

SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

Environment of Care
Annual Report
FY 2013-2014

Approvals

Environment of Care Committee: September 24, 2014

Hospital Executive Staff Committee: October 7, 2014

Nursing Administrative Forum: October 7, 2014

Medical Executive Committee: October 16, 2014

Quality Council: October 21, 2014



INTRODUCTION

The goal of the Environment of Care (EOC) Program is to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses the following six programs/areas:

- Safety Management
- Security Management
- Hazardous Materials and Waste Management
- Life Safety Management
- Medical Equipment Management
- Utility Systems Management

In addition, the SFGH Emergency Management Program is an integral component of the EOC Program, ensuring the hospital's overall preparedness for emergencies and disaster response.

The EOC Program is managed by the EOC Committee. The EOC Committee:

- Identifies risks and implements systems that support safe environments.
- Works to ensure that hospital staff are trained to identify, report and take action on environmental risks and hazards.
- Sets and prioritizes the hospital's EOC goals and performance standards and assesses whether they are being met.
- Works to ensure the hospital is compliant with the EOC-related requirements of all applicable regulatory bodies.

Membership of the EOC Committee is comprised of:

- Program managers for each of the six EOC Management Programs and the Emergency Management Program.
- Representatives from Nursing, Infection Control, Clinical Laboratory, Pharmacy, Environmental Services and Quality Management.

EOC projects and initiatives include opportunities for improvement identified during ongoing hazard surveillance, risk assessment and other EOC activities to promote a culture of safety awareness.

This report highlights the activities of the EOC Program in Fiscal Year 2013-2014.

The report outlines progress and impediments in the six major areas of the EOC Program, as well as the hospital's preparedness for emergency response. For each of the major areas, it is organized as follows:

- Scope
- Accomplishments
- Program Objectives
- Performance Metrics
- Goals and Opportunities for improvement

SAFETY MANAGEMENT

SCOPE

Safety Management is designed to identify and address potential safety risks in the SFGH environment. The Environmental Health and Safety (EH&S) Department provides consultation, resources and training to create, maintain and improve the hospital’s working environment in order to reduce or eliminate employee occupational injuries and illnesses, and provide a safe environment for all. The Safety Management Program’s scope encompasses all departments and areas of the SFGH campus, including the current hospital rebuild.

ACCOMPLISHMENTS

- Developed and implemented hospital-wide policies and procedures for response to “Code Green” missing at-risk patients and a progressive drill program to test response capabilities and further refine procedures to ensure optimal patient safety. Improved staff awareness and interdisciplinary coordination to address patient elopement issues and thereby significantly reduce at-risk patients leaving the hospital.
- Integrated Patient Safety, Quality Management, and Sheriff’s Department in EOC Rounds to further increase focus on falls prevention, fire life safety, infection control and security issues.
- Worked with DPH Occupational Health and Safety to provide ergonomic consultation for eClinicalWorks implementation as well as ongoing evaluations to prevent repetitive motion and other injuries.

PROGRAM OBJECTIVES FOR FY 2013-2014

Objectives	Met / Not Met	Comments and Action Plans
The hospital identifies safety and security risks associated with the environment of care. Annual risk assessments are conducted of the buildings, grounds, equipment, staff activity, and the care and work environment for patients and employees. Additional risk assessments are conducted when substantive changes involving these issues occur.	Met	Hospital-wide risk assessment updated June 2014. Updates include highlighting the risk of aggressive or violent behavior in areas beyond psychiatry and the Emergency Department, including all inpatient areas and clinics, and increased potential for ergonomic issues and repetitive motion injuries. Action plans addressing these updates are included in performance metrics below.
The hospital identifies at-risk patients and ensures their safety by preventing elopement and conducting a thorough search if they are found to be missing.	Met	Developed comprehensive program for identification and monitoring of at-risk patients as well as rapid response procedures to search for and return patients who have left their assigned unit.

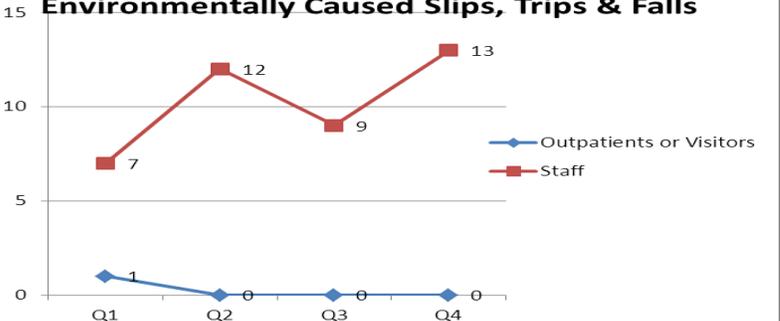
Objectives	Met / Not Met	Comments and Action Plans
The Environmental of Care (EOC) rounds includes all areas of the hospital. All patient care areas are inspected at least twice a year, and other areas are inspected annually.	Met	EOC Rounds were completed as required in all areas, and special follow-up rounds were conducted to monitor specific regulatory survey findings inspection. Improved follow-up communication with Nursing to address findings and required actions.
The EOC Committee receives information from the managers of each of the EOC programs and other sources, identifies key issues and trends, and makes appropriate recommendations for improvement.	Met	Provided more detail on staff injury types and EOC Rounds findings and targeted follow-up actions to more successfully address issues and trends identified such as violent behavior directed at staff and ergonomic interventions needed for increased use of electronic medical records and computer data entry.
All departments have access to the current organization-wide safety policies and procedures. Departmental safety procedures have been reviewed within the past three years and are updated as new procedures are implemented or needs arise.	Met	EOC policies maintained online. New policies on stairwell security and Code Green missing at-risk patient response developed and implemented with extensive staff training and functional drills to test staff knowledge and response. Numerous other policies and procedures updated. Departmental plans have been updated and are inspected during EOC Rounds.
The CEO (or designee) designates the Safety Officer. The Safety Officer's job description is current and reflects the expectations for the responsibility of that position.	Met	Updated letter designating Ed Ochi as Interim Safety Officer was completed on 9/04/13 and remains in effect. Recruitment of a permanent Safety Officer is in progress.
The SFGH Safety Officer assigned to respond to immediate threats to life and health has received appropriate training and has the resources needed to effectively carry out their role and responsibilities.	Met	Senior Industrial Hygienist trained by professional education and certification as well as being a Certified Safety Professional.
An annual evaluation of the scope, objectives, key performance indicators, and the effectiveness of the Safety Management plan and programs is conducted.	Met	Completed via this document.

The Environment of Care Committee has evaluated these objectives for the Safety Management Program and determined that they have been met.

PERFORMANCE METRICS

The following metrics provide the Environment of Care Committee with information needed to evaluate performance of the Safety Management Program activities and to identify further opportunities for improvement:

Objectives & Performance Indicators	Goal	Results
<p>AIM: Risk Assessment -- The Hospital identifies safety risks associated with the environment of care. Initial risk assessments are conducted of the buildings, grounds, equipment, staff activity, and the care and work environment for patients and employees. Additional risk assessments are conducted when substantive changes occur or when opportunities for improvement are identified.</p> <p>Risk Assessment Focus Areas for 2013-2014:</p> <ul style="list-style-type: none"> • Hospital-wide All Risks Update • Magnetic Resonance Imaging (MRI) Safety • Dialysis Evacuation Procedures 	<p>100% = Updates completed</p>	<p>100%</p> <ul style="list-style-type: none"> • Hospital-wide risk assessment completed June, 2014. • MRI: Safety Officer working with Radiology to implement access controls and update departmental and EOC MRI safety policies and procedures. • Dialysis: Completed risk assessment with staff and conducted functional drill to test new evacuation procedures in June, 2014.
<p>AIM: Violence Prevention – De-Escalating Aggressive Behavior & Preventing Assaults</p> <ul style="list-style-type: none"> • All new staff will complete SMART De-Escalation Training during orientation • At least 75 current staff will complete SMART Training (25 / quarter, Oct - Jun) <p>NOTE: Due to a lack of available instructors, DET delayed implementation of regular quarterly offerings of SMART Training for current staff until 2015. Therefore this goal will be continued over into the next fiscal year.</p>	<p>100%</p> <p>75</p>	<p>100%</p> <p>60 (80% of goal) (Training only available October – March; demand remains high)</p> <p>Follow-Up Actions: Improve instructor availability and continue SMART training for new and current staff in 2014-2015.</p>

Objectives & Performance Indicators	Goal	Results															
<p>AIM: Prevent / Reduce Injuries Resulting from Violent Assaults (Prior Year Incidents)</p> <table border="1" data-bbox="215 468 740 810"> <thead> <tr> <th>Injury Type</th> <th>FY 12-13</th> <th>FY 13-14</th> </tr> </thead> <tbody> <tr> <td>Minor injuries to patients or visitors</td> <td>18</td> <td>24</td> </tr> <tr> <td>Minor injuries to staff</td> <td>49</td> <td>36</td> </tr> <tr> <td>Major injuries to patients or visitors</td> <td>0</td> <td>1</td> </tr> <tr> <td>Major injuries to staff</td> <td>0</td> <td>4</td> </tr> </tbody> </table>	Injury Type	FY 12-13	FY 13-14	Minor injuries to patients or visitors	18	24	Minor injuries to staff	49	36	Major injuries to patients or visitors	0	1	Major injuries to staff	0	4	<p>Goals for FY 2014-15</p> <p><18</p> <p><30</p> <p>0</p> <p>0</p>	<p>Significantly reduced minor injuries to staff; however, injuries to patients and visitors and major injuries to staff increased from prior year.</p> <p>Implemented “Help Us Help You” signage to promote staff, patient and visitor awareness of Zero Tolerance for Violence policy.</p> <p>Continued sharing departmental best practices for managing aggressive and assaultive patients.</p> <p>Follow-Up Actions: Continue violence prevention program activities to ensure staff awareness and improve rapid intervention and de-escalation and thereby prevent injuries.</p>
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Minor injuries to patients or visitors	18	24															
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<p>AIM: To reduce and prevent outpatient, visitor and staff slips, trips and falls resulting from environmental causes (wet floors, uneven surfaces, cords or other obstructions, etc.) by at least 10% by 6/30/14. (Data from UO reports: 1 reported in 2012-2013)</p> <ul style="list-style-type: none"> • Attributable to Environmental Causes • Investigated & Corrected <p>Staff Slips, Trips and Falls (data from WC reports; 39 total slips, trips or falls in FY 2013 and 41 total in FY 2014)</p> <ul style="list-style-type: none"> • Attributable to Environmental Causes • Investigated & Corrected 	<p>0</p> <p>0</p> <p>100%</p> <p>< 36</p> <p>0</p> <p>100%</p>	<p>7</p> <p>0</p> <p>100%</p> <p>41</p> <p>13</p> <p>100%</p> <p>Follow-Up Actions: Continue work with Falls Prevention Task Force and Environmental Services to increase staff awareness and prevention of wet floor and other slip, trip and fall hazards. Significant reduction in staff slips and falls due to wet floors noted, down from 22 in FY 2013 to 15 in FY 2014 (reduction of over 30%)</p>															
<p>Environmentally Caused Slips, Trips & Falls</p>  <table border="1" data-bbox="256 1522 1036 1843"> <caption>Environmentally Caused Slips, Trips & Falls Data</caption> <thead> <tr> <th>Quarter</th> <th>Outpatients or Visitors</th> <th>Staff</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>1</td> <td>7</td> </tr> <tr> <td>Q2</td> <td>0</td> <td>12</td> </tr> <tr> <td>Q3</td> <td>0</td> <td>9</td> </tr> <tr> <td>Q4</td> <td>0</td> <td>13</td> </tr> </tbody> </table>			Quarter	Outpatients or Visitors	Staff	Q1	1	7	Q2	0	12	Q3	0	9	Q4	0	13
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Objectives & Performance Indicators	Goal	Results																				
AIM: Reduce At Risk Patient AWOLs <ul style="list-style-type: none"> Total Patients AWOL At Risk Patients AWOL Code Green Searches Conducted Code Green Patients Returned 	Goal = All Patients Returned Safely	<p style="text-align: center;"> 280 55 5 5 </p>																				
<p style="text-align: center;">Patients AWOL, AWOL At Risk & Code Green Searches</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>Graph Data</caption> <thead> <tr> <th>Quarter</th> <th>AWOL</th> <th>AWOL At Risk</th> <th>Code Green</th> <th>Code Green Found / Returned</th> </tr> </thead> <tbody> <tr> <td>Q2</td> <td>69</td> <td>18</td> <td>0</td> <td>0</td> </tr> <tr> <td>Q3</td> <td>99</td> <td>19</td> <td>4</td> <td>4</td> </tr> <tr> <td>Q4</td> <td>112</td> <td>18</td> <td>1</td> <td>1</td> </tr> </tbody> </table>		Quarter	AWOL	AWOL At Risk	Code Green	Code Green Found / Returned	Q2	69	18	0	0	Q3	99	19	4	4	Q4	112	18	1	1	<p>Due to improved staff awareness and proactive actions coordinated with SFSD, 60 At Risk Patients who went AWOL were returned before a Code Green search could be initiated.</p> <p>Note: No prior year baseline data available for comparison. Data includes October – June only.</p> <p>Follow-Up Actions: Continue Code Green Team monitoring of incidents and drills and follow-up activities to ensure safety of at-risk patients.</p>
Quarter	AWOL	AWOL At Risk	Code Green	Code Green Found / Returned																		
Q2	69	18	0	0																		
Q3	99	19	4	4																		
Q4	112	18	1	1																		

EFFECTIVENESS

Effectiveness is based on how well the specific goals are met and how well the scope of the performance metrics fits current organizational needs. The Safety Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-15:

- Hire and orient the new Safety Officer for SFGH.
- Research, purchase and implement an electronic tracking system for EOC Rounds findings and related issues.
- Continue to improve staff awareness and training to recognize potentially violent situations and effectively use of de-escalation techniques to prevent injuries resulting from aggressive patient and visitor behavior.
- Continue efforts to reduce outpatient, visitor and staff falls resulting from environmental causes.
- Continue to improve coordination of response to at-risk patient AWOL attempts by integrating Aeroscout system to ensure rapid return to assigned hospital bed and overall patient safety.

The proposed performance metrics for these goals are:

Safety Management Proposed Performance Metrics for 2014-2015	Target	Comments & Action Plan
<p>AIM: To prevent violence and decrease injuries resulting from aggressive behavior & assaults by at least 20% from prior year results by 6/30/15.</p> <p>Percentage of New Employees Completing SMART De-Escalation Training Number of Current Staff Completing SMART Refresher De-Escalation Training (January – June, 2015 with a goal of 20 per month) Decrease Injuries Resulting from Assaults Minor Injuries to Patients – 20% from 2013-2014 Minor Injuries to Staff – 20% from 2013-2014 Major Injuries to Patients Major Injuries to Staff</p>	<p>100%</p> <p>120</p> <p>≤ 18</p> <p>≤ 29</p> <p>0</p> <p>0</p>	<p>Expand SMART Training to improve early recognition of potentially violent situations and more effective implementation of best practices such as coordinated team-based interventions to reduce and prevent injuries resulting from assaults by at least 20%.</p>
<p>AIM: To reduce outpatient, visitor & staff injuries resulting from environmentally caused falls by at least 10% from prior year results by 6/30/15.</p> <p>Percent of environmentally-caused staff falls investigated for root cause with appropriate corrective measures identified and implemented.</p>	<p>100%</p>	<p>Investigate falls to determine contributing environmental causes and identify and implement appropriate corrective measures.</p>
<p>AIM: To reduce the number of AWOL at-risk patients leaving the SFGH campus to zero by 6/30/15.</p> <ul style="list-style-type: none"> • Total Annual At-Risk Patient AWOL Incidents • At Risk Patient AWOLs Safely Returned 	<p>≤ 75</p> <p>100%</p>	<p>Implement Aeroscout system to prevent patient elopements. Continue refining Code Green response procedures to ensure safe return of any at-risk patients who attempt to leave the hospital.</p>

SECURITY MANAGEMENT

The Security Management Program is designed to ensure the physical and personal security of patients, staff and visitors coming to San Francisco General Hospital and Trauma Center (SFGH). The Security Management Program evaluates and implements processes to minimize the risks of security threats, incidents, or violations, which include injuries, property damage, or theft on the SFGH campus.

The campus is currently undergoing construction to build a 453,000 square foot acute care facility (Building #25). Sheriff's personnel are participating in the development of the security infrastructure for the new hospital.

Sentinel Event – On October 8, 2013, SFGH experienced a tragedy which led to an independent audit of campus security and CMS corrective action measures, recommendations and implementation. The recommendations directly impacted campus security and the San Francisco Sheriff's Department.

Summary of Key Findings, Recommendations and Improvements Related to Hospital Safety and Security – Office of the Mayor - Independent Audit / SFSD Plan of Correction

Finding	Met / Not Met	Corrective Action
Leadership: Communication between SFGH Leadership and the Sheriff's Department was limited.	Met	The Sheriff's Department brought in a new leadership team in response to the sentinel event. The San Francisco Sheriff transferred a Sheriff's Captain, an additional Lieutenant and a Training Coordinator to the unit. The Unit Commander meets weekly with Hospital Leadership to discuss security related issues.
Patient Safety (A): Lack of a comprehensive Security Management Plan as required by the Joint Commission.	Met	The SFSD Security Management Plan was submitted and approved in March 2014 by the DPH Environment of Care Committee.
	Met	Sheriff's Department personnel have been fully incorporated into the day to day operations of the hospital. The Watch Commanders attend SFGH Nursing Administration report-outs (bed meetings) twice a day, every day.
Patient Safety (B): Lack of staff training, awareness and confidence in security.	Met	The Unit Policy and Procedure Manual is currently being revised and updated. All policies directly related to the Corrective Action have been completed. The goal for next year is to complete the update of the policy and procedure manual.

Finding	Met / Not Met	Corrective Action
<p>Patient Safety (C): Lack of a coordinated search plan for missing at risk persons.</p>	Met	The Sheriff's Department developed campus-wide search protocols for missing patients. The new checklist divides the campus into four search quadrants.
	Met	Beginning October 2013, the Sheriff's Department initiated daily stairwell rounds of the emergency evacuation stairwells of Building #5 (Main Hospital).
	Met	Beginning October 2013, the Sheriff's Department initiated new protocols for response to the emergency evacuation stairwell alarms. Staff now deactivates the alarm and searches the stairwell from top to bottom each time an alarm is activated.
<p>Finding D: SFSD has not consistently assisted SFGH staff with detaining at-risk patients who attempt to leave SFGH before the completion of her/his treatment.</p>	Met	SFGH administrative policy and procedure for missing at-risk patients (1.10) was approved and implemented. SFSD Missing At Risk Patient policy and search protocols were approved and implemented. A Code Green task force was created to test the new policy and search plan. The Sheriff's Department fully participated in the development of protocols and campus wide education and training efforts.
	Met	Since the tragedy, all missing at-risk patients have been returned to care at the hospital.
<p>Finding E: The hospital Quality Assurance Performance Improvement (QAPI) failed to set priorities focused on improving security for patients that go missing.</p>	Met	The San Francisco Sheriff's Department is a member of the "Code Green Task Force" for missing at-risk patients. We participate regularly in drills and Environment of Care rounds to identify patient, staff and visitor safety issues.
<p>Contracted Services</p>		
<p>Finding C: Performance criteria and/or related metrics to evaluate the effectiveness of security services and response times were absent</p>	Met	The SFSD has developed a Microsoft Access database to capture the performance criteria cited in this finding. The SFSD now staffs the Sheriff's Operations Center with two persons. The following information is captured by the database: time call received, time call dispatched, time first unit arrived on scene, time units cleared the scene, demographic information, type of call, location of call and the final disposition of the call. The SFSD produces monthly calls for service and crime reports for the campus. These reports are sent to the Environment of Care Committee and Hospital Leadership.

Finding	Met / Not Met	Corrective Action
<p>Finding D: SFSD has not actively or consistently participated in key hospital committees addressing campus safety and security.</p>	Met	<p>SFSD leadership currently participates in the following committees: Environment of Care Committee, Violence Prevention Task Force, Code Pink, Code Green – Missing At Risk Task Force, Disaster Council Committee, Administrative Operations, Employee Health and Safety Committee, Disaster Committee, Hospital Leadership Security Meeting, Management Forum, Smoke Free Campus</p> <p>On an as-needed basis SFSD leadership will attend meetings of other SFGH committees and DPH governing body, including but not limited to:</p> <ul style="list-style-type: none"> • Quality Council • Executive Staff • Medical Executive Committee • Joint Conference Committee • Health Commission
<p>Finding E: Lack of a comprehensive orientation and ongoing training program for security.</p>	Met	<p>The SFSD has assigned a training coordinator who has established a collaborative relationship with the SFGH Dept. of Education to coordinate all DPH related training. All employees assigned to the unit or who work overtime at DPH sites must attend DPH Orientation training within 30 days of assignment. Assigned staff participates in annual DPH training and some yet-to-be specified DPH on-line training courses (Halogen).</p>
	Met	<p>The unit has established and implemented a six week Deputy Field Training Program modeled on a full P.O.S.T. FTO program to establish and maintain professional standards for sworn personnel. All documentation mirrors the industry standard for a FTO program.</p>
<p>Finding G: Existing Security Operations Center (SOC) is staffed by civilians that are not trained emergency dispatchers nor trained security professionals.</p>	Partially – Met	<p>Sheriff's Operation Center is currently being staffed by two persons; a civilian telephone operator and a radio operator (deputy). Professionally trained Emergency Communications Dispatchers have not been hired as of the date of this report. The Sheriff's Department and the Department of Public Health are in negotiations with the Mayor's Office and the CCSF DEM to acquire Emergency Communications Dispatch Services for SFGH.</p>

PROGRAM OBJECTIVES

Each management objective is listed in the following table and marked as met or not met. If an objective is not met, the appropriate Environment of Care (EOC) program manager(s) review the objective to determine what needs to be done to meet it during the next year. The action required to address each change is indicated in the last column of the table.

Objectives	Met / Not Met	Comments and Action Plans
The hospital takes action to minimize or eliminate identified security risks in the physical environment.	Met	Conduct annual risk assessments and work with hospital leadership to prioritize highest risks to be addressed. SFSD on site leadership attends daily Nursing Administration report outs twice a day (bed meetings). SFSD on-site leadership attends weekly security leadership meetings with the SFGH CEO. SFSD adjust security patrols and response procedures to meet the hospital's construction phases as they are implemented and continue interaction with the rebuild committee to stay current on future changes.
When a security incident occurs, the hospital follows its identified procedures.	Met	The hospital will follow established protocols for security incidents as outlined in the SFGH "Emergency & Safety Response Resource" rainbow chart.
The hospital establishes a process for continually monitoring, internal reporting and investigate incidents of damage to its property or the property of others.	Met	Done through quarterly reports to the Environment of Care Committee (EOC) Enhanced the computer capabilities at SFGH/SFSD to provide linked in compatibility with the Sheriff's Department law enforcement infrastructure and criminal justice database.
The hospital reports and investigates incidents of damage to its property or the property of others.	Met	Quarterly incident reports are reported to Environment of Care Committee (EOC).
The hospital will utilize a multi-disciplinary workplace violence prevention team to review all policies, procedures and operations to identify and respond to hazards that exist currently and plan for future threats.	Met	The Violence Prevention Taskforce (VPT) will meet monthly to discuss violence prevention policies, education and exercises. Threats to public safety should be mitigated by a combination of physical and procedural controls. The VPT will discuss solutions and make recommendations.

Objectives	Met / Not Met	Comments and Action Plans
<p>The San Francisco Sheriff's Department will utilize Community Oriented Policing concepts. The SFSD will distribute campus Safety and Crime Prevention bulletins. The SFSD will hold regular community meetings on campus to solicit input receive feedback and work on community based solutions to campus security threats and problems.</p>	<p>Met</p>	<p>The SFSD began producing monthly safety and crime awareness bulletins on a monthly basis in January of 2014.</p> <p>The SFSD will hold campus Community Orientated Policing meetings on a semi-regular basis.</p>

PERFORMANCE METRICS

An analysis of the program objectives and performance metrics is used to identify opportunities to resolve security issues and evaluate the effectiveness of the program. Additionally, it provided the Environment of Care Committee with information that can be used to adjust program activities to maintain performance or identify opportunities for improvement.

Sheriff's Operation Center – Phone Call Audits

AIM: Incoming calls to the Sheriff's Operation Center will be documented accurately, comply with hospital privacy standards and meet professional standards.

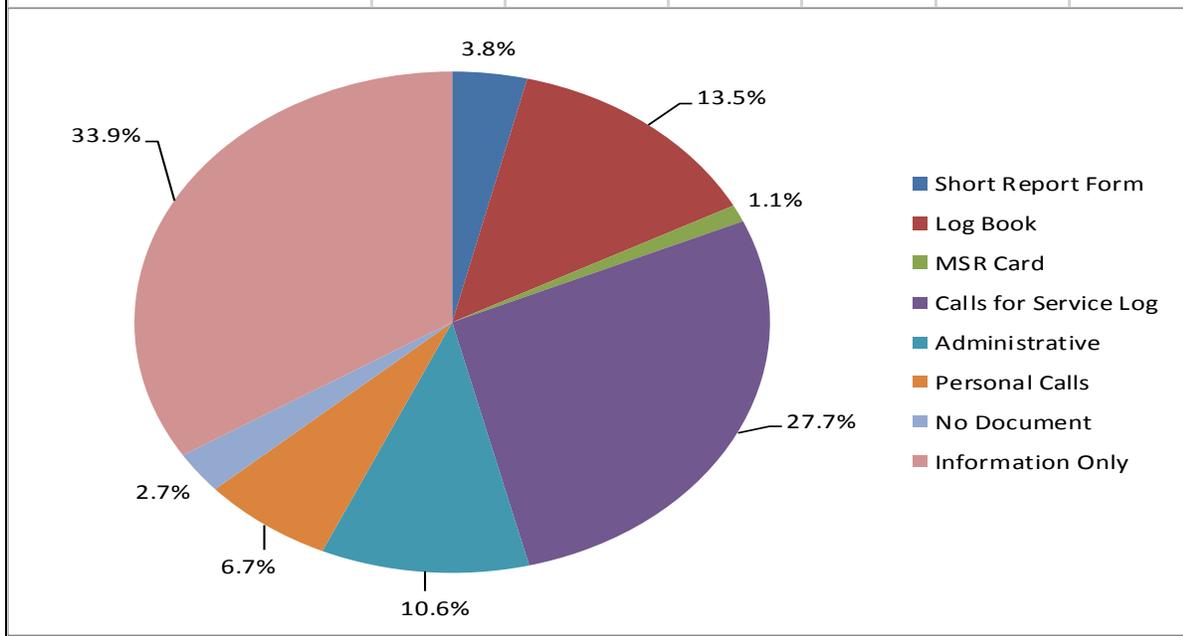
- AIM 1: 100% of audited dispatch records will be accurate
- AIM 2: Zero HIPAA Violations on audited phone calls
- AIM 3: 100% of audited calls demonstrate professional standards met

Ten phone calls per shift (30 calls per month) were audited per month by the Unit Commander or his/her designee (Asst. Unit Commander). During the six month period starting January 2014 through June 2014, 180 phone calls were listened to for compliance with HIPAA and department professional standards. A document audit was conducted on all 180 of the screened phone calls.

Complete and accurate documentation was not found on five (5) of the 180 phone calls or 2.7% of the audited records. Personnel responsible received corrective action counseling and retraining.

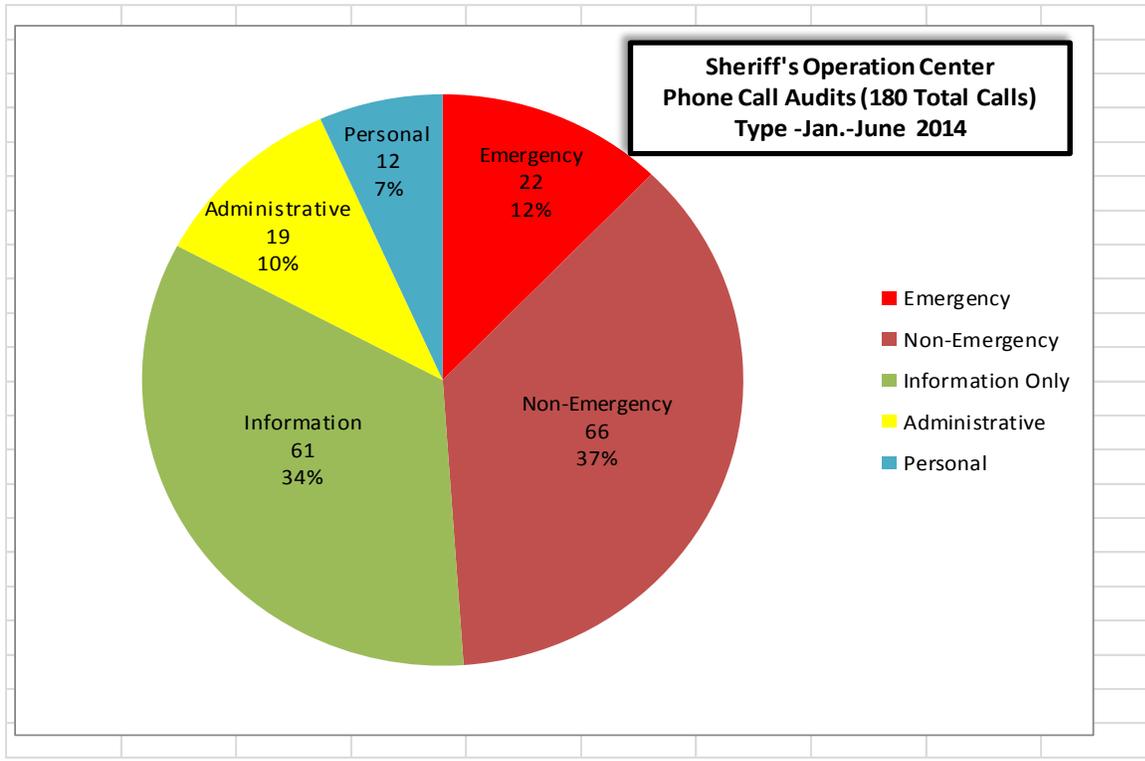
Type of Documentation	Jan-June	Percentage
Short Report Form	7	3.8
Log Book	24	13.5
MSR Card	2	1.1
Calls for Service Log	50	27.7
Administrative	19	10.6
Personal Calls	12	6.7
No Document	5	2.7
Information Only	61	33.9
Total Calls Audited	180	100.0

**Sheriff's Operation Center
Phone Call Audits
Documentation
Jan-June 2014
180 Calls**



DATA SOURCES AUDITED FOR ACCURACY OF CALL DOCUMENTATION

Aim 1: 97% of Calls for Service had accurate documentation. No documentation found for 5 calls. Additional staff training will be conducted regarding the importance of accurate documentation of all calls for service.



Aim 2: **Zero** HIPAA violations were noted

Aim 3: **100%** of calls for service met professional standards

FBI/DOJ Workplace Violence Typology

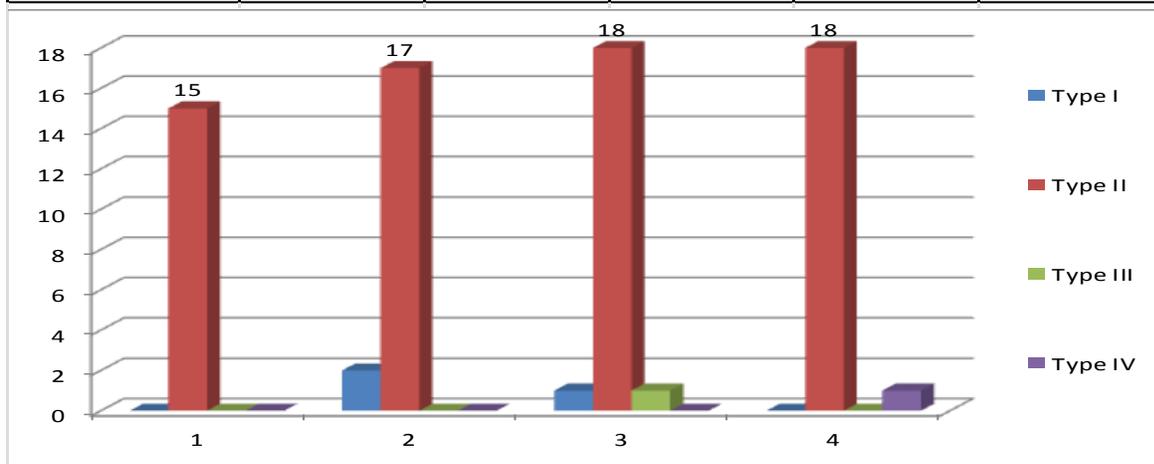
The Federal Bureau of Investigation and the Department of Justice use the following typology to categorize workplace violence events. The San Francisco Sheriff's Department will utilize this typology for reporting campus incidents of violence.

Type of Act	Description of Act
Type I	Offender has no relationship with the victim or workplace establishment. In these incidents, the motive most often is robbery or another type of crime.
Type II	Offender currently receives services from the workplace, often as a customer, client, patient, student or other type of customer.
Type III	Offender is either a current or former employee who is acting out toward coworkers, managers, or supervisors.
Type IV	Offender is not employed at the workplace, but has personal relationship with an employee. Often, these incidents are due to domestic disagreements between an employee and the offender.

AIM: To reduce Type II workplace violence incidents at SFGH by 10% by 6/30/15.

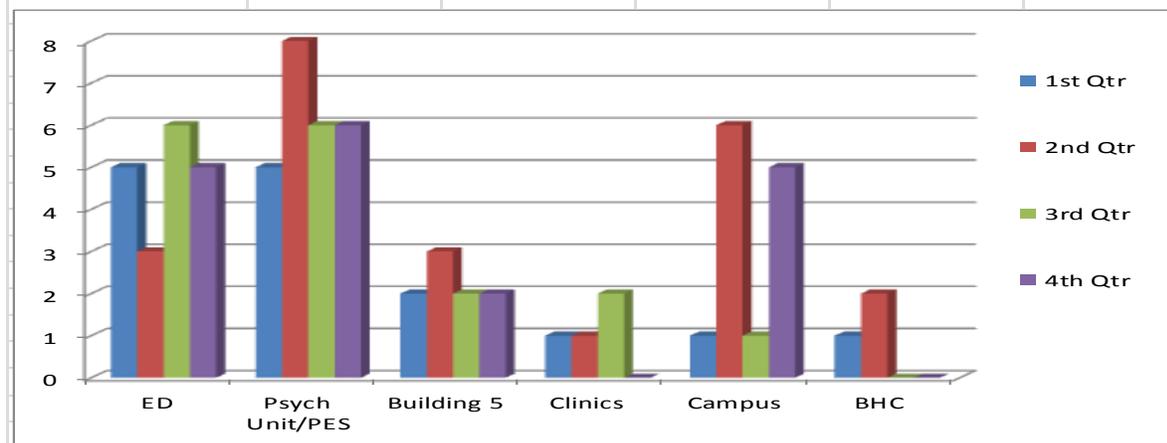
FBI/DOJ Workplace Violence Typology FY 13/14 – SFSD Incident Reports

Performance Metrics	1 st Qtr	2 nd Qtr	3 rd Qtr	4th Qtr	Totals	%
Violent Crime						
Type I	0	2	1	0	3	4.11%
Type II	15	17	18	18	68	93.15%
Type III	0	0	1	0	1	1.37%
Type IV	0	0	0	1	1	1.37%
Totals	15	19	20	19	73	100%



LOCATION - SFGH Workplace Violence - SFSD Incident Reports FY 13/14

Location	1 st Qtr	2 nd Qtr	3 rd Qtr	4th Qtr	Totals
ED	5	3	6	5	19
Psych Unit/PES	5	8	6	6	25
Building 5	2	3	2	2	9
Clinics	1	1	2	0	4
Campus	1	6	1	5	13
BHC	1	2	0	0	3
Totals	15	23	17	18	73



US / Canada Crime Survey	2012	2013	SFGH 13/14
Violent Crime Rate	2.0	2.5	1.25
Assault Rate	10.7	11.1	5.6
	2012	2013	SFGH 13/14
% of Type I Workplace Violence	16%	11%	4 %
% of Type II Workplace Violence	75%	84%	93%
% of Type III Workplace Violence	4 %	2 %	1.5 %
% of Type IV Workplace Violence	5 %	3 %	1.5 %

Including the Behavioral Health Center the San Francisco General Hospital Campus has **500** hospital beds.

- Violent Crime Rate = Murder, Rape, Robbery, etc.
- Assault Rate = Assault and Battery
 - An **assault** is an unlawful **attempt**, coupled with a present ability, to commit a violent injury on the person of another.
 - A **battery** is any willful and unlawful **use** of force or violence upon the person of another

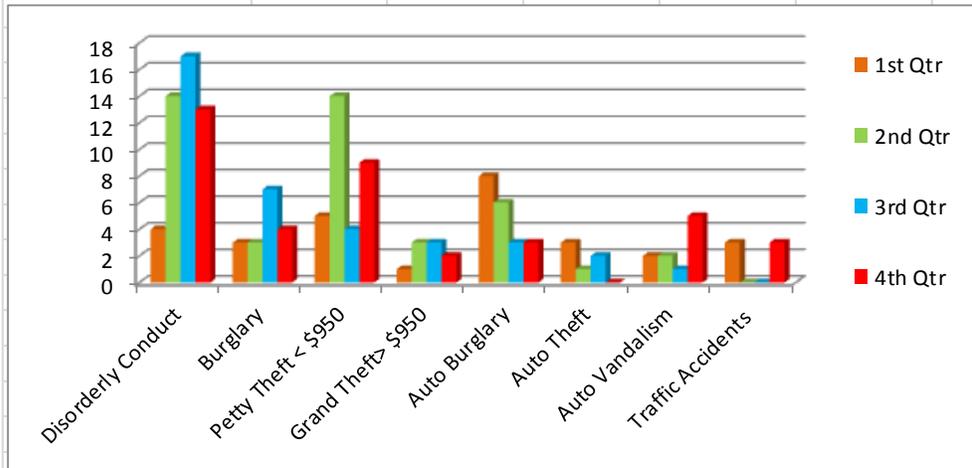
The SFGH Campus data represents an analysis of events that resulted in a San Francisco Sheriff's Department response and an Incident Report.

Non-Violent Crime FY 2013-14 – SFSD Incident Reports

Disorderly Conduct—For the purposes of this report, disorderly conduct captures several offenses that cause a law enforcement response. Many types of unruly conduct (e.g., public drunkenness, disturbing the peace, loitering) that disrupt the delivery of care will, in this case, fit the definition of disorderly conduct.

Non-Violent Crime FY 13/14 – SFSD Incident Reports

	1st Qtr	2 nd Qtr	3 rd Qtr	4th Qtr	Totals
Disorderly Conduct	4	14	17	13	48
Burglary	3	3	7	4	17
Petty Theft < \$950	5	14	4	9	32
Grand Theft> \$950	1	3	3	2	9
Auto Burglary	8	6	3	3	20
Auto Theft	3	1	2	0	6
Auto Vandalism	2	2	1	5	10
Traffic Accidents	3	0	0	3	6
Totals	29	43	37	39	148



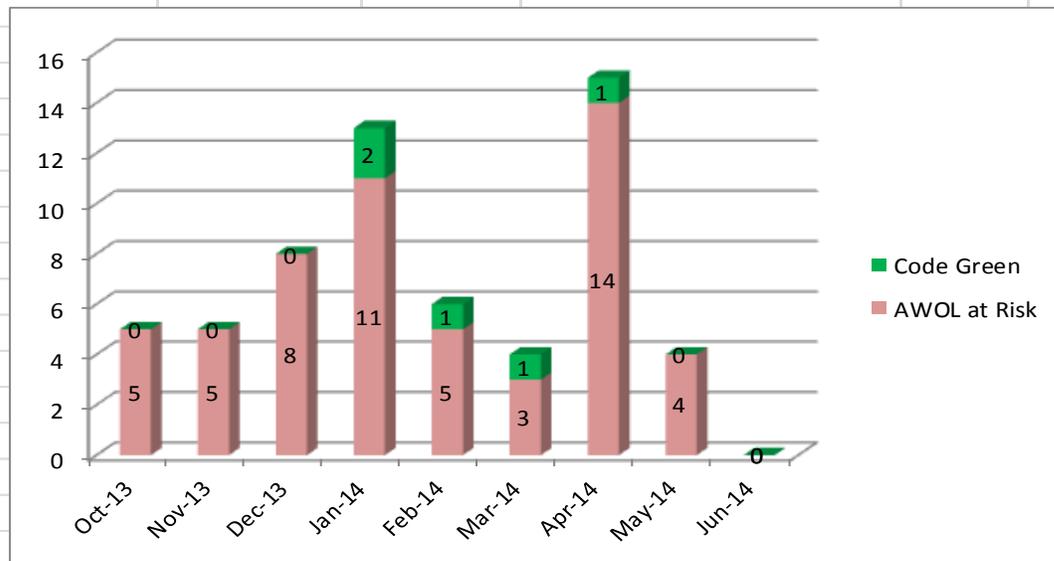
The SFGH campus data represents an analysis of events that resulted in a San Francisco Sheriff’s Department response and Incident Report.

Code Green - AWOL– At-Risk - FY 13/14

Objectives	Met / Not Met	Comments and Action Plans
AIM: SFSD will establish a campus search policy for Code Green & AWOL At-Risk Patients. SFSD will provide assistance with AWOL At-Risk patients who are missing. SFSD will respond to 100% of AWOL-At Risk (Code Green) events reported.	Met	The hospital will monitor for compliance.

Code Green—AWOL At-Risk Data—FY 2013/14

	AWOL at Risk	Code Green	AWOL at Risk / Code Green Patient Found / Returned
Oct-13	5	0	5
Nov-13	5	0	5
Dec-13	8	0	8
Jan-14	11	2	13
Feb-14	5	1	6
Mar-14	3	1	4
Apr-14	14	1	15
May-14	4	0	4
Jun-14	0	0	0
Totals	55	5	60



Data Source: RN/Physician AMA AWOL & AWOL At-Risk Database

Multiple at-risk patients have attempted to AWOL each month, but all (100%) were found and agreed to return until the completion of their care. Reports from hospital staff and the SF Sheriff's indicate that the identification of and response to AWOL at-risk patients has been extremely successful. Most patients are now approached by staff and/or Sheriffs at the Medical/Surgical unit doorway or the elevators and convinced to return to the unit.

EFFECTIVENESS

Effectiveness is based on how well the scope fits current organizational needs and the degree to which current performance measurement statistics weigh against stated performance goals. The Security Management program is considered to be effective. The San Francisco Sheriff's Department is committed to taking the necessary steps to exceed performance standards by setting and enforcing professional standards; providing training, outreach, and education; establishing partnerships with SFGH and UCSF leadership to identify and solve problems; and encouraging continuous improvement in workplace safety.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-2015

- **Reduction of incidents of Type II Workplace Violence** – Although the overall violent crime rate for the SFGH Campus is significantly lower (1.25 incidents per 100 hospital beds) than the national average (2.5 incidents per 100 hospital beds) the instances of Type II Workplace Violence on campus is slightly higher (93% for SFGH vs. 84% nationally). It is recommended that the campus continue to emphasize SMART training during orientation and expand upon this educational effort to reduce workplace violence. Campus staff would benefit from further education regarding the required information needed to request the appropriate response level from the SFSD Sheriff's Operation Center.
- **Reduction of Crime** – The San Francisco Sheriff's Department will conduct highly visible preventive patrols of the campus and surrounding areas. The purpose of this strategy is to prevent crime from occurring, interrupt crimes in progress and decrease Sheriff's Department response time. The Aim is to reduce crime by 10% during the next year.
- **Reduction of Homeless Encampments** – During the past year Homeless persons residing in the encampments on the perimeter of the campus have been responsible for at least four fires. Homeless persons without an appointment or hospital business are routinely found using the restroom facilities in the main hospital to bathe, do laundry and dispose of refuse. Some of the same individuals have been arrested for burglaries, auto burglaries and other criminal activity. The Sheriff's department will continue to conduct proactive patrols in the areas on the perimeter of the campus and tunnel system of the hospital. It is recommended that SFGH coordinate its effort with SF Homeless Outreach Teams (SFHOT) to offer resources and alternative housing to those living on and around the campus.
- **POST Certification of the Deputy Training Program** – The Sheriff's Department is taking steps to have the Deputy Training Program certified by the California Commission on Peace Officer Standards and Training (POST). POST certification will open additional training opportunities and funding streams to ensure that the deputies assigned to the campus are receiving relevant, updated and certified law enforcement training.
- **Active Shooter Preparedness** – The SFSD will continue to prepare for an Active Shooter incident. In July 2014, the SFSD acquired a set of four (4) Active Shooter kits (ballistic protective equipment) for personnel assigned to the unit. The Active Shooter kits will be utilized for the Contact Teams that will be deployed to stop the threat. The equipment was acquired using Homeland Security Grant funding and more equipment is scheduled to be purchased for the unit. SFSD have requested a total of twelve (12) Active Shooter Kits for the SFGH Campus through the Homeland Security Grant Funding. These resources will arrive during the next fiscal year. The unit will train to the Incident Action Plan that has been developed by the Unit Commander for Code Silver incidents. The Incident Action plan takes the unit through initial contact, initial deployment of the contact teams, establishment of command, inner perimeter, outer perimeter, safe ingress/egress, establishment of the Medical Branch, victim triage, transport, and establishment of HICS, a Joint Information Center (JIC) and victim Family Assistance Center (FAC). The SFSD will conduct drills, tabletops, functional exercises and if possible full scale joint training

exercises (SFGH & SFSD). All exercises will utilize the Homeland Security Exercise Evaluation Program (HSEEP) format for exercise conduct and evaluation.

- **Community Policing Outreach and Education** – The San Francisco Sheriff's Department will produce and distribute monthly crime prevention tips and safety bulletins. These bulletins and tips will be distributed using the existing email infrastructure. A recommendation has been made to the Department of Public Health to purchase a mass notification system (text, email, social media) in which crime prevention bulletins and tips can be distributed more widely.

The SFSD is proactively looking to meet with members of the SFGH Campus community to discuss any concerns related to campus safety and law enforcement. The Community Policing philosophy is one of partnership between the law enforcement element and the community it serves. Our community is the San Francisco General Hospital Campus and the immediate surrounding neighborhood.

- **Sheriff's Operation Center** – The Sheriff's Operation Center will be moving to a new campus location in 1C of Building #5 in anticipation of the opening of the new hospital in 2015. Some of the operational inefficiencies identified in the Mayor's Office independent security audit have already been addressed. We have migrated from a paper record keeping system to a computer database. Several of the issues are related to technology and lack of space will not be addressed until we move into the new SOC. The SFSD continues to strive to improve professional standards, response times, accuracy and timeliness of documentation and radio communications for the safety and security of the SFGH Community and surrounding areas. We continue to educate SFSD staff on the importance of proper reporting and documentation.

HAZARDOUS MATERIALS & WASTE MANAGEMENT

The Hazardous Materials and Waste Management Program is designed to minimize the risk of injury and exposure to hazardous materials through proper selection, use, handling, storage and disposal of waste. The program also works to control the risk of exposures to hazardous components such as asbestos and lead in existing building materials which may be disturbed during construction and renovation activities. The program assures compliance with all applicable local, State, and federal codes and regulations.

SCOPE

The Hazardous Materials and Waste Management Program applies to the entire campus of San Francisco General Hospital (SFGH) including the Rebuild and other construction activities. While construction and renovation activities with possible impacts on staff, patients, and visitors have increased and changes have been made to chemical hazard communication standards, the scope still accurately reflects the intent of the program.

ACCOMPLISHMENTS

- Continued to collaborate with Materials Management, Infection Control, and individual departments to screen proposed products and verify that they can be used in a safe fashion within the SFGH operating environment. Worked with Materials Management on the selection of general purpose examination gloves which offered both cost-efficiency and greater protection to users. Selected exam gloves are now deployed throughout the hospital, and improved chemotherapy-agent protective gloves are currently in the process of being deployed.
- Collaborated with Employee Health Services and Infection Control to develop a SFGH-wide unit-specific respirator fit-test matrix identifying which employees within a given unit require annual fit-testing of N95 respirators.
- Collaborated with Pharmacy management and staff to develop, deploy, and train pharmacy staff on an improved chemotherapy spill kit and spill response procedures. Development/pilot training completed for the highest-risk group within the Pharmacy, the Inpatient Pharmacy where concentrated chemotherapy agents are prepared for patient administration.
- Teamed up with Infection Control to identify the least hazardous cleaning and disinfection products to be used for various activities and equipment. Assessment of disinfection practices to continue on a more systematic basis during program year 2014-2015. Continued to work with Environmental Services and Infection Control on the selection of the safest, most effective cleaning and disinfection products for specific activities.
- Continued to work with the Hospital Rebuild Team, SFGH Facilities, and Infection Control to allow construction within operating hospital buildings as well as in very close proximity to staff, patients, and visitors without significant incidents or exposure concerns.
- Maintained SFGH Environmental Permits, and acted as liaison between regulatory agencies including the SF PUC, DPH Hazardous Materials Unified Program Agency, and Cal/OSHA and SFGH. Continued to work with SFGH management and staff regarding Cal/OSHA regulations, policies, and practices and assisted in responding to inquiries from Cal/OSHA regarding concerns about working conditions. Worked with the SFGH Department of Psychiatry, Facilities, and Regulatory Affairs on the resolution of a Cal/OSHA citation which necessitated the implementation of engineering and administrative controls, as well as educating Cal/OSHA staff on the complex operating environment found in hospitals and the delicate balance between employee and patient safety.

PROGRAM OBJECTIVES FOR 2013-2014:

Objectives	Met / Not Met	Comments and Action Plans
The processes used to select, transport, store, use and dispose of hazardous materials, and to separate, segregate, transport, store, package and dispose of hazardous wastes are defined in written procedures.	Met	New chemical products continue to be reviewed for potential hazards as part of the Product Evaluation Process. Construction and renovation projects hazardous materials (asbestos & lead) reviews and hazard mitigation now being documented via construction project Combined Work Permits. New chemotherapy agent spill response procedure developed and deployed within the Inpatient Pharmacy.
Inspections are conducted at least annually to assure that areas used to store and handle hazardous wastes have adequate space, are separated from clean and sterile goods and foodstuffs; and hazardous chemicals are stored appropriately to their hazards.	Met	Hazardous materials storage and handling reviewed as part of periodic EOC rounds.
Staff who handle hazardous chemical materials and/or hazardous wastes are trained about the hazardous of the materials they handle, protective methods, and responses to spills, and exposures.	Met	Staff trained via hazard communications portion of annual EOC training module.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct hazardous materials and waste management in a positive proactive manner.

PERFORMANCE METRICS

The following metrics provide the Environment of Care Committee with information needed to evaluate performance of the Hazardous Materials and Waste Management Program activities and to identify further opportunities for improvement:

Objectives and Performance Indicators	Goal	Results
<p>AIM: Implement expanded Hazard Communication training.</p> <ul style="list-style-type: none"> Percentage of Staff Completing Expanded Hazard Communication Training 	<p>90%</p>	<p>Hazard Communication contents of current Environment of Care Halogen training module expanded to incorporate basic concepts for the new Globally Harmonized System (GHS). NOTE: Halogen training completion date extended to September 2014; as of 08/04/2014 64% of hospital staff had completed this expanded Environment of Care module.</p>
<p>AIM: Increase hazardous materials spill reporting and investigation.</p> <ul style="list-style-type: none"> Percentage of Hazardous Materials Spills reported through Unusual Occurrence (UO) Reporting System Percentage of Reported Spills Investigated by EH&S 	<p>100%</p> <p>100%</p>	<p>Investigation of reported spills identified need for overhaul of spill kits and response procedures for chemotherapy agent spills. Assembled new spill kits with expanded contents and response procedures including clear instructions to file a UO report. Training successfully provided to inpatient pharmacy staff. Follow-Up Action Plan: Roll out training to the rest of the pharmacy staff and the two units where chemotherapy is administered in FY 2014-2015.</p>

EFFECTIVENESS

Effectiveness is based on how well the scope fits current organizational needs and the degree to which current performance metrics result meet stated performance goals. The Environment of Care Committee has evaluated the Hazardous Materials and Waste Management Program and considers it to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-15:

Complete deployment of improved chemotherapy spill cleanup kit and procedures:

Assessment of chemical spills during 2013-2014 identified chemotherapy spills to be of concern. In-depth work with SFGH Inpatient Pharmacy management and staff led to the development of an improved chemotherapy agent spill kit and spill cleanup procedures. Training on kit and procedures within Inpatient Pharmacy was successful. Plan is to now deploy the spill kit and procedures (modified to specific area needs) to the remainder of the pharmacy and patient care areas at SFGH where chemotherapy is most frequently administered.

Identify, review, overhaul, and standardize potentially hazardous cleaning and disinfecting practices.

SFGH Infection Control and Environmental Health and Safety have jointly identified cleaning and disinfection practices which pose both excessive risk to staff performing the cleaning and disinfection and may not provide optimal cleaning and disinfection of reusable equipment. During 2013-2014, one high hazard material, glutaraldehyde ("Metricide") was eliminated from use and a safer product (a proprietary hydrogen peroxide / 2-furoic acid mixture) was deployed. During 2014-2015 Infection Control and EH&S will work jointly to identify other cleaning and disinfection practices, work to identify the appropriate lowest risk cleaning and disinfection practice, and standardize to the practice particularly if it is performed by multiple units.

The proposed performance metrics for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Metrics for 2014-2015	Target
<p>AIM: Complete deployment of improved chemotherapy agent spill kits and spill training throughout SFGH.</p> <ul style="list-style-type: none"> • Modify procedures as needed for other areas of pharmacy and patient care units. • Deploy at least 1 spill kit to each area of pharmacy and patient care units who frequently administer chemotherapy to patients. • Train, coach, or train trainers to provide chemotherapy spill cleanup training in appropriate areas of the hospital. 	<ul style="list-style-type: none"> • Complete procedure modifications • Deploy at least one spill kit each in 4C and 5A. <p>Present at least one training session to the 4C Infusion Clinic and 5A Hem/Onc staff.</p>
<p>AIM: Work with Infection Control to identify at least one potentially hazardous cleaning and disinfection practice used in patient care units, and review, upgrade, and standardize practice to both improve staff safety and infection control effectiveness of practice.</p> <ul style="list-style-type: none"> • Work with Infection Control to jointly review large scale and/or multi-unit cleaning and disinfection practices. • Identify at least one large scale and/or multi-unit cleaning and disinfection practice for in-depth review, identification of the least hazardous most appropriate cleaning and disinfection practice, and training/deployment of the improved cleaning disinfection practice. 	<p>Identify at least 1 process to review</p> <ul style="list-style-type: none"> • Complete at least 1 process overhaul and standardization

LIFE SAFETY MANAGEMENT

The Life Safety Management Plan demonstrates comprehensive understanding, application, and adherence to the latest life safety codes of the National Fire Protection Association (NFPA), State, and local standards. It is designed to ensure an appropriate, effective response to fire emergencies that could endanger the safety of patients, staff and visitors, and the San Francisco General Hospital environment (SFGH).

SCOPE

The Life Safety Management Program applies to the SFGH campus, including all construction projects. The SFGH Rebuild project has developed a Life Safety Management plan that covers any contingencies that should occur within the confines of the construction site. Notification and response to any event includes the SFGH Fire Marshal and Facility Services staff.

ACCOMPLISHMENTS

- Completed a campus-wide fire alarm system study as the basis for planning a fire alarm upgrade.
- Completed test, inspection, and repairs to fire and smoke dampers for 2 floors in the hospital per NFPA standards, which is required every five years per NFPA standards. The intent is to test and inspect two floors per year to maintain compliance.
- Assessed risk and implemented Interim Life Safety Measures (ILSM) for ADA bathroom projects in the hospital.
- Completed the 2-hour fire wall separation project for Long Term Care on Ward 4A as directed by new CMS standards.
- Completed **five**-year sprinkler system recertification.
- **Three** key facilities service staff attended The Joint Commission Environment of Care and Life Safety Chapters trainings
- Approximately 1500 hospital staff were trained by the SFGH Campus Fire Marshal for Fire Life Safety response.

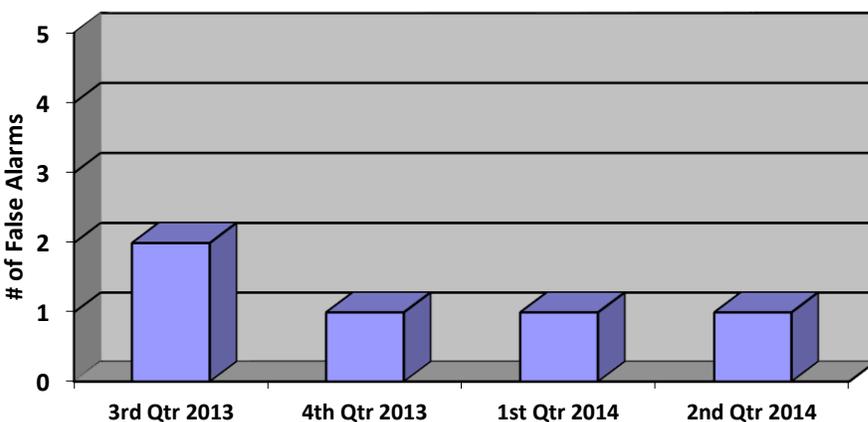
PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Notes/Action Plan(s)
The Fire Plan defines the hospital methods for protecting patients, visitors, and staff from the hazards of fire, smoke and other products of combustion and is reviewed and evaluated annually.	Met	The SFGH Fire Plan is reviewed annually. Problems are assessed for impact on the hospital's core values of safety and responsibility and scheduled for resolution.
The fire detection and response systems are tested as scheduled, and the results forwarded to the EOC Committee quarterly.	Met	The Campus Fire Alarm system serving SFGH is routinely tested and repaired as necessary.
Summaries of identified problems with fire detection, NFPA code compliance, fire response plans, drills and operations, in aggregate, are reported to the EOC Committee quarterly.	Met	Any problems or deficiencies of the fire alarm system are reported in the quarterly Environment of care (EOC) report.
Fire Prevention and Response training includes the response to fire alarms at the scene of the fire alarm, critical locations of the facility, the use of the fire alarm system, processes for relocation and evacuation of patients if necessary, and the functions of the building in protection of staff and patients.	Met	All fire drills required for the facility have been conducted per schedule. Staff training in response and system devices is covered as part of the drill.
Fire extinguishers are inspected monthly, and maintained annually, are positioned to be in visible locations, and are selected based on the hazards of the area in which they are installed.	Met	Fire extinguishers were inspected as required. All units are appropriate to their use and location.
Annual evaluations are conducted of the scope, and objectives of this plan, the effectiveness of the programs defined, and the performance monitors	Met	Items monitored in the annual report and fire drills are assessed for effectiveness and improvement.

PERFORMANCE METRICS

Life Safety Management Performance Metrics	2013 3 rd Qtr.	2013 4 th Qtr.	2014 1 st Qtr.	2014 2 nd Qtr.	Target	Comments and Action Plan
Quarterly Fire Drills; a minimum of 3 per quarter one fire drill per shift, with completed department evaluation forms.	11	11	7	10	3 drills per quarter; 1 per shift	Target exceeded; extra trainings due to size of campus and extra trainings for interim life safety measures. Discuss issues discovered during drills and take corrective actions.
False fire alarms	2	1	1	1	5 or less false alarms per year	Monitor for trends. 40% reduction of false alarms from last year.
Post Drill knowledge test score	99%	99%	99%	99%	95%	Test scores exceed target expectations for emergency response procedures. Reflect that staff understand proper emergency response procedures.

Aim: For FY 2014-15, false fire alarms on campuses will be reduced to three or less per year.



Target of five or less false fire alarms for FY 2013-14 has been met.

Causes of fire alarms:

- 1 patient vandalism
- 1 defective smoke detector
- 3 due to dirty smoke detectors

EFFECTIVENESS

The Life Safety Management Program is considered to be effective based on the objectives and performance metrics indicated in the Plan.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-15

- Continue monitoring for false fire alarms.
- Continue monitoring ILSM for any on-going construction projects within the Hospital, and file the appropriate Risk Assessments; add a risk assessment component to the work permit process
- The existing campus fire alarm system is in need of replacement due to age and parts obsolescence. Replacement of the system will be part of the Department of Public Health proposed general obligation bond project (Nov 2015).
- Train facilities staff on safety equipment, fire plan, and fire life safety systems for the new hospital
- Review and revise all life safety policies and procedures that will be tailored to the new hospital.

Proposed Performance Metrics for 2014-15	Target	Comments and Action Plan
AIM: Train Facilities Services staff on the safety equipment, fire plan and Fire Life safety systems for Bldg. 25	100%	Develop and implement staff trainings on revised policies and new life safety equipment; monitor knowledge in annual skills assessments
AIM: Ensure that all Life Safety policies and procedures are tailored to the new hospital (Bldg. 25)	100%	Review and revise policies in preparation for oversight of Bldg. 25 in 2015.

MEDICAL EQUIPMENT MANAGEMENT PLAN

The Medical Equipment Management Program is designed to minimize the risk associated with the use of medical equipment through the careful selection, acquisition, and maintenance of all patient care medical equipment.

SCOPE

The Medical Equipment Management Program applies to all clinical devices services provided on the SFGH campus including preparations for the opening of Building 25.

ACCOMPLISHMENTS

Program Activities highlights for 2013-2014:

- A new Biomedical Department Manager was hired in February 2014, filling a position that had been vacant since July 2013
- Installation of new Philips Intellivue patient vital signs monitors in the Emergency Department which increased equipment inventory, resulting in improved workflow and quality of patient care
- Upgraded the Computerized Maintenance Management System (CMMS) database which improved medical equipment management, data capture, and expanded capability for identifying trends
- Participated in the multi-disciplinary Critical Alarm Fatigue Committee; reviewed alarmed medical equipment and defined processes and authority for setting alarm limits and reducing unnecessary alarms.
- Hospital Rebuild Project: Reviewed medical equipment needs, plans, safety standards and specifications to ensure consistency of purchases. Collaborated with Medical Staff leadership and made recommendations to reduce quantities and re-use existing equipment, resulting in a projected cost savings of \$10 million.
- Staff Training and Development: Staff technicians attended dialysis equipment trainings resulting in improved on-site responses to equipment problems and cost savings to the Dialysis Department
- Monitoring of Medical Device Hazard Alerts/Recalls through the ECRI Institute Alert Tracking System.

PROGRAM OBJECTIVES

Objectives	Met/Not Met	Comments and Action Plan
The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.	Met	Inventory is kept in the CMMS Database, categorized by risk level and associated with all related historical records, including but not limited to Initial Inspection (II), Preventive Maintenance (PM), Corrective Maintenance (CM), and Alert related Actions.
The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience.	Met	Equipment is currently classified as Life Support and Non-Life Support. Policies and Procedures will be reviewed and updated to reflect any Alternative Equipment Maintenance Plan (AEM). Currently SFGH has no equipment under AEM.
The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.	Met	All related Unusual Occurrence reports are reviewed, investigated, and tracked with adherence to EOC Policy 12.03, Reporting of Medical Device Incidents
The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.	Met	Refer to EOC Policy 12.03, Reporting of Medical Device Incidents
Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks.	Met	Refer to EOC Policy 11.01, Non-medical and Medical Equipment Management
The hospital inspects, tests, and maintains all life-support and non-life support equipment identified on the medical equipment inventory. These activities are documented.	Met	These activities are governed by SFGH Biomed policies and documented in the Biomed CMMS Database.
Annual evaluations are conducted of the scope, objectives of this plan, the effectiveness of the programs defined, and the performance monitors	Met	The Environment of Care Committee (EOC) reviews the annual plan

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct medical equipment awareness in a positive proactive manner.

PERFORMANCE METRICS

PARAMETER	1st QTR		2nd QTR		3rd QTR		4th QTR		ANNUAL	
TOTAL WORK REQUESTS	941		868		966		990		4731	
CORRECTIVE WORK ORDERS	N/A*		N/A*		966		990		4731	
PREVENTATIVE MAINTANCE REQUIRED	2083		1156		1433		1637		6309	
PREVENTATIVE MAINTANCE COMPLETED	2083	100%	1156	100%	1417	99%	1257	92.16%	5913	97.79%

*Not implemented until the third quarter

The current Biomedical Department Manager implemented changes to how metrics were previously calculated on non-life support equipment, which impacted the Preventive Maintenance (PM) completion rates for the 3rd and 4th quarters. Work orders now remain open when a device cannot be immediately located; keeping the work orders open until the equipment can be located impacts the quarterly completion rate. Also, when a device is in use and preventive maintenance cannot be performed within the month, the work order remains open until the equipment is available. The emphasis is shifting to managing 100% of all devices, and metrics for FY 2014/15 will reflect these changes.

Aim: 100% of all medical equipment managed by the Biomedical Engineering Department is accounted for and properly maintained.

TARGET	ACTUALS	
Managed 100%:	98.31%	
PM Completed by due date \geq 90%	92.16%	
CL (could not locate) \leq 5%	4.62%	
UN (unavailable) \leq 5%	1.54%	
ND (not done) = 0%	1.69%	
Total Number of Devices	7126	

Key: **PM:** Preventive Maintenance Completed
CL: Device was not located within the specified month
UN: Device was unavailable for PM during the month
ND: Device was not managed

Aim: To reduce the number of work orders for unexpected equipment repairs to less than 1,000 per year in order to minimize the amount of equipment downtime.

Biomedical Engineering will also track the numbers of equipment identified through Environment of Care rounds and reported through Unusual Occurrence Reports that are in need of repairs and review to ensure that equipment in need of service is being properly identified and reported.

Repairs for 4th Quarter of FY 2013-14

Metrics for FY 14/15	Actual FY 13/14	
Number of Repair Work Orders are ≤ 1000	990	
Number of equipment identified during Environment of Care Rounds needing repairs ≤ 15	25	
Number of equipment identified by Unusual Occurrence reports as needing repairs ≤ 5	4	

New manager began tracking this data in FY 13/14 and based on his findings established the metrics for FY 14/15. Goal over time will be to track repairs and collect more detailed information to reduce unplanned repair work orders.

EFFECTIVENESS

The Medical Equipment Management Program is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT FOR 2014-2015

- Amend Biomedical Department Policies to specify how life support equipment is classified, consistent with evidence-based practice
- Incorporate data on equipment that falls under Alternative Equipment Maintenance (AEM) and include in quarterly reports to the EOC
- Modify the CMMS Database to include:
 - Categorizing work requests to help identify trends (e.g., operator error, broken probes, mechanical failures, electrical failure)
 - Categorizing preventive maintenance: Could Not Locate (CL), Un-Available (UN), or Completed (PM)
 - Identifying trends in electrical safety
 - Increase the accuracy rate for identifying the risk level of every device.

UTILITY SYSTEMS MANAGEMENT

SCOPE

The San Francisco General Hospital Facility Services Department implements and maintains the Utility Management chapter of the Environment of Care. The Utility Management Program ensures the operational reliability and assesses the special risks and responses to failures of the utility systems which support the facility's patient care environment. The major utility systems include but are not limited to: electrical distribution, water and waste systems, vertical transportation, communication systems, HVAC and medical gases.

ACCOMPLISHMENTS

- In the completion stages of installing two 20,000lb/hr boilers serving the SFGH campus. The two existing boilers being decommissioned are rated at 100,000lbs/hr and will not meet future Bay Area Air Quality standards for emissions. Installation completed September 2014.
- Successfully initiated tests of new diesel generators serving emergency power to the SFGH Campus under all load conditions including full load test from the load bank. Completed: July 2014
- Construction of new medical gas tank plant: project scope is to install new medical gas plant next to the power plant and to decommission existing tank on San Bruno Ave. Planned completion date: Winter 2015
- Modernization of Main Hospital (Building 5) elevators: As of September 2014 twelve of thirteen elevators have been accepted as complete by OSHPD. Scope of work is to install new elevator controllers, ADA features and interior cab finishes
- Modernization of Buildings 80/90 elevators: Scope of work is to install new controllers for three elevators including double-ended cab to add elevator redundancy to Building 90. Planned completion date: Spring 2015
- Main Chiller Unit #1 overhaul: Overhaul 11-ton absorber chiller. This chiller serves Building 5 and is approximately 45 years old. Overhaul is 25% of replacement cost. Planned completion date: September 2014
- SFGH Chief Engineer presented the educational segment, "What Not to Flush" at the Hospital Management Forum in July 2014 as part of an ongoing effort to reduce floods caused by non-flushable items in the toilet

PROGRAM OBJECTIVES FOR FY 2013-2014

Objectives	Met / Not Met	Comments and Action Plans
The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life support systems.)	Met	Inventory of equipment for major utility systems maintained in equipment database.
The hospital identifies, in writing, inspection and maintenance activities for all operating components of HVAC systems on the inventory	Met	Documentation of activities is entered into TMS, the automated work order system.
The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.	Met	Utility isolation information located at the Engineering Watch Desk.
The hospital inspects, tests, and maintains emergency power systems as per NFPA 110, 2005 edition, Standard for Emergency & Standby Power Systems.	Met	Testing and inspection of this new system per NFPA 110, 2005 edition
The hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented.	Met	The medical gas system is certified annually. Area alarm panels are checked monthly. Documentation is entered into TMS and separate report.
Annual evaluations are conducted of the scope, and objectives of this plan, the effectiveness of the programs defined, and the performance monitors	Met	Scope and objectives derived from quarterly report data.

Report Indicator	FY 2013-2014 Totals					
	BHC	MH	80	90	100	SB
Emergency Power Failures	0	0	0	0	0	0
Commercial Power Failures	0	1	0	0	0	0
Water System Failures						
Domestic	0	0	0	0	0	0
Waste	0	13	0	0	0	0
Communication Failures	0	0	0	0	0	0
HVAC Failures	0	0	0	0	0	3
Med Gas Failures	0	0	0	0	0	0
Elevator Failures	0	6	0	1	0	0
High Voltage Electric Switchgear	0	4	0	0	0	0

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct utilities management awareness

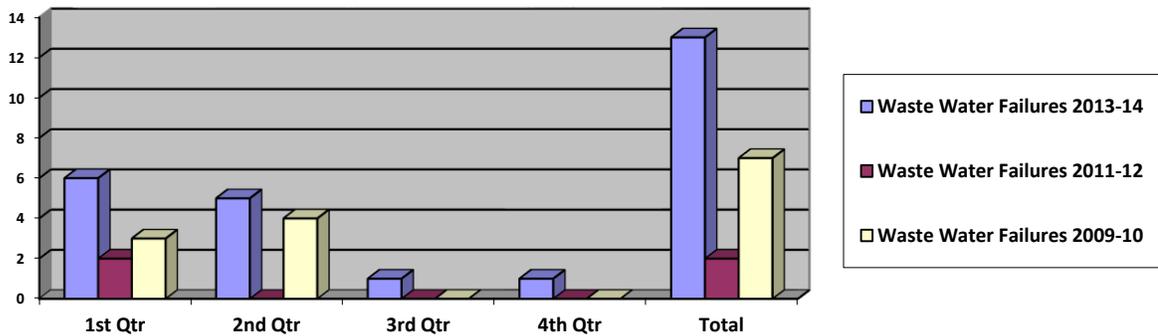
in a positive proactive manner.

PERFORMANCE METRICS

Utility Management Performance Measurement	2013 1st Qtr.	2013 2nd Qtr.	2014 3rd Qtr.	2014 4th Qtr.	Target	Comment s/Action Plan
Unscheduled Waste Water Utilities System Failures	6	5	1	1	Less than 4/qtr	Excessive incidents due to vandalism
Elevator Failures; (13 total cars)	0	4	1	1	Less than 2/qtr	Elevator failures reflect ongoing problems with existing elevators.

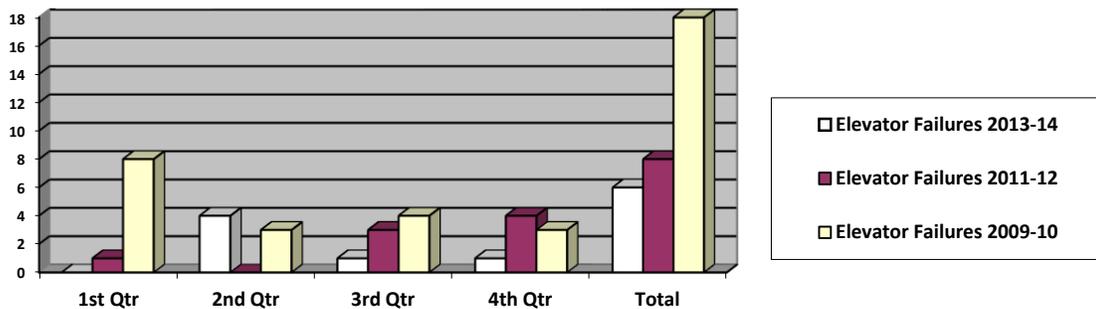
Waste Water Failures

AIM: For FY 2014-15, to reduce by 25% the number of waste water utility system failures.



100% of waste water failures in 2013-14 were due to vandalism

Elevator Failures



For FY 2014-15 a new performance metric will be created to track down categories for elevator failures.

EFFECTIVENESS

The Utility Management Program is considered to be effective.

Proposed Performance Metrics for 2014-15	Target	Comments and Action Plan
AIM: Train Facility Services staff on the new Bldg. 25 Utility systems, including elevators, electrical distribution, water/waste, and medical gas systems	100%	Develop and implement staff trainings addressing revised policies and new utility equipment; monitor knowledge in annual skills assessments
AIM: Ensure that all Utility Systems policies and procedures are tailored to the new hospital (Bldg. 25)	100%	Review and revise policies in preparation for oversight of Bldg. 25 in 2015.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-15

- Continue monitoring for unscheduled Waste Water Utility System failures. Target is to reduce incidents to less than 4 per quarter. Many of the system failures are due to items not intended to be flushed into the sewer system. Develop signage and communicate with staff on “What Not to Flush.” Facility Services will monitor for effectiveness
- SFGH is in the 3rd phase of Elevator Modernization. 12 of 13 elevator cars in Bldg. 5 have been upgraded and are operational. Currently, there are 60% fewer elevator failures (see graph above) The project is scheduled for completion in the spring of 2015
- The existing high voltage electrical distribution equipment serving Bldg. 5 is at the end of normal service life. The system requires a high level of maintenance and repair to keep operational. This equipment has been identified for inclusion in the proposed 2015 Department of Public Health general obligation bond project
- Facilities Services is exploring new approaches to facilities personnel work schedules in an effort to better serve the SFGH Campus with the opening of Bldg. 25
- Train facilities staff on utility systems, including elevators, electrical distribution, water/waste, and medical gas systems for the new hospital
- Review and revise all utility systems policies and procedures that will be tailored to the new hospital

EMERGENCY MANAGEMENT

SCOPE

The Emergency Management Program provides information, planning, consultation, training, resources, and exercises for hospital staff and leadership to ensure that San Francisco General Hospital & Trauma Center (SFGH) effectively mitigates the impact of, prepares for, responds to, and recovers from emergencies and disasters and therefore is able to sustain its Mission of providing quality healthcare and trauma services with compassion and respect. These efforts support SFGH's core value of patient and staff safety as well as the accountability goal of complying with regulatory standards. The Director of Emergency Management develops and implements policies, procedures, protocols and other job aids in accordance with:

- California Administrative Code Disaster and Mass Casualty Program (Title 22)
- National Incident Management System (NIMS) and the California Standardized Emergency Management System (SEMS)
- Hospital Incident Command System (HICS)
- Standard on Emergency Management and Business Continuity Programs (NFPA 1600)
- The Joint Commission Standards and Elements of Performance.

The Emergency Management Program applies to and encompasses all departments and areas of the SFGH campus, including current hospital rebuild activities.

ACCOMPLISHMENTS

- Successfully coordinated the hospital's response to the crash of Asiana Flight 214, and presented lessons learned and best practices to the California Hospital Association Annual Disaster Preparedness Conference, the International Anesthesia Trauma Association, USF's Masters in Public Health program, the California Association for Healthcare Risk Management, and San Francisco International Airport's Emergency Operations Group.
- Further refined procedures and provided training to Management Forum on hospital emergency response to Security Alerts and Shelter-In-Place situations.
- Continued providing Hospital Incident Command System Basics training for SFGH managers and supervisors and Sherriff's Department staff. Also conducted departmental Emergency Management training for Department of Education and Training, Utilization Management and Social Services; Department of Dermatology and Nursing Administration/Administrators-on-Duty.
- Successfully utilized a hospital-wide proactive power alert for the final testing and switchover to the hospital's new diesel generators.
- Worked with SFSD and SFPD to effectively manage a bomb threat received by phone.
- Worked with SFSD, SFPD and UCSF to effectively manage the investigation of and follow-up to a loud noise in Building 1 that was initially reported as a possible gunshot. No evidence of gunfire or foul play was found, and normal hospital and clinic operations were rapidly restored.

- Participated in three major multi-functional exercises, including:
 - The Statewide Health and Medical Exercise, which focused on a major foodborne illness outbreak;
 - The Citywide Tsunami Exercise, which highlighted the recently updated inundation zone forecasts as well as significant impacts on utilities services, supply chains and transportation;
 - Our Annual Hospital-wide Extended Operations Exercise, which is designed to test SFGH's capabilities when regional infrastructure, services and support have been seriously impacted.

- Also conducted hospital-wide multi-casualty incident response and earthquake preparedness departmental drills to ensure the ongoing preparedness of all SFGH staff for emergencies and disasters.

PROGRAM OBJECTIVES FOR FY 2013-2014

Objectives	Met/ Not Met	Comments and Action Plans
The hospital conducts an annual hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the potential impact and consequences of those events. The HVA is updated when significant changes occur in the hospital's services, infrastructure, or environment.	Met	Updated 2/28/14 and shared with SFSD, SFFD, SFPD, DPH, the SF Department of Emergency Management and other SF hospitals on 3/05/14. NOTE: HVA updated 6/06/14 due to construction incident impacting Power Plant building. Appropriate mitigation safeguards are in place to minimize potential hazard.
The hospital develops and maintains a written all hazards Emergency Operations Plan that describes the response procedures to follow when emergencies occur. The plan and associated tools facilitate management of the following critical functions to ensure effective response regardless of the cause or nature of an emergency: <ul style="list-style-type: none"> - Communications - Safety and Security - Utilities - Resources and Assets - Staff Responsibilities and Support - Patient Clinical and Support Activities 	Met	Updated in 2013; will update to new HICS guidelines in 2014-2015.
The hospital implements its Emergency Operations Plan when an actual emergency occurs.	Met	Asiana Crash 7/06/13 Bomb Threat 2/01/14 Security Alert 5/07/14
Objectives	Met/ Not Met	Comments and Action Plans

The hospital's emergency response plan and procedures provide for an effective and scalable response to a wide variety of emergencies and are integrated into and consistent with the Department of Public Health Disaster Plan and the City and County of San Francisco Emergency Operations Plan, and are compliant with the California State Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).	Met	Demonstrated plan effectiveness and scalability during Asiana Crash Response and Extended Operations, Statewide, and Citywide Tsunami Exercises.
The hospital's incident command structure facilitates an effective and scalable response and is integrated into and consistent with the overall Department of Public Health and City and County of San Francisco command structure, and is compliant with the California State Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).	Met	Demonstrated HICS structure effectiveness and scalability during Asiana Crash Response and Extended Operations, Statewide, and Citywide Tsunami Exercises.
The hospital trains staff for their assigned emergency response roles.	Met	<ul style="list-style-type: none"> • New Employee Orientation • Annual Online Emergency Preparedness & Disaster Response Halogen Training • HICS Basics Training
The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be supported by local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours.	Met	Tested during Extended Operations Exercise on 9/06/13 and Citywide Tsunami Exercise on 3/28/14.
The hospital conducts exercises and reviews its response to actual emergencies to assess the appropriateness, adequacy and effectiveness of the Emergency Operations Plan, as well as staff knowledge and team performance.	Met	Completed After Action Reports and performance evaluations for 3 actual emergency activations, 3 multi-functional exercises, and 2 proactive alerts.
Annual evaluations are conducted of the scope, and objectives of this plan, the effectiveness of the program, and key performance indicators.	Met	Annual Evaluation by Disaster Committee completed on 8/14/14.

The Disaster Committee and the Environment of Care Committee have evaluated these objectives and determined that they have been met. The program continues to direct emergency management preparedness and response in a positive and proactive manner.

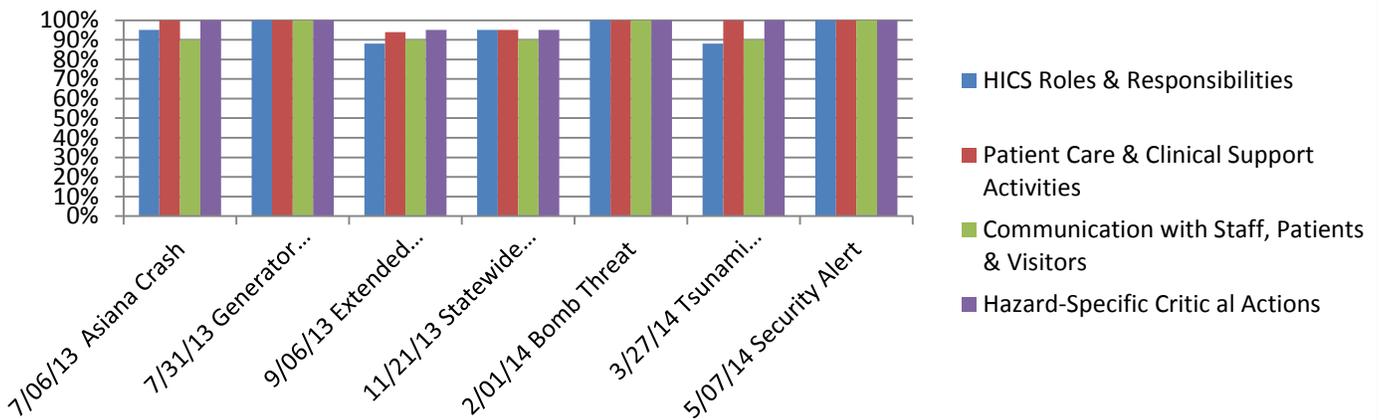
PERFORMANCE METRICS

An analysis of the program objectives and key performance indicators is used to identify opportunities to improve performance and evaluate the effectiveness of the program. This analysis provides the Disaster and Environment of Care Committees with information that can be used to update the Emergency Management program activities. The following are current performance metrics:

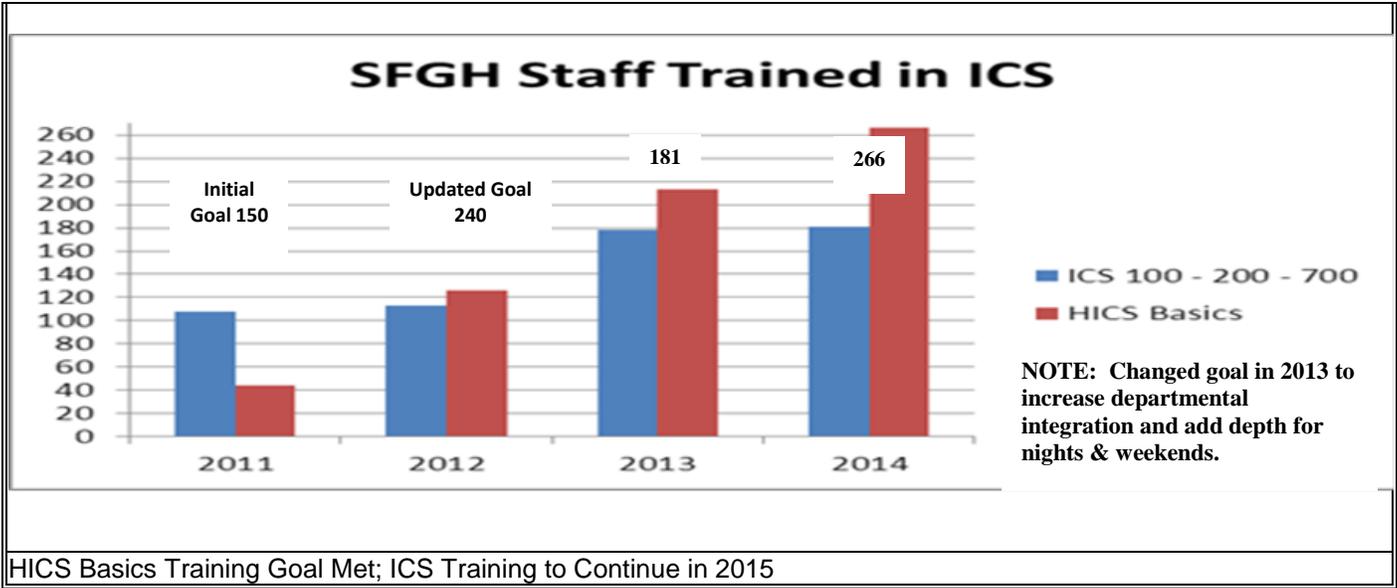
Performance Metrics	2013-2014	2013-2014 Target	Comments & Action Plan
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	Results		
AIM: Measure Performance During Emergency Exercises & Responses to Actual Incidents. Minimum of 2 exercises per year with completed critique of these critical functions: <ul style="list-style-type: none"> • Staff Roles & Responsibilities in HICS; • Patient Care Activities; • Communication; • Hazard-Specific Critical Actions 	7 (Avg) 95% 98% 94% 99%	4 (Avg) 95% 95% 95% 95%	Met. Completed review of 3 actual incidents plus 3 multi-functional exercises and 1 proactive alert. Met. Continuing focus on HICS trainings for staff. Primary issues are failure to complete Job Action Sheet documentation and provide information and direction to staff and patients during incidents. Continue to monitor and develop more clear and detailed criteria for each function.

Emergency Response Performance 2014-2015



Emergency Management Performance Metrics	2013-2014 Results	2013-2014 Target	Comments & Action Plan
AIM: Staff Will Complete Training on the Incident Command System (ICS). <ul style="list-style-type: none"> • Staff completing ICS 100 – 200 – 700 • Staff completing HICS Basics 	181 266	240 240	Partially Met. Continue providing HICS Basics and other trainings for all Supervisory and Management staff. Follow up with staff who have completed HICS Basics to ensure completion of FEMA ICS courses.



EFFECTIVENESS

The Emergency Management program is considered to be effective by both the Disaster Committee and the Environment of Care Committee.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2014-15

- Continue providing training for the Hospital Incident Command System (HICS) Incident Management Team members including section-specific training.
- Improve overall documentation of incident and completion of HICS Job Action Sheets and appropriate HICS forms.
- Update SFGH Emergency Operations Plan, Hazard Specific Plans and related documents, and tools to HICS 2014 standards.
- Develop, implement and test Hazard Specific Plan for Tsunami response to reflect the changes in San Francisco inundation zones and anticipated impacts on infrastructure.
- Develop and implement a progressive exercise program for Code Silver Active Shooter response.

Performance Metrics for 2014-2015	Target	Comments & Action Plan
AIM: Staff Will Complete Training in ICS. Staff who have completed: <ul style="list-style-type: none"> • ICS 100 – 200 – 700 • HICS Basics 	240 280	Increased target includes all Supervisory and Management staff as well as assigned HICS Incident Management Team members and back-ups.
AIM: During Exercises and Actual Incidents, Staff will Complete Appropriate HICS Documentation. <ul style="list-style-type: none"> • Job Action Sheets • HICS Forms 	95% 95%	Implementation of new forms and repeated prompts during drills and activations should help to ensure more thorough completion of documentation.
AIM: Update Emergency Plans and HICS Tools to 2014 Standards. <ul style="list-style-type: none"> • Emergency Operations Plan • Hazard Specific Plans • Job Action Sheets • HICS Forms 	100% 100% 100% 100%	Complete updates using new HICS guidelines and templates released 5/29/14. Review and approval by Disaster Committee (or designated select work group) completed by 6/30/15.
AIM: Develop & Implement Tsunami Hazard-Specific Plan for SFGH. <ul style="list-style-type: none"> • Tsunami HSP Completed, Approved, Distributed & Implemented Including Staff Awareness Training 	100%	Draft Plan and ensure it includes considerations and contingencies to address expanded inundation zones and extended operational impacts anticipated.
AIM: Develop and Conduct Code Silver Exercises to Ensure Hospital Staff are as Prepared as Possible for Active Shooter Incidents. <ul style="list-style-type: none"> • Table Top Exercise – Campus Incident • Table Top Exercise – Main Hospital Incident • Departmental Response Exercises – Key Areas 	1 1 5	Coordinate with SFSD to update plan and provide safe, controlled exercises to further develop and test critical staff actions for initial response and management of an incident after the shooter is neutralized.