service to patient care units; and to assess potential weak links in the system while actively taking steps to upgrade the system and reduce interruptions.

SCOPE:

Health Science Campus-wide: all buildings, with special emphasis on patient care units and academic laboratories.

PERFORMANCE:

The objectives of the utility systems plan are achieved through performance of the following activities or initiatives:

- regular preventive maintenance (which includes inspecting, testing and repairing as needed) of utility system components, in particular critical systems related to patient care functions
- development and maintenance of utility system operational plans that will ensure consistency and reliability in the provision of those utilities
- completion of work orders and requests for service from building occupants

EFFECTIVENESS:

Regulatory Measures

- 100 % of preventative maintenance work orders were completed on time.

Performance Improvements

- Facilities also instituted an ongoing daily inspection and PM work on patient rooms.
- In additional Facilities created a new work order for preventative maintenance to include monthly touch up painting throughout the clinical areas.

Additional Key Improvements

In addition, Facilities Maintenance oversaw the completion of improvement projects in CY2017 including the re-lamping of lighting with LED lights to provide a better quality and longer lasting bulb. This will also decrease disposal costs for Universal Waste in the future.

All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Utilities Systems Plan was reviewed and assessed in 2017.

MEDICAL EQUIPMENT

OBJECTIVES:

To create and maintain a medical equipment management program that ensures and promotes the safe and effective use of medical equipment for both patients and users.

SCOPE:

Primary focus is on patient care units, buildings and medical equipment, although other aspects of the medical equipment management program extend campus-wide, to academic laboratories and all campus buildings and departments.

PERFORMANCE:

The objectives of the medical equipment management plan are achieved through performance of the following activities or initiatives:

- use of a screening grid to ensure acquisition of safe and functional medical equipment
- assessment performed on all equipment in the program to ensure adequate preventive maintenance frequencies are achieved
- tracking and monitoring of medical equipment histories
- compliance with all provisions of the Safe Medical Device Act of 1990
- monitoring and tracking of all medical equipment hazard notices and recalls

EFFECTIVENESS:

Regulatory Measures

- 100 % of preventative maintenance work orders were completed on time.
- Less than 5% of equipment malfunctions were due to operator error.
- 100% of chemical and biological water testing was completed
- 100% of performance testing of sterilizers was completed.

Performance Improvements

Performed annual review of preventative maintenance procedures to ensure manufacturers requirements are being met or an alternative equipment maintenance program is in place.

Additional Key Improvements

In addition, the following initiatives were completed:

- Implemented new IV pumps in the hospitals.
- Provided monthly in-servicing to staff to increase response time and decrease down time.
- Replaced vaporizers in Anesthesia as part of a new agreement to reduce expenses
- Reduced expenses by replacing SCD pumps as part of a new agreement.

All performance monitoring data/benchmarks were within established parameters, therefore, this component of EC was considered effective in CY 2017. The Medical Equipment Plan was reviewed and assessed in CY2017.

Heather Lorenz, Director
Environmental Health and Radiation Safety Department
January 27, 2018

Safety and Health Committee Review and Approval Date: March 22, 2018

cy2017annualsafety.doc

ANNUAL PERFORMANCE EVALUATION FOR 2017

Program: Emergency Management

Reviewer: Nicole M Meagher

Review Date: JAN 2018

Safety and Health Committee Review and Approval Date: March 22, 2018

Review of Program

A. PURPOSE

To assure compliance of all Emergency Management standards as required by the Joint Commission. An emergency in the University of Toledo Medical Center (UTMC) and associated clinics or within our community could suddenly and significantly affect the need for our services or our ability to provide those services. UTMC has an Emergency Operations Plan that comprehensively describes our approach to handling these emergencies.

B. SCOPE

The Emergency Operations Plan (EOP) covers the Medical Center and other associated clinics. The EOP describes an “all-hazards” command structure for coordinating six critical areas within the facility during an emergency. The program serves as a resource for all facilities and staff where patient services are provided.

C. AUTHORITY

The Director of Environmental Health and Radiation Safety or designee serves as the program manager and is charged with the overall responsibility to direct and coordinate the emergency management program, along with other members of the Environmental Health & Radiation Safety Department. The Emergency Preparedness Task Force of the UT-HSC Safety and Health Committee is responsible to review, critique, monitor and revise all emergency management activities. A report from the Emergency Preparedness Task Force is a standing item on the Safety and Health Committee agenda.

D. MEETING ATTENDANCE

Task Force members are expected to attend all meetings. If they are unable to attend, they are to notify the chair of their absence before the meeting or send a representative. Members who notify the chair are given an excused absence. In the event of an absence, members are still expected to review the minutes and give feedback on any materials related to the meeting.

In 2017, the average attendance for the 19 members was 54%. Members are part of a taskforce that reports regularly to the Safety and Health committee.

C. ANNUAL INVENTORY

UTMC maintains an inventory for supplies including critical items like PPE and other consumable medical supplies. This inventory is reviewed annually. It is available for hard-copy in the resource manual (MLB Board Room 201) and electronically on the shared Z: drive.

The organization keeps a cache of supplies if our normal supply sources are negatively impacted during an emergency. The caches are maintained in the area below the Emergency Department, Decontamination Trailer, and Central Supplies.

F. REVIEW OF KEY PROCESSES/ACCOMPLISHMENTS

Elements of Performance	Met	Not Met	Partially Met
EM.01.01.01 The organization engages in planning activities prior to developing its written Emergency Operations Plan.	**X**		
EM.02.01.01 The organization has an Emergency Operations Plan.	**X**		
EM.02.02.01 As part of its EOP, the organization prepares for how it will communicate during emergencies.	**X**		
EM.02.02.03 As part of its EOP, the organization prepares for how it will manage resources and assets during emergencies.	**X**		
EM.02.02.05 As part of its EOP, the organization prepares for how it will manage security and safety during an emergency.	**X**		
EM.02.02.07 As part of its EOP, the organization prepares for how it will manage staff during an emergency.	**X**		
EM.02.02.09 As part of its EOP, the organization prepares for how it will manage utilities during an emergency.	**X**		
EM.02.02.11 As part of its EOP, the organization prepares for how it will manage patients during emergencies.	**X**		
EM.02.02.13 During disasters, the organization may grant disaster privileges to volunteer licensed independent practitioners (LIPs).	**X**		
EM.02.02.15 During disasters, the organization may assign disaster responsibilities to volunteer practitioners who are not LIPs, but who are required by law and regulation to have a license, certification, or registration.	**X**		
EM.03.01.01 The organization evaluates the effectiveness of its emergency planning activities.	**X**		
EM.03.01.03 The organization evaluates the effectiveness of its EOP.	**X**		

G. SUMMARY REVIEW OF PROGRAM EFFECTIVENESS

NIMS/HICS 100, 200, and 700 was offered on-line through FEMA for new management staff. Training is tracked utilizing the online UT test bank. Additional HICS training, for upper level staff requiring advanced level ICS courses, was also offered.

Annually a hazard vulnerability analysis (HVA) is performed and utilized to direct areas of exercise and training for the year. The 2017 HVA indicated the following high risk areas: Combative Situation (50%), IT Failure/Supply Shortage/Internal Floods/Mass Casualty Incident (44%).

The following high risk areas were selected to be exercised:

1. Combative Situation: In April of 2017 HSC Security instituted Non-Abusive Psychological and Physical Intervention (NAPPI) training for officers and clinical staff.

2. IT Failure: UTMC presented a tabletop exercise to work with IT personnel on areas of vulnerability within the network. The tabletop was held during an EP taskforce meeting and included IT/Nursing Administration/ED Nursing Director/Pharmacy/Infection Prevention.

3. Mass Casualty Incident: UTMC conducted a simulated active shooter drill in the emergency department to test the Active Shooter Annex and the Code Violet as well as our capabilities for an internal mass casualty situation.

UTMC and associated clinics completed the following exercises (and real events) as well participated in community and regional exercises including multiple communication drills and a Regional drill exercising our IDA plan.

- 3/03/17 Pharmacy Cache Functional Exercise
- 3/24/17 Code Copper (Real Event)
- 4/12/17 Regional Functional Exercise (Infectious Disease)
- 5/03/17 Code Copper (Real Event)
- 6/28/17 IT Non-Community Support Table Top Exercise
- 7/21/17 Active Shooter/Code Yellow Functional Exercise (ED)
- 8/09/17 IT (Real Event)
- 11/17/17 Code Brown Functional Exercise
- 12/8/17 Code Adam Functional Exercise

ASPR grant items were purchased:

- Chain link fencing/gate/supplies to secure Emergency Management supplies
- Various Stage 1 and 2 filters for HEPA units from Abatement Technologies
- Fire Hose to be utilized for decontamination response
- Upgraded Vinyl body bags to be utilized in for Mass Fatality events

Updated/Revised documents:

Code Yellow, Code Gray, Code Orange, Code Black, Code Green, Code White, Code Copper, Code Red Fire Response, Building Coordinator Policy, Emergency Communications Plan, Infectious Disease Agent Plan (IDA), Volunteer Management Plan, COOP Plan, and an annual review of the Emergency Operations Plan was completed.

H. Goals for 2018:

- Plans/Procedures
  - Annual EOP for UTMC
  - COOP Plan and all seven Emergency Code Procedures.
- Exercises and Training (Based in part on 2018 HVA)
  - Continue to secure NIMS/HICS 300/400 training for management
  - Continue NAPPI and A.L.I.C.E. training
  - Community and regional exercises
  - Supply Shortage (included in community drill)
  - Code Brown and Code Adam Functional Exercise
  - Active Shooter Functional Exercise