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Monthly Board Meeting

Date: March 3, 2021

Location - Meeting link: https://unitedmedicaldc.webex.com/unitedmedicaldc/j.php?MTID=m5d00c0e612ad9277278535956d0d8848

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THE NOT-FOR-PROFIT HOSPITAL CORPORATION
BOARD OF DIRECTORS
NOTICE OF PUBLIC MEETING

LARUBY Z. MAY, BOARD CHAIR

The monthly Governing Board meeting of the Board of Directors of the Not-For-Profit Hospital Corporation, an independent instrumentality of the District of Columbia Government, will convene at 5:30pm on Wednesday, February 24, 2021. Due to the Coronavirus pandemic, the meeting will be held via WebEx.

Meeting link: https://unitedmedicaldc.webex.com/unitedmedicaldc/j.php?MTID=m5d00c0e612ad9277278535956d0d8848
Meeting number:132 681 0644 **Password:** AEeqmmmx352 **Via Phone:** +1-415-655-0001,
Access code: 1326810644

Notice of a location, time change, or intent to have a closed meeting will be published in the D.C. Register, posted in the Hospital, and/or posted on the Not- For-Profit Hospital Corporation's website (www.united-medicalcenter.com).

DRAFT AGENDA

I. CALL TO ORDER

II. DETERMINATION OF A QUORUM

III. APPROVAL OF AGENDA

IV. READING AND APPROVAL OF MINUTES - January 27, 2021 - Pg. 4

V. CONSENT AGENDA

A. William Strudwick- Chief Medical Officer - Pg. 15
B. Dr. Gregory Morrow- Medical Chief of Staff - Pg. 21
C. Dr. Jacqueline Payne-Borden, Chief Nursing Officer- Pg. 23

VI. EXECUTIVE MANAGEMENT REPORT

A. Colene Daniel, Chief Executive Officer- Pg. 29
B. Brian Gradle, Chief Compliance Officer

VII. HUMAN RESOURCES REPORT

A. Trenell Bradley, Human Resources Director- Pg. 46

VIII. CORPORATE SECRETARY REPORT

A. Toya Carmichael, VP Public Relations/Corporate Secretary- Pg. 60

IX. NFPHC COMMITTEE REPORTS

A. Performance Improvement- Pg. 63
B. Finance- Pg. 193.

X. PUBLIC COMMENT

XI. OTHER BUSINESS

A. Old Business
B. New Business

XII. ANNOUNCEMENTS

XIII. ADJOURN

NOTICE OF INTENT TO CLOSE. The NFPHC Board hereby gives notice that it may close the meeting and move to executive session to discuss collective bargaining agreements, personnel, and discipline matters. D.C. Official Code §§2-575(b)(1)(2)(4A)(5),(9), (10),(11),(14).

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General Board Meeting Date:
March 3, 2021

Reading and Approval of Minutes

Minutes Date:
January 27, 2021

Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING
Wednesday, January 27, 2021, 5:30pm
Held via WebEx

Absent: Dir. Bobb

Directors:
LaRuby May, Angell Jacobs, Velma Speight, Wayne Turnage, Dr. Konrad Dawson, Girume Ashenafi, Dr. Malika Fair, Millicent Gorham, William Sherman

UMC Staff: CEO Colene Daniel, Dr. Gregory Morrow, CMO, William Strudwick, CNO Dr. Jacqueline Payne-Borden, CFO Lillian Chukwuma, Corp. Sec. Toya Carmichael, HR Dir. Trenell Bradley, CCO Brian Gradle, Ken Blackwell,

Mazars: Cheyenne Holland, Marc Grossman,

Other: Kai Blisset

Agenda Item	**Discussion**
Call to Order	By Chair May at 5:38pm. Quorum determined by Toya Carmichael
Approval of the Agenda	Motion by Dir. Speight 2nd by Dir. Gorham, unanimous vote. Chair May gave special kudos to Dir. Gorham on her award from the National Action Network.
Approval of the Minutes	Motion by Dir. Gorham, 2nd by Dir. Ashenafi, unanimous vote.
Discussion	**CONSENT AGENDA** **CHIEF MEDICAL OFFICER REPORT: William Strudwick** • Been on staff now for three months so report is more robust than his last report given after three days on staff. • Highlighted the vaccination clinic portion of his report.

	• We have created a good monster with our clinic and is a model for the rest of the departments. • Gave kudos to the various departments that have contributed to the success of the clinic. There have been no call outs from nursing working in the vaccination clinic. • People who have a choice of where to go to get their vaccine are choosing to come to us, this is important because the clinic is an example of what we can do going forward. • We have had media from Canada, Guyana, Korea, Netherlands, and local and national media. • The exposure we are getting throughout the clinic. We had an Ophthalmologist, who is now negotiating space in the MOB and wants to bring all of his cardiac surgery patients to UMC and our OR. • This past Friday we had the Super bowl MVP Doug Williams choose to get vaccinated at our clinic. • 2,304 doses distributed to date. 1740 first doses and 164 second doses. • When the MRI comes up, if we run the MRI department in terms of registration and the welcome people receive this will become the chosen site for people to obtain MRIs. • Chair May noted that Dr. Strudwick hit the ground running at UMC and if he continues to lead the way he has with the vaccination clinic then he is right, we should hope to see an increase in revenue and activity across the hospital. The reservation line team despite the hard and busy work they are doing they always have a smile on their face. We are not coming up in the Press Conferences as a vaccination site with problem and I am very thankful for the work of Dr. Strudwick and his team and am looking forward to that energy being spread throughout the hospital. • Dr. Fair noticed somewhere in the Board book a mention of the mobile van and wonders if there has been any conversation with DOH about taking the vaccines out in the community to serve those who are not able to leave their homes. Marcela answered yes, we will be out twice a week vaccinating senior residents of the DC Housing Authority sites beginning the first week in February. • Dr. Dawson seconded the sentiment of Chair May and the vaccination clinic has been excellent. Received his vaccine at UMC and is really proud to see the work we are doing and we should take great pride in the what we have accomplished. Thanked Dr. Strudwick, Maxine Lawson, Marcela, Dr. Payne Borden and Toya Carmichael for their work with the clinic. It is run better than all the other sites it he city and we should consider giving the team more resources like an extra nurse or reservation specialist. • Dr. Marilyn McPherson Corder added that CM Gray and his wife and mother in law received their vaccines at UMC at the suggestion of herself and Dr. Dawson.

- Chair May noted that Toya Carmichael has been doing a fantastic job of highlighting those who have come to UMC for their vaccine and educating the public. Encouraged everyone to follow us on social media and like and share the information. Asked Dr. Strudwick if there is a way for us to capture data from those who have been vaccinated and send them the newsletter or stay in touch with them about what we are doing around the hospital. Dr. Strudwick said yes we are considering that and we have asked patients to leave us positive reviews on social media.
- Chair May asked about the COVID outbreak mentioned in Dr. Strudwick's report and whether or not agency staffing and OT cost are triggered when we have folks in departments out due to COVID? Dr. Strudwick answered yes, it definitely does add to the staffing challenges and overtime costs. Chair May asked Dr. Strudwick to explain how staffing impacts the ED. Dr. Strudwick explained the throughput system and how call outs impact the ED because the ED can't stop and it is not able to move patients when there is a shortage of nurses or transporters etc. ICU patients and those who require telemetry have been boarding in the ED. Studies show that these patients do not get the same level of care in the ED that they receive when there are on the patient floor so it also impacts patient care.
- Dr. Jacqui added that if one nurse calls out from the telemetry unit that means there are 6 patients who are not without a nurse. If there's a call out from the 5th floor that is 7 patients, ICU is 2 patients without a nurse so it does add up and it really impacts our throughput. Chair May asked if we have a high volume of call outs? Dr. Jacqui said yes, it is in her report and in December we had a large number of nurses who called out, namely those from the SNF who may have been calling out because it was there last month on the job.

CHIEF OF MEDICAL STAFF REPORT: Dr. Gregory Morrow

- Gave greetings and looks forward to working with the board on all the initiatives for the medical staff.
- Gave a quick overview of the new MEC leadership.
- Major focus at this point is OPPE.
- Dr. Dawson welcomed Dr. Morrow to the Board Meeting and thanked Dr. Corder for all her work and reminded her that she is always welcomed to attend.
- Chair May asked about the increase in the infection rate in the ED.
- Dr. Morrow said we had a discussion with the lab and the increase may have been due to employee turnover. Explained that in conjunction with the lab we are working on having dedicated staff from the lab do the blood draws and we expect a decrease of contamination. Chair May asked if that is because of lack of staff. Dr. Morrow answered that yes and moving forward we are looking to expand the staff in the lab so they can be consistently available. Dr. Strudwick noted that it is not uncommon to having a high rate of contamination when there is a lot of chaos

in the ED, this is not a unique situation at UMC. Dr. Dawson noted that yes this is a fairly common problem, the problem comes usually when the patient gets home and you don't know if it is a false negative or positive. Chair May noted the report stuck out to her because it was listed as "unacceptably high" and to her there is a difference between "high" and "unacceptably high". Dr. Fair noted that the PI Committee will follow up and see if there have been any changes in the rate of infection after phlebotomy does the blood cultures.

CHIEF NURSING OFFICER: Dr. Jacqueline Payne-Border

- New report style based on our focus on the Quadruple Aims.
- Will deploy a survey tomorrow for employees to discover why they work here and if they have other jobs what do they like about their other jobs.
- Highlighted new staff in Respiratory Department, we promised JCO we would have a new manager in Respiratory and now we do.
- To date we have 94.4% of our staff who received the flu vaccine.
- Went over the recent trainings offered to various departments throughout the hospital.
- Had 40 nurses and a few monitor techs have a review of EKG interpretation and Mindray came in and did some training for us.
- Improving patient and customer experience, the ICU had been exploring the options for obtaining IPads for patients to be able to communicate with their families, IT is working with the ICU on getting this technology up and running.
- As part of satisfied providers we collaborating with Brian Gradle on creating A Leadership Formation Program and are working getting DCNA involved in the process.
- Chair May asked if the flu vaccine is mandatory? Dr. Jacqui noted it is mandatory and explained that if a staff member is not vaccinated by the deadline they are not terminated but taken off the schedule until they receive the flu vaccine in Occupational Health or through their provider.
- Chair May asked how many on the nursing staff have received the COVID vaccine? Dr. Jacqui did not have the figure in front of her and shared that she was at first skeptical of the vaccine but took it early to serve as a role model for the staff and the believes our staff numbers are increasing. Dr. Strudwick agreed.
- Dr. Dawson asked if the COVID vaccine is mandatory and Dr. Jacqui stated not at this time. Colene Daniel added that the decision to make it mandatory is the city and DC Health's to make.

Motion to accept the MCOS and CNO reports by Dir. Jacobs, 2nd by Dir. Speight. Unanimous vote.

EXECUTIVE MANAGEMENT REPORT: CEO Colene Daniel

- Highlighted that we submitted our evidence standard of compliance and JCO sent questions about those 5 and we turned those answers around in three days. They just us a new report that cleared us of everything accept the CMS conditional level.
- We asked for a waiver to repair 105 fire doors because there was no way we could repair those doors in the timeframe and they should be complete by April.
- Went through the December highlights referenced in her report.
- VP Harris visited UMC for her vaccine with her husband in December.
- We also completed the price transparency requirement on time.
- The rest of the report is focused on the quadruple aim.
- Noted the requests for us to provide Monoclonal Antibody for treating COVID patients.
- Facilities report included and highlighted IT projects.

Questions:

- Chair May asked about the safety security issue the hospital experienced since our last board meeting. Asked how we have worked to address the issue to avoid the risk in the future?
- Colene gave a briefing on the armed robbery in the Excel Pharmacy. Noted that we have a meeting scheduled with the Pharmacy to talk about their desire to increase their business and our need to keep the hospital safe.
- Chair May asked if the issue was due to the presence of the Pharmacy or our security system? Colene noted that our security demands are increasing and we are trying to redo the schedule and cover with overtime the mandate from Behavioral Health to have 24/7 security coverage on that unit. Because patients are becoming more violent they now want three officers instead of two to escort those patients. The demand from security is growing from DC Health, Behavioral Health and what we need to keep the staff safe. We had 15 assaults in December and 13 combative patients who required three officers, we also had 7 gunshot wounds in December. We had 29 BHU combative patients, 68 FD12 escorts, and 43 BH medication assisted.
- Dir. Jacobs asked if our security staff are UMC employees or we use an outside company for staffing? Colene said we have both and there is a contract for special police officers. Ken Blackwell said that it is about 70% UMC and 30% contract staff and we are also supplemented by MPD which we pay for. Colene said MPD also helps us with the grounds.

Dr. Faye called back in to share that the nursing staff is vaccinated 100% for COVID.

CHIEF COMPLIANCE OFFICER – Brian Gradle

- Report incorporated in Executive Management Report.
- Highlighted the COVID vaccine education plan submitted to DC Health.
- Shared that one of the strengths of the hospital is our nimbleness. A few weeks ago the CEO of DC Central Kitchen contacted Brian because they had received little to no information about the vaccine so Brian volunteered to provide them with training. Started today and did an hour long zoom call accompanied by Dr. Strudwick and next week Dr. Maxine Lawson will present additional training to them as well.

Motion to accept CEO and CCO reports Dir Ashenafi, 2nd Dir Jacobs, unanimous vote.

HUMAN RESOURCES REPORT: Trenell Bradley

- Highlighted the open enrollment with 76% of employee participation.
- Noted that two union bargaining agreement have been completed and will move to the Finance Committee soon.
- We are currently in a good position with SEIU (our largest union) and we are still working our way through the review of each position and salaries for those positions.

Motion to accept by Dir Jacobs, 2nd by Dir Ashenafi, unanimous vote.

CORPORATE SECRETARY: Toya Carmichael

- Toya highlighted areas referenced in her written report.

Discussion:

- Dr. Dawson asked if he had attempted to leverage the press we received from the VP Harris visit to gain additional media or resources. Toya Carmichael noted that the media has been calling us daily since the VP visit and other community partners have called to partner with our mobile unit to get additional residents primarily seniors vaccinated which we are.

Motion to accept management report by Dir Jacobs, 2nd by Dir Ashenafi. Unanimous vote.

COMMITTEE REPORTS

PERFORMANCE IMPROVEMENT: Dr. Fair

- Highlighted the accomplishments listed on page 137 of the board book with regard to Doctor Communication and EVS/Food Services.
- Minutes from both meetings will be included in the next board book.

FINANCE COMMITTEE: DM Turnage

- Believes we will need an emergency board meeting next week to discuss the trouble we are having but provided an outline of the current situation.
- On the revenue side the declines are being driven by a continually decline in admission because we have lower activity in the hospital we will leave DISH funding on the table, if we don't have business you can't claim any losses to obtain DISH revenue. The normally reliable GW collections are now lower than budget by 24% and 29% year to date. We have a picture of a hospital in a financial free fall and then you look at the expense side and for reason DM Turnage can't understand our expenses continue to grow while our activities are dropping. We are 1.8 million over the yearly budget. Employee benefits are over budget by 27% 13% year to date.
- We are also under strict regulations about our need for financial resources from the city if we request any more than 15 million dollars a year the board we have to be reconstituted and a new board will be formed.
- There is some disagreement between the finance committee and the CEO we are running at 50-60% of our operating capacity. The hospital has done a fantastic job with the vaccination clinic and Dr. Nesbitt called to sing our praises but that can't stand as the reason for the cost increases that we are seeing. We have 700 employees in the hospital, vaccine programs are not expensive so that is not the reason we are seeing these struggles.
- When you consider these factors, it is not reliable to say to the operator you have to give us those savings, they are not coming.
- We have two options, the Finance Committee has requested a detailed reduction plan for staffing and support and without that you can't get to $22million dollars and until such a plan is received we are pretty much broke. We can't continue to spend on some of the things that really impact the hospital going forward. We think there is only $200 for the legal services contract.
- DM Turnage reminded the board he is duty bound to take measures to the CA and the Mayor and he will not take a request for $22 million to the city for a hospital with low activity, high expenses and no legitimate reduction plan. The plan is to be presented to the Finance Committee on February 19th and then it will be presented to the board. If the board does not feel comfortable accepting the reduction plan and we ask the city for more money and there is no change in the legislation the control board will come in.

	• The Mayor's budget is being developed now and we have to let her know that she has a $22 million problem in her budget that needs to be addressed. • Dir. Jacobs noted this projected loss has nothing to do with the payroll, this is truly the projected loss from our operations. Asked the operator to do the expense reduction plan and give the components needed to run a hospital so they can determine optional services. • Chair May asked if there is an expectation that more funds will be provided by the city? Dir. Jacobs said no, it is expected that if we ask for more money the control board will be triggered. We need a plan from the operator on how they are going to close the Gap. Chair May clarified that the plan should be for the closure of the $22 million gap not 28.4. Dir Jacobs and DM Turnage agreed. Motion to accept Finance Committee report specifically the financials from November and December 2020 by Dr. Fair, 2nd by Dir. Ashenafi. Unanimous vote.
Public Comment	. N/A .

Other Business	N/A
Closed Session	Mike Austin notified Chair that the justification was not read. Motion to enter closed session by Dir Speight 2nd by Dir Ashenafi. Mike Austin read the justification for entering closed session. Roll call vote: absent Dir. Bobb Open session suspended at 7:37pm Motion to end closed session by Dr Dawson, 2nd by Dir. Gorham, unanimous vote. Closed session ended at 8:31pm.
Announcements	During closed session the Board voted to accept credentials, change in status, reappointments, and recognition presented by the medical staff and voted to approve four contracts for Contemporary Nursing, Dixon Hughes Goodman LLP, Mazars USA LLP, and Carlton Fields PC.
Adjourned.	Motion to adjourn by Dir. Gorham, 2nd by Dr. Dawson. Unanimous vote. Meeting adjourned at 8:32 pm.

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General Board Meeting

Date: February 24, 2021

Consent Agenda

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General Board Meeting

Date: March 3, 2021

CMO Report

Presented by:
Dr. William Strudwick
Chief Medical Officer

Not-For-Profit Hospital Corporation
CMO February 2021 Report & Accomplishments

Dr. William Strudwick

During my third month as the NFPHC/UMC Chief Medical Officer, my focus has been balancing the day- to- day management of the Vaccination Clinic with my other administrative and clinical oversight responsibilities. My overarching thought is leveraging the interdepartmental success of the Vaccination Clinic throughout the hospital's ambulatory clinics and outpatient services.

COVID-19 Vaccination:

- Acceptance by hospital personnel and the Ward 7 and 8 community has continued to accelerate. Superbowl MVP quarterback Doug Williams came to our clinic for his vaccination and agreed to be a public super "Influencer".
- We continue to get positive media attention locally, nationally, and internationally. I did local interviews, live streaming with The Washington Informer, and on WOL with Dr. Corder. Dr. Lawson did an interview with ABC highlighting our clinic's role in decreasing social disparities in vaccination access.
- Responding to a request from the DC Central Kitchen myself, Dr. Lawson, and Brian Gradle give four 1 hour Zoom seminars to their staff about COVID-19 and the safety and efficacy of the vaccine.
- Continuous management of our supply of vaccine while balancing our appointments for first and second doses, has allowed us to avoid canceling appointments, which has been an issue at other vaccination clinics.
- We reported our COVID-19 volumes and interventions during weekly COVID-19 Situational Awareness meetings with the DC Hospital Association.

Joint Commission:

- The Joint Commission accepted our corrective action plans. We have to maintain continuous preparedness to validate the execution of our plans whenever TJC returns for inspection.
- We engaged the MedStat Medical Affairs application to automate our physician Ongoing Professional Practice Evaluation (OPPE) program. Training for this program began in January.

DC Department of Behavioral Health (DBH):

- With all 3 facilities that accept FD-12 behavioral health patients having been closed or limited secondary to COVID-19 "outbreaks", meetings with DC Health and DBH are scheduled to consider options for care when city-wide beds are limited.

Patient Advocacy:

- Fielded appropriate patient and family complaints using L.A.S.T. (Listen, Apologize, Solve, and Thank), successfully achieving patient recovery in most instances.

Case Management:

- Ongoing guidance to manage "Gatekeeper" process to admit patients to the appropriate status directly from the Emergency Department – decreasing denials.
- Reached out to introduce myself to Chief Medical Officers of AmeriHealth and Care First MCOs. Will foster collaboration and open communication to strive for mutual sustainability.
- Collaborated with Physician Advisor, Nursing Leadership, and Emergency Department (ED) Leadership to decompress the ED by identifying discharges on the medical surgical units.

Ambulatory Care/Clinics:

- Requested financial data for clinics including billing and revenue. Also requested monthly volumes/productivity.
- Met with wound management contractor Healogics and discussed transitioning the contract from a fixed fee contract to a per patient contract – seeking to create more incentive to increase volume. Awaiting new contract proposal

Recruitment/Contracts:

- Considered multiple physician contracts and call coverage. Reviewed contracts using MDMA national data to appropriately level on- call rates.
- Had one- on- one meetings with Dr. Shighany, Dr. Wilder, Dr. Divachi, and Dr. Momoh.
- Received contract proposal from Fresenius to outsource inpatient dialysis.

Other

- Collaborated with CNO to establish plan to move medical surgical care from 8W to the 3rd floor. Plan considers negative airflow rooms needed for respiratory isolation of COVID-19 patients.
- Collaborated with Diabetic Educator, CIO and Dr. Dennis to plan a continuous glucose monitoring program – using the Dexcom monitoring sensor - for brittle diabetics who are treated in our Internal Medicine clinic.
- Began creating education manual and reference book for the Administrator -On-Call (AOC).

Respectfully submitted,

William Strudwick, MD

Not For Profit Hospital Corporation (UMC) Vaccination Clinic Daily Numbers 2-03-2021

December 16th – **60** Pfizer #1

17th – **64** Pfizer #1

18th – **105** Pfizer #1

21st – **54** Pfizer #1

23rd – **60** Moderna #1

28th – **70** Moderna #1

29th – **70** Moderna #1

30th – **110** Moderna #1

January 5th – **96** Pfizer #2

6th – **10** Moderna #1 / **48** Pfizer #2 (**58**)

7th – **54** Pfizer #2

8th – **30** Pfizer #2

11th –**27** Pfizer #1 / **45** Pfizer #2 (**72**)

12th – **120** Moderna #1

13th – **120** Moderna #1

14th - **130** Moderna #1

15th – **146** Moderna #1 / **3** Moderna #2 (**149**)

19th – **81** Moderna #1 / **40** Moderna #2 (**121**)

20th – **106** Moderna #1 / **15** Moderna #2 (**121**)

21st – **84** Moderna #1 / **56** Moderna #2 (**140**)

22nd – **84** Moderna #1 / **46** Moderna #2 (**130**)

25th – **38** Moderna #1 / **93** Moderna #2 (**131**)

26th – **101** Moderna #1 / **29** Moderna #2 (**130**)

27th – **107** Moderna #1 / **13** Moderna #2 (**120**)

28th – **99** Moderna #1 / **1** Moderna #2 (**100**)

29th – **70** Moderna #1

February 1st – **25** Pfizer #2 / **11** Moderna #2 (**36**)

2nd – **65** Moderna #1 / **6** Moderna #2 (**71**)

3rd – **66** Moderna #1 / **4** Moderna #2 (**70**)

Totals: **310** Pfizer #1 doses; **298** Pfizer #2 doses; 1737 Moderna #1 doses; **313** Moderna #2 doses / **2658** total doses of vaccine.

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General Board Meeting Date:
March 3, 2021

Medical Chief of Staff Report

Presented by:
Dr. Gregory Morrow
Medical Chief of Staff

CHIEF OF STAFF

MONTHLY SUMMARY REPORT

JANUARY 2020

The UMC Medical Staff selected a new set of officers for the Medical Executive Committee starting in January 2021.

Chief of Staff	Gregory D. Morrow, MD
Vice Chief of Staff	Francis O'Connell, MD
Secretary Treasurer	Jancy Mathew, MD
Memebers at Large	Nabil Fallouh, MD
	Laura Fox, MD

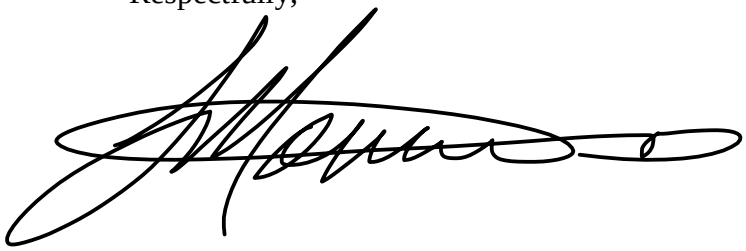
We look forward to working in conjunction with the Board of Directors and the Hospital Administration to continue provide excellence in care and service to the surrounding community.

The UMC Medical Staff is currently working on the following projects:

1. Physician OPPE process
2. Physician contracts review
    a. Quality of Care concerns
    b. Performance standards
    c. Level of provider service
3. Review and Update of Bylaws regarding provider credentialing

I will be able to elaborate more on these items in the meeting.

Respectfully,



Gregory D. Morrow, M.D., F.A.C.S.

Chief of Staff

Amaechi Erondu, M.D., Chairman

JANUARY 2021

PERFORMANCE SUMMARY:
Our total volume for all surgical cases for January 2021 was 147 while the December 2020 stood at 149.

QUALITY INITIATIVES AND OUTCOME:
SCIP protocols are ensured for all our patients with no fall-outs. Surgical and anesthesia time outs followed per protocol including preoperative antibiotics, temperature monitoring and all relevant quality metrics. All relevant quality metrics documented in the various anesthesia record for easy access and reference.

VASCULAR ACCESS SERVICE:

	PIV	ACCUCATH/ POWERGLIDE	MIDLINE	PICC	TOTAL
2020 CENSUS					
JANUARY	162		11	3	176
FEBRUARY	168		12	3	183
MARCH	110	25	15	3	158
APRIL	115	35	10	4	164
MAY	102	28	30	3	163
JUNE	94	25	20	4	143
JULY	87	27	11	4	129
AUGUST	134	35	13	0	182
SEPTEMBER	92	23	4	1	120
OCTOBER	72	21	4	0	97
NOVEMBER	110	22	13	2	145
DECEMBER	91	25	17	4	137
TOTAL	**1337**	**266**	**164**	**31**	**1798**

PAIN MANAGEMENT SERVICE
We are facilitating the chronic pain management to ensure adequate service coverage for hospital inpatient.
Interventional Pain Management service has recommenced service slowly and ramping up the volume. As shown in the chart below, *Pain management service provides the next highest OR volume and is among the top 4 high volume services*.
Radiofrequency ablation (RFA) has commenced as we increase awareness of the service in the region.

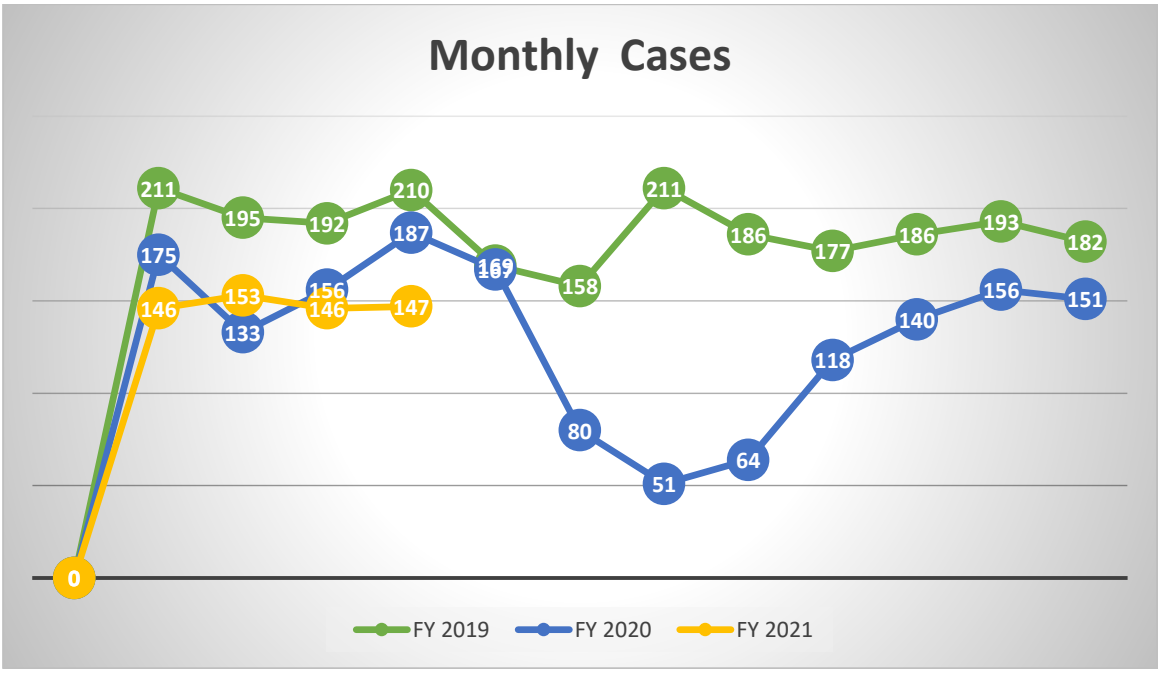
Spinal Cord Stimulation Trials: This a new service offered by the Pain management. It is important to note that, UMC is the only center that offers this service in the area. This will drive enormous revenue for the hospital as we increase the service.

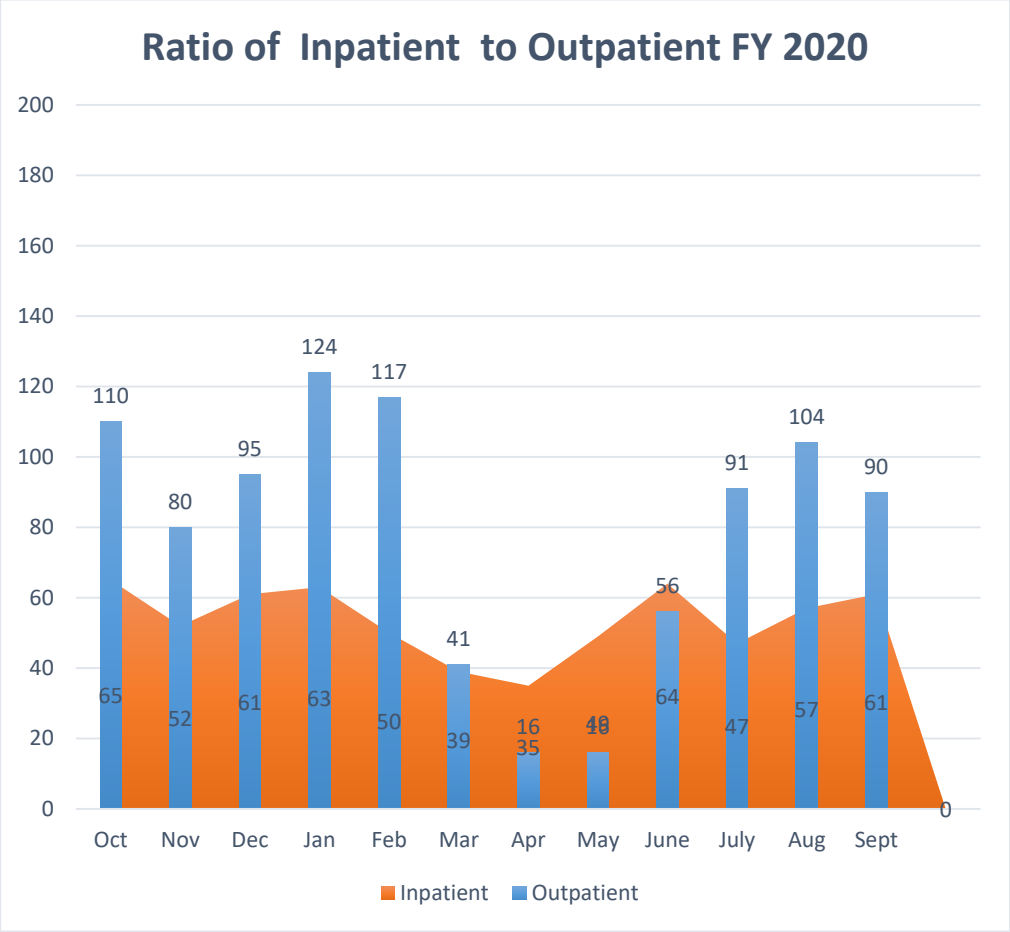
OR UTILIZATION
Our current utilization has decreased due to low surgical volume. We accommodate cases to ensure appropriate staff utilization.

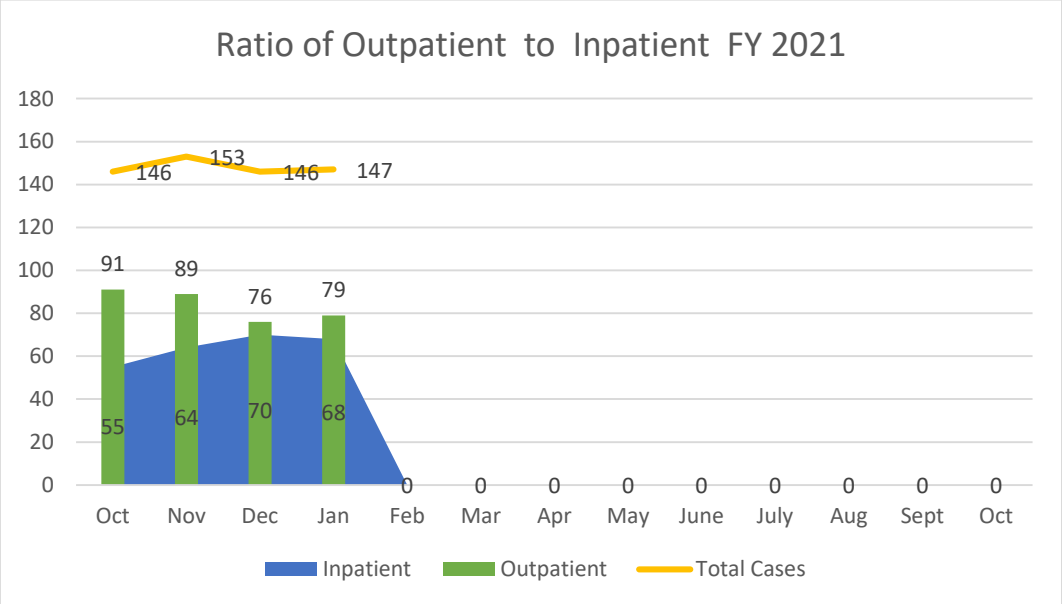
EVIDENCE-BASED PRACTICE AND PRACTICE MANAGEMENT.
Virtual **Mortality and Morbidity Conference** will continue in February 2021.

OR CLINICAL MANAGEMENT QUARTERLY LECTURE SERIES to ensure adequate OR staff learning and clinical process management. Our first lecture was on *Malignant Hyperthermia*. We had a second presentation on this topic to the ER/Nursing and ICU staff to ensure awareness and clinical preparedness.

MONTH	2018	2019	2020	2021
JAN	150	210	187	147
FEB	181	169	167	
MARCH	204	158	80	
APRIL	177	211	51	
MAY	219	186	64	
JUNE	213	177	118	
JULY	195	186	140	
AUG	203	193	156	
SEPT	191	182	151	
OCT	211	175	146	
NOV	195	133	153	
DEC	192	156	146	
TOTAL	2,331	2136	1559	




Ratio of Inpatient to Outpatient FY 2020
200
180
160
140
120
100
80
60
40
20
0
110
80
95
124
117
41
16
56
91
104
90
0
65
52
61
63
50
39
35
64
47
57
61
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Inpatient
Outpatient


Ratio of Outpatient to Inpatient FY 2021
180
160
140
120
100
80
60
40
20
0
146
153
146
147
91
89
76
79
55
64
70
68
0
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Inpatient
Outpatient
Total Cases

Mina Yacoub, M.D., Chairman

JANUARY 2021

UMC ICU COVID-19 DATA TO DATE

As of February 7th, 2021 the ICU has managed 106 patients with Covid-19 infection, of whom 54 have died. The overall ICU mortality rate for Covid-19 patients to date is 51 %.

The ICU experienced another increase in Covid-19 admissions starting around mid-November and is currently seeing a steady plateau of cases. Generally, patients with Covid-19 infection have prolonged ICU courses. Accordingly, the ICU length of stay and Average Daily Census remain higher than pre-Covid-19 times, despite lower overall admissions to ICU compared to same times last year.

Admissions, Average Daily Census and Average Length Of Stay

In January, the Intensive Care Unit had 48 admissions, 44 discharges, and 301 Patient Days. Average Length of Stay (ALOS) increased to 6.8 days (compared to 6 days in December). The ICU managed a total of 54 patients in January.

Overall, ICU admissions continue to continue to be low for this time of the year. Average daily census in January increased to 11 patients, compared to 8.5 patients in December. There were no readmissions to ICU within 48 hours of ICU discharge.

JANUARY 2021 PERFORMANCE DATA

ICU Infection Control Data

In January, the ICU had 184 Ventilator Days with no Ventilator Associated Pneumonias. There have been 2949 days since the last Ventilator Associated Event. In January also, the ICU had 184 Central Line Device Days with no Central Line Associated Blood Stream Infection (CLABSI) and 221 Urinary Indwelling Device days with no Catheter Associated Urinary Tract Infections (CAUTI). The ICU infection control data is reported regularly to the National Hospital Safety Network (NHSN).

ICU SEPSIS DA

Before the Covid-19 pandemic, the national goals for hospital deaths due to severe sepsis were at 15% or less. National deaths due to Covid-19 have driven the severe sepsis mortality rates for hospitals higher since the beginning of the pandemic. Overall, UMC ICU severe sepsis mortality for January was 26.5%.

BLOOD CULTURE CONTAMINATION

Contamination rates of blood culture specimens for ICU patients drawn on admission to ED continue to be significantly high. This presents challenges in clinical decision making and increases risk and cost. Solution remains ED staff education and/or staffing the Pathology lab to draw the specimens. Department of Pathology is conducting a study of performance and outcomes of blood culture collection practices.

In January, the ICU managed 21 cases of severe sepsis (excluding Covid-19 patients). Three of those patients died due to severe sepsis, for a severe sepsis mortality rate of 14% (excluding Covid).

In January the ICU managed 13 cases of severe sepsis due to Covid-19. Six of those patients died, for a January sepsis mortality caused by Covid-19 of 46%.

ICU Mortality

ICU managed 54 patients in January. There were a total of 12 deaths for 44 discharges, with an overall ICU mortality rate of 27 % (the same rate as December) and with half the deaths being due to Covid-19 infection.

BLOOD CULTURE CONTAMINATION

Contamination rates of blood culture specimens for ICU patients drawn on admission to ED continue to be unacceptably high. In December, 29% of ICU patients had at least one contaminated blood culture specimen. This presents challenges in clinical decision making and increases risk and cost. Solution remains ED staff education and/or staffing the Pathology lab to draw the specimens.

Rapid Response and Code Blue Teams

ICU continues to lead, monitor and manage the Rapid Response and Code Blue Teams at UMC. Reports are reviewed monthly in Critical Care Committee meeting with Nursing and Quality Department. Goal is to increase utilization of Rapid Response Teams in order to decrease cardiopulmonary arrest episodes on the medical floors, and improve patient outcomes. Code Blue and Intubation practices have been modified during the Covid-19 pandemic to help improve outcomes and to protect healthcare providers.

Mina Yacoub, MD,
Chair, Department of Critical Care Medicine
December 11th 2020

Francis O'Connell, M.D., Chairman

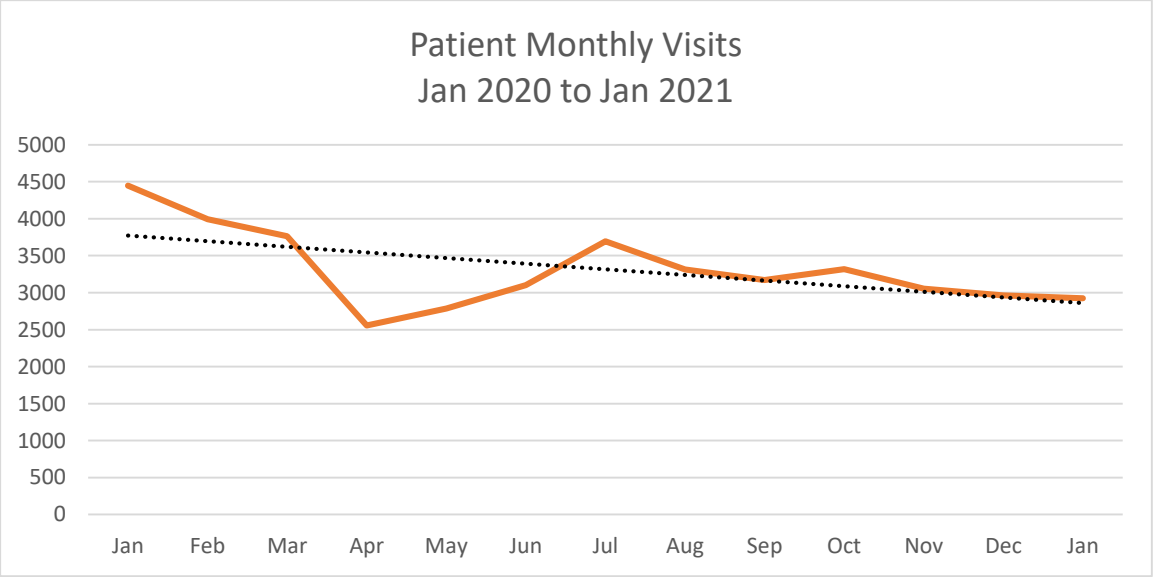
JANUARY 2021

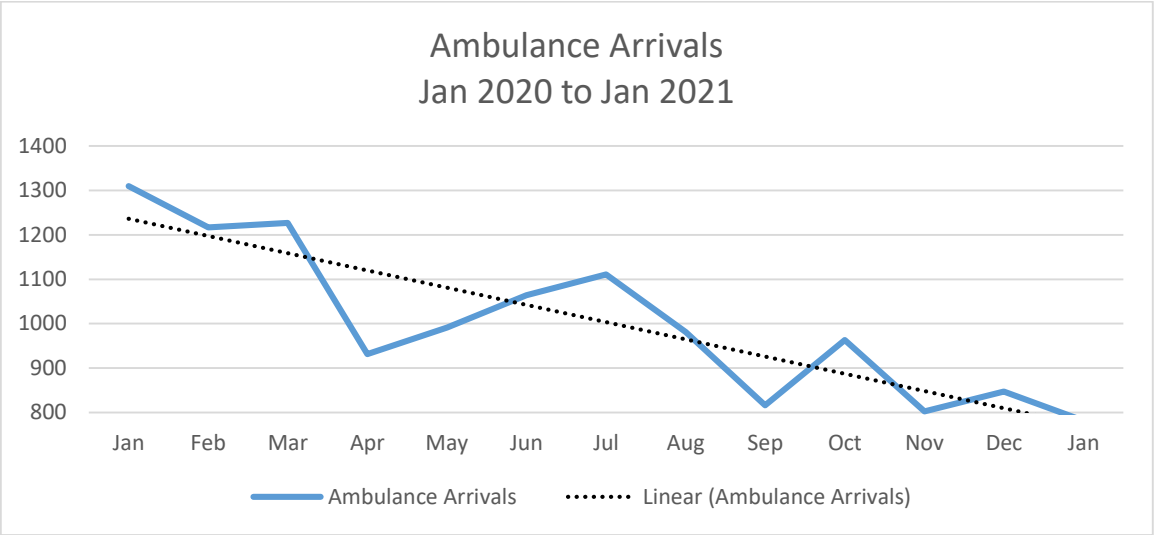
Enclosed is a summary of United Medical Center's (UMC) Emergency Department (ED) volume and key measures for January 2021. Also included are graphic tables to better highlight important data.

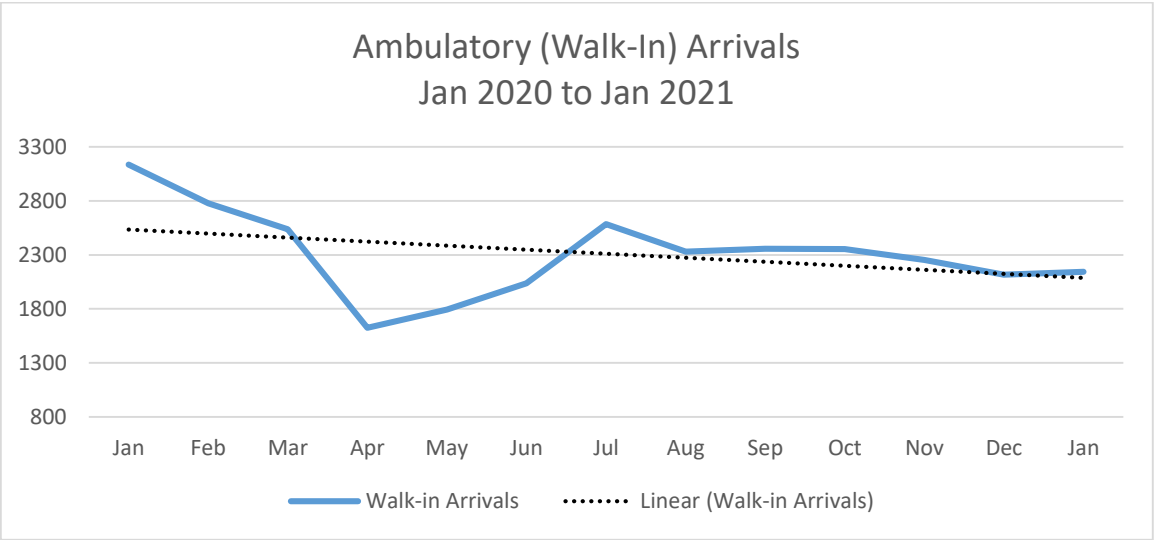
Data used for this and past ED reports was derived from Meditech (hospital EMR) raw data provided by hospital's IT department.

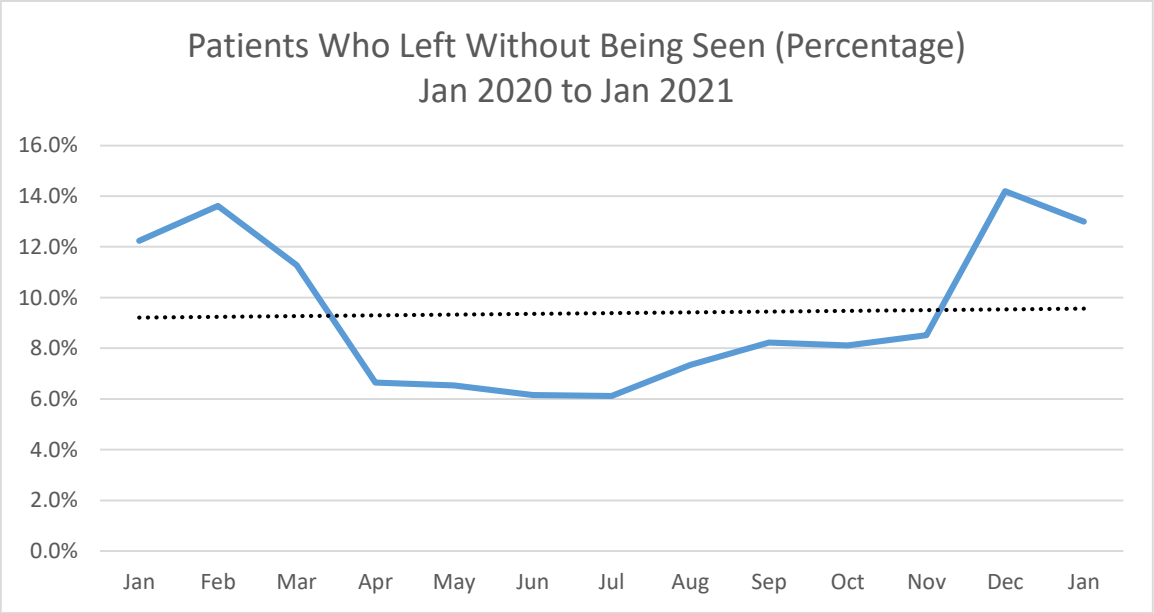
Definitions of the terms used in this report are as follows:

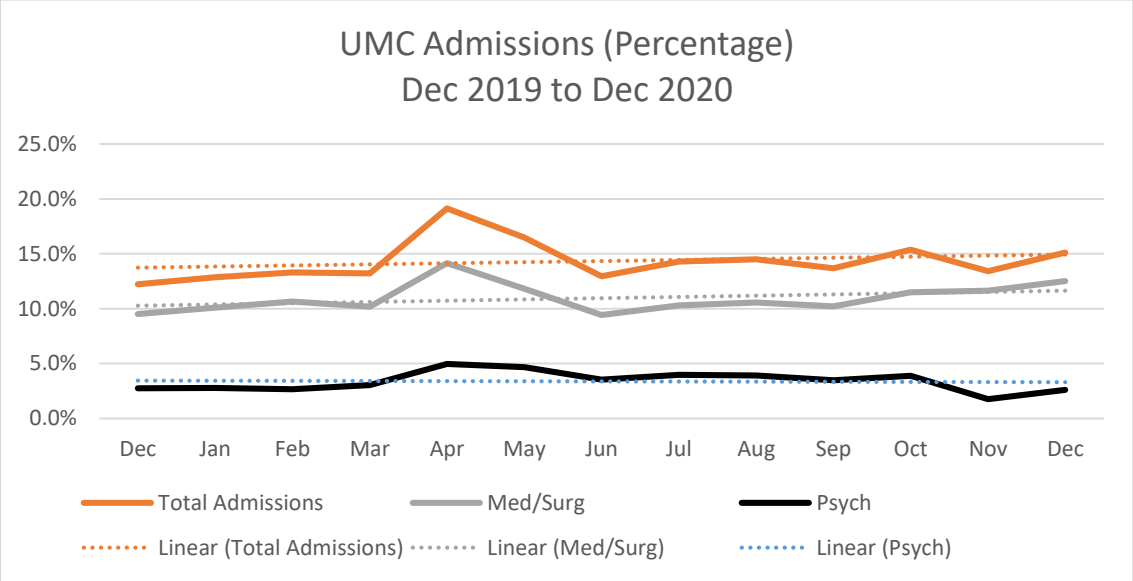
- **Total Patients**: number of patients who register for treatment in the ED
- **Daily Average Census:** total patients divided by days of the month
- **Ambulance Arrivals**: number of patients who arrive by ambulance
- **Admit**: number of admissions to UMC
    - **Med/Surg:** number of medical/surgical patients admitted (includes ICU admissions)
    - **Psych:** number of patients admitted to the behavioral health unit
- **LWBS:** Left without being seen rate is the number of patients who leave prior to seeing a provider and is made up of two categories: LAT and LPTT
- **Ambulance Admission Rate:** percentage of ambulance arrivals that are admitted
- **Walk-In Admission Rate:** percentage of walk-in patients that are admitted

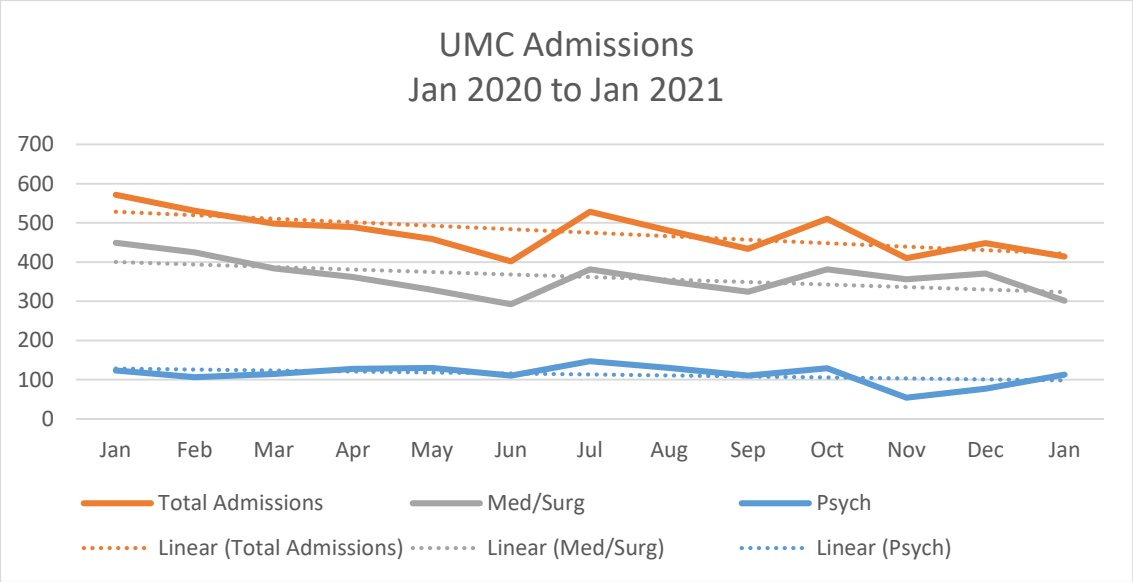



Ambulance Arrivals
Jan 2020 to Jan 2021
1400
1300
1200
1100
1000
900
800
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
Ambulance Arrivals
Linear (Ambulance Arrivals)


Ambulatory (Walk-In) Arrivals
Jan 2020 to Jan 2021
3300
2800
2300
1800
1300
800
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
Walk-in Arrivals
Linear (Walk-in Arrivals)


Patients Who Left Without Being Seen (Percentage)
Jan 2020 to Jan 2021
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan


UMC Admissions (Percentage)
Dec 2019 to Dec 2020
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Total Admissions
Med/Surg
Psych
Linear (Total Admissions)
Linear (Med/Surg)
Linear (Psych)


UMC Admissions
Jan 2020 to Jan 2021
700
600
500
400
300
200
100
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Total Admissions
Med/Surg
Psych
Linear (Total Admissions)
Linear (Med/Surg)
Linear (Psych)

Data tables:

ED Volume and Events - January				
	Jan 2020	**%**	**Jan 2021**	**%**
Total patients	4447		2925	
Daily Avg Census	143		94	
Ambulance Arrivals	1310	29.5%	781	26.7%
Admit	572	12.9%	414	14.2%
• Med Surg	449	10.1%	301	10.3%
• Psych	123	2.8%	113	3.9%
LWBS	544	12.2%	380	13.0%
Ambulance Admission Rate	29.8%		34.4%	
Walk-In Admission Rate	5.8%		6.8%	

Analysis:

1. The monthly census for Jan 2021 decreased slightly from the previous month and is down from the previous year.

2. The total number of medicine admissions in Jan 2021 is less than that of 2020. The percentage of admissions of med/surg and psychiatric patients rose slightly from the previous year.

3. The percentage of patients who left without seeing a provider (LWBS) remainder elevated. The LWBS continued to rise over the past 5 months.

4. The total number of ambulances coming to UMC declined from the previous month and continues to decline, approximately 40% down from the previous year.

5. Ambulance visits remains a large contributor to ED volume and admissions as more than one-third of patients who arrive by ambulance are admitted.

The two trends that are significant are the persistent decline in ambulance traffic and the elevated LWBS.

As noted in previous letters, most of the hospital admissions and approximately a third of the ED census are derived from ambulance traffic. Disruptions to ambulance traffic directly impacts the ED census and hospital admissions.

Throughput remains problematic in the ED because of the high levels of boarding. Because an inordinate number of beds are occupied by patients waiting to go to the ICU and inpatient units, ambulances do not have beds to offload patients and waiting room times increase. This leads to ambulances queuing resulting in DC and PG Fire and EMS rerouting ambulances away from UMC. The long wait times also lead

to patient dissatisfaction and premature departure from the waiting room (increased percentage of LWBS).

Hospital-wide nursing staffing shortfalls are likely contributory to the elevated LWBS rate. During the lowest LWBS periods, the hospital did not have nursing staffing shortages. A comparison of nursing staffing levels and the LWBS would be likely show that is the case.

With more robust and consistent nursing and tech staffing, throughput would improve, and ambulance rerouting periods could be avoided. With all other things remaining constant, the ED census will likely rise and the LWBS rate will decrease.

The goal remains to improve the Emergency Department throughput and the patient experience in the department. In order to do that, obtaining more data from the electronic medical record (EMR) to better identify and comprehend the areas in need of improvement are essential. Without a robust data analysis, we can only comment on noted trends and make broad, rather than targeted interventions to address the declining ED census and increasing LWBS rate.

We continue to support the efforts related to COVID patient visits over the last month.

Francis O'Connell M.D.
Chair, Emergency Medicine

Eric Li, M.D., Chairman

JANUARY 2021

MONTH	1
Reference Lab test – Urine Eosinophil (2day TAT) 90%	98% 82
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	100% 16/16
Review of Performed ABO Rh confirmation for Patient with no Transfusion History. Benchmark 90%	100%
Review of Satisfactory/Unsatisfactory Reagent QC Results Benchmark 90%	100%
Review of Unacceptable Blood Bank specimen Goal 90%	100%
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators Benchmark <90%	100%
Utilization of Red Blood Cell Transfusion/ CT Ratio – 1.0 – 2.0	1.1
Wasted/Expired Blood and Blood Products Goal 0	1
Measure number of critical value called with documented Read Back 98 or >	100%
Hematology Analytical PI Body Fluid	100% 16/12
Sickle Cell	0/0
ESR Control	100% 46/22
Delta Check Review	100% 297/297
Blood Culture Contamination – Benchmark 90%	100% ER Holding 90.6% ER 97.3 ICU
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%	93% ER 91% Lab
Pathology Peer Review Discrepancies	0/0 Frozen vs Permanent 0/2 In house vs consultation

LABORATORY PRODUCTIVITY RESULTS - We developed performance indicators we use to improve quality and productivity.

TURNAROUND TIME - Turnaround time is a critical factor that directly influences customer satisfaction.

CUSTOMER SATISFACTION - The key to business is providing great customer service, superior quality, and creating a unique customer experience.

COMPLAINTS - Complaints are an important metric for evaluating the quality of our laboratory processes.

EQUIPMENT DOWNTIME - It is important that laboratories track, monitor, and evaluate equipment failure rates and down time.

Eric Li, M.D.
Pathology Department

Shanique Cartwright, M.D., Chairwoman

JANUARY 2021

	UMC Behavioral Health Unit January 2021 Board Report												
Description		**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Admissions													
	ALOS (Target <7 Days)	4.63											
	Voluntary Admissions	31											
	FD12	83											
	Total Admissions	114											
	Average Daily Census	17											
Other Measures	**Average Throughput (Target: <2 hrs)**	4.2											
	# TeleCourt Meetings (Pt Hearings)	0											
	# Psych Consultations	94											
	Psychosocial Assessments (Target:	44%											
Discharge													
	Discharges	102											

Key - TBA - Data to be provided by Access.

Shanique Cartwright, M.D.
Department of Psychiatry

Riad Charafeddine, M.D., Chairman

JANUARY 2021

Exam Type	Exams (INP)	Units (INP)	Exams (ER)	Units (ER)	Exams (OUT)	Units (OUT)	Exams (TOTAL)	Units (TOTAL)
Cardiac Cath							0	
CT Scan	79		509		147		735	
Fluoro	19		1		25		45	
Mammography					92		92	
Magnetic Resonance Angio								
Magnetic Resonance Imaging								
Nuclear Medicine	11		1		5		17	
Special Procedures	13		0		4		17	
Ultrasound	63		180		135		378	
X-ray	196		828		438		1462	
Echo	52		26				78	
CNMC CT Scan			23				23	
CNMC X-ray			212				212	
Grand Total	433		1780		846		3059	

Quality Initiatives, Outcomes:

1. **Core Measures Performance**

   100% extracranial carotid reporting using NASCET criteria
   100% fluoroscopic time reporting
   100% presence or absence hemorrhage, infarct, mass.
   100% reporting <10% BI RADS

2. **Morbidity and Mortality Reviews:** There were no departmental deaths.
3. **Code Blue/Rapid Response Teams ("RRTs") Outcomes:** No code.
4. **Evidence-Based Practice (Protocols/Guidelines):**

Staff attention and PPE procedures for COVID -19 is regular. Most of Radiology full time staff has been vaccinated with initial Pfizer vaccine, and Moderna first dose at UMC.

Radiology protocols are being reviewed and optimized to reduce the need for repeat procedures if patients are transferred to other facilities.

Services:

MRI: The new uMR 570 United 1.5T magnet is here and set-up. The MRI services to be fully functional pending permitting from DCRA.

Fluoroscopy Philips bariatric table room completion is pending a dedicated humidifier. This is tailored to general diagnostic Barium exams mainly GI (gastrointestinal) applications, fluoroscopic radiological procedures, with added standing Chest Xray/exams options.

Nuclear Medicine: GE Discovery dual head camera provides wide range of exams, including cardiac software and SPECT applications is readily available.

Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues.

Riad Charafeddine, Chairman
Department of Radiology

Gregory Morrow, M.D., Chairman

JANUARY 2021

For the month of January 2021, the Surgery Department performed a total of 147 procedures. The chart and graft below show the annual and monthly trends over the last 9 calendar years:

	2013	2014	2015	2016	2017	2018	2019	2020	2021
JAN	173	159	183	147	216	155	210	195	147
FEB	134	143	157	207	185	194	180	167	
MAR	170	162	187	215	187	223	158	82	
APRIL	157	194	180	166	183	182	211	57	
MAY	174	151	160	176	211	219	186	74	
JUNE	159	169	175	201	203	213	177	126	
JULY	164	172	193	192	189	195	186	140	
AUG	170	170	174	202	191	203	193	161	
SEP	177	168	166	172	171	191	182	162	
OCT	194	191	181	177	214	211	175	146	
NOV	137	157	150	196	152	196	138	156	
DEC	143	183	210	191	153	192	156	146	
TOTAL	1952	2019	2116	2242	2255	2374	2152	1612	147

This month started the 2021 calendar year equivalent to where we left off in December 2020 and down 25% as compared to the same time last year. The Covid-19 pandemic continues to linger, but to a lesser extent yet still impacting outpatient procedure volumes. Our outpatient procedures have dropped in relationship to the inpatient volumes by 20%.

We will continue to monitor trends related to the Covid-19 pandemic and resurgence and institute additional measures, as necessary. We currently test all elective patients for Covid-19 on or within 72hrs prior to the day of surgery.

We continue to meet or exceed the monthly quality measures benchmarks outlined for the Surgery Department.

MEASURE	UMC	NAT'L AVG
1) Selection of Prophylactic Antibiotics	100%	92%
2) VTE Prophylaxis	100%	95%
3) Anastomotic Leak Interventions	0%	2.2%
4) Unplanned Reoperations	1.8%	3.5%
5) Surgical Site Infection	1%	4.8%

We will continue assess the data and make improvements where possible.

We are developing surgery specialty specific measures to support OPPE and the regularity with which these evaluations will be performed and reported.

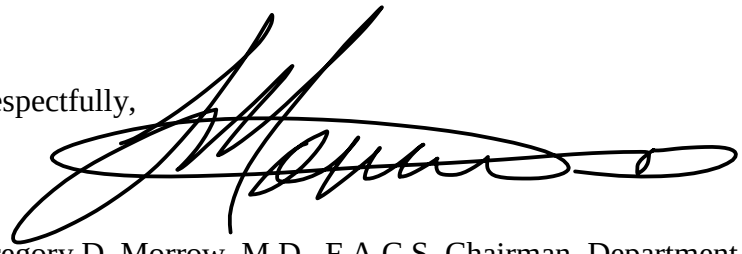
All educational conferences within the department continue to be held by Zoom conferencing and focused on Covid-19 updates and procedures for UMC.

With the New Year, Surgery and Perioperative services continue to evaluate how best to utilize our resources to respond to the anticipated surge of hospitalized patients in response to the Covid-19 pandemic and will continue to collaborate with other departments to formulate a comprehensive strategic plan.

Our reopening plan for the operating rooms for elective procedures has worked well and there have been no identified problems noted. We will continue to make modifications as information is updated. We continue to evaluate and modify how we manage Covid-positive patients to minimize exposure to the staff in all areas of the hospital.

We are currently working with administration to review, plan and realign our surgical services to make sure that we are focusing our resources in the areas that are most in need by the community. This means that we will be enhancing and complimenting some service lines, whereas others may be eliminated. We are evaluating and proposing revisions of the current physician contracts within the department.

Respectfully,



Gregory D. Morrow, M.D., F.A.C.S. Chairman, Department of Surgery

UMC
UNITED
MEDICAL CENTER

General Board Meeting Date:
March 3, 2021

CNO Report

Presented by:
Jacqueline Payne-Borden
Chief Nursing Officer

Nursing: Board Report
January 2021

The Not-For-Profit Hospital Corporation's FY 2021 Goals are grounded by the Quadruple Aims of Better Outcomes, Improved Patient Experience, Reduced Care Cost and Satisfied Providers. As such, the Nursing Administration/Patient Care Services report is guided by those principles and the hospital's mission, vision and values.

Nursing Administration/Patient Care Services

I. Better Outcomes Better Outcomes

- During the month of January, nurses and nursing personnel cared for over 2925 patients via Emergency Department visits, 403 admissions; of that 114 were behavioral health admissions. Of the 114 behavioral health admissions, 78 (68.4 %) were involuntary/FD12 status. A patient in FD12 status, initially at a minimum requires additional support such as a Sitter, Security, and more frequent nursing assessment. Eighty-one patients received hemodialysis in the Dialysis Unit. Overall, there were 177 dialysis treatments performed.

- The numbers in Table 1 does not reflect potential interhospital unit transfers.

Table 1. Number of Admissions Nov.20 - Jan. 2021

UNIT	Nov. 2020 Admissions	Dec. 2020 Admissions	Jan. 2021 Admissions
8W- Med/Surg/Telemetry	236	246	159
5W – Med/Surg	105	99	115
4E & 4W- Behavioral Health	54	81	114
ICU/Critical Care	14	18	15
Total	**409**	**444**	**403**

Data provided by UMC Analytics.

- Staffing challenges persists throughout the hospital units despite well-coordinated, routine, pre-scheduling six weeks staffing intervals. Factors such as staff absence due to illness, and staff call outs and hard to fill staffing vacancies such as the specialty areas and recently in the medical surgical areas. It is alleged that staff may be attracted to locations where premium pay rates are offered to care for covid-19 patients or attracted to facilities to administer Covid-19 vaccines. The hospital teams continue to attempt to recruit experienced staff for the specialty areas such as ICU/Critical Care, ED, and Dialysis.

Emergency Department

- The Emergency Department continues to be the natural hub of activities for the hospital. Over this past month the ED throughput and throughput hospital wide continues to be negatively impacted due to various barriers to include staffing, temporary closure of inpatient psychiatric services at certain area hospitals and frequent CPEP capacity. As a reminder, there are

approximately 13 hospitals in DC, at least 8 of the hospitals provide psychiatric service, of the 8 hospitals, 3 accept patients with a FD12 designation. United Medical Center is one of three hospitals that accepts patients with an FD12 designation.

- The following table provides insight into the activities of the ED and the beginning point of our throughput process. Every effort is made to expedite the throughput by addressing the needs of both medical staff and nursing personnel. The primary goal is to have adequate numbers of reliable and competent staff hospital wide to support our ED operations and hospital operations in general.

Table 2. Emergency Dept. Metrics FY21

ED Metrics Empower Data	Nov	Dec	Jan
Visits	3055	2968	2925
Change from Prior Year (Visits)	3883	4425	4451
% Growth	-27.10	-49.09	-52.17
LWBS	8	12	19
Ambulance Arrivals	802	849	781
Ambulance Admissions	258	305	281
Ambulance Patients Admission Conversion	0.31	0.36	0.36
% of ED Patients arrived by Ambulance	0.26	0.29	0.27
% of Ambulance Patients Admitted	0.31	0.36	0.36
Reroute + Diversion Hours	60	141	75

Data provided by UMC Analytics

Table 3. Emergency Dept. Metrics FY21

ED Metrics Empower Data	*Goal in Mins	Nov	Dec	Jan
Door to triage	30	19	33	35
Door to room	45	61	96	95
Door to provider	60	67	98	100
Door to departure	150	206	234	230
Decision to admit to floor	240	315	335	345

Data provided by UMC Analytics

***The goals in minutes are a national standard by the Emergency Medical Service (EMS)

Skin and Wound Care

- Our certified skin and wound care nurse work diligently with staff to improve, staff development, reinforcement of appropriate documentation, utilization of prevention equipment, supplies and wound prevention techniques. Many patients present with wounds on admission; however, the goal is to prevent further deterioration of wounds and most importantly for patients not to acquire any Hospital Acquired Pressure Injury (HAPI) wounds.

Table 4. Patients with wounds and unit.

	# Patients	# Pressure Injuries	# HAPIs
ICU/CCU	16	54	3
BHU	0	0	0
5 W	13	42	1
8W	12	28	2
Total	41	124	6

Data provided by Wound Care Specialist

Diabetes Center

- Diabetic Center Manager/Diabetic Educator continues to provide a range of service for patients and staff education. On an average, over 50% of our hospitalized patients have Diabetes Mellitus (DM) as their primary diagnosis or co-morbid diagnosis.

Table 4. Diabetes Metrics

	Nov-20	Dec-20	Jan-21	Total
Average # DM patients per work day	42	47	56	
Total DM patient days per month	753	840	1057	2650
Number patients with DM per month	228	237	226	691
Per Month % patients with Diabetes	74.27	63.54	63.84	67.21
Total Hospital Census	307	373	354	1034

- There were 26 patients who received an insulin drip – insulin given through intravenous route to decrease high blood glucose levels quickly and safely. A total of 194 insulin drips were administered for calendar year 2020.

- Audits are accomplished daily to monitor if the correct dose of subcutaneous insulin was given. Since the 95% target have been met and maintained; the frequency of audits was decreased from daily to every 3 days to ensure target is maintained.

Respiratory Department

- The new Respiratory Department Manager began this month. We are excited and fortunate to have Ms. Shay Bowie join our team. She comes to us from the MedStar Health System with many years of experience and leadership.
- The Respiratory Therapists are vital member of the Rapid Response and Code Blue lifesaving teams. As part of the department's performance improvement initiatives there are monthly audits of number of nebulizers ordered and given. The current performance rate remains at 95%.

Occupational Health

- Our Occupational Health Department continues to be vital to our hospital. The primary focus over the past several months were performing COVID-19 test and administration of the influenza vaccine. At the time of preparing this report, the compliance rate of staff receiving flu vaccine was 97%, the goal is 100%. Per Mandatory Influenza Vaccination

Policy IC6-08, staff who are not compliant by a certain date will voluntarily resign employment or voluntarily terminated their contractual relationship.

-

Table 5. Occupational Health Activities Dec. 2020-Jan. 2021

Month	Flu Vaccine	Pre-Employment Physicals	Annual Physical	COVID Testing	Back to Work Clearances	FIT Tests	Other Activities	Total
Dec.	89	12	7	473	18	21	7	627
January	18	21	5	241	25	37	14	361

Culture of Safety

- The hospital's Management Council which includes nursing services continues its proactive daily morning safety huddles. Potential safety risks are discussed in real time, are transparent, provide timely follow up and solutions.
- Nursing Administration/Patient Care Services continues a twice a day and as needed, throughput huddles to determine safe and effective movement of patients from admission, hospital stay and discharge. The Case Management Department works closely with nursing on these efforts.

Education/Training/Competency

- Each department has unit specific annual training or several spontaneous trainings depending on the needs. Training or refresher during this month included: Narcotic administration- pull, administer and waste time, PPE, Covid -19 precautions- BHU perspective, Alarm Management, and Wound Care and Prevention.

Covid-19 Vaccination Clinic

- Nursing Administration/Patient Care Services continues to provide nursing support for the Covid-19 Vaccination Clinic. Nurses are crucial to the clinic team as they administer the vaccines and assess vaccine recipients for untoward effects post administration.

- Three partner university's school of nursing students are scheduled to assist in the clinic. George Washington University nursing students has already commenced. Washington Adventist University and Trinity University will provide a few hours of support beginning in February.

II. Improve Patient and Customer Experience

- IPAD – in February, ICU will begin using IPAD technology for increasing communication with family members to include decision making as well as for families to have a visual of patients during pandemic. Information Technology (IT) is finalizing compatibility etc.
- Reinforce – Consistent Handoff report to support a smooth transition from staff to staff from department to department. These reports include - evaluation of patient's response to both nursing and medical interventions, effectiveness of plan of care, goals and outcomes.

III. Reduced Care Cost

- Members of the nursing and respiratory teams remain active participants in weekly Revenue Cycle and Initiatives Monitoring meetings to explore ways to accurately and timely capture deserved revenue and explore cost savings and effective initiatives.

- Participation in daily Multi-Disciplinary Rounds facilitated by Case Management to improve care, ensure appropriate discharge and limit patient hours in observation status amongst other patient centered activities.

IV. Satisfied Providers

- Routine ED Throughput meeting continue for collaboration, insight and solutions to issues ranging from staffing, IT and supplies.
- Awaiting ratification of the District of Columbia Nurses Association (DCNA) in order to begin implementation of example new nurse: patient ratios and increased compensation amongst other positive changes.
- Implemented a simple 11- item qualitative survey for nursing personnel with the aim of a better understanding of staffing on the units. The survey results will be shared at the next Board Meeting.

Respectfully submitted,
Jacqueline A. Payne-Borden, PhD, RN
Chief Nursing Officer

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General Board Meeting Date:
March 3, 2021

Executive Management Report

Presented by:
Colene Y. Daniel
Chief Executive Officer

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NOT-FOR-PROFIT HOSPITAL CORPORATION

Not-for-Profit Hospital Corporation
Executive Management Report & Accomplishments

February 24, 2021

Respectfully Submitted: Colene Y. Daniel

"If a man is called to be a street sweeper, he should sweep streets even as Michelangelo painted, or Beethoven composed music, or Shakespeare wrote poetry. He should sweep streets so well that all the host of heaven and earth will pause to say, here lived a great street sweeper who did his job well."
The Rev. Dr. Martin Luther King Jr.

January's Accomplishments

The NFPHC-UMC has been strategically focused on changing the culture at the hospital to achieve the Quadruple Aim. Each week the leadership addresses one of the Quadruple Aim: Better Outcomes, Improved Patient Experience, Reduce Care Cost, and Satisfied Staff and Providers. At the monthly Management Council and Medical Executive Committee meetings – each division is engaged to help drive change to foster positive disruptions or changes. People and quality go hand-in-hand. When led with quality, the employees and physicians respond because they, too, want to be exceptional in all that we do. Each day we look for problems, processes, or procedures to improve. At each meeting we ask everyone to think outside the box and be willing to accept and implement new ideas. The Executive Team has embraced the culture of safety, change, innovation, and employee and physician engagement in order to improve our quality of service and quality of care. The Executive Management Committee Tracking sheet highlights accomplishments for the month of January.

- COVID-19 Vaccination Clinic Call Center – The hospital telecommunication system was not equipped to handle the monumental increase in phone calls to register Ward 7 and Ward 8 residents for COVID-19 vaccines. Consequently, a call routing system was developed in order to correctly route calls directly to registration. Additionally, the Meditech schedule configuration was updated to track the complexity of scheduling Dose 1 patients and Dose 2 patients within the same time period.

- COVID-19 Training – the COVID-19 Team conducted training for the staff at UMC on a daily basis, as well as to staff of the DC Central Kitchen regarding COVID-19 vaccines for front-line staff while focusing on the safety and effectiveness of the vaccines in accordance with DC Health guidelines.

- As of January 6, 2021, UMC and DCNA concluded its bargaining and have come to agreement on all terms related to the employment for registered nurses. The final bargaining agreements were finalized have been presented to the OCFO and the Mayor's Office for review and approval. Once the bargaining agreements are approved, they will be presented to the Board for approval and then to City Council. We wish to thank Akia Embry for leading these efforts and the bargaining team of Dr. Payne-Borden, Teka Henderson, and Pavan Khoobchandani for their hard work and dedication. Additionally, we have completed negotiations for UFSPO, for the special police officers. The agreement was submitted to the OCFO and Mayor's Office for review and approval.

- We are in the final stages of negotiations with 1199 SEIU, our largest union, and expect to close out negotiations by the end of February.

- In response to the COVID-19 pandemic, UMC recognizes that there is an increased demand on employees to ensure around-the-clock patient care and employees may not be able to access Accumulated Leave consistent with normal operations. In addition, employees may have reached the maximum allowable Accumulated Leave, preventing them from accruing additional leave. Given these challenges, UMC, in accordance with HRD 05-001 and all applicable collective bargaining agreements, is approving a one-time cash payout option for Accumulated Leave to employees who have Accumulated Leave in excess of 240 hours. Any cash out under this option will require the employee to reduce their Accumulated Leave balances to 240 hours. There is no option for an employee to cash out a portion of their Accumulated Leave over 240 hours. The Executive Management Committee Tracking Sheet – January & February (Attachment 1)

Chief Medical Officer

The Chief Medical Officer report is submitted separately by Dr. William Strudwick.

Chief Nursing Officer

The Chief Nursing Officer report is submitted separately by Dr. Jaqueline Payne-Borden

Children's National Medical Center

UMC has updated the Purchase Service Agreement Exhibit B – Charge Master and provided a cost comparison to CNMC. UMC obtained several Fair Market Value (FMV) reports to provide CNMC with a FMV range of the rental rate per square foot. The rental rate and the proposed limits of employer liability are the last redlined item in the lease agreement.

Compliance

Achieving Quadruple Aim and Becoming a High Reliability Organization

- Conduct weekly, in-person training sessions in UMC auditorium in Leadership Formation Program regarding *Empathy and Understanding the Patient Experience*. Participants included staff from IT, Behavioral Health, Nursing, Security, Medical Affairs, and Food Service.

Patient Safety and Patient Satisfaction

- Prepare Staff and Patient Investigations Initiative.
- Address and resolve patient concerns regarding ED wait times with Patient Advocate from Hotline.
- Provide in-person support/assistance to ED patients regarding wait-times, registration concerns.

COVID-19 Vaccination Program – Education and Communication

- Prepare and present live, Zoom-based vaccination education program for DC Central Kitchen leadership and staff, in conjunction with Dr. William Strudwick and Dr. Maxine Lawson.
- Prepare revised Communications Plan for DC Health regarding hospital vaccine program.
- Provide daily education and updates regarding vaccine program, White House Pandemic Strategic Initiative at morning Safety Huddle.

- Conduct periodic rounding on floors to provide education and training to staff regarding vaccination program.
- Draft revised and updated Vaccine FAQs; place on hospital intranet, employee sign-in locations.

Compliance Program Assessment
- Prepare and complete compliance program training modules on fraud and abuse, medical documentation, and false claims.

Regulatory Compliance: Workers Compensation and Short-Term Disability
- Conduct review regarding hospital experience with WC and STD claims.

Implementation of Culture of Safety
- Draft Culture of Safety Implementation Plan, in conjunction with Dr. Shephard

Improving the Patient Experience: Patient Theft Initiative
- Initial research regarding program to address theft of patient valuables in order to reduce financial exposure (and related insurance claims).

Marketing and Outreach
- Prepare for and tape interview for inclusion in *Fraud, Waste and Abuse: Stark* course at Fordham Law School Master of Studies in Law program.

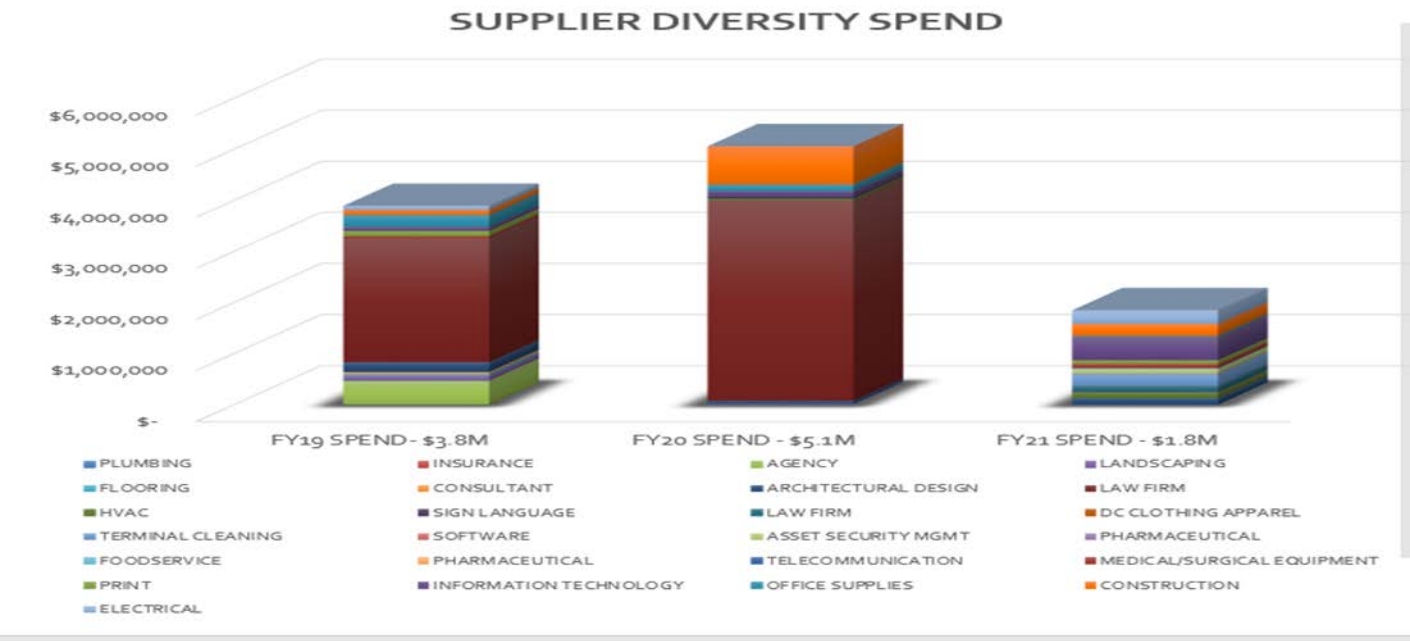
Contracts & Procurement

Procurement was able to carry the strategic sourcing into the new year despite the material challenges that are plaguing the world right now due to COVID-19. Procurement has implemented some great sourcing work the team is completing along with the more streamlined fulfillment processes and enhancement to our PAR Levels throughout the organization. This work has all been completed with the same number of resources from the start of the pandemic which is a testament to the team's overall commitment and agility to the organization during one of the worse times.

PPE PRICE COMPARISON

	DISTRIBUTOR PRICING (PRE-COVID)	COMPETITOR PRICING	MARKUP
ISOLATION GOWN	$ 0.51	$ 5.95	1067%
N95	$ 1.80	$ 4.70	161%
SURGICAL MASK	$ 0.20	$ 0.80	300%
SURGICAL GOWN	$ 0.44	$ 6.89	1466%
SHOE COVER	$ 0.06	$ 0.50	733%
HEAD CAP	$ 0.10	$ 0.52	420%
STETHOSCOPE	$ 1.95	$ 3.36	72%
FACESHIELD	$ 1.36	$ 4.75	249%

Hospital wide COTR training for the DSLBD website took place, which trained all COTR's on how to use their system to source for local businesses to conduct services with UMC. This training will help facilitate our goal of increasing our CBE/SBE spend for UMC. We have been able to integrate UMC procurement activities into Vizient supplier diversity programs, which will help us increase and track our local spend more efficiently. We are already trending at $2.1 million in Diversity spend for FY21, in the month of January we had $255K alone. Chart below.



Through our Vizient Achieve program we have been able to activate 51 contracts and generate a savings of $308K since the program started. We were also able to generate a new program which our mail room clerk manages called OptiFreight through Cardinal which has generated $69,656 in savings for Jan with all of our freight shipping expenses.

The Procurement Office initiated a new Monthly Operational Review (MOR) launched in July 2020 and continued the positive momentum with the team into January 2021. We have developed 10 strategic KPIs to measure team and individual performance throughout SPD, Materials Management, and Procurement. We are continuing to train the leaders of each KPI on how to measure each team's performance and expectations monthly to change the UMC environment into one of a continuous improvement mindset. We were able to identify some areas for improvement and initiated mini project teams to improve our metrics to better run the department and hospital. These initiatives are to create procedures for reporting claims to suppliers timely, managing our patient lost charges and report to nursing staff, and conduct working instructions for all procurement activities to enhance our business continuity. Our Material Management Department had 2% of complaints for all orders delivered to every department throughout the hospital in

Dec, which highlights their process assurance for the safety of patients and staff. Our Patient lost charges remain the same month over month, but this information is now shared with nursing staff and is an area we plan on attacking to reduce during Q1 2021. We have also introduced a new technology and started the contract process to fully integrate into Medi-tech. This technology JUMPTECH will provide our supply chain with the tools necessary to the real time reporting and analytics we need to work more productivity. It will also help our nurses more accurately charge patients for the supplies they are using on them. We were also able to complete the Cardinal supplier assurance glove program which holds Cardinal accountable for the quantity of gloves they keep in stock to deliver solely to UMC, this program will help with the market volatility.

We also received vendor contract finalized signature from Ramco and UMC a company that will enhance temperature screening processing into the hospital. IT and facilities are now in the implementation phase of the project with the vendor. The new temperature screening devices have the potential if implemented and utilized correctly to generate a $488K annually cost savings on labor, while also enhancing the employee screening and safety experience. With the increasing cases of Covid-19 and more and more vendors become stressed with PPE ordering we are happy we were able to acquire so much product early in the pandemic to ensure the safety of our employees and patients.

- Procurement Savings (Closed Book)
- CBE/Diversity Spend (Closed Book)
- Contracts & Agreements (Closed Book)
- Procurement Dashboard (Closed Book)

Corporate Secretary – VP of Community Affairs

The Corporate Secretary – VP of Community Affairs report is submitted separately by Toya Carmichael.

Facilities & Support Services

Environment of Care Key Initiatives:

1. Fire drill matrix inspection - Compliant
2. Fire door repairs – 60% complete
3. Ice Machine Weekly inspection – Compliant
4. Revised Exit Light Monthly Documentation- Compliant
5. H-Cylinder Storage Inspection Log- Compliant
6. Fire Door Functional Inspections – Compliant
7. IT Closet Floor Penetration Inspections – Compliant
8. ICU Depicted as a Suite on LS Drawings – Compliant
9. NO Exit signs posted - Compliant
10. Storage rooms door functional test – Compliant
11. Missing Ceiling Tile Inspections - Compliant
12. Storage less than 18 inches to sprinkler head – Compliant
13. Escutcheon Plate Inspections – Compliant
14. Hydrocollator Water Change Inspection – Compliant
15. Ceiling inspections – Compliant

16. BHU EVS Room Inspections – Compliant
17. BHU thermostat covers Inspections - Compliant

Grants

Currently, the Grants Team is focusing its efforts on outreach and community health. We are using the Mobile clinics as the key point of contact for more of our community members to access the high quality services that UMC has to offer.

Using funding provided by DC Department of Health, HIV/AIDS, Hepatitis, STD and TB Administration (HAH STA) and the District Housing Authority, we have been able to administer thousands of CODIV-19 screenings and hundreds of HIV tests over the past 6 months through our "Wellness on Wheels" campaign. These grant driven efforts have helped us build capacity to administer the COVID-19 vaccines to members of Ward 8 and Ward 7 communities.

We are currently looking to work with community partners to identify additional opportunities to administer a minimum of 100 vaccinations per week through our "Operation Community Immunity" campaign.

Additionally, our Ryan White Case Management and Health Education awards have recently renewed. We are working to develop plans for our mobile and community based programs to support the work we do in the area of HIV/AIDS treatment and prevention. Also, UMC's grant award for Opioid response has been renewed in the Emergency Department and has now been expanded to provide overdose response and services to in-patient services. We are in communication with program officials to explore providing these services in a mobile setting as well.

Human Resources

The Human Resource Report is submitted separately by Trenell Bradley. (Closed Report)

Information Technology

Applications

- Updated (multiple patches) 3M system software
- Successfully submitted eCQMs to CMS for Meaningful Use
- Created updated scheduling and registration screens for COVID vaccinations
- Supported clinical and registration staff for the COVID vaccination clinic
- Reconciled and sent daily electronic transmission/reporting of COVID vaccinations to Health Department
- Assisted Human Resources and Finance with year-end closing work in Meditech, including payrate adjustments, AL payouts, 1099's, and W2's
- Trained new nursing staff on Meditech
- Produced cost and other reports for Finance
- Updated and documented reports for Price Transparency
- Successfully serviced 74 Help Desk/Service tickets in January 2021

Infrastructure

- Applied security patches to servers and workstations
- Built additional Workstation on Wheels (WOWS) and remediated patient room televisions in preparation for re-opening of the 3rd floor
- Built and deployed additional workstations and printers for the COVID-19 clinic registration and scheduling staff
- Fixed reception issues for televisions in Radiology department
- Initiated/sent quarterly audit reports to department managers to validate end-user network access
- Maintained the 3rd floor disaster recovery replication of PACs, Exchange, and Pyxis systems
- Continued 24/7 network monitoring tools and services with Mazars' team
- Regularly monitored network and user traffic for potential security issues/attacks
- Resolved open issues to complete cooling for 5 network closets
- Decommissioned the 2008 Domain Controller
- Successfully upgraded the PACS Archive EA Test server
- Successfully serviced 298 Help Desk/Service tickets in January 2021

Operations

1. COVID19 Vaccination Clinic fully operational:
    a. Planning & coordination with DC Health & DCHA (include delivery, reporting & tracking of vaccine vials)
    b. Clinic operation activities
    c. Vaccination clinic expense tracking (staff, contract labor & supply expenses)
    d. Daily Reporting to HHS, DC Health, DCHA & Partner Hospital
    e. Tracking administration of vaccination staff, UMC Medical Staff, Community Providers
    f. Developed a new Automated Voice Call system for the Vaccination clinic to handle increase in volume of calls: (communicating hours of operation, notification services, etc.).
    g. Created a separate call line for cancellation/rescheduling of appointments
    h. Onboard & schedule Nursing students to assist in vaccination clinic
        i. HR Onboarding
        ii. IT Onboarding & Training
        iii. Relias Training
        iv. Nurse Training

2. UMC Mobile Clinic operations:
    a. Currently mobile clinic is operational 3 times a week providing the following:
        i. HIV Screening
        ii. HIV Testing
        iii. COVID19 Testing
        iv. Added additional point of care testing
    b. Starting in mid-January, mobile team is providing vaccine education and preparing to start vaccination administration to seniors in Ward 7 & 8.

   c. Coordination with senior community to schedule vaccinations for our patients in Ward 7 & 8.

3. AOC training & AOC binder preparation

4. DC HMC & DCHA – Emergency Management: January 6th Insurrection & January 20th Inauguration preparations

5. Grant Program Oversight & operations

6. Radiology: MRI & Fluoroscopy operations preparations; Registration/scheduling/billing setup.

7. Human Resources:
   a. Contracted with new staffing agency to provide ED & ICU nurses
   b. Weekly meetings with nursing leaders to track recruiting/onboarding of nurses and nursing staff.
   c. Leadership oversight during both Director & Manager absences
   d. Addressed labor relation issues with HR Labor staff & Security

8. Staff Recognition:
   a. Recognition for successful COVID19 Vaccination Clinic – Pharmacy, Registration/Scheduling, Nursing, IT, EVS, Materials Mgmt.

9. Screener Program Extension: extended screening staff with .5 Nursing FTE to provide coverage at all entrances (Main Lobby, ED, Security & MOB Entrances)

10. HR: Benefits Open Enrollment – 60% of eligible employees elected to enroll in Benefits compared to ~45% last year.

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
2021 Budget	Download Budgets – Premier	EMC Team	Downloading Hospital and Departmental Budgets is imperative to monitor spending and to hold departments accountable.	January 2021	
	***Meditech	EMC Team	***Marcela and Cheyenne shall review October, November & December expense spend and OT tracking.	January 2021	
COVID-19 Vaccination Clinic Call Center		William Strudwick Marcela Maamari David Parry	Update schedule configuration in Meditech. Implement Call routing system due to increase call volume.		Completed January 28, 2021
COVID-19 Training	DC Central Kitchen	William Strudwick Brian Gradle Maxine Lawson	Conduct Zoom based training to the staff of DC Central Kitchen regarding COVID-19 vaccines for front-line staff while focusing on the safety and effectiveness of the vaccines and in accordance to the DC Health's categories.	January – February 2021	UMC provided 4 one-hour zoom training sessions to DC Central Kitchen. Final session was February 4, 2021.
3rd Floor Opening		William Strudwick Fay Goode-Vaddy Ken Blackwell EMC Team	Per the DC Government's requirement – the hospital needs to relocate from the 8th floor to the 3rd floor.	Bio-Med move in – January 31, 2021 Clinical move-in-date – February 15, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
FEMA Money		Marcela Maamari Marlanna Dixon	Submission of expenditures and staffing expenses through December 2020	February 22, 2021	
Excel Pharmacy		Colene Y. Daniel William Strudwick Marcela Maamari Toya Carmichael		Marketing Meeting with Excel – February 9, 2021	Completed February 9, 2021.
DCHHA Vaccination Scheduling	Map out COVID-19 1st and 2nd Vaccination Schedule for health care workers	Colene Y. Daniel Marcela Maamari William Strudwick David Parry Toya Carmichael Vineela Yannamreddy	Map Out COVID-19 Vaccination Schedule – "MAP" second doses to ensure first doses are available for the following groups: • COVID-19 Clinic • DCHHA – Per The Final Plan • Mobile Van Unit	Meeting on February 11, 2021	
Relocate Case Management Office		William Strudwick Jacqueline Payne-Borden Ken Blackwell EMC Team	Relocate Case management office from the 5th floor to rooms 3 and 15 on the 3rd floor	February 11, 2021	
COTARS	Training for locating CBEs and Vendor Quotes	Tamika Hardy	• How to access system to locate CBEs • How to access system for vendor quotes	February 11, 2021 February 16, 2021	
3rd Floor Opening – Clinical Decisions		William Strudwick Jacqueline Payne-Borden Ken Blackwell EMC Team	Relocate ICU Director's office to the current case management office on the 5th floor. ICU Director's office to be the new tele monitoring room on 5W.	February 12, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
SNF	Closure	Marcela Maamari	Provide closure update	February 28, 2021 DC Health	
Fire Suppressant	Auditors, TJC, & CMS Requirement	David Parry Ken Blackwell	Must implement the correct Fire Suppressant in the Data Center – Review	On target to complete February 28, 2021	
Department of Behavior Health	Behavior Health Unit	William Strudwick Jacqueline Payne-Borden	There is a need to review the BHU staffing plan for Security	February 28, 2021	
Mobile Clinic Vaccination Project		Marcela Maamari Toya Carmichael	In partnership with DC Health & DC Housing Authority, vaccinate senior residents at two locations in Ward 6 & 8. Current grant provides funding for Mobile van on Tuesday's and Thursday's.	February 9, 2021 and throughout the month of February 2021	
Human Resources	Recruitment	EMC Team	• Medical Staff Director – • Infection Control Director –	In Progress In Progress	
Wound Care	Contract Review	William Strudwick Jacqueline Payne-Borden Lilian Chukwuma Colene Y. Daniel	Review the contract to provide additional support for the Wound Care Program: • Outpatient	February 28, 2021	
File Room	Review and modify HR's current File System	Marcela Maamari Tamika Hardy Ken Blackwell	Materials Mgmt. & Facilities assist with removing existing shelving and replace with new shelving to accommodate HR filing needs	February 28, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
Projects	Finalize the AOC Booklet & Training Program	Colene Y. Daniel Marcela Maamari	Write the AOC Program – Including Diversion	February 28, 2021	
	Emergency Management	Ken Blackwell	Finalize the Emergency Flip Chart	February 28, 2021	
	Building	Ken Blackwell	Fluoroscopy – Building Plans to open the units	February 28, 2021	
	Operations	Marcela Maamari	Fluoroscopy – Operational Plans to open the units	February 28, 2021	
Theft of Patient Valuables	The theft of Patient Valuables Plan is designed to address the high volume and value of claims that are being made against the hospital by patients for lost or stolen property.	Brian Gradle	Plan will include an assessment of current policy and practices; among the changes that are anticipated is replacement of lost or stolen items, and no longer reimbursement in cash.	February – March 2021	
Patient Safety and Abuse Initiative	The Patient Safety/Abuse Task Force will be comprised of representatives from Compliance, Risk Management, Human Resources, Quality. Security, Legal, Patient Advocacy,		Initiative will include new posters regarding use of Hotline for patient safety/abuse; whistle-blower protection for those that identify incidents; and additional training and education to managers and staff regarding patient safety and duty to report issue	February – March 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

	Nursing, Public Relations, and the medical staff, and will be directed by the Compliance and Risk Management Departments, who may add such additional members as deemed appropriate.				
Executive Rounding	Visit various departments to help assist with checklist for TJC	EMC Team	Provide updated department executive rounding assignment list.	March 1, 2021	
5W Tele Monitoring		Ken Blackwell	Establish approval for tele monitoring on 5W	March 2, 2021	
3rd Floor Opening		Ken Blackwell Fay Goode-Vaddy Quality	Walkthrough on 3rd floor to establish readiness for relocating 5W patients	March 7, 2021	
Relocation of 5W Patients		Ken Blackwell Fay Goode-Vaddy 5W Staff	Relocate 5W patients to 3rd Floor	March 8, 2021	
Installation of Tele Cables – 5W		Ken Blackwell Candace Brown	Begin installation of tele cables on 5W	March 9, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
CRISP	Regional Health Information Exchange	David Parry Mike Austin	Legal needs to renew contract that expired over 14 month ago	March 12, 2021	
Temperature Scanner Program – Electronic		Ken Blackwell	30-Day Trial	March 12, 2021	
Emergency Room	Glass Doors	Ken Blackwell	Work with Stanley regarding replacing/repairing ER glass doors	March 18, 2021	
Emergency Room	Bays	Ken Blackwell	Negative Room	March 18, 2021	
Projects	Building	Ken Blackwell	MRI – Building Plans to open the units	March 30, 2021	
	Operations	Marcela Maamari	MRI – Operational Plans to open the units	March 30, 2021	
	Building	Ken Blackwell	New Inpatient Pharmacy	March 30, 2021	
	Operations	Marcela Maamari Maxine Lawson	New Inpatient Pharmacy	March 30, 2021	
COVID-19 Budget		Marcela Maamari Lilian Chukwuma (Marlanna Dixon & Kim Bussie)	Retro/Ongoing	March 31, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
Tele Wiring – 5W		Ken Blackwell Candace Brown	Complete tele wiring for 5W	March 31, 2021	
Software Upgrade		David Parry	Merge PACs Software	March 31, 2021	
Staffing		Jacqueline Payne-Borden Fay Goode-Vaddy	Ongoing recruitment via HR for ED, ICU, BHU and Telemetry Nurses to reduce contractor costs.	April 1, 2021	
5W Tele Monitoring		Fay Goode-Vaddy Ken Blackwell Quality EVS	Walkthrough on 5W to determine operability of tele monitoring system.	April 1, 2021	
Facility Wide Steam Outage		Ken Blackwell		Spring 2021	
3rd Floor Patient Transfer to 5W		Fay Goode Vaddy 5W Staff	Transfer 5W patients from the 3rd floor back to 5W	April 5, 2021	
3rd Floor – 8th Floor Readiness		Fay Goode-Vaddy Ken Blackwell Quality EVS	Walkthrough on 3rd floor to establish readiness for 8th floor transfer	April 6, 2021	
Transfer 8th Floor Patients to 3rd Floor		Fay Goode-Vaddy Ken Blackwell Quality 8th Floor Staff	Transfer patients from 8th floor to 3rd floor	April 7, 2021	

FY 2021 Executive Management Committee Tracking Sheet
January & February 2021

Issue Identified	Plan Description	Responsible Exec(s)	Discussion	Date/Priority	Date Completed
TJC & CMS – Evidence of Standards Compliance	Complete the Fire Door Contract	Ken Blackwell Mike Austin	***The Fire Door Project must be started with a detail plan for completion	April 30, 2021	
Cintas Scrub Machine	Procurement	Tamika Hardy	Implementation of scrub machine for nursing and administration	April 30, 2021	
Kronos	***On-Boarding & Meditech	David Parry Marcela Maamari	Develop an On-Boarding Program	In Progress	
Auditors	Final Year-End Audit	Lilian Chukwuma Colene Y. Daniel EMC Team – as required	The final Year-End Audit must be completed over the next three (3) weeks.		
JUMP START	Inventory Software	Tamika Hardy David Parry Mike Austin	Management software to assist Meditech.	June 30, 2021	

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General Board Meeting Date:
March 3, 2021

Human Resources Report

Presented by:
Trenell Bradley,
HR Director

Human Resources Board Report

January 2021

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Trenell Bradley,
Human Resources Director
Wednesday, February, 24 2021

HUMAN RESOURCES UPDATES

- Cost of Living Adjustments (COLA) FY20
- CARES ACT, Corona Virus Relief Fund
- UNION NEGOTIATIONS for Collective Bargaining (1199 SEIU)
- UMC LOCAL HIRE PROGRAM (Ongoing)

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COST OF LIVING ADJUSTMENTS FY20

ANNOUNCEMENT

On January 29, 2021; UMC non-union employees received a Cost of Living Adjustment (COLA) of three percent (3%) that was effective October 1, 2019 as approved in the FY2020 budget.

The retroactive portion of the payment (October 1, 2019 to January 16, 2021) was paid as a lump sum.

CARES ACT, CORONA VIRUS RELIEF FUND

NEW PROCESS

UMC HR has partnered with finance, infection control, and occupational health to implement a process to track employees who are out on leave that is related to the corona virus.

Employees who either tested positive or are required to self-quarantine in response to COVID-19 exposure compensation is reimbursable according to the relief fund.

The process will require managers, UMC's infection control and occupational health departments to report employees time off for COVID-19 related absences. This reporting will be submitted to human resources and finance. Once human resources is notified of the absence, HR will contact the employees to provide information regarding, DC FMLA and workers compensation information when applicable.

In addition, the process will allow finance to submit the compensation information for reimbursement.

Collective Bargaining

UPDATES

SEIU

- UMC's largest union is reviewing the Hospital's economic proposal for employee wages. The bargaining team will meet on February 22, 2021 for the union's response.

DCNA

- Effective January 6, 2021, UMC and DCNA concluded its bargaining and came to tentative agreements on all terms related to the employment for registered nurses. The Collective Bargaining Agreement was submitted to the Finance Committee and OCFO on January 22, 2021.

UFSPO

- On December 22, 2020, UMC and UFSPO concluded its bargaining and came to tentative agreements on all terms. The Collective Bargaining Agreement was submitted to the Finance Committee and OCFO on January 22, 2021

UMC HIRE LOCAL PROGRAM

UPDATES

In January, UMC HR worked with DOES to review roles at UMC that could be supported through DOES programs with financial support.

UMC security officer role was identified as a position that properly aligns with the DOES's On-The-Job Training Program.

The Director of Safety and Security has agreed to undergo the orientation and training for the program and to conduct a virtual site visit.

Human Resources will support security with developing a training program. The program provides financial support for up to six months while the employee is in training.

TALENT ACQUISITION/RECRUITING

UPDATES

HR is working with Public Relations to get all open positions posted on UMC Website. The new website will allow employees to apply to open positions directly from the hospital website.

The following are a list of open positions at UMC:

OPEN POSITIONS

As of February 10, 2021

EMERGENCY DEPARTMENT	
Position Title	**FTEs**
Registered Nurse	4 FTE
Emergency Room Tech II	3 FTE
Emergency Room Tech I	1 FTE
Patient Sitter	4 FTE
Peer Recovery Coach	1 FTE
CARE MANAGEMENT	
Case Manager	2 FTE
Social Worker	3 FTE
Social Worker II	1 FTE
INTENSIVE CARE UNIT	
Registered Nurse	6 FTE
TELEMETRY	
Registered Nurse	7 FTE
NURSING ADMINISTRATION	
Licensed Practical Nurse	4 FTE
OFFICE OF THE GENERAL COUNSEL	
Staff Assistant	1 FTE
Corporate Paralegal/Contracts Administrator	1 FTE
MEDICAL SURGICAL	
Registered Nurse	2 FTE
Monitor Tech	4 FTE
Unit Secretary	2 FTE
Medical/Surgical Tech	2 FTE
BEHAVIORAL HEALTH UNIT	
Registered Nurse	2 FTE
Psychiatric Tech	1 FTE
Clinical Social Worker	1 FTE
RADIOLOGY	
MRI Technical Aide	1 FTE
MRI Technologist	1 FTE
CLINICAL LABORATORY	
Phlebotomist	5 FTE
TOTAL COUNT:	**59 FTE**

STAFF COMPOSITION – JANUARY 2021

Employee Data				
Employee Data by Group	**# of EEs**	**DC**	**Ward 7**	**Ward 8**
Total FTE	694	172	58	85
Total Active Employees (Full-time, Part-time, and relief staff)	848	189	59	95
Total Union (Active EEs)	521	123	40	60
Total Non-Union (Active EEs)	327	66	19	35

Employee Demographics								
Age (Average)	50 Years Old	Race	African American 85%	Gender	Female - 70%	Male – 30%	Average Tenure	9 Years

Union Data				
Total Active Union EE by Group	**# of EEs**	**DC**	**Ward 7**	**Ward 8**
Total Active Union EEs DCNA	198	14	2	7
Total Active Union EEs SEIU	286	95	34	47
Total Active Union EEs UFSO	27	11	4	5

UMC Annual Turnover (YTD)			
	UMC Rates	NE Region	National Average
Hospital Turnover	8.5%	16.2%	17.1%
RN Turnover Rate	5.1%	15.9%	15.9%

The Hospital FY20 turnover rate is significantly below the national and northeast region averages according to the 2020 Nursing Solutions National Health Care Retention & RN Staffing Report.

TALENT ACQUISITION/RECRUITING

New Hires (Year to Date)												
Department Name	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
4W Psych Unit		1	-	-	-	-	-	-	-	-	-	-
5W Med/Surg.		2	-	1	-	-	-	-	-	-	-	-
8W Telemetry		1		1								
ER Admission (OCFO)		1	-	-	-	-	-	-	-	-	-	-
Care Management		-	3	-	-	-	-	-	-	-	-	-
Central Scheduling		-		-	-	-	-	-	-	-	-	-
Clinical Lab		2	1	1	-	-	-	-	-	-	-	-
Critical Care Unit	1	1	-	-	-	-	-	-	-	-	-	-
Emergency Dept.	4	5	1	.8	-	-	-	-	-	-	-	-
Environmental Svs.		-	-	-	-	-	-	-	-	-	-	-
General Counsel		-	-	-	-	-	-	-	-	-	-	-
Hospital Admin		-	-	.1	-	-	-	-	-	-	-	-
Health Info Mgt.		-	-	-	-	-	-	-	-	-	-	-
Information Tech		-	-	-	-	-	-	-	-	-	-	-
Medical Affairs		1	-	-	-	-	-	-	-	-	-	-
Nursing		-	-	-	-	-	-	-	-	-	-	-
Nursing Admin		-	-	-	-	-	-	-	-	-	-	-
Office of the CFO	2	-	-	-	-	-	-	-	-	-	-	-
Operating Room		-	-	-	-	-	-	-	-	-	-	-
Patient Care Center		1	-	-	-	-	-	-	-	-	-	-
Pharmacy		-	-	1	-	-	-	-	-	-	-	-
Surgery		-	-	1	-	-	-	-	-	-	-	-
Radiology/MRI/Cat		3	1	-	-	-	-	-	-	-	-	-
Respiratory Therapy	1	-	-	1	-	-	-	-	-	-	-	-
Security		-	-	1	-	-	-	-	-	-	-	-
Telecom		-	1	-	-	-	-	-	-	-	-	-
Totals	8	18	7	16	-	-	-	-	-	-	-	-

New Hire Positions – January 2021		
Department	Position Title	Number
Clinical Lab	Phleb/Access Tech	1
Emergency Department	Benefit Ineligible RN	2
Emergency Department	Clinical Nurse	3
Emergency Department	Emergency Room Tech	1
Emergency Department	Patient Sitter	2
Primary Care Clinic	Medical Assistant	1
8W Telemetry	Clinical Nurse (Rehire)	1
5W Med/Surge	Med Surge Tech	1
Pharmacy	Pharmacy Ops Mgr.	1
Respiratory	Respiratory Care Mgr.	1
Security	Special Police Officer	1
Hospital Admin	Sr. Administrative Asst.	1
	Total	**16**

OFFICE OF THE CHIEF FINANCIAL OFFICER – Jan 2021		
	Total	**0**

January UMC New Hire Residence	
Residence	Number
Washington, DC	**0**
Washington, DC Ward 7	**3**
Washington, DC Ward 8	**1**
Maryland	**12**
Virginia	**0**
Totals	**16**

January OCFO New Hire Residence	
Residence	Number
Washington, DC	**0**
Washington, DC Ward 7	**0**
Washington, DC Ward 8	**0**
Maryland	**0**
Virginia	**0**
Totals	**0**

SEPARATIONS

Separations (Year to Date)												
Department Name	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
CCU/ICU		-	-	-	-	-	-	-	-	-	-	-
4W Psych Unit		1	-	.1	-	-	-	-	-	-	-	-
5W Med/Surg		1	-	-	-	-	-	-	-	-	-	-
8W Tele/Med		-	-	.1	-	-	-	-	-	-	-	-
Emergency Dept	2	-	1	-	-	-	-	-	-	-	-	-
Clinical Lab		-	-	-	-	-	-	-	-	-	-	-
Office of CFO				1								
Centralized Sched (OCFO)		-	1	-	-	-	-	-	-	-	-	-
Respiratory Therapy	1	-	-	-	-	-	-	-	-	-	-	-
Risk Mgt		1	-	-	-	-	-	-	-	-	-	-
Human Resources		-	1	-	-	-	-	-	-	-	-	-
Bio Medical Eng		1	-	-	-	-	-	-	-	-	-	-
Skilled Nursing Facility	2		78	-	-	-	-	-	-	-	-	-
Totals	5	4	81	3	-	-	-	-	-	-	-	-

Involuntary Separations (Year to Date)												
Department Name	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
Environmental Services	-	-	-	-	-	-	-	-	-	-	-	-
Emergency Dept.	-	-	-	-	-	-	-	-	-	-	-	-
Primary Care (MOB)	-	-	-	-	-	-	-	-	-	-	-	-
ICU	-	-	-	-	-	-	-	-	-	-	-	-
8W Med/Surg	-	-	-	-	-	-	-	-	-	-	-	-
5W Med/Surg	-	-	-	-	-	-	-	-	-	-	-	-
Resp. Therapy	-	-	-	-	-	-	-	-	-	-	-	-
Skilled Nursing Facility	-	1	78	-	-	-	-	-	-	-	-	-
Medical Lab	-	-	-	-	-	-	-	-	-	-	-	-
Special Police	-	-	-	-	-	-	-	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	-	-	-	-	-	-
Nursing Administration	-	-	-	-	-	-	-	-	-	-	-	-
Communications	-	-	-	-	-	-	-	-	-	-	-	-
4W BHU	-	1	-	-	-	-	-	-	-	-	-	-
Radiology	-	-	-	-	-	-	-	-	-	-	-	-
Totals	-	2	78	-	-	-	-	-	-	-	-	-

UMC
UNITED
MEDICAL CENTER

General Board Meeting Date:
March 3, 2021

VP of Public Relations/ Corporate Secretary Report

Presented by: Toya Carmichael
VP Public Relations/ Corporate Secretary

UMC
UNITED
MEDICAL CENTER

NOT FOR PROFIT HOSPITAL CORPORATION

CORPORATE SECRETARY REPORT

TO: NFPHC Board of Directors

FROM: Toya Carmichael
VP Public Relations / Corporate Secretary

DATE: February 16, 2021

GENERAL UPDATE

During the month of January, the PR team continues to support the Vaccination Clinic and Mobile Unit by creating and distributing content educating the public about the vaccine and encouraging members of the public to get vaccinated when they are able. We also continued to foster new relationships with community organizations seeking to partner with our mobile unit and/or provide services inside the hospital to our patient community.

COVID COMMUNITY SUPPORT

During the month of January UMC received donated meals from All Purpose Pizza and a small financial donation from a private donor who wanted to show appreciation for the wonderful treatment they received during their vaccination visit. The funds were used to purchase lunch for the vaccination clinic team from a small DC based CBE caterer.

PUBLIC RELATIONS

Weekly Newsletter – Distributed bi-weekly on Friday via all staff email and included on UMC website. During the month of January, the UMC Newsletter re-introduced the Quadruple Aims to the hospital staff, celebrated the success of our vaccination clinic, and provided tips for how to get/stay healthy in the new year. If Board members would like to include a special note, article, or upcoming event please submit to the PR team.

News Media– The PR team continues to track news articles and social media mentions which are now listed in the bi-weekly newsletter. UMC appeared in seven news articles in the month of January. We were also represented by Dr. Strudwick and nurse Patricia Cummings on two separate episodes of WIN TV with the Washington Informer. UMC had weekly visits from media outlets around the world including the Netherlands and Canada.

Important Dates- March 4, 2021, Performance Oversight Hearing – DC Council Committee on Health.

UMC
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General Board Meeting

Date: March 3, 2021

Performance Improvement Committee Report

- **Last meeting was held on Tuesday, February 16, 2021.**

NFPHC Performance Improvement Committee
(Quality and Safety)
February 16, 2021 | 4:00 – 5:30 pm| Conference Call & Zoom Meeting

AGENDA ITEMS

1. Call Meeting to Order

2. Approval of the Minutes (January, 2021)

    - October 2020 – Pg. 5
    - January 2021 – Pg. 12

New Business – Hospital-Wide Programs

~~3. Emergency Department Report – Dr. Francis O'Connell and Teka Henderson~~

4. Provisions of Care, Treatment & Services Report – Dr. Jacqueline Payne-Borden
    - Improvements with Patient Care **(Attachment 1, Pg. 20)**
    - Staffing and Recruitment Updates
    - Occupational Health – Flu Vaccine Report **(Attachment 2, Pg. 22)**

~~5. The Safety Culture Action Plan & Training & Education – Dr. Isabel Shepard~~
    - ~~Safety Culture Education with all staff – quarterly training at the Management Council.~~
    - ~~Departmental audits to review the patient safety and medication safety information.~~
    - ~~**Safety Survey included for reference on Pg. 64**~~

6. Compliance Report – Brian Gradle **(Attachment 3, Pg. 23)**

7. DC Health Hospital Survey Readiness – Dr. Isabel Shepard
    - Action Plan for the upcoming hospital survey. (Window begins February onwards)

COVID-19 Reports

8. COVID -19: Monoclonal Antibody-Bamlanivimab Treatment for seniors – Dr. William Strudwick & Maxine Lawson - Updates

    The NFPHC-UMC under the leadership of Dr. William Strudwick and Dr. Francis O'Connell will provide the Monoclonal Antibody-Bamlanivimab, treatment in the Emergency Department. NFPHC-UMC as required has partner with three locations:
    - Transitional Care Center Capital City
    - Jeanne Jugan Residence/St. Joseph
    - Serenity Nursing Home

9. COVID-19 Vaccination Report – Dr. William Strudwick **(Attachment 4, Pg. 26)**

Standing Reports – Old Business

~~10. Quality Assessment Performance Improvement (QAPI) Department Reports and Quality Dashboards – Dr. Isabel Shephard~~

- ~~January Reports **(Attachment 5, Pg. 28)**~~

11. Pharmacy – Maxine Lawson **(Attachment 6, Pg. 43)**

~~12. Patient Experience/Patient Advocacy – Denise Vernon~~

- ~~Press Ganey Report **(Attachment 7, Pg. 52)**~~
- ~~Management Council January Presentation – Management Council with Patricia Cummings~~

13. Safety & Security Report and Fire Drill Matrix Report – Derrick Lockhart **(Attachment 8, Pg. 58)**

14. Facilities & Support Services – Ken Blackwell
    - Utility Report – Ken Blackwell **(Attachment 9, Pg. 62**)

Environment of Care Key Initiatives: January 2021 – Ken Blackwell

1. Fire drill matrix inspection - Compliant
2. Fire door repairs – 60% complete
3. Ice Machine Weekly inspection – Compliant
4. Revised Exit Light Monthly Documentation- Compliant
5. H-Cylinder Storage Inspection Log- Compliant
6. Fire Door Functional Inspections – Compliant
7. IT Closet Floor Penetration Inspections – Compliant
8. ICU Depicted as a Suite on LS Drawings – Compliant
9. NO Exit signs posted - Compliant
10. Storage rooms door functional test – Compliant
11. Missing Ceiling Tile Inspections - Compliant
12. Storage less than 18 inches to sprinkler head – Compliant
13. Escutcheon Plate Inspections – Compliant
14. Hydrocollator Water Change Inspection – Compliant
15. Ceiling inspections – Compliant
16. BHU EVS Room Inspections – Compliant
17. BHU thermostat covers Inspections - Compliant

Facilities: January 2021 Project Updates

Project	Status	Targeted Completion Date
IT Closets	80 % complete. The project is progressing as planned. Two additional closets were added which increased the targeted completion date.	March 31, 2021
MRI	75% complete. The project is moving as planned. The mobile unit was delivered. However, we've had to amend the current permit to	March 31, 2021

	include the required work within the mobile unit. Amended permit submitted, awaiting a response from DCHA.	
Pharmacy	Certificate of Occupancy Received. Punch list Created.	March 31, 2021
Fluoroscopy	98% Completed. Application for the Certificate of Occupancy is in preparation.	February 28, 2021
Data Center	60% of the FM 200 unit Suppression unit has installed.	February 28, 2021
Fire Door Repairs	60% completed which includes all fire doors on floors 8 – 4.	March 31, 2021
Chiller #1 Replacement	New chiller was ordered in November with a 20 lead time.	March 31, 2021
9 Air Handler Unit Replacements	Award was issued on 6/19. Upon final approval by DC Council, we anticipate the project to last 7 to 8 month.	.TBD
3rd Floor Reopening	Telemetry Equipment Installation	Completed
5th Floor	Telemetry Equipment Installation	April 7, 2021
Kitchen Cart Wash	Assigned To Architect preparing to reapply for DCRA permit.	TBD
Materials Management	Design phase completed. New shelfing was installed as a part of the Pharmacy project	TBD

15. Information Technology: Key Performance Improvement Initiatives – David Parry

- Cures Act – Expansion of clinical information on patient portal (April 5, 2021)
- CMS ADT notification to providers (May 1, 2021)
- Authorized end-user audits – quarterly validations to ensure only authorized users have UMC
- system access (initial - March 1, 2021)
- Pharmacy Drug Database Upgrade to improve charges and clinical interaction checks (April 1 2021)
- Patient and family video conferencing – Enable for ICU patients (March 1 2021)

Reports – Standing Reports have been updated and are attached for your perusal and the Team is ready to address questions.

16. Hospital Licensure/Survey/Accreditation Activities for 2021

17. The Joint Commission – Ken Blackwell, Sylvia Clagon, and Dr. William Strudwick
    The SAFER Matrix Monitoring Sheet and monthly monitoring is to ensure all corrections are in compliance. **Pg. 125**

Closed Session

~~18. Risk Management Report (RCAs) – Dr. Isabel Shepard~~

19. Adjournment

NFPHC Performance Improvement Committee

(Quality and Safety)

October 23, 2020 | 1530pm | Conference Call

Meeting Minutes

Attendees:
Directors - Dr. Fair, Dir. Gorham, Dir Ashenafi,
UMC Staff – Colene Daniel**,** Toya Carmichael, Brian Gradle, Dr. Shepard, Ken Blackwell, Alfea Leyva, Dr. Jacqueline Payne Borden, Denise Vernon, Dr. Lawson, Missi Sylvain, Derrick Lockhart

Call to Order	Meeting called to order 3:34pm by Dr. Fair	
Agenda Items		Action Item
Meeting Minutes	Motion to approve minutes by Gorham, 2nd by Ashenafi, unanimous vote.	
Meeting Discussion	***Accreditations, Audits, Surveys & Inspections – Colene*** • Boiler inspection almost finished just waiting for certification from downtown. • Audits are still ongoing Lillian is tied up today with the auditors. • JC should be here on or after November 2nd. • Nuclear regulatory commission may be delayed, they want to come out at the same time as the MRI, etc. and sign off on the CAT Scan at the same time. • Isabel has been working hard on the Leapfrog so we should be ready for submission by December. ***FY21 Goals and SMART Objectives – Colene*** • The attachment 1 says how we are going to do that. The only change that has been made is #9 transition for the new facility so we think it is a little premature for that so we now have 10 goals	

	instead of 11 and we will review these with the Executive team on Monday and we will have the goals ready to submit for the next meeting. • Dr. Fair asked if these goals are the same as the ones included in the MAP? • Colene said yes, these are new goals but they went to the Board during the retreat. • Colene noted the new goals that have been added. (Continued regulatory compliance, enhancing patient experience, increase community engagement, expand supplier diversity, maintaining infrastructure, improve employee and clinician engagement) *Emergency Department Update – No one on the line to report out.* ***FY21 Regulatory Calendar – Isabel*** • The calendar started in January and we may have to add on. • We are in the process of closing down the SNF but the inspection is still on the calendar since we are still going through the closure process. • January-February 21 FTA yearly survey, cap and aabb 2021 Cleya February-March • Calendar list the frequency of the inspection. ***COVID-19 – Colene*** • Wanted to make sure the committee is aware of the changes. The first is we monitor everyone's temperature and ask questions and if the temp is over 100 they have to be sent home. • Cloth face mask in the hospital are no longer allowed and everyone has to have an N-95 masks. In patient areas you have to have googles or a face shield and we are handing out both • Mandatory requirement for all employees to have a flu shot. Last Colene heard we are at 30%. • Dir. Ashenafi asked if we have a flu shot goal? Colene said it is 100% which is required by DC Health. If employees don't have a flu shot by December 31st they are not allowed to come back to work. • Dr. Fair asked if we are having resistance to temperature checks or hospital masks. Colene said no in terms of temperature checks but some people do not want to cover up their fashion masks. DC Health said the reasons for the hospital masks is that some people are not washing their cloth masks before they come into the hospital. • Dr. Fair asked if there are discrepancies between the text in the agenda and the attachment? Colene said no we can just use the agenda and can take attachment out.	Toya to create a table of contents for the pdf document.

Monthly Reports & Updates

Regulations & Accreditation Visits – Isabel

- Went over the QAPI Tracker which now shows the averages between May-July and she will now be reporting monthly as well.
- For the last two months, everyone is working really hard. Directors are following through on the low percentages and have submitted their plans going forward.
- Dashboard – The colors were changed slightly so it is more legible. Focused on Sepsis and Reconciliation. We just dipped down to 80% for September in August we were at 83.3. We were two months behind but now we are on track and we have trended up about 6% since earlier this year which Isabel expects to continue.
- We received 100% for the random audit in the ER with the bundle for 1,3,6 hours.
- Out of 14 cases 4 pass 5 failed. They were looking at improving initial fluid, repeating the fluid volume, and repeated acid level.
- Dr. Fair asked if the report is internal or shared externally?
  Isabel said no it is shared with CMS and available for anyone to see so that is why it is so important because we do not want patients to feel like they will die of Sepsis.
- Dr. Fair asked how can we tell from the dashboard if we are doing well or not doing well?
  Isabel responded that the dashboard just identifies what we had, in August we did not have any but we only had 7 patients. This is just our internal data.
- Dr. Fair stated, she thinks it would be helpful to know what the target is, it seems concerning that half of the cases failed but Dr. Fair doesn't know what that means when compared to other hospitals.
  Isabel said she will meet and work with Colene to report out how we compare nationally.
  Colene said we will also check in with Dr. Yacoub and find out what he wants to do because Sepsis is really important to him.
- Dr. Fair said that half of the cases failed in terms of the chart revenue but what does it look like in real time? Isabel said in the ED when they did their extraction they are looking at the five areas as well (asked for time to pull out the five areas and report out before the conclusion of the meeting).

Safer Matrix – Ken Blackwell

- We have made great strides. Only outstanding we have is leadership and turned it over to Colene for detailed report.
- LD.03.06.01 – Colene noted that we are working on staffing and our specialty departments, ICU, Dialysis and ER. Overall we are fine and med surge we are fine right now.

	• Dr. Jacqui added Med Surge is fine. • Ken added that under low wide spread, staff education- the form needs to be updated to add completion field, he needs to get validation from IT that this was completed. ***Infection Prevention & Control – Ken Blackwell*** • Happy to report that at the beginning of this particular survey there were a lot of findings. Quite challenging as well because of the stage of the building and trying to bring things in compliance. From a facilities perspective we have completed all of our outstanding items. The only item is on page 3 of the report, HR.01.05.03 which is ongoing and will be updated next month as we get more clarity from HR. • Under the high IC.01.03.01 had to do with dialysis and according to Ms. Clagon that was completed as of 10/15. There are no other open non-compliant standards in the report. ***Quality Assessment Performance Improvement – Isabel provided the report during last month's meeting.*** ***Sepsis Detail Report – Isabel*** • Sepsis screening was completed on July 30th so the Press Gainey will be different now that we have implemented the safety nets so everyone knows what the next steps are. …. looking at lactic acid, getting their labs, etc. in August we had 90% and in September it was 100% so 10/10 so they are doing daily education and real time catches for the Sepsis. Isabel will meet with Colene and Dr. Yacoub to reflect what we are actually doing. • Dr. Fair asked if the ones that went to Press Gainey where half passed and half failed is old data? Isabel yes we don't do that Press Gainey just goes into our charts…for the next few reports when we get them she will share so we can compare them to our internal audit. • Dr. Fair asked in general how are the Sepsis bundles going? Colene stated the last critical care report that went out on Monday to the MEC shows the numbers are improving and the work is starting in the ED and they are following up with patients in ICU. After the call, Colene will try to get her hands on the critical care report so Dr. Fair can review that. ***Pharmacy – Dr. Lawson*** • One of the items up for discussion at the next T&T are the antidotes and we do have some in house, $22,000 per treatment per patient. This is for reversal of ??? as well as our anticoaligation policy will be updated to reflect us adding this antidote to our formulary.	Colene to send Dr. Fair the critical care report. Maxine to report out about the cost to patients and the hospital for Remdesivir.

	• We were getting Remdeivisr* at no cost by DC government but now we will have to pay. The fee has been approved by T&T and the MEC as well. • Dr. Fair asked if the cost of the medication is being covered by Medicare Medicaid or private insurance? Dr. Lawson said we have to do further research; some hospitals use Essentra* but we have to do more investigation on that. This is the first adverse drug event that we had with Zelrata* use to the extent that the patient had to be transferred out. • Dr. Lawson said she has not heard of any coverage for this drug. Dr. Fair asked if patients being billed for the full cost of the drug? Dr. Lawson has to look into it because we were not originally being charged. This is not under formulary so it has not been approved by Medicare or Medicaid. ***Patient Experience/ Patient Advocacy – Denise*** • Press Gainey scores, box 1 is reflective of inpatient stays for the last quarter. We decreased from the last month. • The second box on the right shows the trend of our average scores for the last 6 quarters. • Box 3 is basically the same as the one above and is based on a scale of zero – 100. • Box 4 is where we stand compared to other hospitals. We are in the 10th percentile compared to other hospitals. • Over the half of the responses we get is 9 or 10. Denise will focus on 6,7, & 8 to move those up because it is easier to move up from there than it will be to move from the 1 or 2 sections. • Box 8-unit performance Box 9 is the same it just breaks it out by unit or specialty. • Box 10 indicates the top 10 survey questions that have the most impact on our patient ratings. These are the questions that have the most impact on how people rate us and identifies areas for improvement. ***Facilities & Support Services – Ken Blackwell*** • Been tracking is the use rate of the utility components in May we were at 50% due to us hiring a subcontractor we have been able to take the number up to 100% which is really good. • Quarterly differently testing which happens in OR and procedure rooms and we are at 100% although we do have a company coming in, we recently completed our checks and balances of those areas and we noted some deficiencies and we have a company coming in to work on our HVAC system to bring those spaces in compliance. • 100% on legionella and those test but the outcomes are 100% as well.	Cecelia to send RCA report.

- Steam utility failures were only 2 in September. Air handler is at about 70% and this is a challenge for us but we have a RFP that has been awarded to address 9 of our air handlers.
- We only had 1 power fluctuation in September that lasted about 3 seconds.
- We left the work order completion rate blank, not sure why but will update.
- 10 water intrusions in the month of September. We are taking a proactive approach and had a mechanical engineer come in and look at our piping which we are looking to replace to decrease the pipes rusting because of rust.

Safety & Security Report – Derrick

- Assaults were up from August. Combative patient response is down. Elevator incidents is wow really good we did not have any. Gunshot wound response we had 5. Smoking infractions we are doing much better, we have really begun to encourage staff to go to the designated areas but we did have one.
- FD12 escorts went down to 81 from 110 in August.
- 100% on physician restraints, unsecured doors, fire drills, and fire extinguishers checks. We are also 100% on the timing of the fire drills they have to be spread out so they are not predictable.
- Dr. Fair asked if the sitters who were hired last year or this year, are they still here and have we hired new sitters? Are we appropriately staffed to avoid the FD12 issues we had last year? Derrick noted the sitters are still here and they are good, we have some of the same sitters and have hired additional sitters to replace those who were lost. Dr. Jacqui noted the sitters are now in a dedicated unit and not floating from the staffing office. Some did leave, they did not release they are the safety net for the hospital so we did lose a few.

Information Technology – Ken Blackwell and Colene Daniels

- Dr. Fair asked if everything is up and running at the hospital now given the outlook outages last week.
  Colene said yes and asked Ken to give an update on the some of the projects.
- Ken reported that with regards to the pharmacy that our certificate of occupancy is in the final stages of review and we hope to have it next week. Once fluoroscopy is approved the contractor said it should only take two weeks.
- Colene noted that DC OCTO worked with us and we have been doing checks every week. Our team and Microsoft have been sitting together for several days doing diagnostics and doing a deep dive to make sure it does not happen again. We have been giving reports to DC OCTO and we are moving forward.

	• Colene noted that next Friday from 6pm until Saturday at 6am the water system at the hospital will be cut off. We have been meeting with clinical staff to make sure we are ready for emergencies and we will be on divergence during that time. Ken added that we are cutting off the water because we have a six-inch intrusion on a particular pipe that has to be addressed and the only way to address it is to shut the water completely down. We anticipate the process will go very smoothly. 1. ***Adjournment @ 4:44pm.***	

Next scheduled meeting
TBD
Conference Call 1-866-820-5602 Passcode 7266397#

NFPHC Performance Improvement Committee

(Quality and Safety)

January, 22 2021 | 1:00 – 3:00 pm | Conference Call & Zoom Meeting

Meeting Minutes

Attendees:
Directors - Dr. Fair, Dir. Gorham, Dir Ashenafi,
UMC Staff – Colene Daniel**,** Faye Goode-Vaddy, Dr. William Strudwick, Dr. Shepard, David Parry, Ken Blackwell, Dr. Jacqueline, Denise Vernon, Dr. Lawson, Derrick Lockhart, Teka Henderson

Call to Order	Meeting called to order at 1:06pm by Dr. Malika Fair	
Agenda Items		Action Item
Meeting Minutes	The October 2020 meeting minutes are not ready but will be distributed in February.	
Meeting Discussion	***Hospital Licensure/Survey/Accreditation Activities for 2021 (Attachment 1)*** • Colene introduced CMO William Strudwick • Colene went through the findings of the Joint Commission Survey ***The Joint Commission – Colene Daniel & Ken Blackwell*** *Report and TJC Evidence of Standard Compliance submission – January 12, 2021. The SAFER Matrix Monitoring Sheet and monthly monitoring to ensure all corrections are in compliance. (Attachment 2)* • Ken Blackwell reported out on the low limited items, LS.02.01.35 EP 6, LS.02.01.30 EP 3, MS.06.01.07 EP 9 (go back to other section highlights), • Dr. Strudwick reported out on the medical findings.	

	• Dr. Shepard reported out on …Dr. Lawson added that we do not always have the single dose available so the Pharmacy made sure we have instructional posters to inform staff on how to utilize the other dosage. • Ken Blackwell reported out on 02.06.01 EP20 and EC02.05.09 EP12 this had to do with the storage of our H tanks. • Colene noted that we have already completed the review for January to ensure that we are in compliance. JC was supposed to come back and verify that we completed all our tags but they are not doing so because of the pandemic. They will be monitoring our inpatient COVID numbers and will determine a day to come back for a one-day review. The last component is the waiver that was submitted in December for our fire doors. We will provide a monthly update on where we are with the fire doors which will be confirmed by JC. Ken Blackwell noted that JC may conduct our 45 re-inspection virtually. • Colene noted that this is the last month UMC will provide a full overview of the Matrix but wanted to do so today since this is our first meeting since the survey. ***Leapfrog Report – and the follow-up status regarding the submission. Dr. William Strudwick, Dr. Jaqueline Payne-Borden and Dr. Isabel Shephard*** • Dr. Shepard noted that right now we are in the corrections period. Our report was submitted and accepted but right now we are updating our surgical services but we are not being penalized for this. ***The 2020 – 2021 Flu Season Report – Dr. Jacqueline Payne-Borden*** • The Flu Campaign began in September due to COVID. Right now we are at 94% compliant. Three percent of our staff had health complications and others took the COVID vaccine. Only 1 percent of our staff is not in compliance and Dr. Jacqueline is working with managers • Dr. Fair asked if we are doing better or worse than last year? Dr. Jacqueline said that we were doing better last year, we are at 99% by December 31, 2019 but this year people were hesitant to go to Occupational Health due to COVID. ***Provisions of Care, Treatment & Services Report – Dr. Jacqueline Payne-Borden*** • Improvements with Patient Care – 2021 • Staffing and Recruitment Updates • Once the COVID #s picked up we started to place positive patients together on the 8th floor. But since the 8th floor is a telemetry floor and they do not usually require that, so we put those	Toya to create a table of contents for the pdf document.

COVID patients who do not require telemetry to the 6th floor. Staff understands that we have to be flexible.

- We have done a lot of training and paid for training classes for staff on the 8th and 5th floor. Our goal is to have all our divisions be able to do telemetry. We had a refresher on the Hoya list which we had not used in months. We also prepared nurses to use the new Mindray system.
- Staffing has been challenging and nursing has been working with HR to do recruiting, we are trying another route for recruiting.
- Teka Henderson noted that we have on boarded 22 new staff members including contract staff thus far in January 2021.
- Dr. Fair asked what type of staff UMC is referring to when speaking of staff? Dr. Jacqui noted she was referencing nurses and sitters. (go back and capture data provided by Teka)
- Dr. Fair asked Dr. Jacqui to clarify what type of investigations are being conducted? Dr. Jacqui said that these are investigations of individual nursing practices that prevent the nurse from being placed on the schedule for work. Dr. Fair also asked how many investigations are underway and whether this is a typical number. Dr. Jacqui stated that there are two nurses and this is an increase. We usually have one nurse every five months or so.

Safety Culture initiative – Dr. Isabel Shephard

- Based upon the evaluation of the 2020 results – the new Safety Culture Action Plan is presented for discussion and approval. The action plan will focus on the strengths and areas for improvement from 2020.
- The Safety Culture Action Plan – Training & Education (Management Council - Attachment 3)
  - Patient Safety Education with all staff – quarterly training at the Management Council.
  - Making sure the clinical staff are reviewing the patient safety information and medication from the Patient Handbooks
- Dr. Shepard noted this document is shared as an FYI. Directed attention to noteworthy areas of improvement. Acknowledged Brian Gradle who she worked with to complete this document. We are doing everything we say we are doing. Noted Brian Gradle is very involved with the patient safety education program.

Compliance Report – Brian Gradle (Brian did not attend as he was presenting to hospital staff.)

DC Health Hospital Survey Readiness – Dr. Isabel Shepard

- Action Plan for the upcoming hospital survey. (Window begins February onwards)
- We are in the window and will begin doing our tracers in individual departments.

Emergency Department – Dr. Francis O'Connell and Teka Henderson

- Teka Henderson provided update.

Colene to send Dr. Fair the critical care report.

<u>COVID-19 Reports</u>

COVID -19: Monoclonal Antibody-Bamlanivimab Treatment for seniors – Dr. William Strudwick & Maxine Lawson (Attachment 4)

The NFPHC-UMC under the leadership of Dr. William Strudwick and Dr. Francis O'Connell will provide the Monoclonal Antibody-Bamlanivimab, treatment in the Emergency Department. NFPHC-UMC as required has partner with two locations:

- *Transitional Care Center Capital City*
- *Jeanne Jugan Residence/St. Joseph*
- *Serenity Nursing Home*
- Dr. Strudwick provided update.
- Dr. Lawson added that we have developed a protocol for use of the medication which will go to PNT and then to MEC for approval. Discussed the doses and patients who returned subsequent to receiving the medication.
- Dr. Fairs asked if there is a separate area we put patients who receive the antibodies? Dr. Lawson said yes, they are treated in the isolation rooms in the ED because they have to test positive
- Dr. Fair asked if patients are being referred to UMC for the antibodies? Dr. Lawson said no thus far, our patients came to us through the ED. Dr. Strudwick added that yes this can impact throughput, they are a long stay ED patient because they have to be tested and we wait for their results before administering the antibodies. At this time no significant impact on throughput but if this patient demo grows it may have significant impact later.

Maxine to report out about the cost to patients and the hospital for Remdesivir.

	COVID-19 – Vaccination Report (Attachment 5) – Dr. William Strudwick & Marcela Maamari ***"Lessons Learned" and total numbers to date.*** • Our vaccination program has been great, attracting the Vice President was great for us as we are now seeing individuals from all over the District who have never been to UMC. We also vaccinated NFL Superstar Doug Williams. The reception to the vaccine has been good among staff. The MVPs of our program are Ms. Lavan and her reservation team. They are wonderful on the phone with patients and give greetings when individuals arrive for their vaccine. • Dr. Jacqui gave kudos to the C Suite for being the first group of influencers modeling for staff that the vaccine is safe. • Dr. Strudwick noted our staff numbers may look better than others because of our influencers program. • Dr. Fair asked about equity across the city and Dr. Strudwick noted that we do see less residents from Wards 7 & 8 coming in to take the vaccine but they also have inequities with resources like computers and also the overall distrust of vaccines. However, we are continuing our education program and we are seeing progression of acceptance of the vaccine. • Dr. Fair asked us to look into • Dir. Ashenafi asked for clarity on the 1,800 number Dr. Strudwick provided. Dr. Strudwick noted that the number represents doses overall. Asked if we see a drop off of patients come back for their 2nd doses. ***<u>COVID-19</u>*** ***Capital Spend Plan – Marcela Maamari (Attachment 6)*** *Completed FY2021 Capital Spend Plan; updated existing prior year capital spend plans & COVID19 plan.* • Colene reported on current spend thus far and noted that this number is expected to go up as we have promised we would relocate the 8th floor to the 3rd floor.	Cecelia to send RCA report.

Standing Reports – Old Business

Quality Assessment Performance Improvement (QAPI) Department Reports and Quality Dashboards – Dr. Isabel Shephard

a. *December Reports (Attachment 7)*
b. No updates but the dashboard presented next month will include a year view.
c. Dr. Fair asked about med conciliation, is there any update on the work that is being done to improve med conciliation. Dr. Shepard noted that she broke it out on the dashboard so we can see the difference between the ED and inpatient physicians. We are trending up and will work with the ED physicians so we can get them up to speed.

Pharmacy – Maxine Lawson

- Staffing for the vaccine clinic is an issue as noted by President Biden. We are currently using our regular staff to assist with the vaccine clinic and we have our newly on boarded staff member in the Pharmacy Dept. who rotates with Dr. Lawson in the vaccine clinic.

Patient Experience/Patient Advocacy – Denise Vernon

d. *Press Ganey Report (Attachment 8)*
e. *Schedule of Department Reviews for 2021*
f. *Management Council December Presentation – Management Council*
g. Directed attention to bullet number 4. We are trending upward in terms of the all the hospitals that use Press Ganey to survey their patients. Explained the data presented. Shared a patient story noting that Vice President Harris' professor from Howard University reached out to us and asked that we schedule her for a vaccine appointment with nurse Patricia Cummings who also vaccinated the Vice President.

Safety & Security Report and Fire Drill Matrix Report – Derrick Lockhart (Attachment 9)

- We had 15 assaults in December, zero elevator issues, 7 gunshot responses, we have started tracking our BHU escorts up from November with 58 escorts in December. We were 100 compliant with physician ordered restraints, door checks, and fire extinguishers. For our fire matrix it was cut off but we did do our drills in December.
- Dr. Fair asked and then gave kudos for our organized response to issues in BHU.

Facilities & Support Services – Ken Blackwell

- *Utility Report – Ken Blackwell (Attachment 10)*

- IT closets are 90% complete just require some patches identified during inspection. MRI is 70% complete we had a set back and had to amend the permit to complete work inside the unit. Pharmacy certificate of occupancy received and now we have completed a punch list and we are exploring creating office space for Dr. Lawson and her staff.

Environment of Care Key Initiatives FY 21 – Ken Blackwell

The Joint Commission (TJC) Compliance Requirements:

- *Continuity of Operation Plan - Completed*
- *Emergency Operations Plan - Completed*
- *Hazard Vulnerability Analysis (HVA) - Completed*
- *2021 Performance Indicators – Completed*
- *Annual Review of the 7 Management Plans – Completed*
- *Co-Chair of the Environment of Care Committee – Ken Blackwell. The joint EOC and ICC surveillance rounds have increased in the number of rounds and monitoring, which has improved the EOC results. (the monthly results are reported to the Infection Control Committee)*

Closed Session

Risk Management Report (RCAs) – No RCAs to report

Adjournment at 2:41pm by Dr. Fair.

2. Adjournment @ 4:44pm.

Next scheduled meeting
TBD
Conference Call 1-866-820-5602 Passcode 7266397#

February 5, 2021

NFPHC Performance Improvement Committee

Provision of Care, Treatment & Service Report

- Improvement with Patient Care:
  The major focus at present is providing adequate and consistent staffing.
- Staffing and Recruitment Updates:
  There are steady increases with the gaps in staffing which proves challenging. Gaps include vacancies, terminations, resignations, and illnesses, including illnesses due to Covid-19.

Unit	Covid-19	FMLA	Other Illnesses	Termination	Resignation	Onboarded
BHU	0	Tech 0.9	MSW 1.0	Tech 0.9 RN 0.2	0	RN 0.2 Tech 0.9
ICU/CCU	RN 4.8	RN 2.3	0	0	0	0
5W	RN 1.0 Tech 2.0 Sitter 0.5	RN 0.6 Tech 0.6	RN 2.7 Tech 2.0 Sec. 1.0 Sitter 1.0	Sitter 1.0	Tech 0.6	Tech 1.0 Sitter 1.0
ED	RN 1.8	0	0	0	0	RN 0.3 Sitter 1.0
OR/PACU	0	0	0	0	0	0
DIALYSIS	0	0	0	0	0	0

<u>Recruitment and Onboarding by Unit</u>

Recruitment efforts continues for all units. While we await outcome of recruitment efforts we continue to utilize supplemental staff for the Intensive Care Unit and Emergency Department. Below is a sample of stages within the hiring process.

- ED: 4 approved RN sufficiency forms of the 9 vacancies
- ED: 4 approved Tech positions of the 4 vacancies
- ED: 4 approved Sitter positions of the 8 vacancies

- ED: Unit Coordinator - 0.9 approved of the 0.5 needed
- ICU: 6 of the 9 RNs positions approved
- Dialysis: 3 of the 4.5 RNs positions approved
- 8W: of the 7 RNs – 2 RNs interviewed and offered positions, 2 additional candidates being interviewed and 3 additional sufficiency forms approved
- 8W: MedTech – 7 of the 10 approved sufficiency: 7 offers made, 4 accepted

Leadership anticipates positive outcomes with nurse recruitment efforts once the collective bargaining contract for nurses have been ratified. Bargaining continues with SEIU.

- Occupational Health Influenza Vaccine Report
  Occupational Health started administering flu vaccines in September 2020 with an intended end date of December 31, 2020. However, the end date has been extended to February 21, 2021 to accommodate staff who took the Covid-19 vaccine prior to taking the flu vaccine. This decision was based on the current public health necessity and intent for all health care workers along with the general population to be vaccinated against the corona virus. At present 97% staff received the flu vaccine or have a documented waiver. Per Mandatory Influenza Vaccination Policy, IC 6-08, "If after 14 days, has not obtained an exemption or proof of Immunization, he/she will have voluntarily resigned employment or voluntarily terminated the contractual relationship/affiliation and will not be allowed to work, practice, provide services, or perform usual duties at this facility." February 21 is the last day Occupational Health will be providing flu vaccines; March 7 2 will be deadline to produce documentation to support waiver or confirmation of receiving vaccine. This communication sent in memorandum format via UMC Management Council.

UNITED
MEDICAL CENTER

MEMORANDUM

TO: Not-For-Profit Hospital Corporation Management Council

FROM: Jacqueline Payne-Borden, PhD, RN JPB
Chief Nursing Officer

William Strudwick, M.D.
Chief Medical Officer

DATE: February 6, 2021

RE: Influenza Vaccine

Occupational Health started administering flu vaccines in September 2020 with an intended mandatory end date of December 31, 2020, per Mandatory Influenza Vaccination Policy IC 6-08. However, the end date has been extended to February 21, 2021, to accommodate staff who took the COVID-19 vaccine prior to taking the flu vaccine. This decision was based on the current public health necessity and goal for all health care workers along with the general population to be vaccinated against the corona virus. The current compliance rate is 97%.

Important Dates:

1. February 21, 2021, is the last day Occupational Health will be providing flu vaccines.
2. March 7, 2021, will be the deadline to produce documentation to support exemption/ waiver or confirmation of receiving flu vaccine.
3. After March 7, 2021, staff will have voluntarily resigned employment or voluntarily terminated their contractual relationship.

***Occupational Health Office Hours: 7:00am-4:00pm**
***Closed – Lunch Break: 12:30pm -1:30pm**

Thanks as always for your follow through.

February 5, 2021

To: NFPHC/UMF Performance Improvement Committee
From: Brian D. Gradle, Chief Compliance Officer
Subject: Compliance Report - Staff and Patient Investigations Initiative

In response to a recognized need to enhance the safety and quality of patient-centered care, and to ensure that any deviations from such standards of care by the staff of the Not-for-Profit Hospital Corporation (NFPHC)/United Medical Center (UMC) are expeditiously identified and addressed, the staff and patient investigations initiative described below will be developed and implemented. This initiative is intended to supplement, and not supplant, any and all related work that is currently underway at NFPHC/UMC.

A. Review and Revision of Staff and Patient Investigation Processes

1. A taskforce comprised of representatives from Compliance, Risk Management, Human Resources, Employee Relations, Quality, Security, Legal, Patient Advocacy, Nursing, and the medical staff, will review and revise the current policies and processes related to the investigation of staff actions related to patient safety or patient abuse. This taskforce will be directed by the Compliance and Risk Management Departments.

2. Among the goals of the taskforce will be to ensure that any disciplinary decisions regarding staff who are involved in incidents with patients are fair, equal, and standard throughout the hospital.

3. The following examples illustrate the type of revisions to current policies that are anticipated:

    a. A "see something...say something," commonly known as a "Neglect to Report" provision, will be added to current policies.
    b. Timelines will be added to and/or amended within policies as appropriate, such as the Victims of Abuse, the Workplace Violence, and the Corrective Action policies.
    c. Behaviors constituting "Negligence" under the Corrective Action policy will be increased.

B. Expansion of Training with Staff regarding Patient Safety and Identifying Patient Abuse.

1. The taskforce will also develop and implement appropriate training and education for the hospital staff regarding patient safety and the identification and prevention of patient abuse.
2. This training and education will be in addition to all current training and education being provided by hospital departments.
3. Training may be both in-person and on-line.

C. Expansion of Training with Staff regarding Duty to Report Patient Care Concerns.

1. The taskforce will also develop and implement appropriate training and education for the hospital staff regarding its duty to report in an appropriate and timely manner all patient care concerns, including patient safety and the identification and prevention of patient abuse. This includes but is not limited to identifying other staff members involved in such activity.

2. This training and education will be in addition to all current training and education being provided by hospital departments.

3. Training may be both in-person and on-line.

D. Expansion of Training with Managers/Directors regarding Duty to Conduct Staff and Patient Investigations.

1. The taskforce will also develop and implement appropriate training and education for the hospital managers/directors regarding how to conduct appropriate investigations regarding patient care concerns, including patient safety and the identification and prevention of patient abuse.

2. This training and education will be in addition to all current training and education being provided by hospital departments.

3. This training may be both in-person and on-line.

E. Creating and Dissemination of Posters regarding Patient Safety/Abuse Hotline

Finally, in order to help ensure that the staff utilizes the hospital's anonymous hotline (the Compliance Hotline) when appropriate to report patient safety and patient abuse concerns, posters regarding the availability of an anonymous hotline for such purposes (which shall be the same toll-free number as the Compliance Hotline) will be created and disseminated in the hospital and the MOB.

Not-For-Profit Hospital Corporation (UMC)
COIVD-19 Vaccination Clinic
Daily Numbers 2-03-2021

Submitted by: William Strudwick, MD

December 16th – **60** Pfizer #1
17th – **64** Pfizer #1
18th – **105** Pfizer #1
21st – **54** Pfizer #1

23rd – **60** Moderna #1
28th – **70** Moderna #1
29th – **70** Moderna #1
30th – **110** Moderna #1

January 5th – **96** Pfizer #2
6th – **10** Moderna #1 / **48** Pfizer #2 (**58**)
7th – **54** Pfizer #2
8th – **30** Pfizer #2
11th –**27** Pfizer #1 / **45** Pfizer #2 (**72**)

12th – **120** Moderna #1
13th – **120** Moderna #1
14th - **130** Moderna #1
15th – **146** Moderna #1 / **3** Moderna #2 (**149**)

19th – **81** Moderna #1 / **40** Moderna #2 (**121**)
20th – **106** Moderna #1 / **15** Moderna #2 (**121**)
21st – **84** Moderna #1 / **56** Moderna #2 (**140**)
22nd – **84** Moderna #1 / **46** Moderna #2 (**130**)

25th – **38** Moderna #1 / **93** Moderna #2 (**131**)
26th – **101** Moderna #1 / **29** Moderna #2 (**130**)
27th – **107** Moderna #1 / **13** Moderna #2 (**120**)
28th – **99** Moderna #1 / **1** Moderna #2 (**100**)
29th – **70** Moderna #1

February 1st – **25** Pfizer #2 / **11** Moderna #2 (**36**)
2nd – **65** Moderna #1 / **6** Moderna #2 (**71**)
3rd – **66** Moderna #1 / **4** Moderna #2 (**70**)

Totals: **310** Pfizer #1 doses; **298** Pfizer #2 doses; 1737 Moderna #1 doses; **313** Moderna #2 doses / **2658** total doses of vaccines.

Plan of Correction QAPI Tracker

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Compliance Key:

Compliance Goal
Within 10% of Goal
< 10% of Goal

Plan of Correction	Performance Improvement Metric	Denominator	Compliance Goal	Reporting Schedule	Average 5-7/2020	Average 8-10/2020	Nov-20	Dec-20	Responsible Party
H002-Page 3/ H-169 Page 37	Discharge Planning/Inpatient Initial Case Management Assessment	20 charts/monthly	80%	Monthly	93%	95%	100%	100%	Dr. Morgan
	Discharge Planning/Inpatient Reassessment	20 charts/monthly	80%	Monthly	92%	93%	95%	100%	Dr. Morgan
H002-Page 4/H097-Page 13 H-142 Page 21	Physician Chief Complaint Reassessment documentation	5 charts/monthly	100%	Monthly	100%	100%	100%	100%	Medical Staff
H002- Page 7	Expired Medication Removal	Monthly logs	100%	Monthly	100%	100%	100%	100%	Dr. Lawson
H002-Page 8	Methadone Medication Order Review	Weekly Audit of all Methadone Paitents	100%	Monthly	69%	89%	80%	100%	Dr. Lawson
H002-Page 9	Performance Appraisals-90 day	20 Employee files/Monthly	85%	Quarterly	70%	92%	80%	90%	Mr. Bradley
	Performance Appraisals-Annual Reviews	20 Employee files/Monthly	85%	Quarterly	97%	93%	65%	55%	Mr. Bradley
H097-Page 14/H120- Page 19/	Glucose Monitoring Documentation	10 charts/monthly	100%	Monthly	100%	100%	100%	100%	Chair of Medicine
H097-Page 15/H120- Page 20	History & Physical Documentation	10 charts/monthly	100%	Monthly	99%	99%	100%	100%	Chair of Surgery

Plan of Correction	Performance Improvement Metric	Denominator	Compliance Goal	Reporting Schedule	Average 5-7/2020	Average 8-10/2020	Nov-20	Dec-20	Responsible Party
H102- Page 16	Employee Expiring Licenses	20 Employee files/Monthly	85%	Quarterly	83%	83%	100%	100%	Mr. Bradley
H116- Page 17	HR- Employee Annual Competencies	20 Employee files/Monthly	85%	Quarterly	90%	92%	100%	90%	Mr. Bradley
H-142 Page 22	Huddle-Discharge Instructions/Signage	10 charts/monthly	100%	Monthly	100%	97%	100%	90%	Ms. Henderson
H-145 Page 23	Emergency Department/ Patient Assessment	10 charts/monthly	100%	Quarterly	97%	93%	90%	100%	Ms. Henderson
	ED Reassessment Q2 hours	10 charts/monthly	100%	Quarterly	100%	100%	80%	100%	Ms. Henderson
	ED Vitals Signs at Discharge	10 charts/monthly	100%	Quarterly	73%	50%	80%	60%	Ms. Henderson
H-145 Page24 H-169 Page 38	Timely Wound Consults	10 charts/monthly	100%	Monthly	97%	73%	70%	70%	Ms. Doyle/Fontoh
H-145 Page27	Small Volume Nebulizer therapy-Policy	10 charts/monthly	100%	Monthly	96%	96%	96%	95%	Lead Respiratory Therapy
H-145 Page29	Care Plan Implementation	10 charts/monthly	100%	Monthly	89%	98%	93%	100%	Dr. Goode-Vaddy
H-145 Page30	Skin and Wound Care Documentation	10 charts/monthly	100%	Monthly	74%	88%	93%	93%	Ms. Aldene/Fontoh
H-145 Page26/H-153 Page 35	"Medication Administration and Narcotic Control Documentation and Count".	10 charts/monthly	100%	Monthly	98%	87%	97%	98%	Dr. Goode-Vaddy
H-183 Page 44	Hand Hygiene	Total observed hand hygiene encounters	90%	Monthly	97%	99%	97%	99%	Ms. Sylvain

Plan of Correction	Performance Improvement Metric	Denominator	Compliance Goal	Reporting Schedule	Average 5-7/2020	Average 8-10/2020	Nov-20	Dec-20	Responsible Party
H-235 Page 46	Preventive Maintainance/Cleaning	Cleaning Logs	90%	Quarterly	100%	100%	100%	100%	Ms. Barry
H-239 Page 57	Biomed Preventive Maintainance	10 MonthlyAudits	80%	Quarterly	100%	100%	100%	100%	Ms. Brown
H-239 Page 58	Expired Supplies	Daily TJC Rounding Log	100%	Monthly	100%	99%	100%	99%	Dr. Goode-Vaddy
H-239 Page 59	Telephone Cords-Ligature Risk	Rounding Log	100%	Monthly	100%	100%	100%	100%	Mr. Anderson

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
BLOOD PRODUCTS MANAGEMENT																		
BLOOD TRANSFUSION REACTIONS																		
# Transfusion Reaction Cases		1	0	0	0	0	1	0	0	0	0	0	0	1	1	0	0	2
Allergic Reaction		1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Febrile Reaction		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hemolytic Reaction		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Specific Reaction		0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	1
BLOOD TRANSFUSION RECORD REVIEW																		
Transfusions		185	198	110	106	147	159	115	111	117	119	136	128	493	412	343	383	1631
Cryoprecipitate Transfusions		8	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	8
Fresh Frozen Plasma Transfusions		17	17	7	11	12	18	2	0	7	6	15	11	41	41	9	32	123
Platelet Transfusions		2	8	4	2	4	10	1	11	12	10	8	9	14	16	24	27	81
Covid-19 Covalescent Plasma						3	10	2	7	6	2	2	15		13	15	19	47
RH Immunge Globulin (RhIG)		2	3	2	1	1	1	1	0	0	1	0	1	7	3	1	2	13
Total Red Blood Cells (RBCs) Transfused		156	170	97	92	127	120	109	93	92	100	111	92	423	339	294	303	1359
Total RBC units Crossmatched		177	185	131	121	150	155	136	117	113	117	136	112	493	426	366	365	1650
Crossmatch/Transfusion Ratio Threshold <2		1.1346	1.0882	1.3505	1.3152	1.1811	1.2917	1.2477	1.2581	1.2283	1.17	1.2252	1.2174	1.16548	1.2566	1.2449	1.20462	1.214128
BLOOD TRANSFUSION JUSTIFICATION																		

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Times O- BLOOD TRANSFUSED TO NON O- PT		0	12	2	2	7	5	3	6	9	5	9	3	14	14	18	17	63
BLOOD TRANSFUSION DOCUMENTATION	THRESHOLD 100%																	
MD Order Confirmed		100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consent Signed		83%		91%	100%	97%	97%	100%	100%	100%	100%	100%	100%	87%	98%	100%	100%	97%
2 RN Signature		98%		99%	98%	97%	96%	94%	99%	96%	96%	93%	98%	98%	97%	96%	96%	97%
FALL PREVENTION																		
# Falls Housewide		7	8	6	11	12	8	13	8	11	8			21	31	32	8	92
# Falls - ED		0	0	0	0	1	1	0	1	0	0			0	2	1	0	3
# Falls - Outpatient		1	0	0	0	0	0	0	1	0	0			1	0	1	0	2
# Falls - Inpatient		6	8	6	11	11	7	13	6	11	8			20	29	30	8	87
# Falls - Visitor		0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
Inpatient Days		2201	2619	2596	2687	3001	2516	2177	2175	2074	2136	1772	2158	7416	8204	6426	6066	28112
# Falls - With Injury		0	0	0	0	0	3	0	0	1	2			0	3	1	2	6
INPATIENT FALL RATE		2.7	3.1	2.3	4.1	3.7	2.8	6.0	2.8	5.3	3.7			2.7	3.5	4.7	1.3	3.1
INFECTION PREVENTION AND CONTROL																		
NPSG: REDUCE THE RISK OF HEALTHCARE ASSOCIATED INFECTIONS																		
INFECTION SURVEILLANCE - DEVICE ASSOCIATED HAI																		
CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI)	THRESHOLD <1/YR																	

UMC QUALITY Dashboard		At or Exceeds Target			Within 10% of Target				Target not Met					Amended				
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
CLABSI -Medical/Surgical		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical/Surgical CLABSI RATE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CLABSI Telemetry		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Telemetry CLABSI rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CLABSI-Critical Care Unit (CCU)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CCU CLABSI RATE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CATHETER ASSOCIATED URINARY TRACT INFECTON (CAUTI)		THRESHOLD < 1/YR																
CAUTI -Medical/Surgical		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical/Surgical CAUTI Rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAUTI- Telemetry		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Telemetry CAUTI Rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAUTI -CCU		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAUTI -CCU RATE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VENTILATOR ASSOCIATED EVENTS		THRESHOLD < 1/YR																
Ventilator Associated Condition (VAC)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ventilator Associated Condition Rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MULTI DRUG RESISTANT ORGANISMS (MDRO)		THRESHOLD RATE <1/YR																
MRSA-HAI (Healthcare Acquired Infection)		0	1	0	0	0	0	1	0	0	0	0	0	1	0	1	0	2

UMC QUALITY Dashboard		At or Exceeds Target			Within 10% of Target				Target not Met				Amended					
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
MRSA Rate		0	0.3818	0	0	0	0	0.4593	0	0	0	0	0	0.13484	0	0.15562	0	0.071144
CLOSTRIDIUM DIFFICILE (C.DIFF)						THRESHOLD RATE <1/YR												
C.Diff-HAI (Healthcare Acquired Infection)		0		0	2	0	1	1	0	0	0	1	0	0	3	1	1	5
C.Diff Rate		0		0	0.7443	0	0.3975	0.4593	0	0	0	0.5643	0	0	0.3657	0.15562	0.16485	0.17786
VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)						THRESHOLD RATE <1/YR												
VRE Healthcare Acquired Infection		3	3	3	0	0	0	0	0	3	2	1	0	9	0	3	3	15
VRE Rate		1.363	1.1455	1.1556	0	0	0	0	0	1.4465	0.9363	0.5643	0	1.21359	0	0.46685	0.49456	0.53358
INFECTION SURVEILLANCE : SURGICAL SITE INFECTIONS (SSI)						THRESHOLD <4 INCIDENCE/YR												
# Colon Surgeries		3	2	0	0	0	3	0	0		0	0	0	5	3	0	0	8
#SSI from Colon Surgeries		0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0
# Major Orthopedic Surgeries		2	0	0	0	0	0	0	0		0	0	0	2	0	0	0	2
# SSI fromOrthopedic Surgeries		0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0
DEVICE UTILIZATION RATE (DUR)																		
# PATIENT DAYS-TOTAL		2225	2140	2291	2047	2155	1954	1785	1733	1772	1765	1699	2053	6,656	6,156	5,290	5,517	23,619
# Patient Days - MS		594	478	617	587	681	564	501	513	456	461	495	548	1,689	1,832	1,470	1,504	6,495
#Patient Days-Tele		1351	1379	1445	1174	1145	1116	1091	981	1049	1069	997	1237	4,175	3,435	3,121	3,303	14,034
#Patient Days MS/T		1945	1857	2062	1761	1826	1680	1592	1494	1505	1530	1492	1785	5,864	5,267	4,591	4,807	20,529
# Patient Days - CCU		280	283	229	286	329	274	193	239	267	235	207	268	792	889	699	710	3,090

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
FOLEY DUR							THRESHOLD: < 1/YR											
# Foley Days - MS		62	42	49	87	41	71	27	29	50	26	23	33	153	199	106	82	540
FOLEY DUR - MS		0.10	0.09	0.08	0.15	0.06	0.13	0.05	0.06	0.11	0.06	0.05	0.06	0.09	0.11	0.07	0.05	0.08
#Foley Days-Tele		215	168	171	118	111	202	202	85	213	184	230	159	400	431	500	573	2058
FOLEY DUR - Tele		0.16	0.12	0.12	0.10	0.10	0.18	0.19	0.09	0.20	0.17	0.23	0.13	0.10	0.13	0.16	0.17	0.15
# Foley Days - CCU		184	159	158	217	219	165	119	182	215	185	155	220	718	601	516	560	2178
FOLEY DUR - CCU		0.66	0.56	0.69	0.76	0.67	0.60	0.62	0.76	0.81	0.79	0.75	0.82	0.91	0.68	0.74	0.79	0.70
# Foley Days - TOTAL		461	369	220	205	152	273	229	114	263	210	253	192	1050	630	606	655	2942
CENTRAL LINE DUR							THRESHOLD: MS< 1/YR TELE < 1/YR CCU < 1/YR											
# Central Line Days - MS		17	3	28	14	26	6	5	5	4	8	7	9	48	46	14	24	132
CENTRAL DUR - MS		0.03	0.01	0.05	0.02	0.04	0.01	0.01	0.01	0.01	0.02	0.01	0.02	0.03	0.03	0.01	0.02	0.02
#Central Line Days Tele		19	31	44	13	33	28	24	35	27	43	11	21	329	74	86	75	329
CENTRAL DUR TELE		0.0141	0.0225	0.0304	0.0111	0.0288	0.0251	0.022	0.0357	0.0257	0.0402	0.011	0.017	0.08	0.02	0.03	0.02	0.02
# Central Line Days CCU		71	74	72	147	160	165	41	95	77	83	62	81	217	472	213	226	1128
CENTRAL DUR - CCU		0.25	0.26	0.31	0.51	0.49	0.60	0.21	0.40	0.29	0.35	0.30	0.30	0.27	0.53	0.30	0.32	0.37
# Central Line Days TOTAL		107	108	144	174	219	199	70	135	108	134	80	111	359	592	313	325	1590
VENTILATOR DUR							THRESHOLD: TELE< 1/YR	CCU 1/YR										
# Ventilator Days - CCU		120	117	85	179	209	132	32	119	157	107	68	185	322	520	308	360	1510

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
VENT DUR - CCU		0.43	0.41	0.37	0.63	0.64	0.48	0.17	0.50	0.59	0.46	0.33	0.69	0.40657	0.5849	0.44063	0.51	0.488673
# Ventilator Days TOTAL		120	117	85	179	209	132	32	119	157	107	68	185	322	520	308	360	1510
TRANSMISSION BASED PRECAUTIONS																		
Airborne-MS/T		0	5	10	3	5	7	0	1	2	8	0	1	15	15	3	9	42
Airborne-CCU		0	0	2	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Airborne-Total		0	5	12	3	5	7	0	1	2	8	0	1	17	15	3	9	44
Droplet - MS/T		21	27	119	529	622	318	50	54	86	9	3	5	167	1469	190	17	1843
Droplet-Covid MS/T													201				201	201
Droplet - CCU		1	8	26	132	155	84	8	31	40	0	0	0	35	371	79	0	485
Droplet-Covid CCU													86				86	86
Droplet - TOTAL		22	35	145	661	777	402	58	85	126	9	3	292	202	1840	269	304	2615
Contact - MS/T		180	124	190	103	122	140	87	55	84	125	94	70	494	365	226	289	1374
Contact - CCU		80	64	63	8	36	31	7	6	15	31	40	53	207	75	28	124	434
Contact - Total		260	188	253	111	158	171	94	61	99	156	134	123	701	440	254	413	1808
Contact Enteric - MS/T		49	24	8	25	8	8	10	4	18	2	12	1	81	41	32	15	169
Contact Enteric - CCU		10	6	7	3	2	4	0	0	10	1	12	2	23	9	10	15	57
Contact Enteric - TOTAL		59	30	15	28	10	12	10	4	28	3	24	3	104	50	42	30	226
Neutropenic - MS/T		0	0	0	0	0	2	0	4	1	0	0	3	0	2	5	3	10

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Neutropenic - CCU		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neutro - TOTAL		0	0	0	0	0	2	0	4	1	0	0	3	0	2	5	3	10
HAND HYGIENE COMPLIANCE	THRESHOLD >90%																	
# Hand Hygiene Compliance		192	194	153	189	194	211	174	203	226	198	174	159	539	594	603	531	2267
# Hand Hygiene Obs.		210	202	160	190	200	220	175	208	227	201	180	160	572	610	610	541	2333
Compliance-Hospital Wide		91%	96%	96%	99%	97%	96%	99%	98%	99%	99%	97%	99%	94%	97%	99%	98%	97%
HAND HYGIENE COMPLIANCE STRATIFIED PER ROLE	THRESHOLD>90%																	
# Obs. EMPLOYEE (Non Provider)		193	179	148	158	168	197	157	162	201	185	164	144	520	523	520	493	2056
# Compliant Obs. Employee (Non Provider)		175	172	141	158	162	189	156	158	200	182	158	143	488	509	514	483	1994
EMPLOYEE RATE		91%	96%	95%	100%	96%	96%	99%	98%	99%	98%	96%	99%	94%	97%	99%	98%	97%
# Obs. PROVIDER		17	23	12	32	32	23	18	46	26	16	16	16	52	87	90	48	277
# Compliant Obs. PROVIDER		16	22	12	31	32	22	18	45	26	16	16	16	50	85	89	48	272
PROVIDER RATE		94%	96%	100%	97%	100%	96%	100%	98%	100%	100%	100%	100%	97%	98%	99%	100.0%	98%
HAND HYGIENE COMPLIANCE STRATIFIED PER PATIENT CARE DEPARTMENT	THRESHOLD 90%																	
# Obs. ED		40	30	30	30	30	30	26	30	30	30	30	30	100	90	86	90	366
# Compliant Obs.ED		35	28	27	30	29	26	26	29	30	29	28	30	90	85	85	87	347
ED RATE		88%	93%	90%	100%	97%	87%	100%	97%	100%	97%	93%	100%	90%	94%	99%	97%	95%
# Obs. PeriOperative (PeriOP)		30	30	30	30	30	30	30	30	30	30	30	30	0	90	90	90	360

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Compliant Obs. PeriOp		30	30	30	30	30	30	30	30	30	30	30	30	90	90	90	90	360
PeriOp Services RATE		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
# Obs. MS/T		100	100	60	90	90	90	74	86	93	74	60	60	260	270	253	194	977
# Compliant Obs. MS/T		89	94	57	89	86	86	73	83	92	73	58	60	240	261	248	191	940
MS/T RATE		89%	94%	95%	99%	96%	96%	99%	97%	99%	99%	97%	100%	93%	97%	98%	98%	96%
# Obs. CCU		30	30	30	30	30	30	27	50	54	37	40	30	90	90	131	107	418
# Compliant Obs. CCU		28	30	30	30	29	29	27	49	54	37	39	30	88	88	130	106	412
CCU RATE		93%	100%	100%	100%	97%	97%	100%	98%	100%	100%	98%	100%	98%	98%	99%	99%	99%
MEDICATION SAFETY																		
BARCODE MEDICATION ADMINISTRATION (BCMA) - Hospital Wide		THRESHOLD >95%																
%Pt Scanned		99.94%	99.94%		100.00%	99.98%		99.89%	99.91%	99.75%	99%	100%	100%	99.94%	99.99%	99.90%	99.60%	99.82%
%Medications Scanned		84.09%	82.68%		86.53%	84.15%		81.28%	82.60%	83.13%	83.95%	80.40%	81.60%	83.39%	85.34%	82.34%	83.95%	83.04%
MEDICATION RECONCILIATION COMPLETED -		THRESHOLD >95% (Breakdown of ED Physician and Attending Physician Compliance)																
# Patient Records Reviewed - ED PHYS 10/20		138	3782	3585	2461	2722	3037	2935	3220	3095	3191	2795	2729	7505	8220	9,250	8,715	33690
# Records Med Rec Complete ED PHYS 10/20		103	2878	2576	1740	2053	2516	2430	2682	2489	2548	2198	2108	5557	6309	7,601	6,854	26321
% Med. Reconciliations completed ED Phys		74.6%	76.1%	71.9%	70.7%	75.4%	82.8%	82.8%	83.3%	80.4%	79.8%	78.6%	77.2%	74.0%	76.8%	82.2%	78.6%	78.1%
# Patient Records Reviewed Attending Phys											405	290	359	0	0	0	1,054	1054

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Records Med Rec Complete Attending Phys											372	260	328	0	0	0	960	960
% Med. Reconciliations completed Attending Phys		-	-	-	-	-	-	-	-	-	91.9%	89.7%	91.4%	-	-	-	91.1%	91.1%
MEDICATION ERRORS REPORTED																		
# TOTAL ERRORS		8	18	5	3	2	1	3	7	6	5	0	0	31	6	16	5	58
ERROR TYPE																		
MED-GIVEN IN SPITE OF DOCUMENTED ALLERGY		0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
MED-DELAY		0	2	0	0	0	1	1	1	0	1			2	1	2	1	6
MED-WRONG STRENGTH		0	0	0	0	0	0	0	0	0	1			0	0	0	1	1
MED-OMISSION		4	7	0	0	0	0	0	0	0	0			11	0	0	0	11
MED-UNORDERED MED.		0	0	0	0	0	0	0	1	0	0			0	0	1	0	1
MED-OTHER		1	3	4	3	1	0	0	2	6	1			8	4	8	1	21
MED-WRONG DOSE		3	6	1	0	1	0	2	3	0	0			10	1	5	0	16
MED-WRONG MEDICATION		0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
MED-WRONG PATIENT		0	0	0	0	0	0	0	0	0	2			0	0	0	2	2
MED-WRONG RATE		0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
MED-WRONG TIME		0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
PATIENT SATISFACTION/PERCEPTION OF CARE																		
#Grievances/Complaints		8	20	25	15	15	25	15	15	29	17	14	11	209	55	59	42	209

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Recommend Hospital UMC Target 50%		67%	39%	11%	26%	11%	30%	60%	38%	13%	23%	58%	13%	38.73%	22%	34%	31%	32.33%
Overall Hospital Rating UMC Target 50%		67%	54%	45%	45%	44%	30%	67%	67%	26%	44%	58%	13%	55.13%	40%	47%	38%	46.58%
STAR Rating		2	2	2	2	2	2				2	2	2	2	6	0	6	2
CLINICAL OUTCOMES																		
Total Code Blue Events (outside of CCU)		1	4	5	18	7	4	0	5	1	5	6	7	10	29	6	18	63
Code Blue Rates		0.4494	1.5273	2.1825	6.6989	2.3326	1.5898	0	2.2989	0.4822	2.3408	3.386	3.2437	1.3864	3.5404	0	0	2.211006
Patient Days		2225	2619	2291	2687	3001	2516	2177	2175	2074	2136	1772	2158	7135	8204	6426	6066	27831
Tele		1	3	3	14	6	4	0	5	1	3	6	6	7	24	6	15	52
M/S		0	0	2	4	0	0	0	0	0	2	0	1	2	4	0	3	9
BHU		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dialysis		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OR		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PACU		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Radiology		0	1	0	0	1	0	0	0	0	0	0	0	1	1	0	0	2
Total Rapid Response Events		17	7	6	19	15	17	12	3	12	8	9	8	30	51	27	25	133
Rapid Response Rates		7.6404	2.6728	2.6189	7.0711	4.9983	6.7568	5.5122	1.3793	5.7859	3.7453	5.079	3.7071	4.20463	6.2165	4.20168	4.12133	4.778844
Tele		13	5	5	10	11	6	10	3	10	5	5	5	23	27	23	15	88
3 West						0	4	0	0	0	0	0	0	0	4	0	0	4

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
M/S		1	1	0	5	2	3	1	0	1	2	3	3	2	10	2	8	22
BHU		0	0	1	4	1	3	1	0	1	0	1	0	1	8	2	1	12
Dialysis		3	1	0	0	1	1	0	0	0	1	0	0	4	2	0	1	7
OR		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PACU		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Radiology		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE Prophylaxis MS/T Compliance >95%		92.09%	93.34%	92.79%	88.69%	89.82%	91.06%	87.58%	90.36%	89.08%	88.57%	90.00%	86.00%	92.74%	89.86%	89.01%	88.19%	89.95%
VTE Prophylaxis CCU Compliance >95%		100%	100%	99%	100%	96%	100%	96%	100%	100%	100%	98%	100%	99.80%	98.53%	98.67%	99.33%	99.08%
CLINICAL SAFETY INDICATORS																		
Number of Restraint Hours Behavioral Health Unit		2.4	0.116	0	0	0	0	1.083	0	0	0	0	0	2.516	0	1.083	0	3.599
Restraint Rate		4.94	0.0021	0	0	0	0	0.079	0	0	0	0	0	4.9421	0	0.079	0	5.0211
Deliveries in the ED		0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1
SQ Insulin Administration Adherence >95%		97%	97%	100%	95%		87%	97%	95%	96%	98%	97%	97%	98%	91%	96%	97%	96%
PRESSURE ULCERS																		
Total Patient Days		2225	2619	2291	2687	3001	2516	2177	2175	2074	2136	1772	2158	7135	8204	6426	6066	27831
# Hospital Acquired Pressure Injuries		1	0	4	5	10	14	3	6	10	3	11	2	5	29	19	16	69
Incidence Rate <1		0.4494	0	1.746	1.8608	3.3322	5.5644	1.378	2.7586	4.8216	1.4045	6.2077	0.0927	0.70077	3.5349	2.95674	2.63765	2.47925
OCCURRENCE REPORTS																		
# OCCURRENCE REPORTS		117	135	122	114	114	103	114	119	113	117			374	331	346	117	1168

UMC QUALITY Dashboard		At or Exceeds Target			Within 10% of Target				Target not Met				Amended				
2020	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
EQUIPMENT		1	1	1	0	4	3	1	4	2	1			3	7	7	1	18
FALLS		7	8	6	11	12	8	13	8	11	8			21	31	32	8	92
MEDICATION		8	18	5	3	2	1	2	7	6	5			31	6	15	5	57
OTHER		101	108	110	100	96	91	98	100	94	103			319	287	292	103	1001
# NEAR MISSES		UNK	UNK	UNK	UNK	UNK	UNK	UNK	UNK	UNK	UNK			0	0	0	0	0
# SENTINEL EVENTS		0	1	0	0	0	1	0	0	0	0			1	1	0	0	2
SEPSIS MEASURES																		
Sepsis (Principal DX) 30 Day Readmit		0	1	0	0	0	0	0	0					1	0	0	0	1
Simple Severe Sepsis w/Shock		11	9	10	26	15	16	15	7					30	57	22	0	109
Sepsis Patients Observed Mortality (APR DRG 720)		0	0	0	0	0	0	0	0					0	0	0	0	0
Sepsis Patients Volume (APR DRG 720)		24	28	24	21	31	16	21	18					76	68	39	0	183
CASE MANAGEMENT		THRESHOLD LOS < 5.5																
Average Length of Stay		5.18	4.82	5.34	5.7	5.97	6.25	6.09	5.11	5.35	4.75	4.9	6.7	5.11333	5.97333	5.516667	5.45	5.5133333
FD12 PATIENT ADMISSIONS/ELOPEMENT TRACKING																		
FD12 ADMISSIONS		80	73	72	74	85	99	104	78	68	103	31	46	225	258	250	180	913
FD12 Elopement Cases		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLOOD CONTAMINATION RATES		THRESHOLD 90% (under 90% is non-compliant)																
ER Holding		100%	100%	95%	96%	100%	100%	82%	94%	100%	97%	94%	95%	98.33%	98.73%	92.00%	95.33%	96.10%
ER General		91%	94%	93%	87%	91%	95%	88%	89%	91%	89%	86%	88%	92.43%	91.00%	89.43%	87.67%	90.13%
ICU		97%	99%	95%	85%	83%	95%	79%	100%	100%	81%	100%	91%	97.17%	87.57%	93.00%	90.67%	92.10%

Pharmacy and Therapeutics Committee

United Medical Center

Pharmacy Services

January 29, 2021

Policies/Procedures

- Pfizer-BioNTech and Moderna COVID-19 Vaccine
- Monoclonal Antibodies for COVID-19
- Kcentra Policy

Copies of Policies available upon request/emailed to all members

ASP/Clinical Report

ASP Goals & Outcome

- A significant reduction in UMC Days of therapy (DOT) for fluoroquinolones compared to national Averages.

- A 10 – 20 % reduction in drugs (fluoroquinolones) acquisition cost from previous year.

- Outcome:
- A significant downward trend in fluoroquinolones DOT below national averages from QTR 1 to QTR 3 2020 approx. 19.2 % below national average.

ASP Goals & Outcome:

- DOT reduction compared to national averages
- Acquisition Cost Reduction
- Outcome:
- DOT significantly above national averages at approx. 154%

ASP Interventions Cost Savings:

- Vancomycin Pharmacy Dosing & Extended Infusion Pip/Tazob:

- Jan 2020 – Dec 2020:

	# of Interventions	**$ saved**
Vancomycin Protocol	533	79,950
Pip/Tazobactam Protocol	587	88,050
Total:	1120	168,000

Antimicrobial Expenditures Analysis 2019 VS 2020:

- 2019
- **QTR 1** **QTR 2** **QTR 3** **QTR 4** **TOTAL**
- %

Antibacterial	63,403.46	72,178.00	87,713.57	108,607.32	331,902.35
Antifungal	42,093.29	4792.52	4612.15	10,893.47	62,391.43
Antiviral	15,568.34	11,782.85	16,442.82	23,456.38	67,250.39
TOTAL:	121,065.09	88,753.37	108,768.54	142,957.17	461,544.17

- Total Antimicrobial expenditures 2019: 331,902.35 (71%)
- Total Antifungal expenditures 2019: 62,391.43 (14%)
- Total Antiviral expenditures 2019: 67,250.39 (15%)

Antimicrobials Expenditures Contd:

	2020				
	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
Antimicrobial	91,033.77	93,183.16	79,066.13	86,829.55	350,112.61
Antifungal	11,289.61	9,074.38	3,133.27	8,474.05	31,971.31
Antiviral	22,859.85	18,701.25	9,307.37	13,727.84	64,596.31
TOTAL:	125,183.23	120,958.79	91,506.77	109,031.44	446,680.23

Total Antibacterial expenditures 2020: 350,112.61 (78%)

Total Antifungal expenditures 2020: 31,971.31 (7%)

Total Antiviral expenditures 2020: 64,596.31 (15%)

Antimicrobials Expenditures 2020 Summary:

- A slight 3.3% decrease in total antimicrobial expenditures from 2019.
- A significant decrease in antimicrobial expenditures for the last 2 QTRS of 2020 compared to 2019. (19% and 31% respectively)
- Additional ASP clinical services to be introduced in 2021 may result in lower antimicrobial expenditures:
- Vancomycin AUC Monitoring
- Meropenem Extended Infusion
- Cefepime Extended Infusion

UNITED MEDICAL CENTER

Monthly Report Performance Improvement Committee
(February 15, 2021)
(Patient Experience)

Accomplishments

- Emergency Department overall scores and number of responses continue to improve on a rolling 12 month basis. In comparison (for period 2/1/19 – 1/31/2020 n=91 vs. 2/1/2020 – 1/31/2021 n=166).

- Real time positive remarks from 5 West patients:
  - "Very pleasant hospital stay"
  - "Staff was very competent and friendly"
  - "All staff was polite and communicated with me, gentle and always greeted me with a smile"
  - "Daytime nurses were good"
  - "Although my stay was short the staff did a good job making me comfortable and taking care of my needs and the needs of others. I appreciate them!!"

Challenges and Current Action Plan

- Although scores and responses continue to improve on a 12 month rolling basis for the Emergency Department, the monthly response rate ("N") continues to be low.

Time Period	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021
n	17	17	20	16	13	13
Top Box Score	45.54%	55.67%	38.06%	45.83%	39.49%	44.05%
Percentile Rank	1	7	1	1	1	1

  - Continue to inform patients of the Press Ganey survey
  - Encourage participation in completing the survey

- Inpatient stays: For the question , "Rate the hospital 0-10" the score has declined as well as the number of responses on a 12 month rolling basis

(2/1/2019 – 1/31/2020 n= 155 vs. 2/1/2020 – 1/31/2021 n=143). No current trend information can be updated due to 6 responses received for the month of January 2021.

- 5 West unit responses are consistently low with 17 responses for Qtr. 4 2020. However, 5 West had no ratings scores below "5" for the last quarter. This demonstrates that the opportunity lies in turning "good" experiences to "great" experiences. Continued focused improvement to include the following:
  - "Nurses communication"
  - "Attention to unique patient needs"

Regulatory/Corrective Action Follow-up

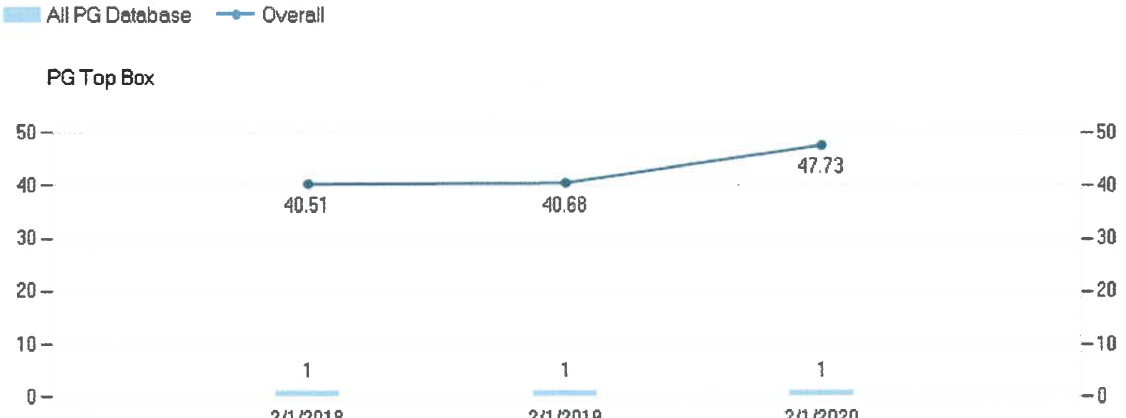
- N/A

PRESS GANEY®

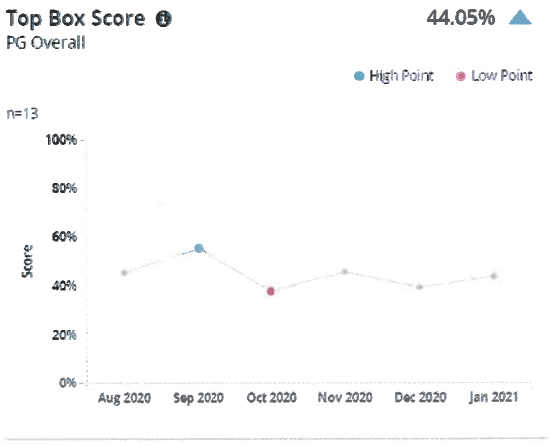
United Medical Center: Patient Experience Insights – January 2021

ER Overall Rating

Emergency Department



Received Date	2/1/2018 1/31/2019	2/1/2019 1/31/2020	2/1/2020 1/31/2021
Benchmark Period	11/1/2018 1/31/2019	11/1/2019 1/31/2020	10/1/2020 12/31/2020
Sample size	n=130	n=91	n=166
Peer group size	N=2510	N=2515	N=2526

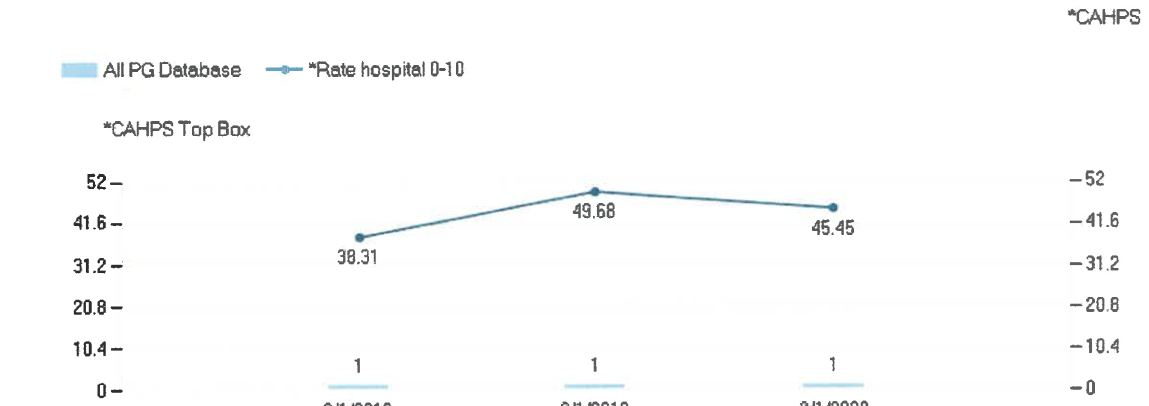


Time Period	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021
n	17	17	20	16	13	13
Top Box Score	45.54%	55.67%	38.06%	45.83%	39.49%	44.05%
Percentile Rank	1	7	1	1	1	1

PRESS GANEY®

HCAHPS Rate 0-10

Inpatient

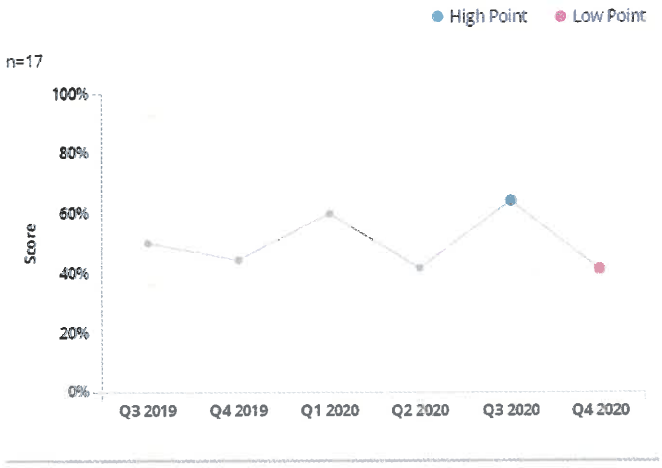


Received Date	2/1/2018 1/31/2019	2/1/2019 1/31/2020	2/1/2020 1/31/2021
Benchmark Period	11/1/2018 1/31/2019	11/1/2019 1/31/2020	10/1/2020 12/31/2020
Sample size	n=201	n=155	n=143
Peer group size	N=2736	N=2647	N=2601

Unit 5 West

Top Box Score ⓘ 41.18% ▼

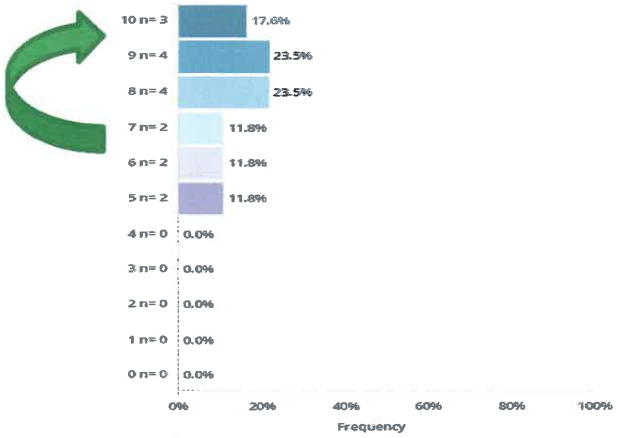
CAHPS Rate 0-10



Time Period	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
n	4	9	15	12	14	17
Top Box Score	50.00%	44.44%	60.00%	41.67%	64.29%	41.18%
Percentile Rank	1	1	10	1	21	1

PRESS GANEY®

Distribution of Responses
CAHPS Rate 0-10



Priority themes for Unit 5 West are nurse communication and attention to unique patient needs:

Priority Index

PG Report Period: 6 months | CAHPS Report Period: 12 months
Benchmark by: All Respondents

Current Order	Survey Type	Question	Percentile Rank	Correlation
1	PG	Nurses kept you informed	1	0.72
2	PG	Explanations:happen during T&Tf	1	0.67
3	PG	Staff include decisions re:trtmnt	1	0.6
3	PG	Likelihood of recommending	1	0.6
5	PG	Attention to needs	2	0.63
6	PG	Friendliness/courtesy of doctorsf	1	0.59
6	PG	Staff addressed emotional needs	1	0.59
8	CAHPS	Nurses listen carefully to you	2	0.6
9	PG	Nurses' attitude toward requests	1	0.58
9	PG	Overall rating of care	1	0.58

HCAHPS Reporting Schedule 2021

DEPARTMENT	January	February	March	April	May	June	July	August	September	October	November	December
Emergency Department	x			x			x			x		
5 West		x			x			x			x	
8 West			x			x			x			x

COMPLETED FIRE DRILL MATRIX

Hospital Name: United Medical Center (UMC) Score at EC

Quarterly Hospital Fire D

Day = M, Tu, W, Th, F, Sa, Su **Time: 24 hour formatted**			Q1			Q2			
			Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.
1st Shift	Normal	**Location/Building**	1st Core						
		Day	F						
		Date	1/8/21						
		Time	1330						
	ILSM	**Location/Building**							
		Day							
		Date							
		Time							
2nd Shift	Normal	**Location/Building**	3rd Fl						
		Day	Tu						
		Date	1/12/21						
		Time	2001						
	ILSM	**Location/Building**	CNMC						
		Day	Su						
		Date	1/31/21						
		Time	2130						
3rd Shift	Normal	**Location/Building**	5th Fl						
		Day	Th						
		Date	1/22/21						
		Time	0300						
	ILSM	**Location/Building**							
		Day							
		Date							
		Time							

Previous and Current High Risk Fire Drills (recommended not requ

Location:	**Previous**	**Current**	**Location:**	**Previous**	**Current**	**Location:**	**Previous**	**Current**	**Location:**
Kitchen			**Surgery**			**Cath/EP Lab**			**MRI**
Day	W	Th	Day			Day			Day
Date			Date			Date			Date
Time			Time			Time			Time

Quarterly Ambulatory Fire Drills

		Q1	Q2	Q3	Q4		Q1
1st Shift	**Location/Building**	AST				**Location/Building**	
	Day	Tu				Day	
	Date					Date	
	Time					Time	

Annual Business Occupancy Fire Drills (2 Years of drills)

	Previous	**Current**		**Previous**	**Current**		**Previous**	**Current**	
Building	**Medical Office Buliding**		**Building**			**Building**			**Building**
Day	W	Th	Day			Day			Day
Date			Date			Date			Date
Time			Time			Time			Time

Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)

COMPLETED FIRE DRILL MATRIX

1st	
2nd	
3rd	

NA Not applicable for no shift, building,
NC Not completed or missed

COMPLETED FIRE DRILL MATRIX

C.02.03.03 EP3

rills

Q3		Q4		
Aug.	Sep.	Oct.	Nov.	Dec.

uired)

Previous	Current	Location:	Previous	Current
		Plant		
		Day		
		Date		
		Time		

Q2	Q3	Q4

Previous	Current		Previous	Current
		Building		
		Day		
		Date		
		Time		

location or ILSM.

Utility Management Performance Indicators

QUALITY/SAFETY **UTILITIES**

#	MEASURE	GOAL	PERFORMANCE											
			YTD 2021	JAN	FEB	MAR	APRIL	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC
#	PROCESS														
1	PM Completion Rate on Utility Components or Systems	100%		50%											
2	Quarterly Differential Pressure Testing of Special Environment Areas	100%		100%											
3	Domestic water sampling/treatment (commenced in March)	100%		100%											
4	Steam Utility Failures	10 % reduction or 5		1											
5	Air Handler Reliability	<5%		70%											
6	Power Fluctations/Outages			0											
7	Water Intrution/Flooding Incidents			8											

Utility Management Performance Indicators

Hospital Survey on Patient Safety Culture Results

UMC UNITED MEDICAL CENTER

Quality Department

United Medical Center

The Hospital Survey on Patient Safety Culture

- "As Hospitals continue to strive to improve patient safety and quality, hospital leadership increasingly recognizes the importance of establishing a culture of safety. Achieving such a culture requires leadership, physicians, and staff to understand their organizational values, beliefs and norms about what is important and what attitudes and behaviors are expected and appropriate"(Agency for Healthcare Research and Quality (AHRQ), 2020).

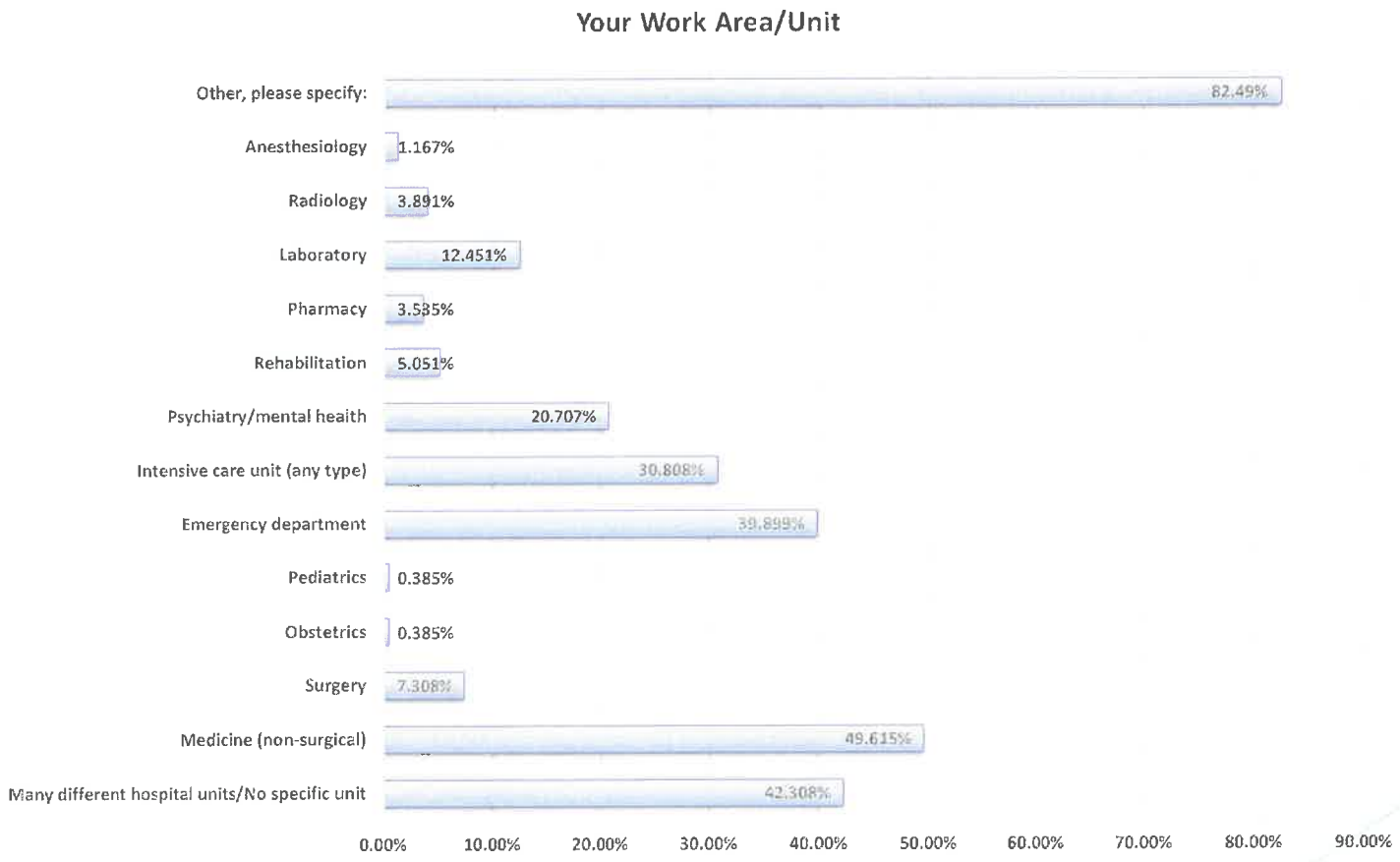
What is a Culture of Safety???

- A culture of Safety is an atmosphere of mutual trust in which all staff members can **talk freely about safety problems and how to solve them, without fear of blame or punishment**

(Institute for Healthcare Improvement (IHI), 2020).

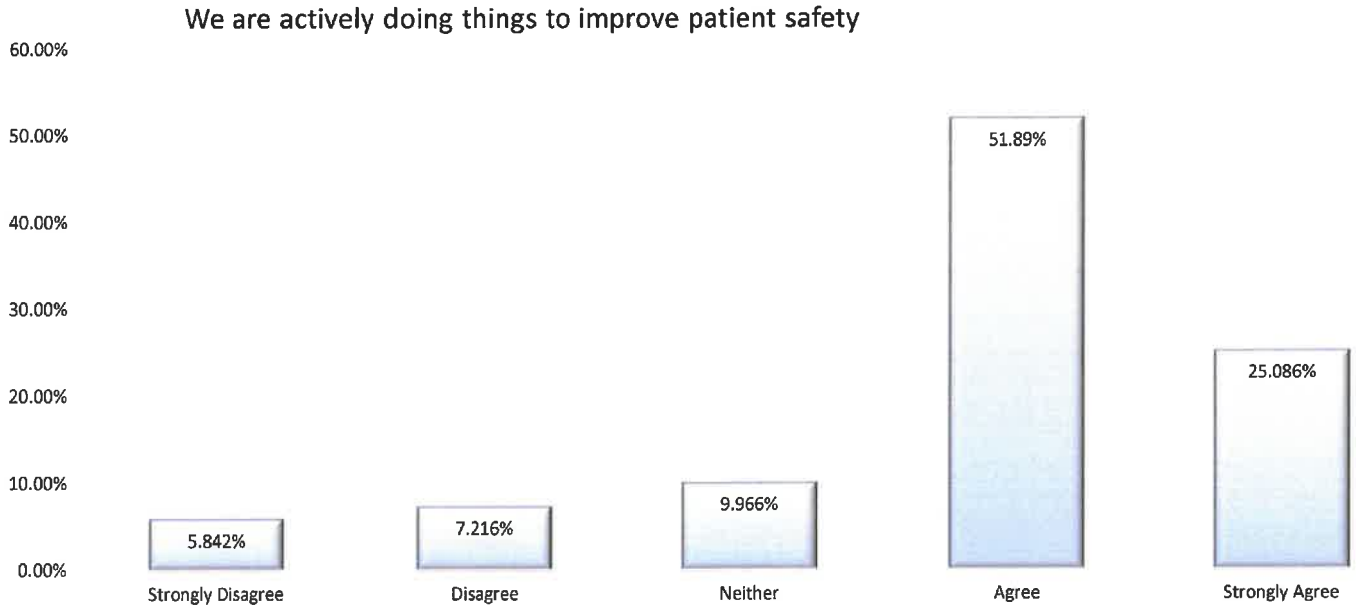
Does United Medical Have a Culture of Safety???

- The hospital survey is designed for hospital staff and asks their opinions about the culture of patient safety at their hospitals.
- The survey can be used to:
  - Raise staff awareness about patient safety,
  - Assess the current status of patient safety culture,
  - Identify Strengths and areas for patient safety culture improvement,
  - Examine Trends in patient safety culture change over time,
  - Evaluate the cultural impact of patient safety initiatives and interventions, and
  - Conduct comparisons within and across organizations.

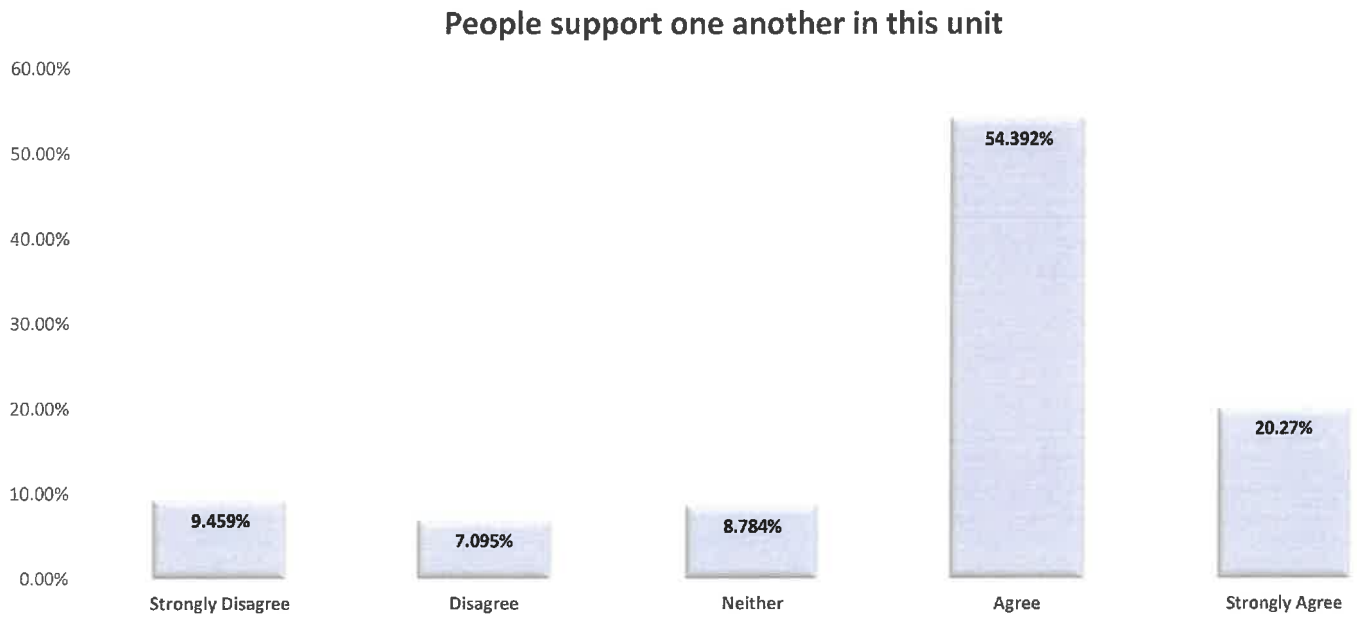


Approximately 302 Employees participated in the Survey!!!

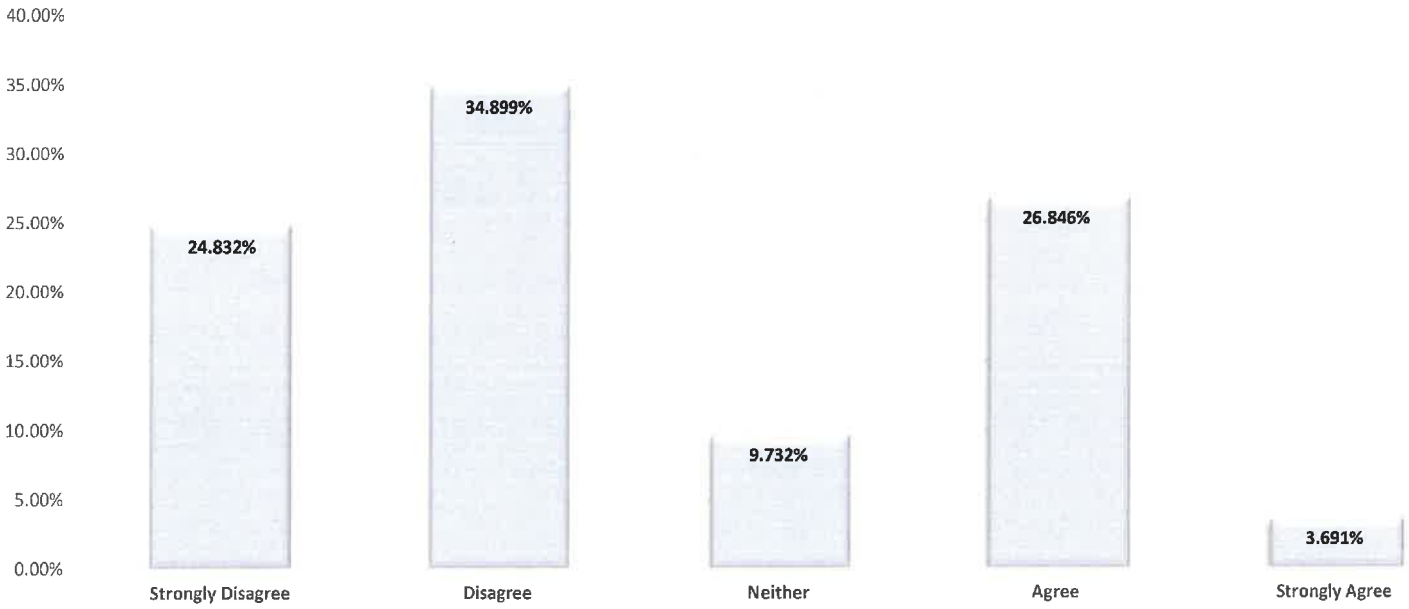
The Work Area



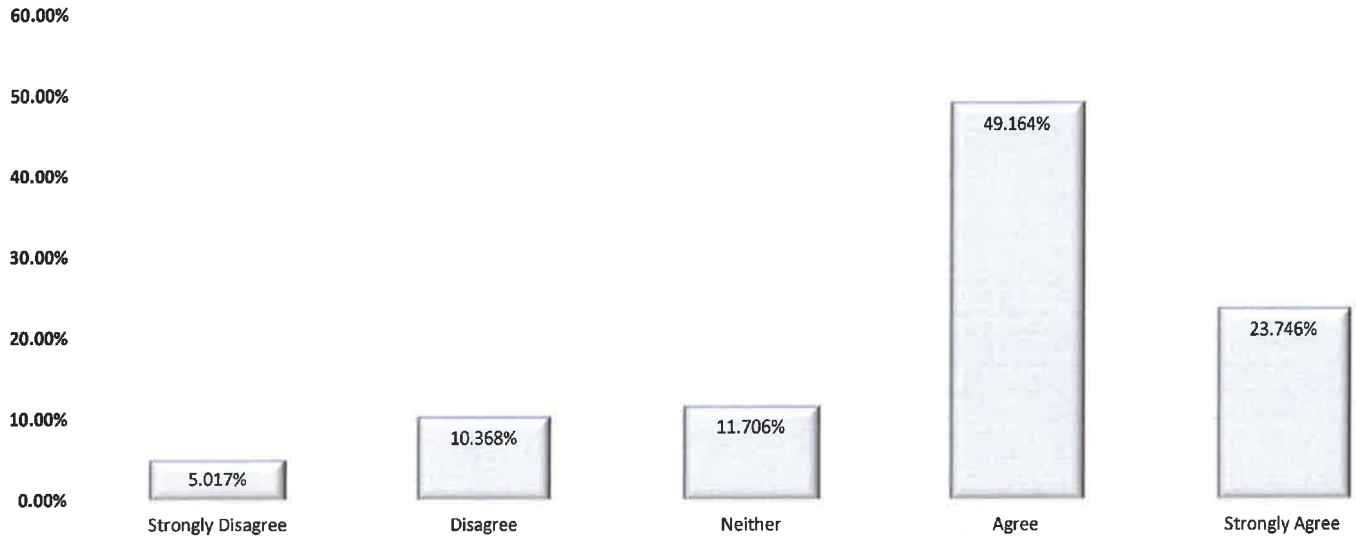

We have enough staff to handle the workload.
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
24.832%
34.899%
9.732%
26.846%
3.691%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

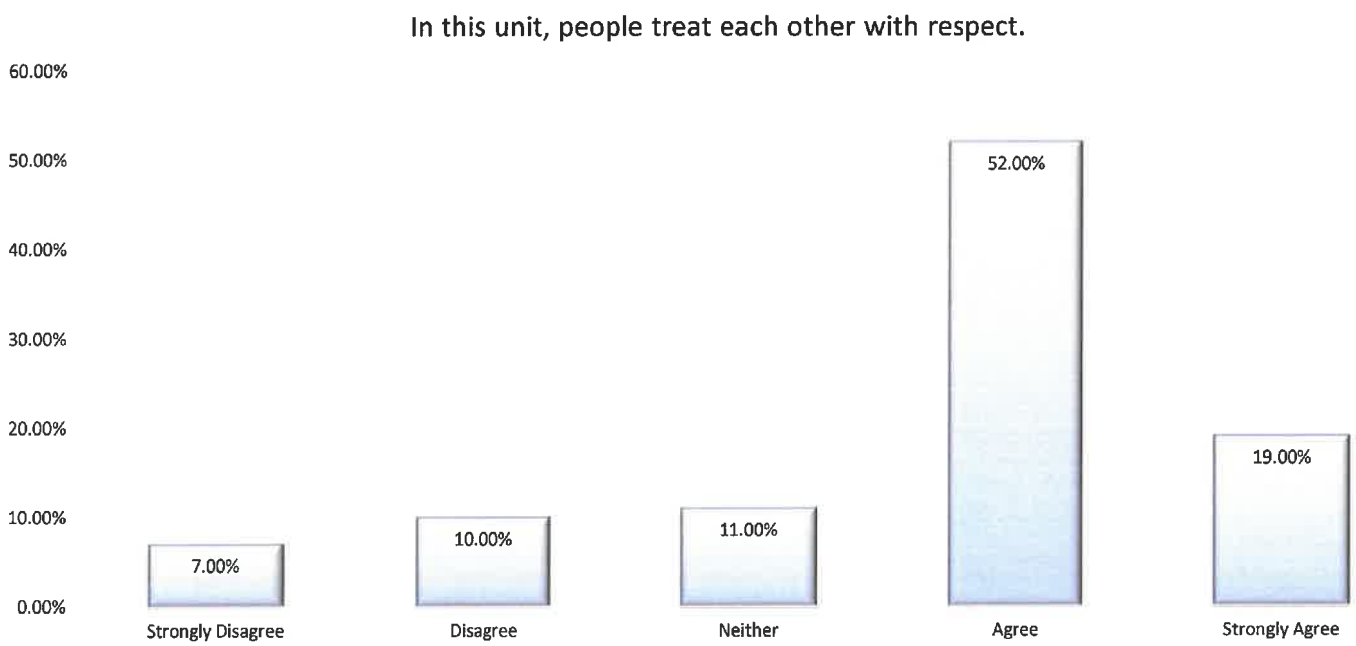

People support one another in this unit
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
9.459%
7.095%
8.784%
54.392%
20.27%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

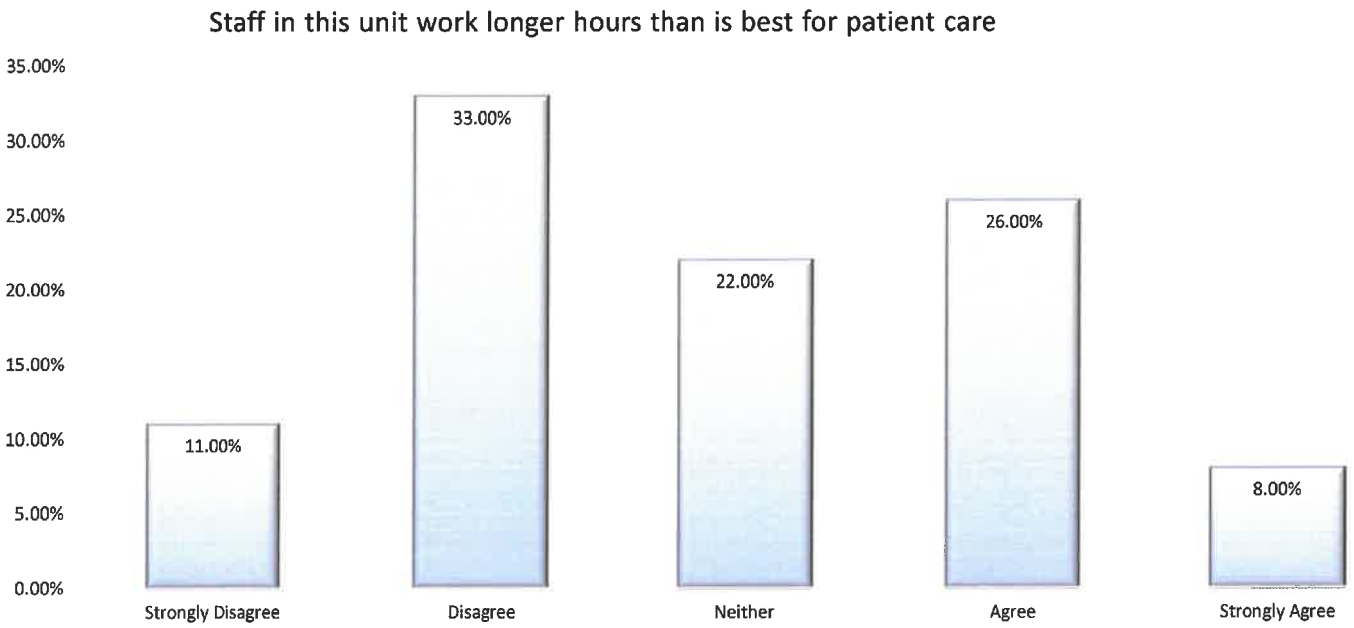
We have enough staff to handle the workload.



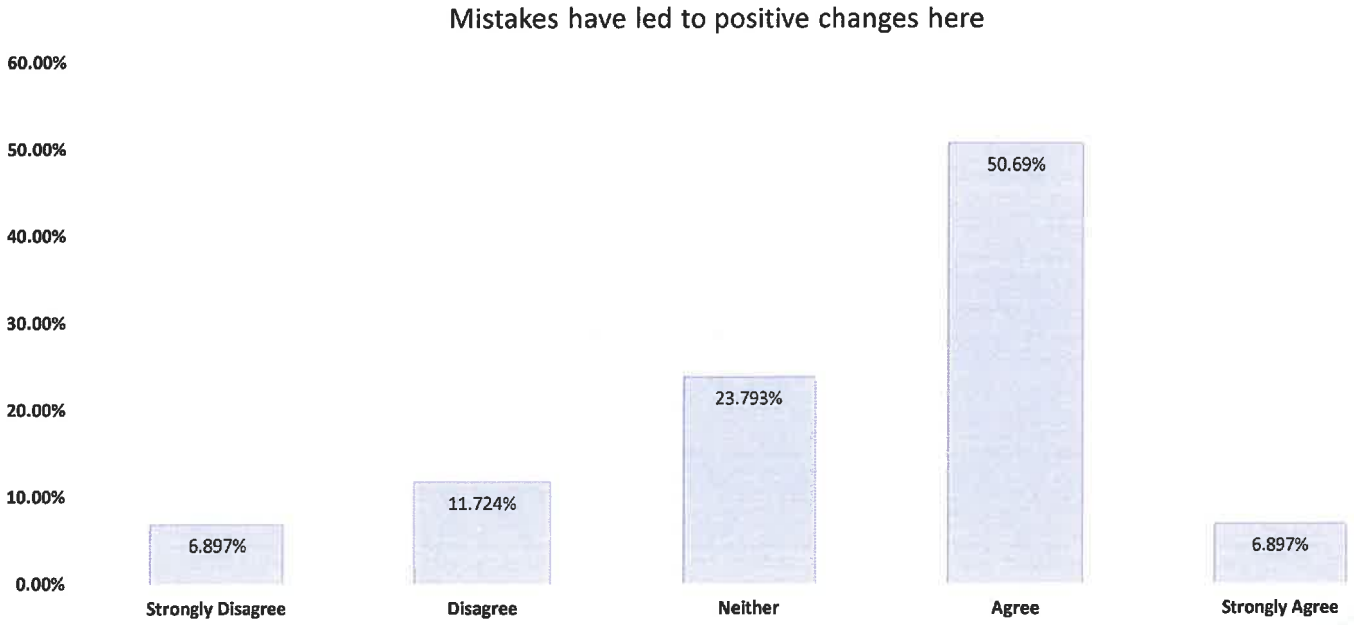
When a lot of work needs to be done quickly, we work together as a team to get the work done.

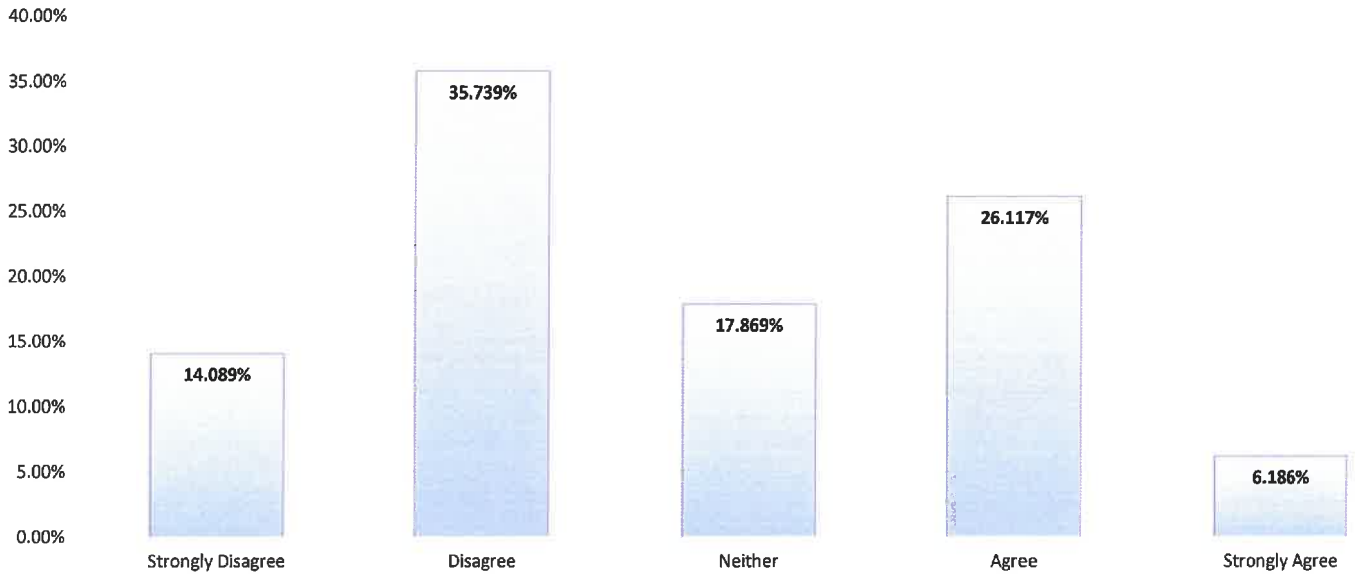



In this unit, people treat each other with respect.
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
7.00%
10.00%
11.00%
52.00%
19.00%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


Staff in this unit work longer hours than is best for patient care
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
11.00%
33.00%
22.00%
26.00%
8.00%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

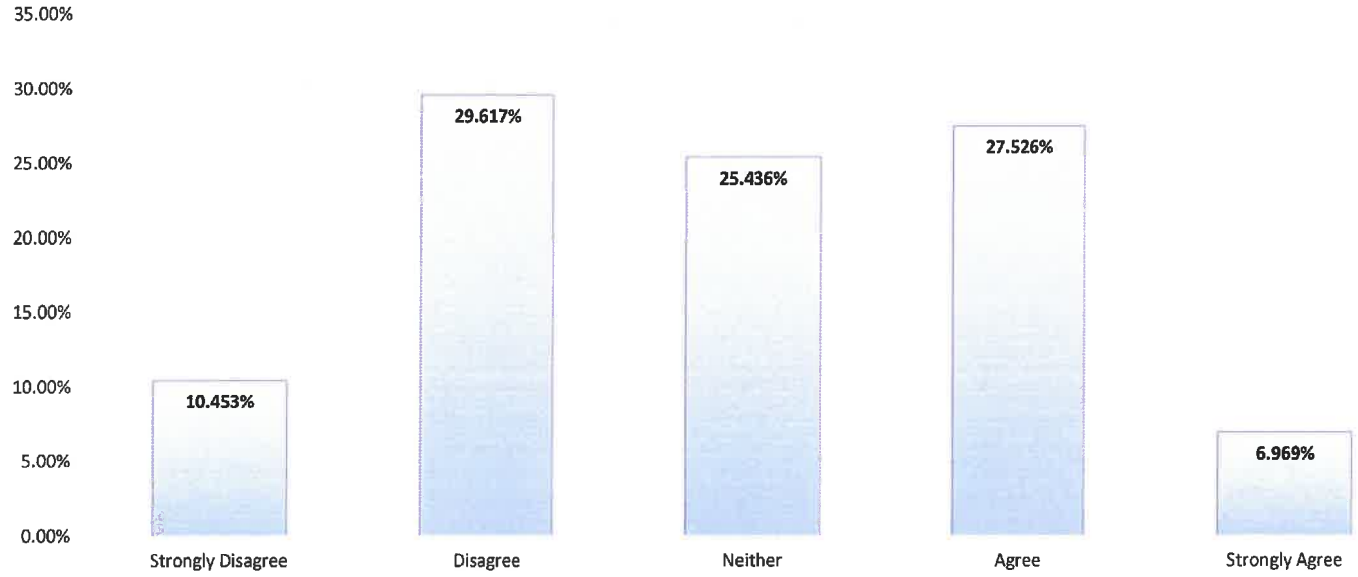

Staff feel like their mistakes are held against them.
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
8.136%
31.864%
24.407%
28.475%
7.119%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

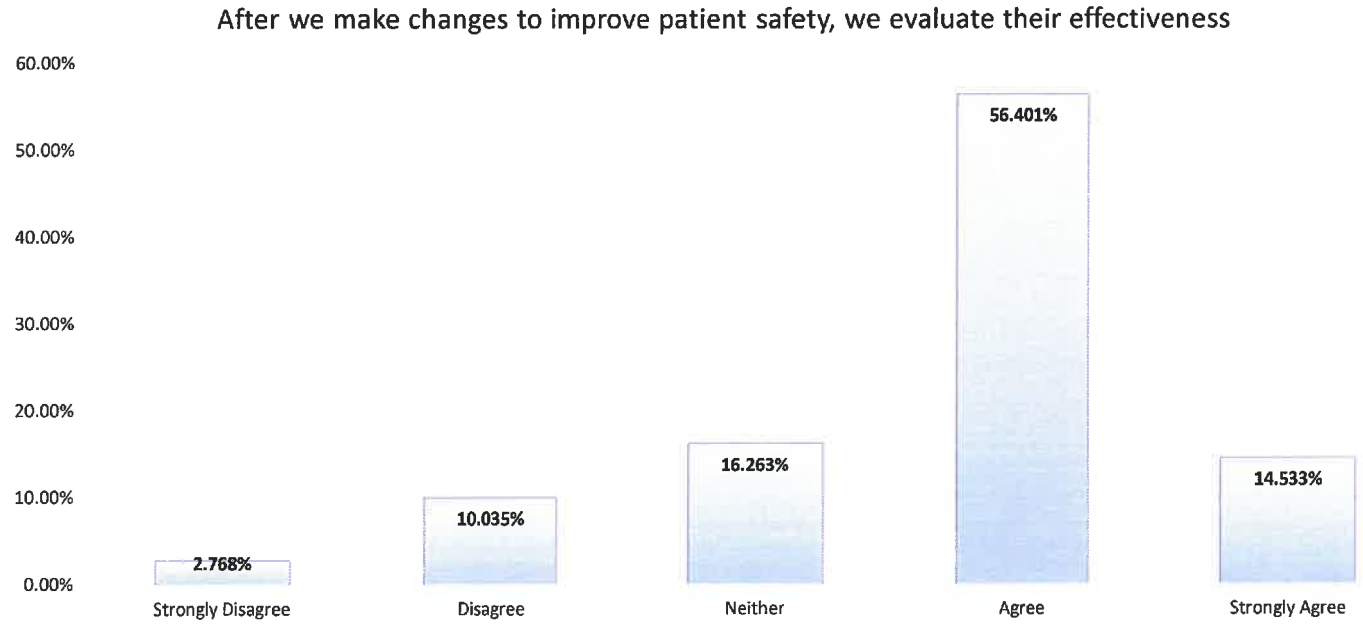

Mistakes have led to positive changes here
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
6.897%
11.724%
23.793%
50.69%
6.897%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


It is just by chance that more serious mistakes don't happen around here
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
14.089%
35.739%
17.869%
26.117%
6.186%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

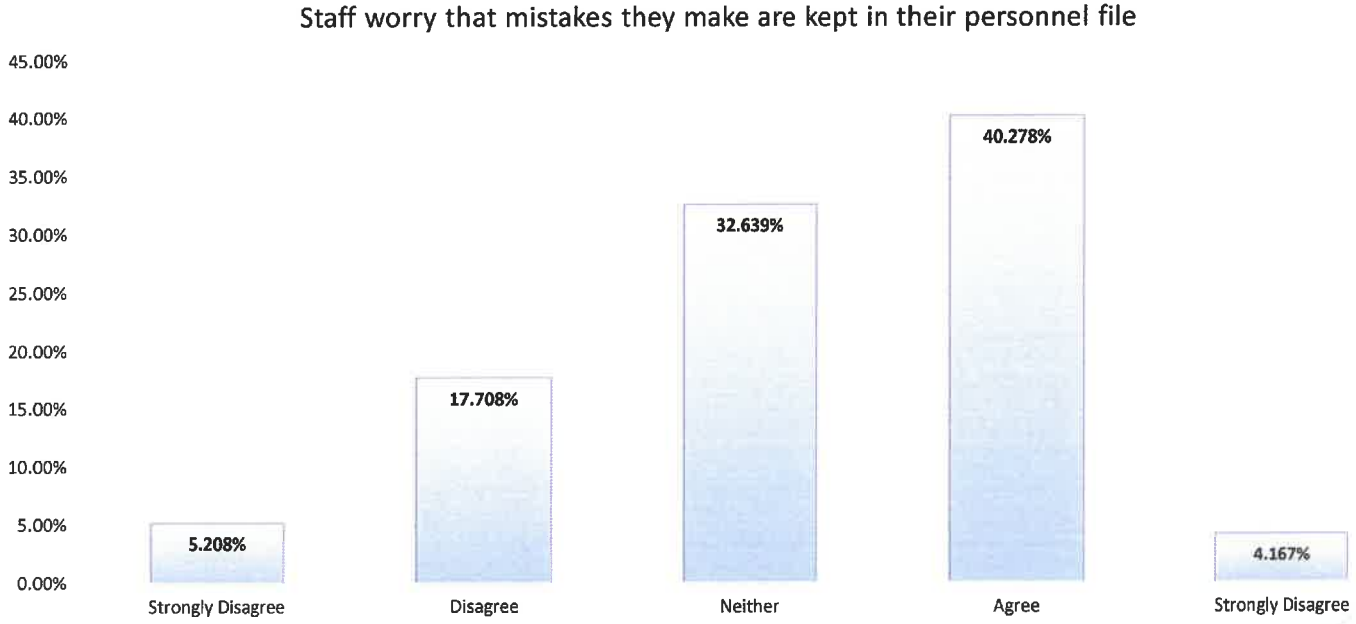

When one area in this unit gets really busy, others help out
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
8.651%
14.879%
12.111%
51.211%
13.149%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

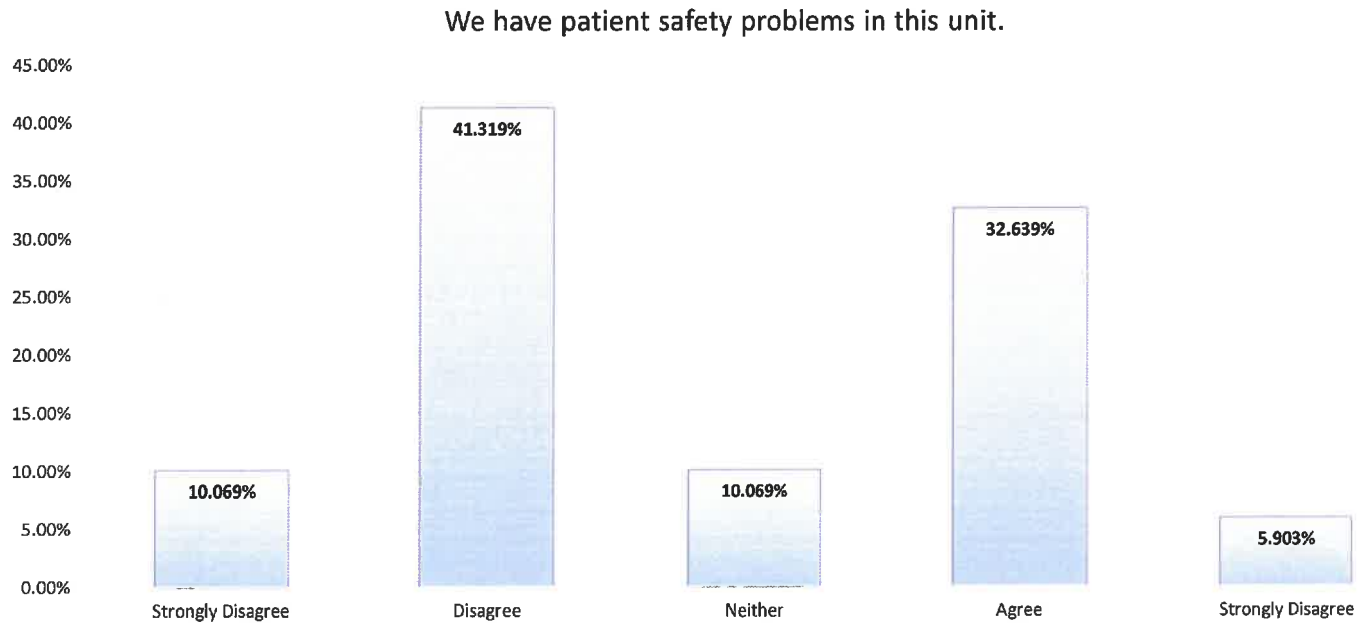
When an event is reported, it feels like the person is being written up, not the problem.

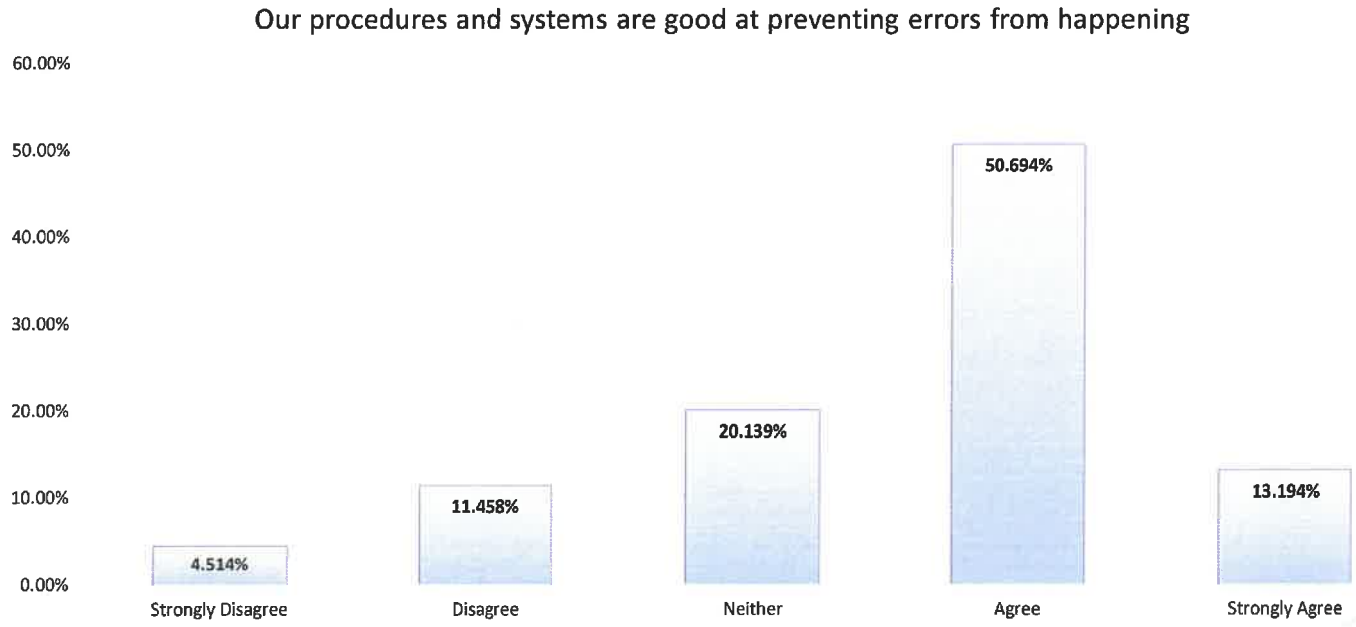



After we make changes to improve patient safety, we evaluate their effectiveness
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
2.768%
10.035%
16.263%
56.401%
14.533%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


Patient safety is never sacrificed to get more work done
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
4.844%
18.685%
12.457%
42.215%
21.799%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

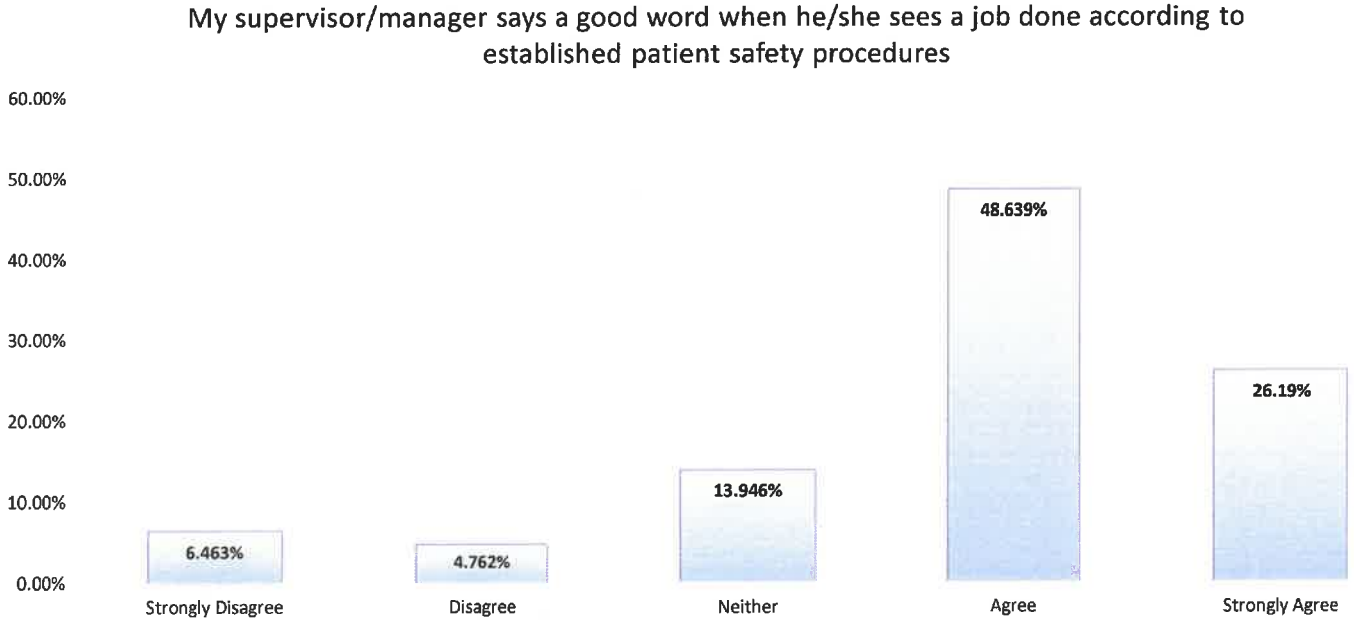

Staff worry that mistakes they make are kept in their personnel file
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
5.208%
17.708%
32.639%
40.278%
4.167%
Strongly Disagree
Disagree
Neither
Agree
Strongly Disagree

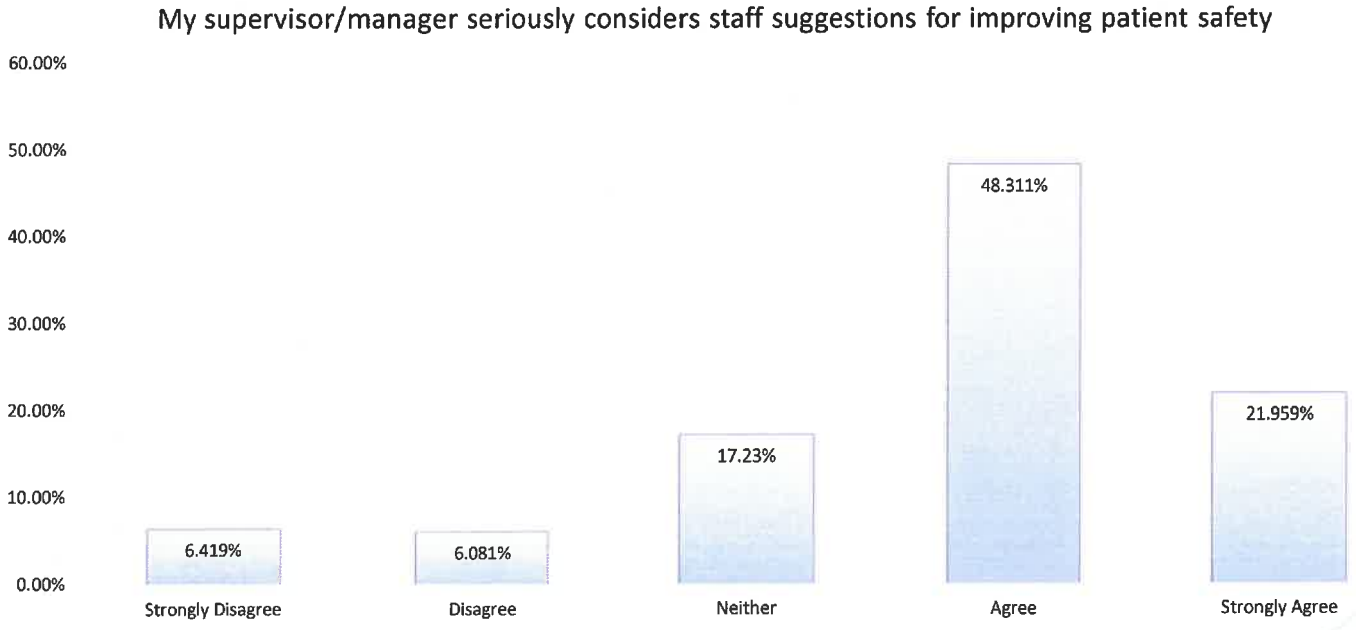

We have patient safety problems in this unit.
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
10.069%
41.319%
10.069%
32.639%
5.903%
Strongly Disagree
Disagree
Neither
Agree
Strongly Disagree

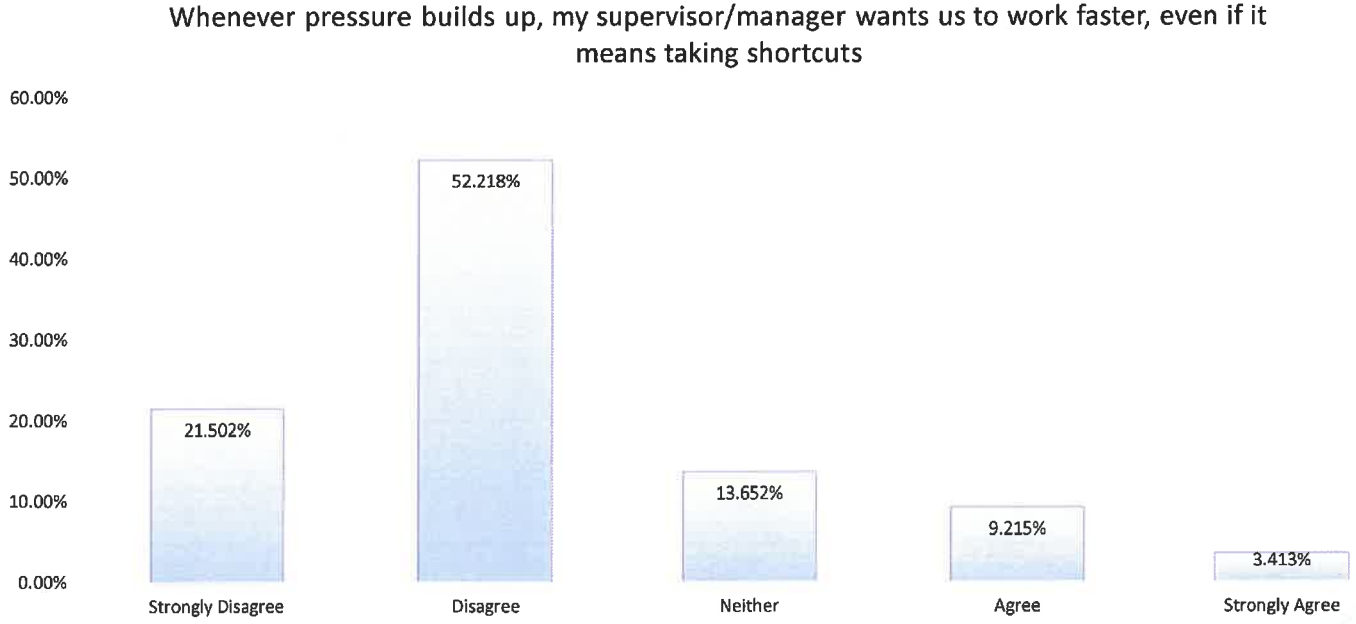

Our procedures and systems are good at preventing errors from happening
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
4.514%
11.458%
20.139%
50.694%
13.194%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

22

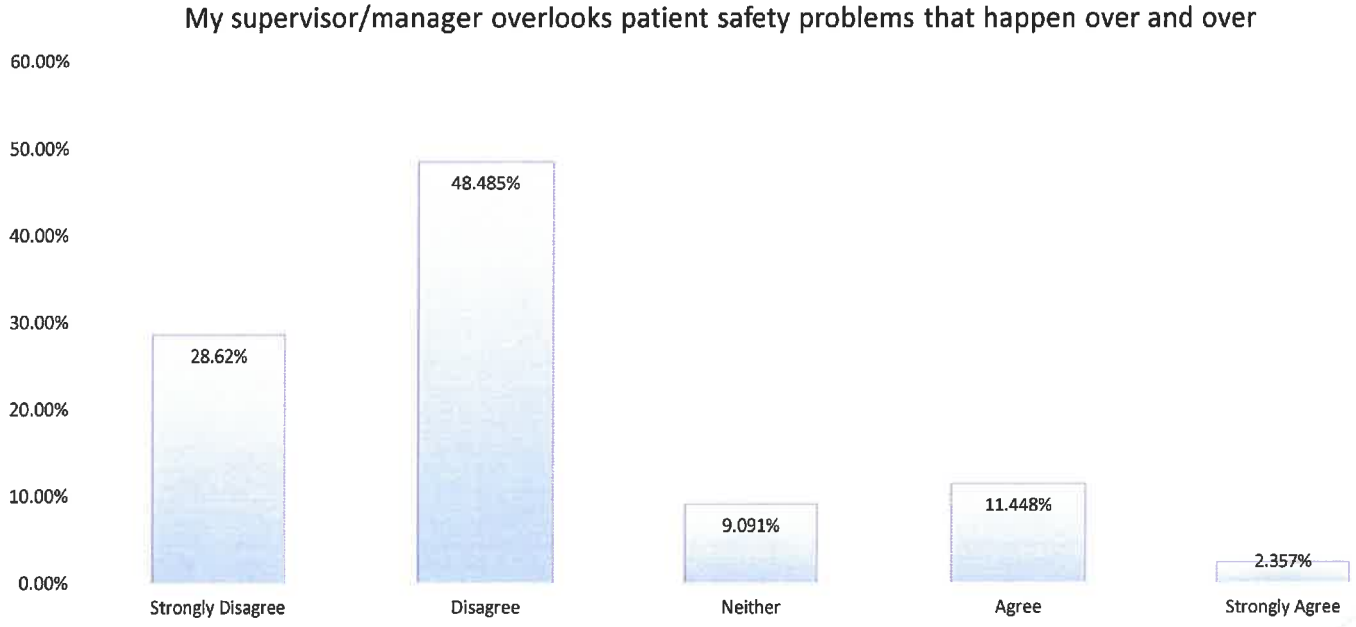
Supervisor/Manager



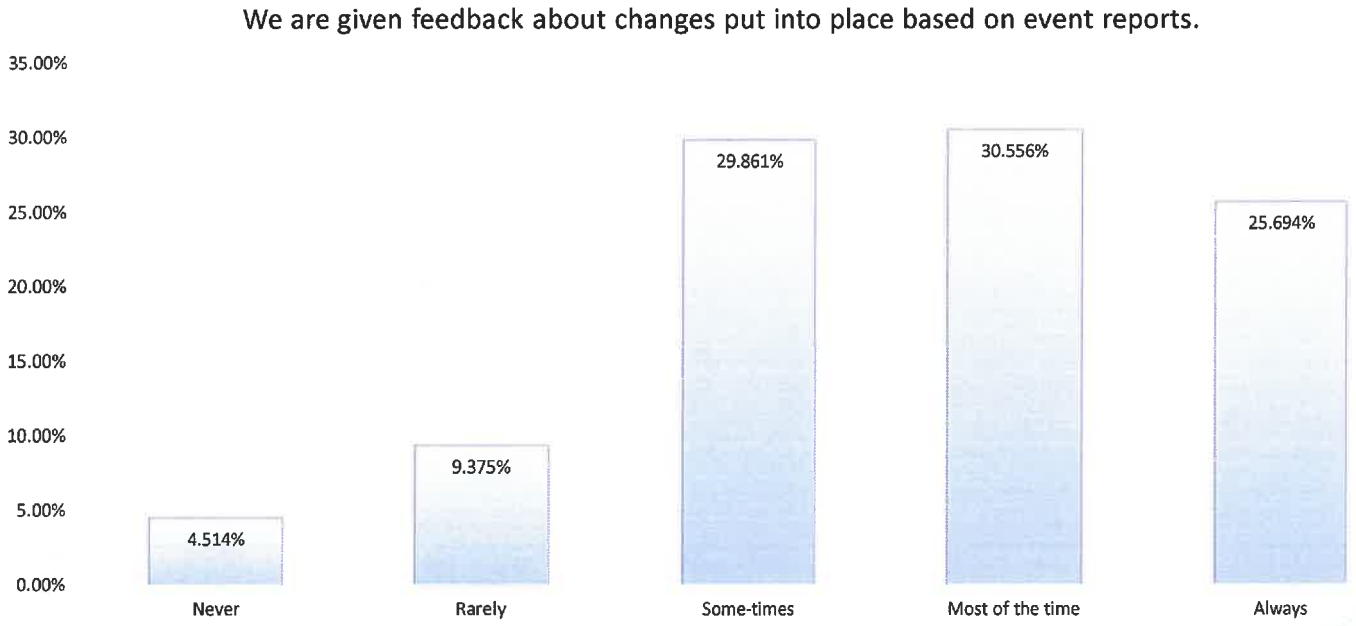

My supervisor/manager seriously considers staff suggestions for improving patient safety
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
6.419%
6.081%
17.23%
48.311%
21.959%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
21.502%
52.218%
13.652%
9.215%
3.413%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

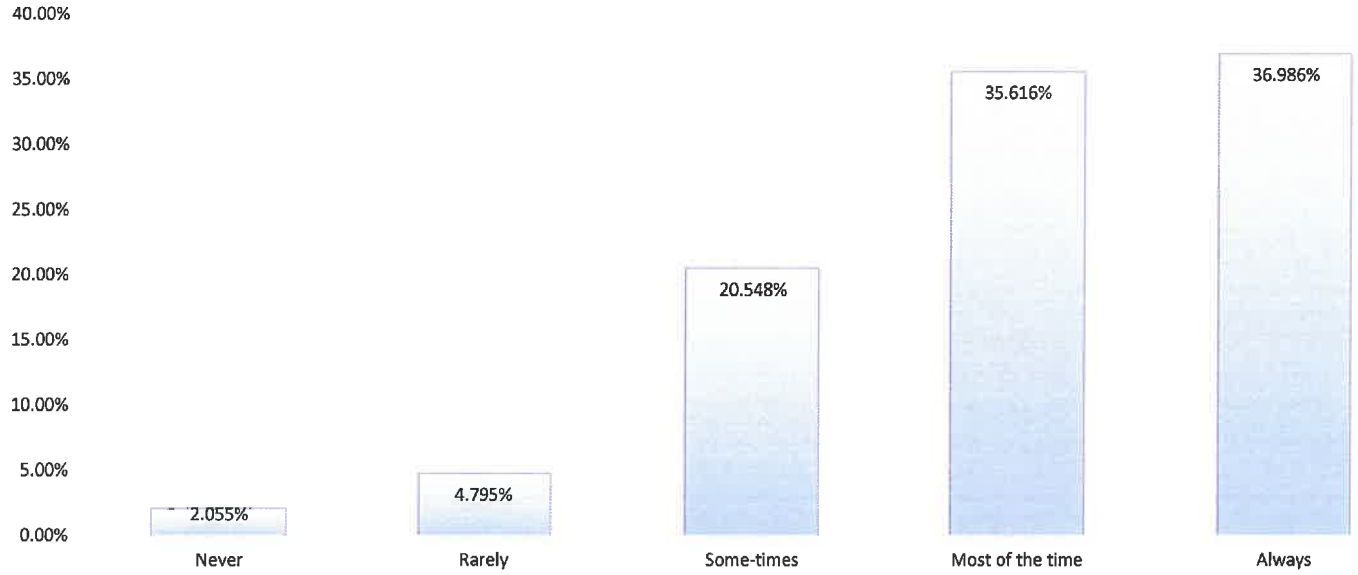
25


My supervisor/manager overlooks patient safety problems that happen over and over
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
28.62%
48.485%
9.091%
11.448%
2.357%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

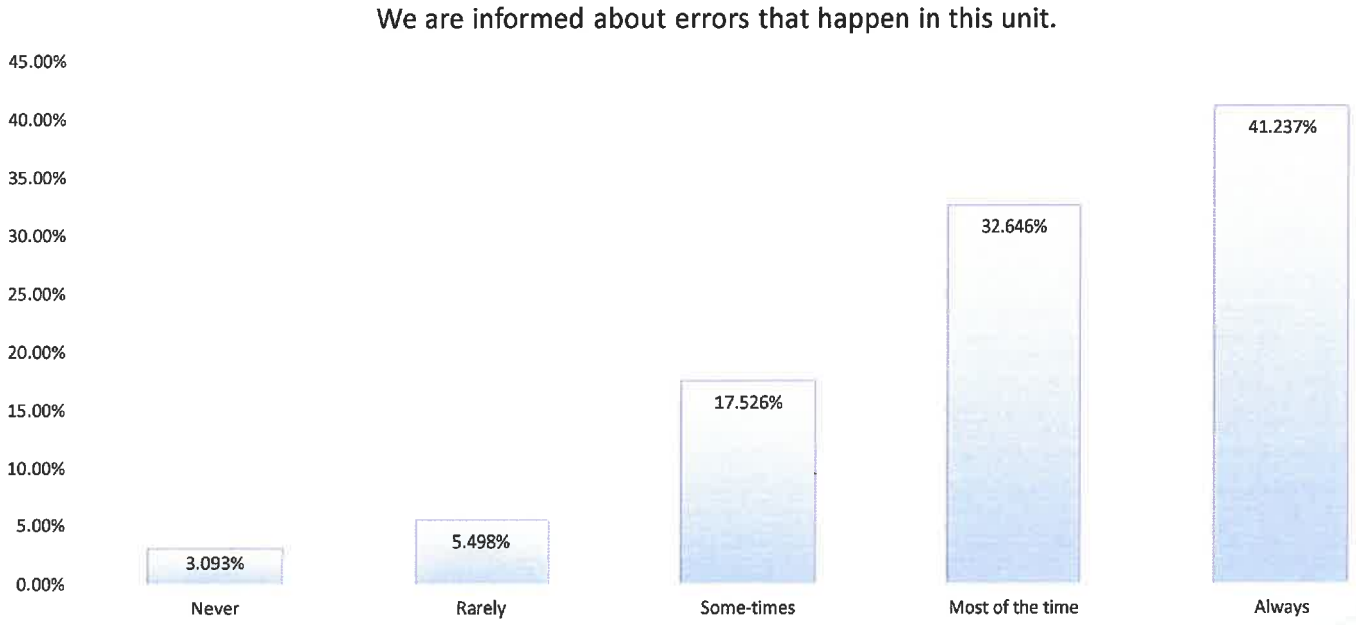
Communications: How often do the following things happen in your work area/unit?



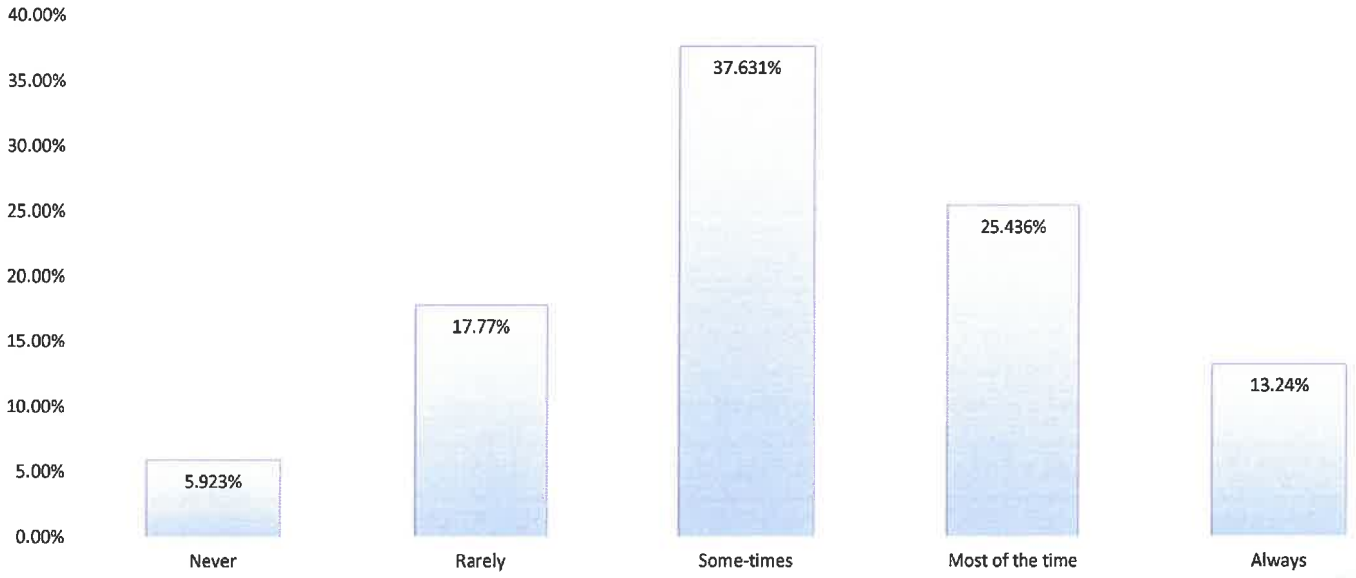
Staff will freely speak up if they see something that may negatively affect patient care.



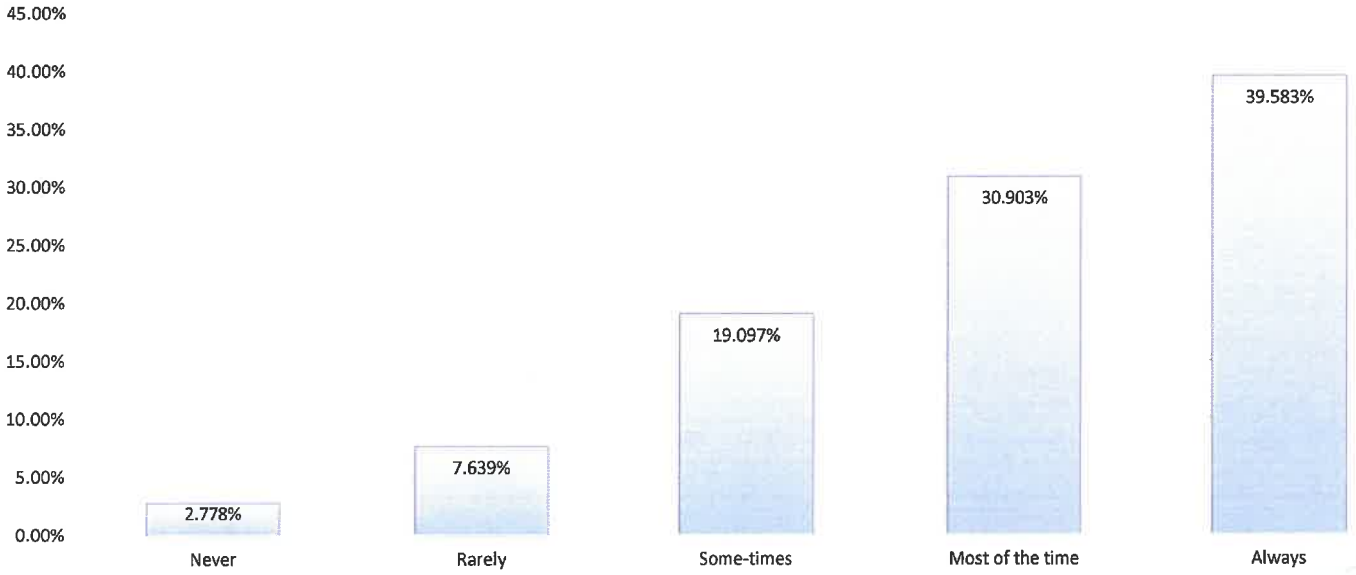
28


We are informed about errors that happen in this unit.
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
3.093%
5.498%
17.526%
32.646%
41.237%
Never
Rarely
Some-times
Most of the time
Always

Staff feel free to question the decisions or actions of those with more authority.

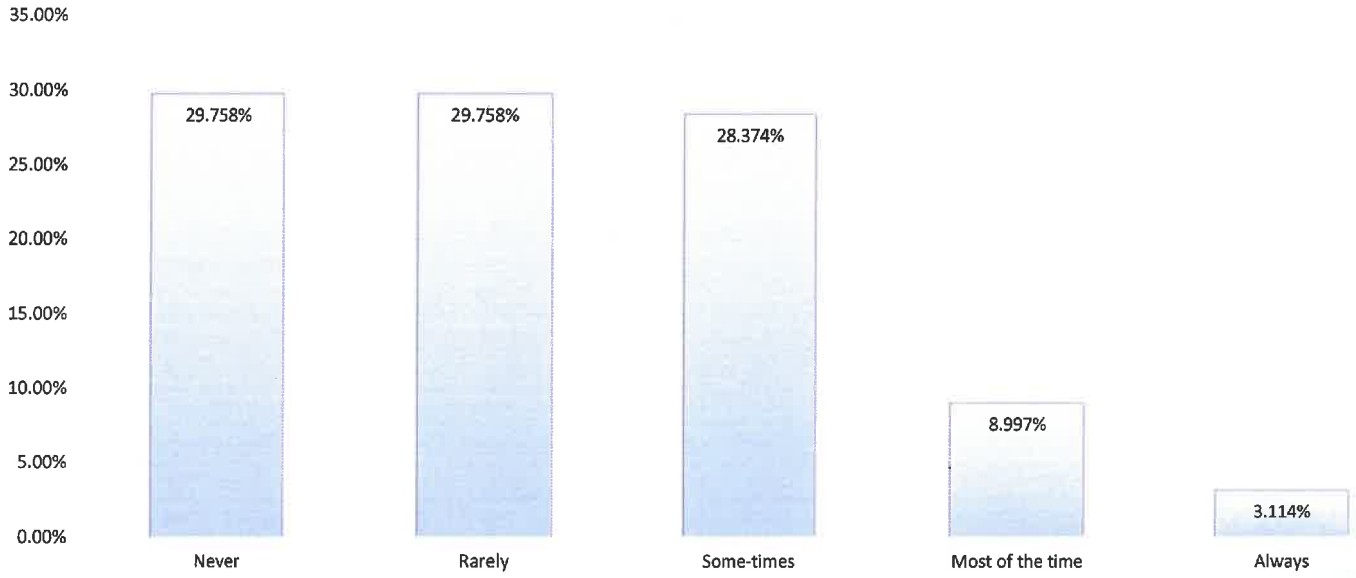


In this unit, we discuss ways to prevent errors from happening again.



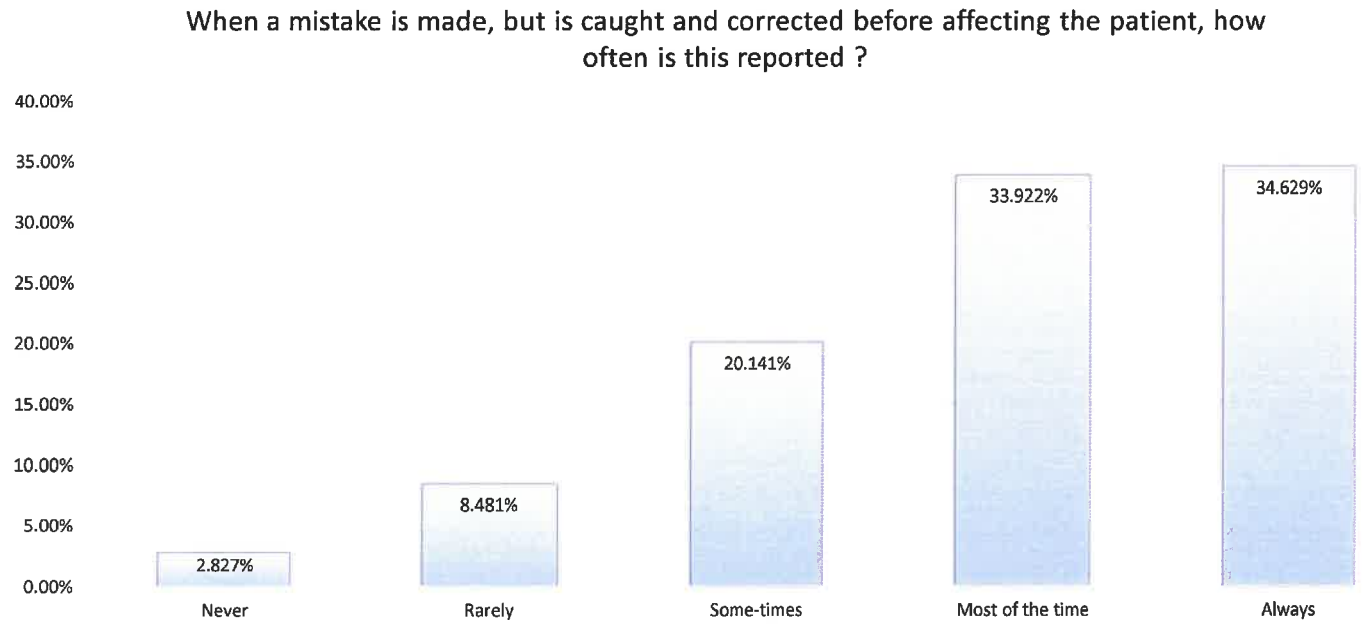
31

Staff are afraid to ask questions when something does not seem right.



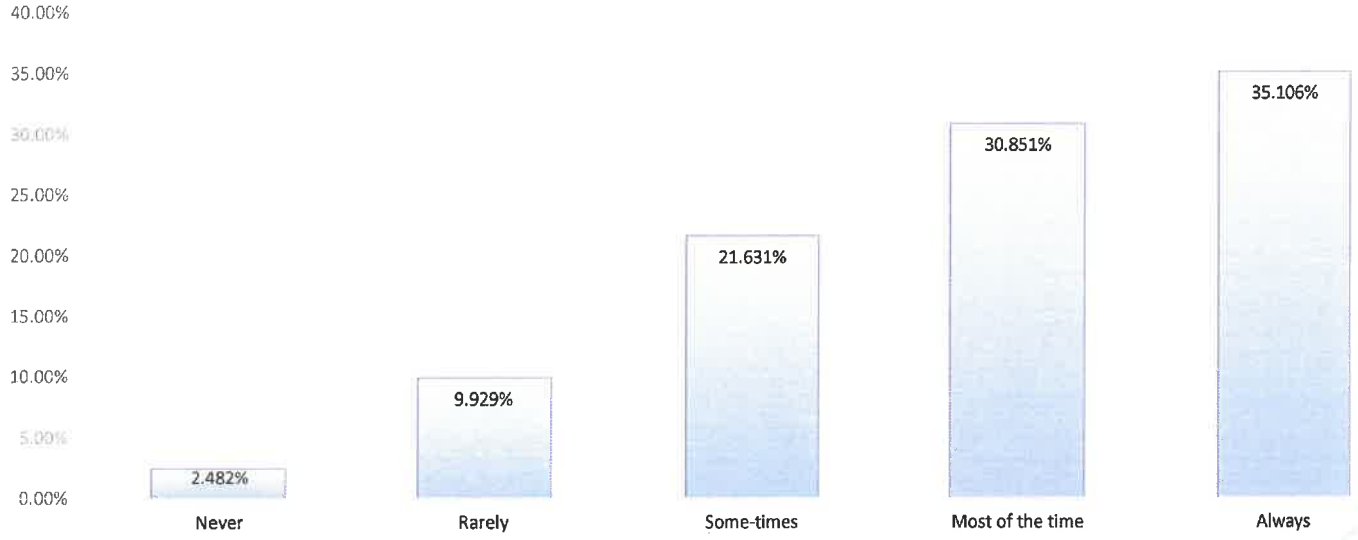
32

Frequency of Events Reported In your hospital work area/unit, when the following mistakes happen, how often are they reported?



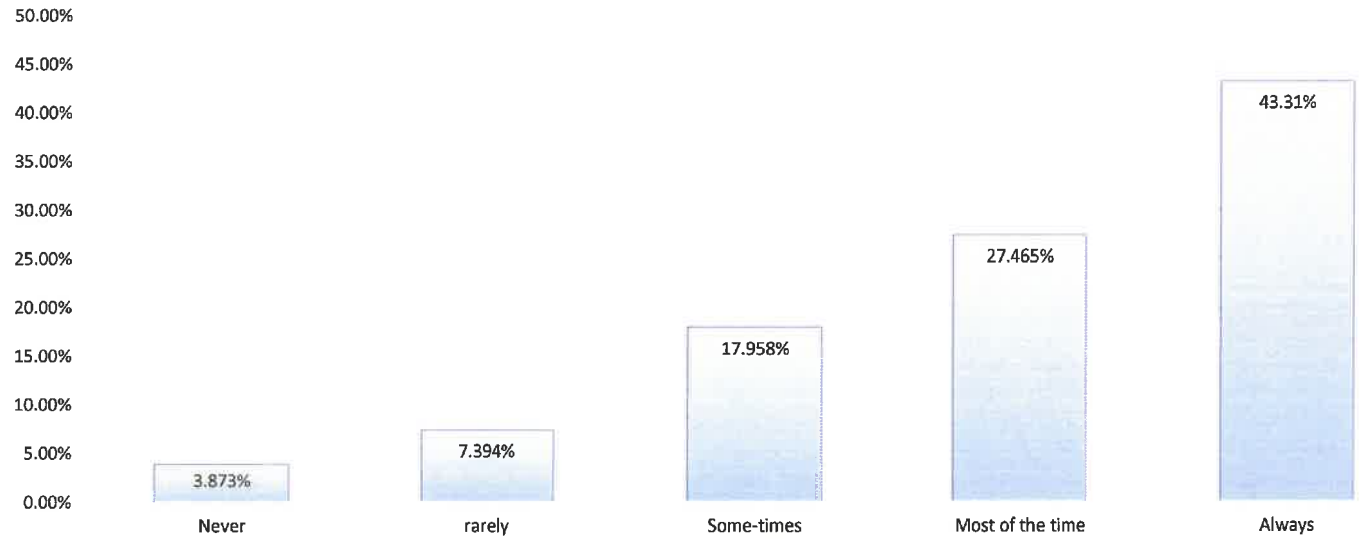
33

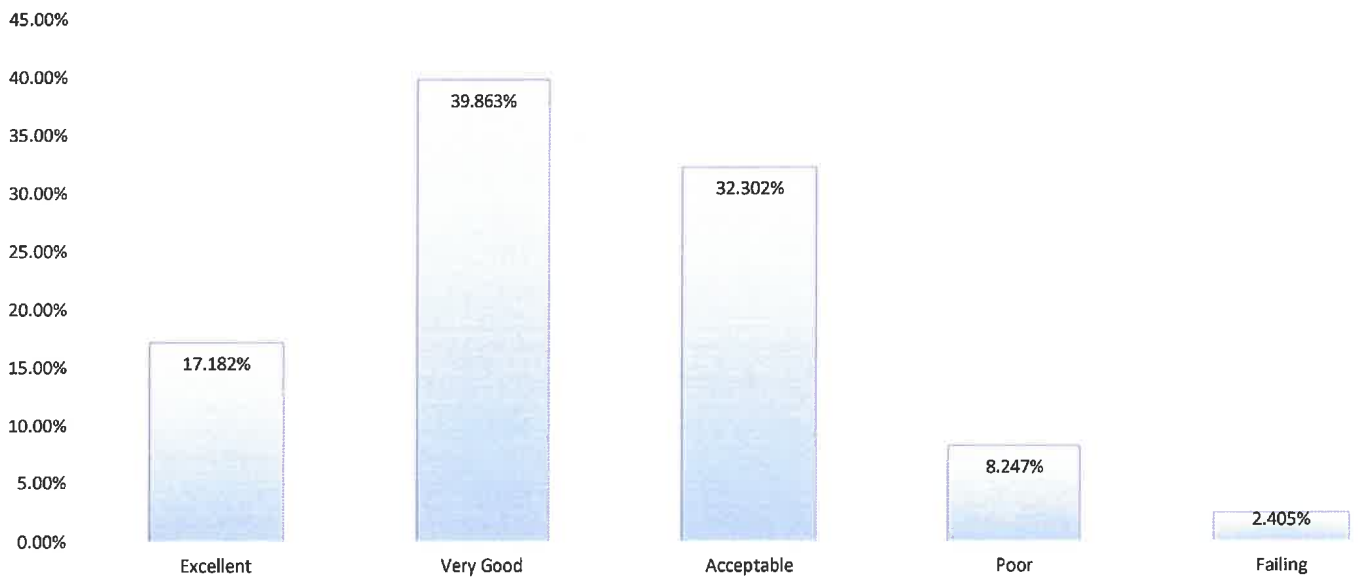
When a mistake is made, but has no potential to harm the patient, how often is this reported?



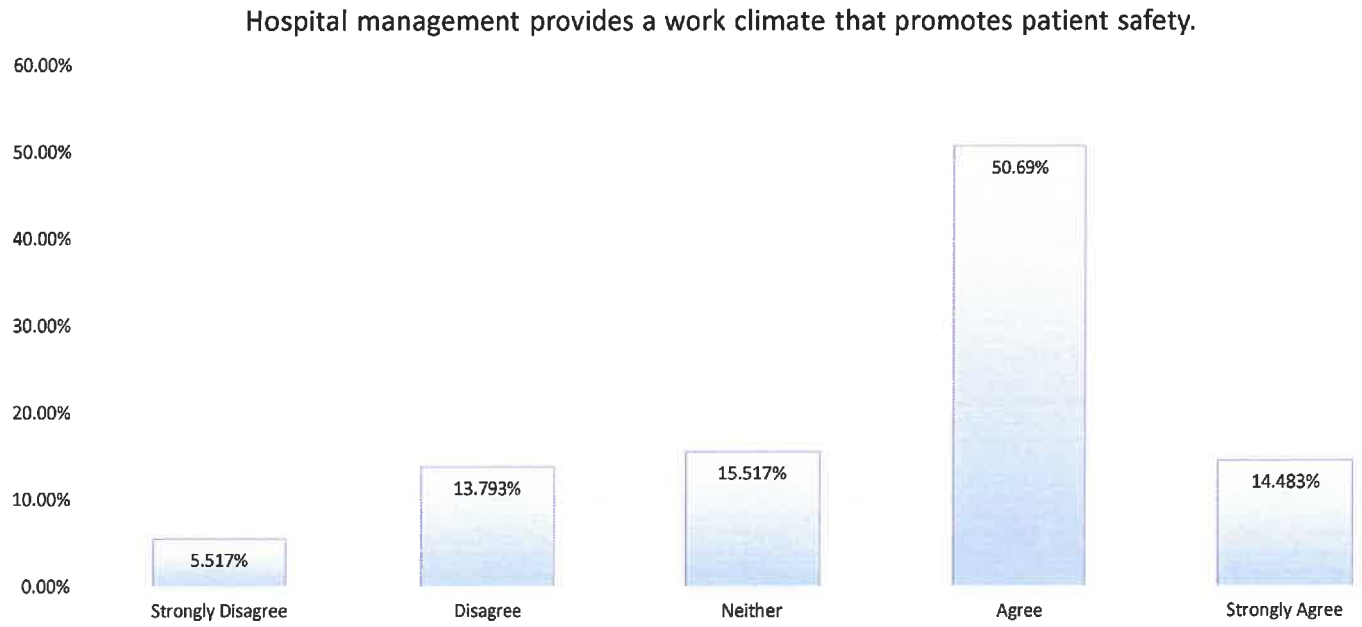
34

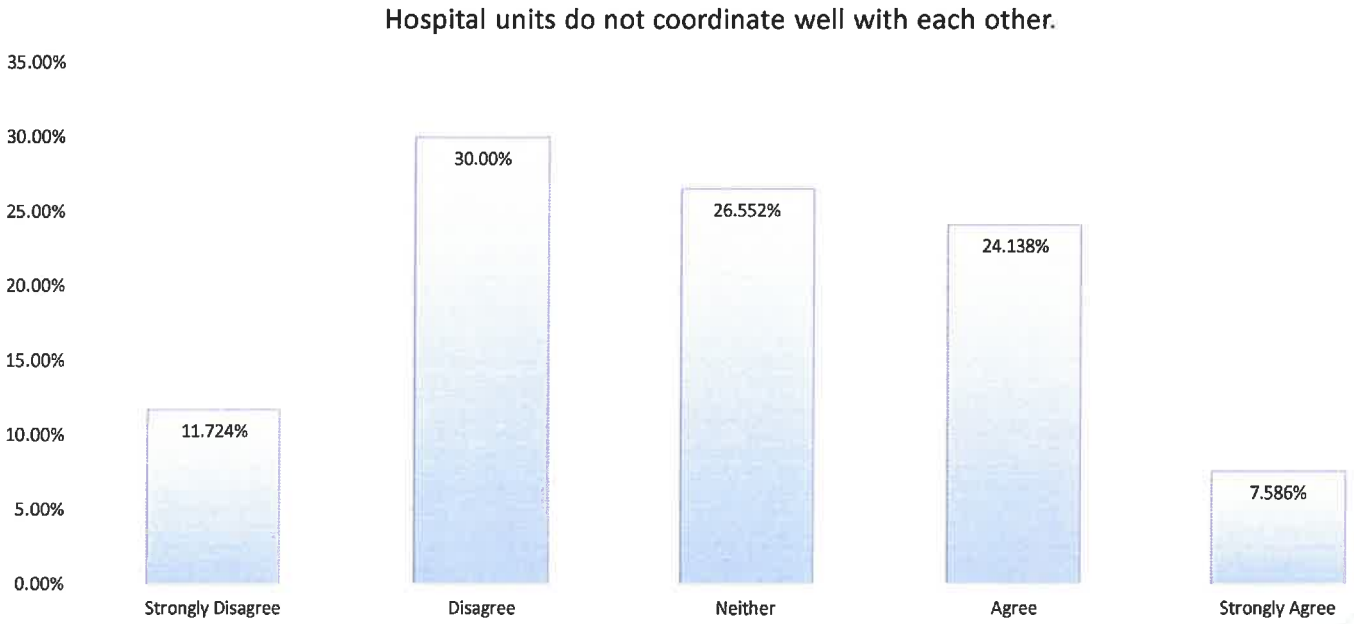
When a mistake is made that could harm the patient, but does not, how often is this reported?

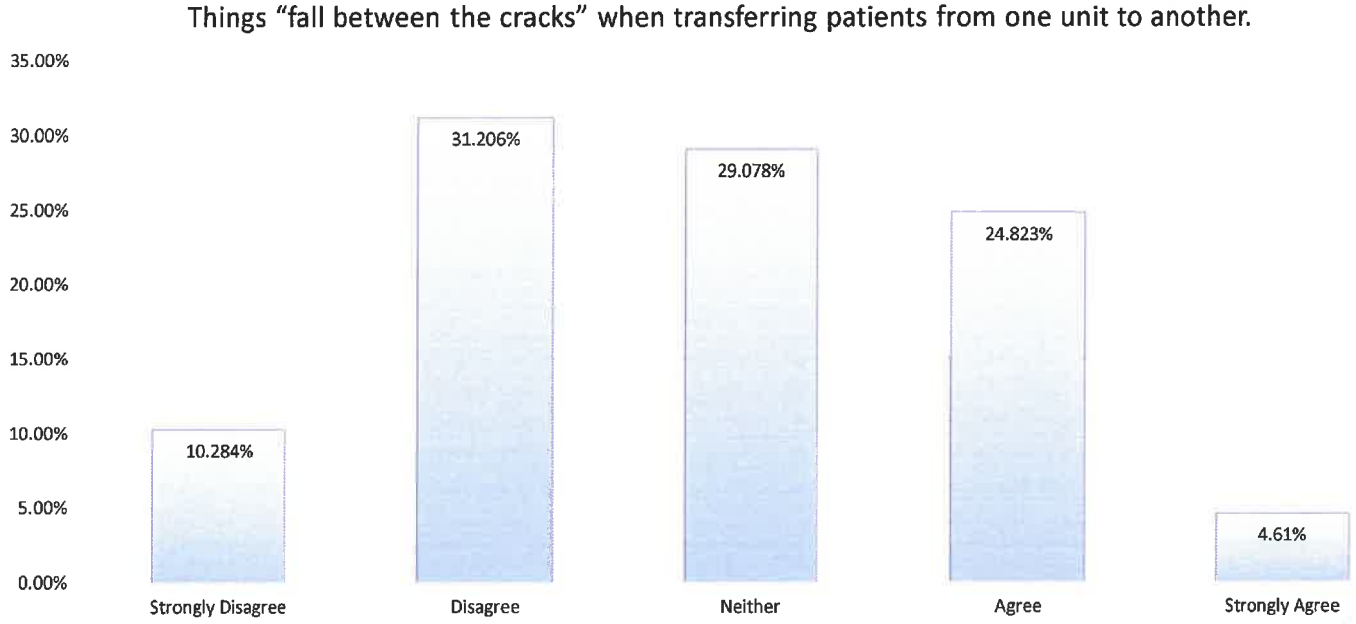



Please give your work area/unit in this hospital an overall grade on patient safety.
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
17.182%
39.863%
32.302%
8.247%
2.405%
Excellent
Very Good
Acceptable
Poor
Failing

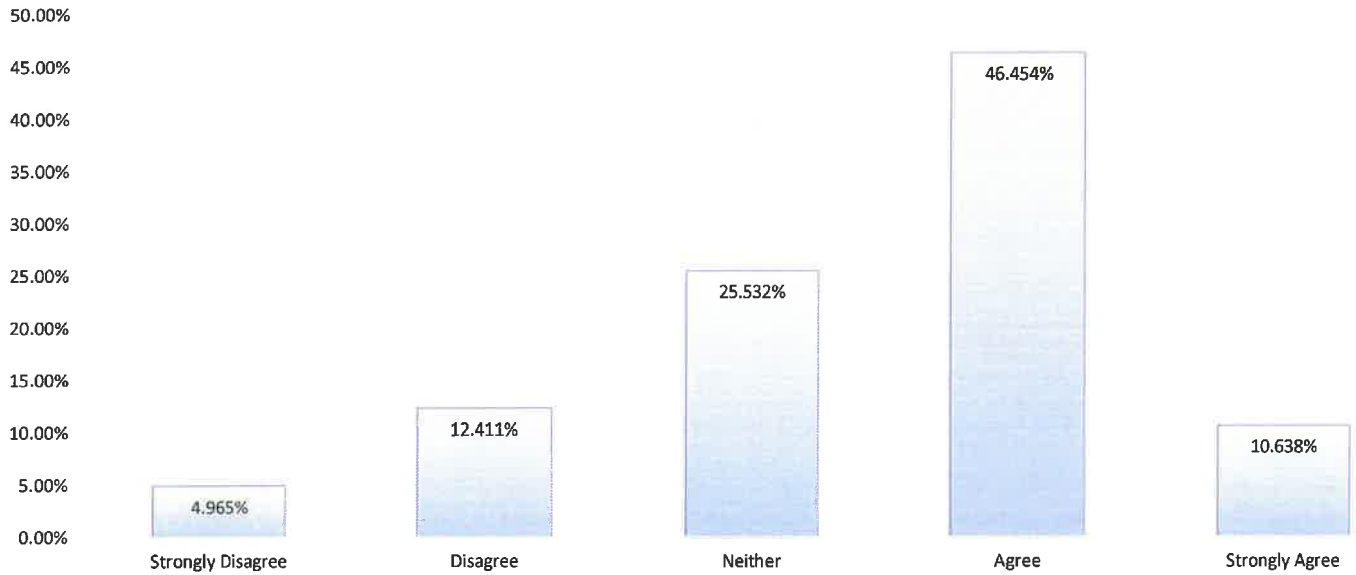
About Your Hospital

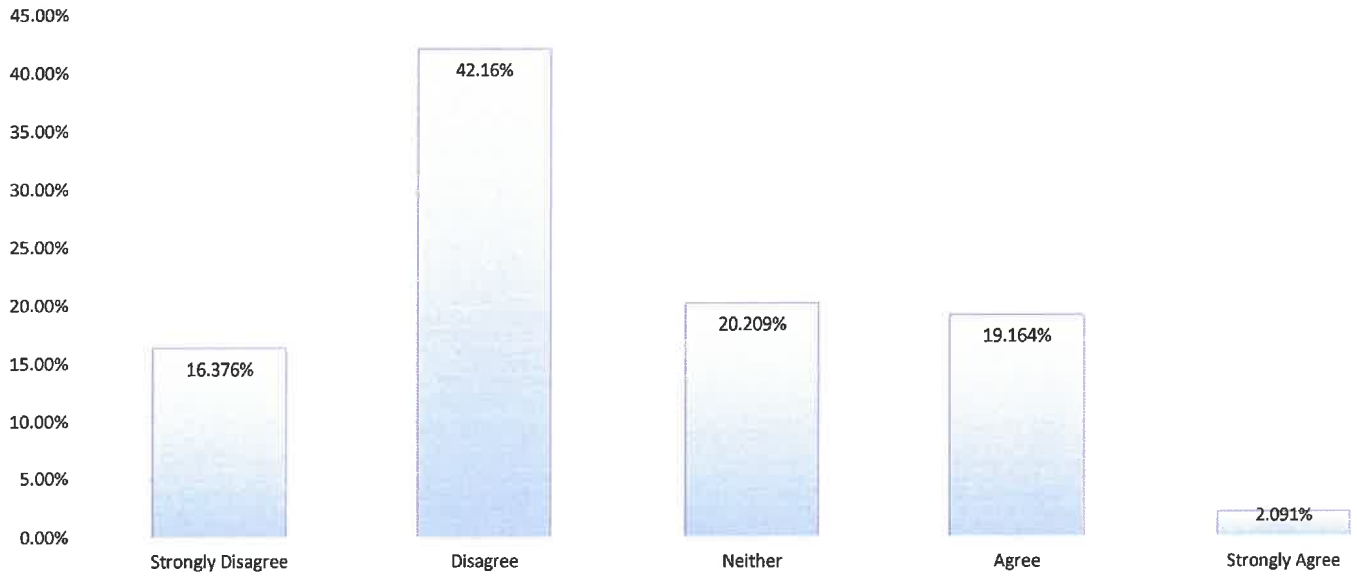


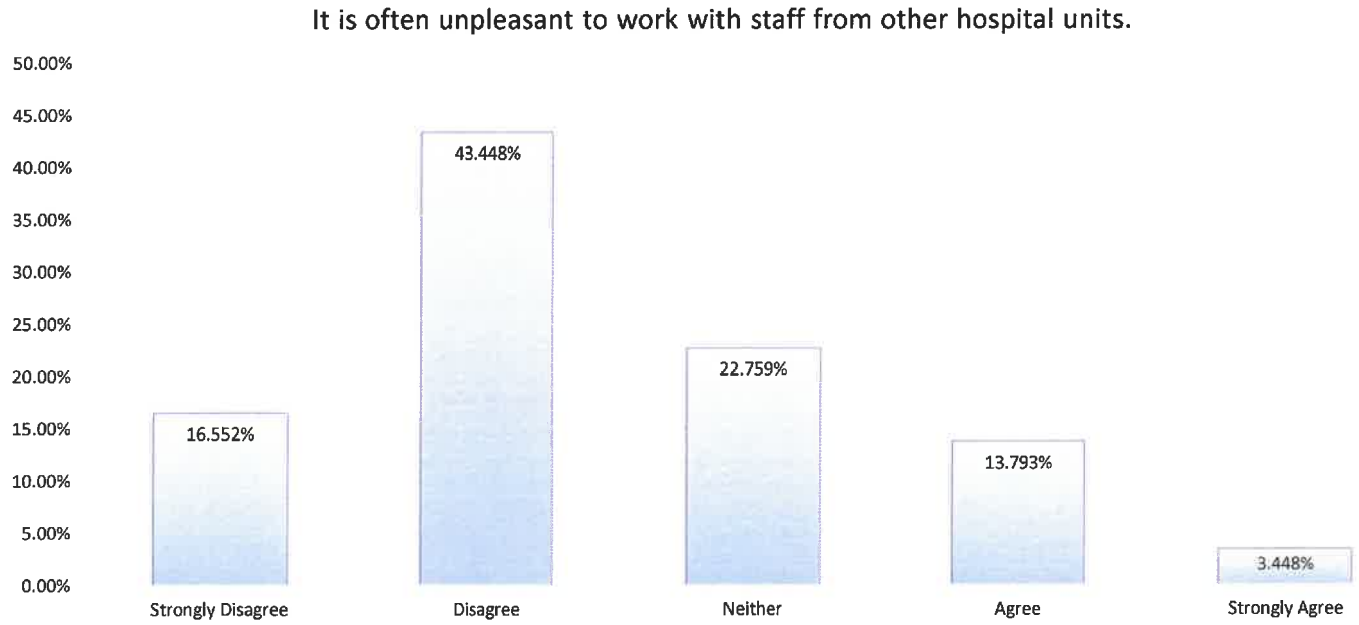

Hospital units do not coordinate well with each other.
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
11.724%
30.00%
26.552%
24.138%
7.586%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

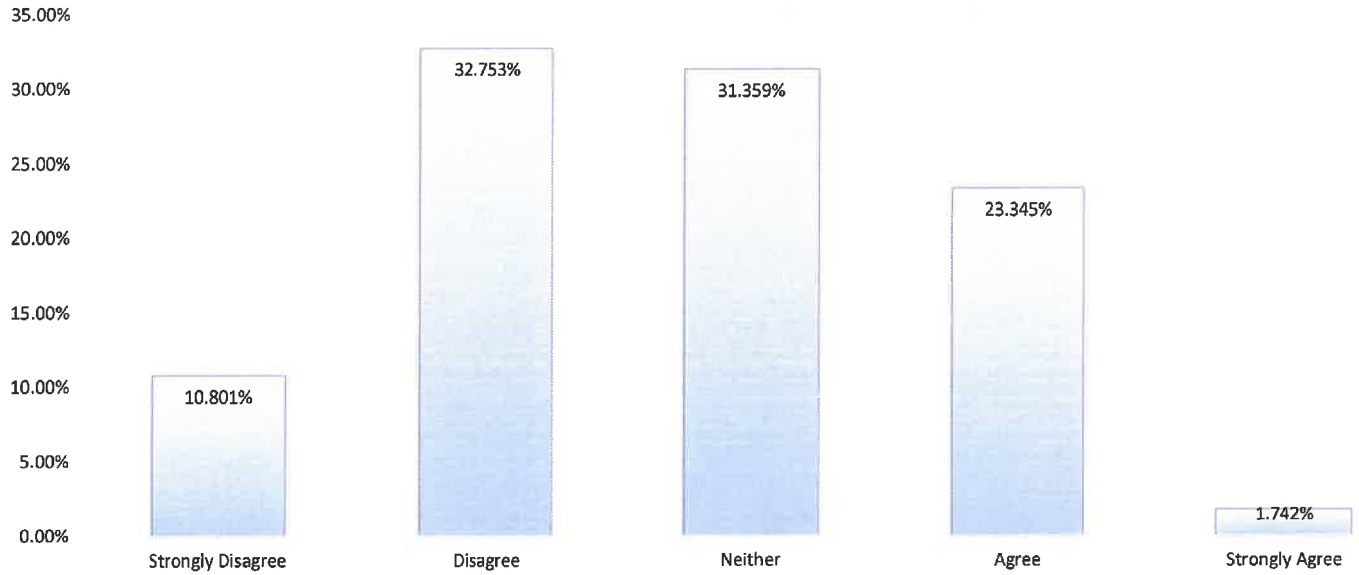

Things "fall between the cracks" when transferring patients from one unit to another.
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
10.284%
31.206%
29.078%
24.823%
4.61%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

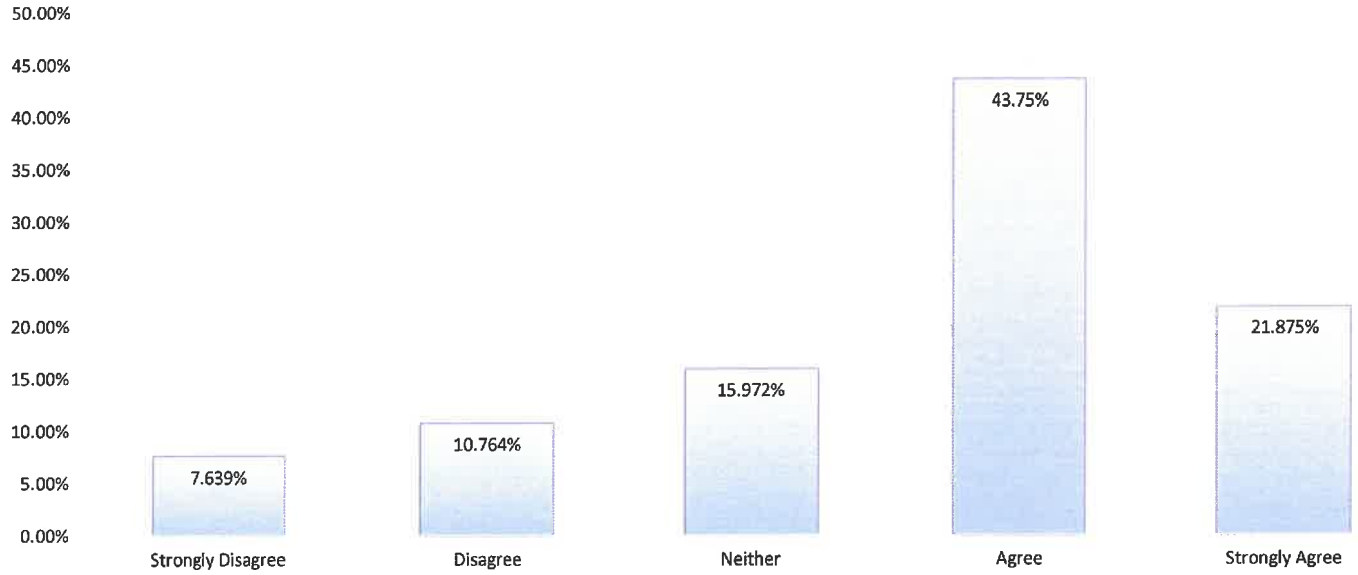
There is good cooperation among hospital units that need to work together.



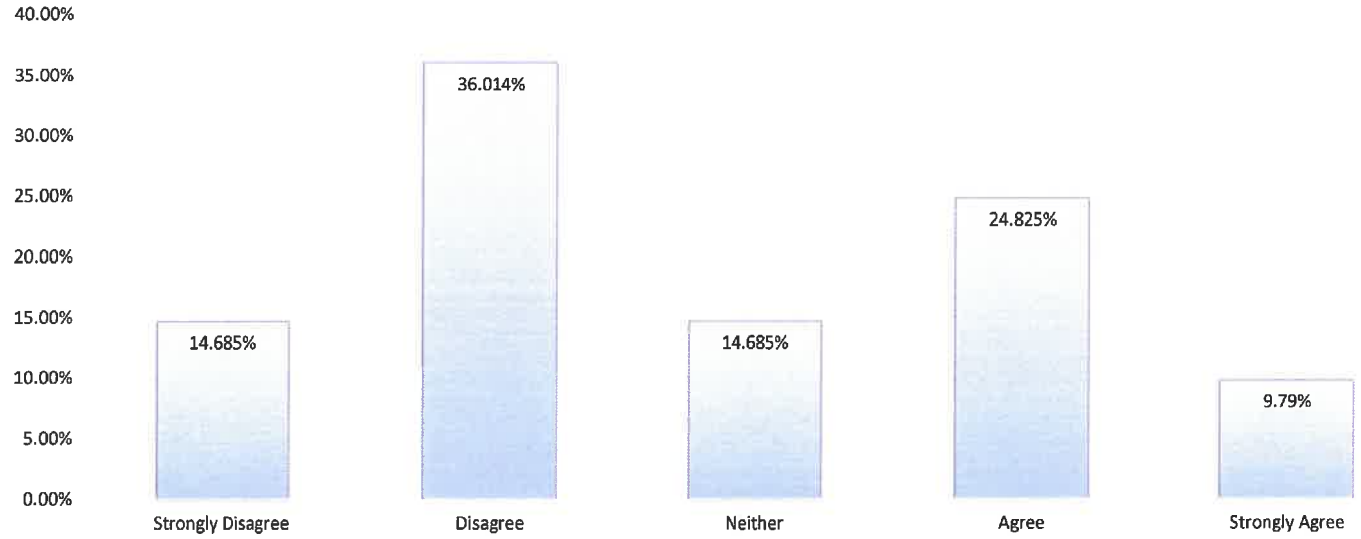

Important patient care information is often lost during shift changes.
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
16.376%
42.16%
20.209%
19.164%
2.091%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

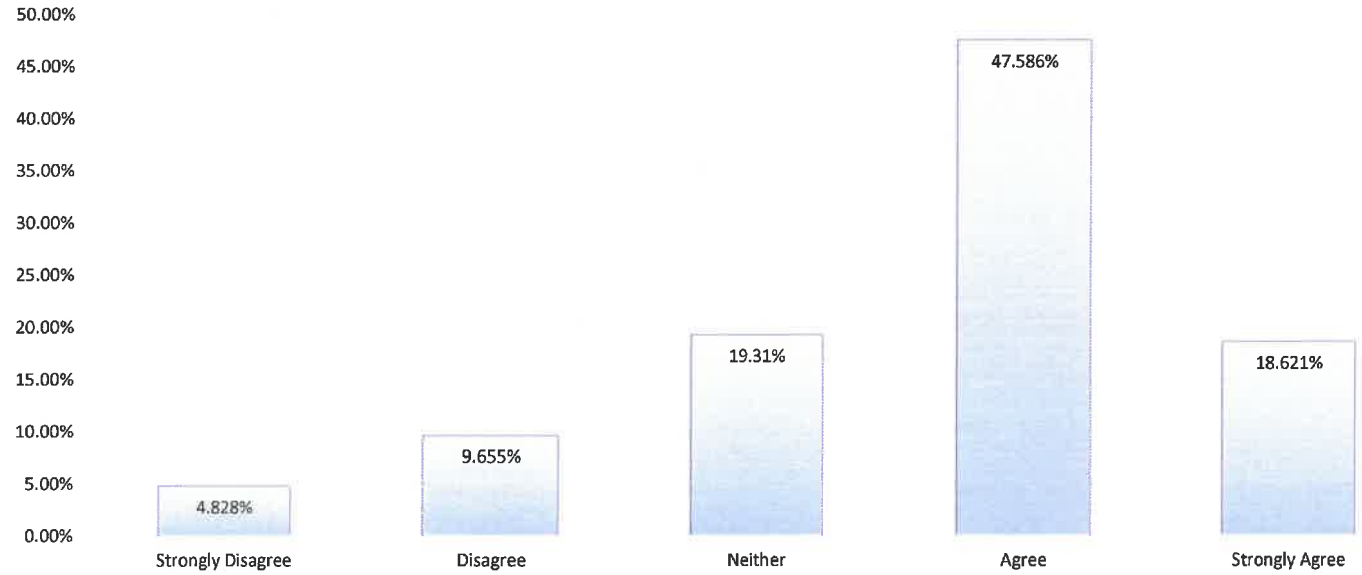

It is often unpleasant to work with staff from other hospital units.
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
16.552%
43.448%
22.759%
13.793%
3.448%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

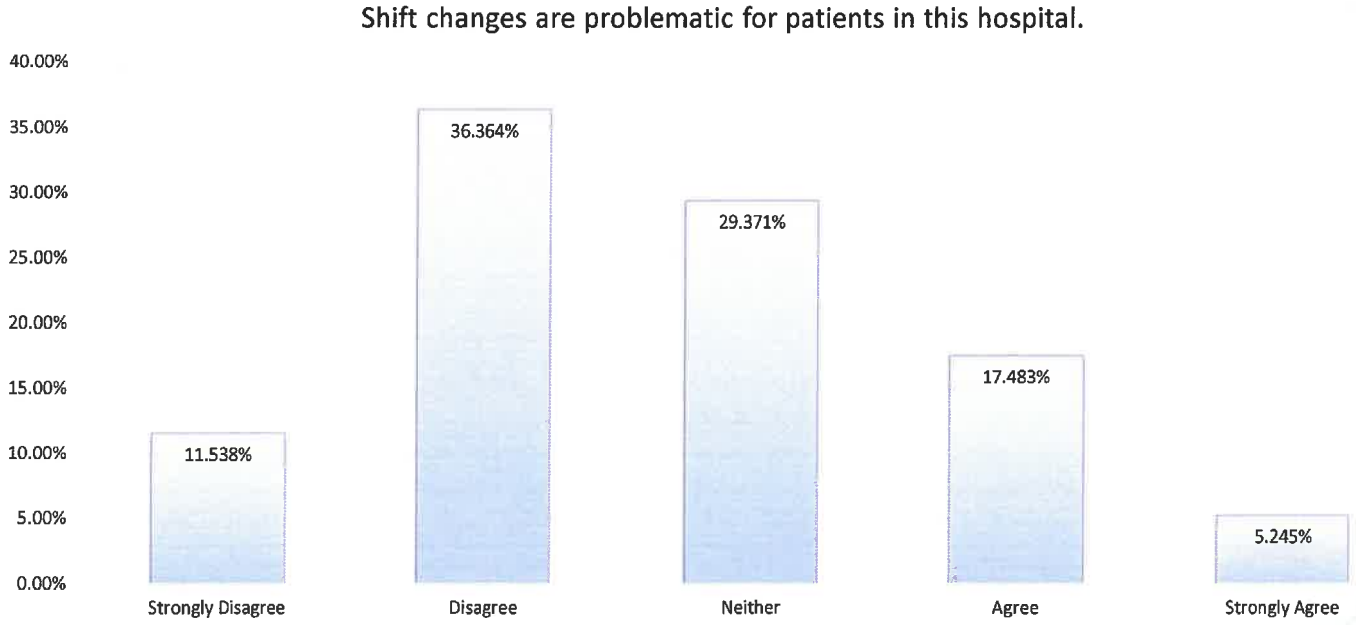

Problems often occur in the exchange of information across hospital units.
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
10.801%
32.753%
31.359%
23.345%
1.742%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


The actions of hospital management show that patient safety is a top priority.
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
7.639%
10.764%
15.972%
43.75%
21.875%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

Hospital management seems interested in patient safety only after an adverse event happens.

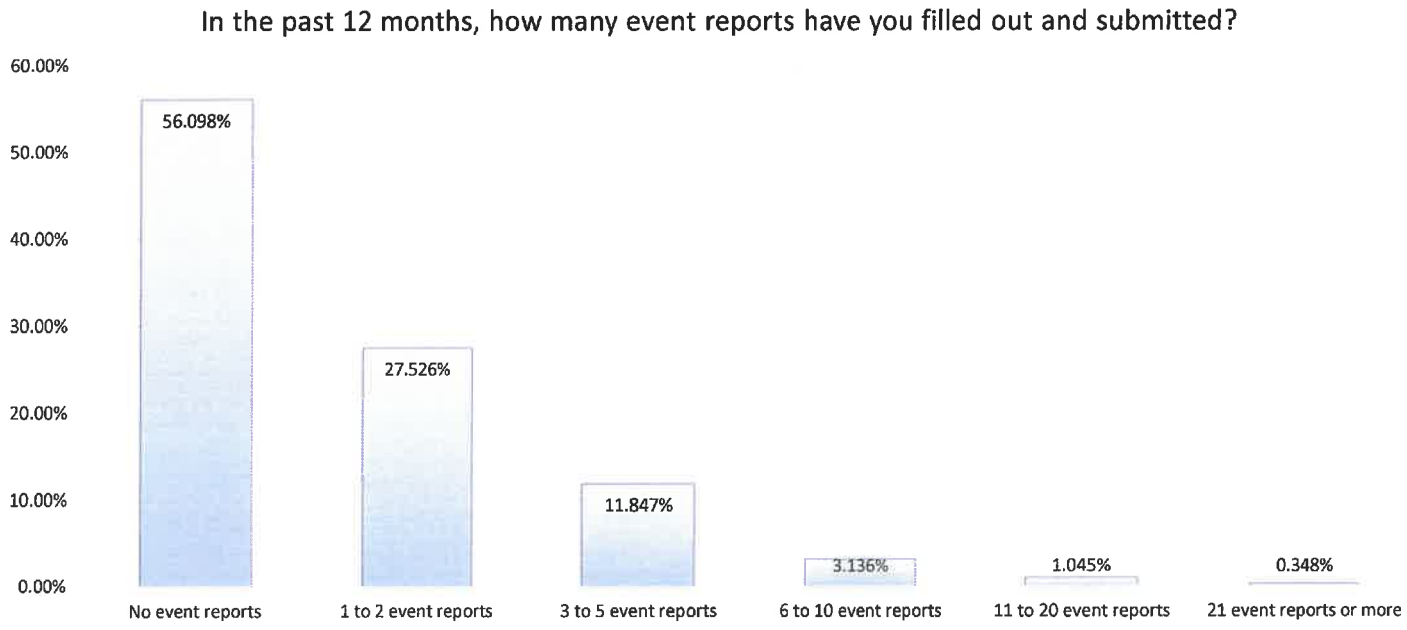



Hospital units work well together to provide the best care for patients.
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
4.828%
9.655%
19.31%
47.586%
18.621%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

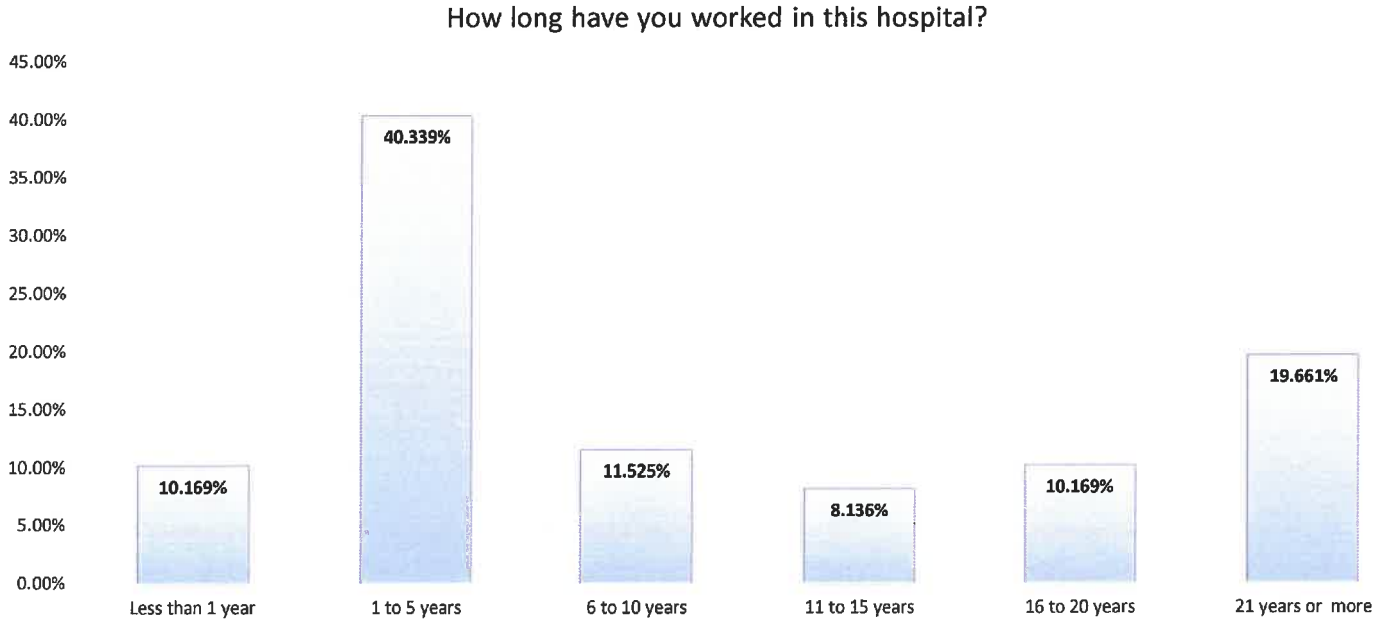

Shift changes are problematic for patients in this hospital.
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
11.538%
36.364%
29.371%
17.483%
5.245%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree

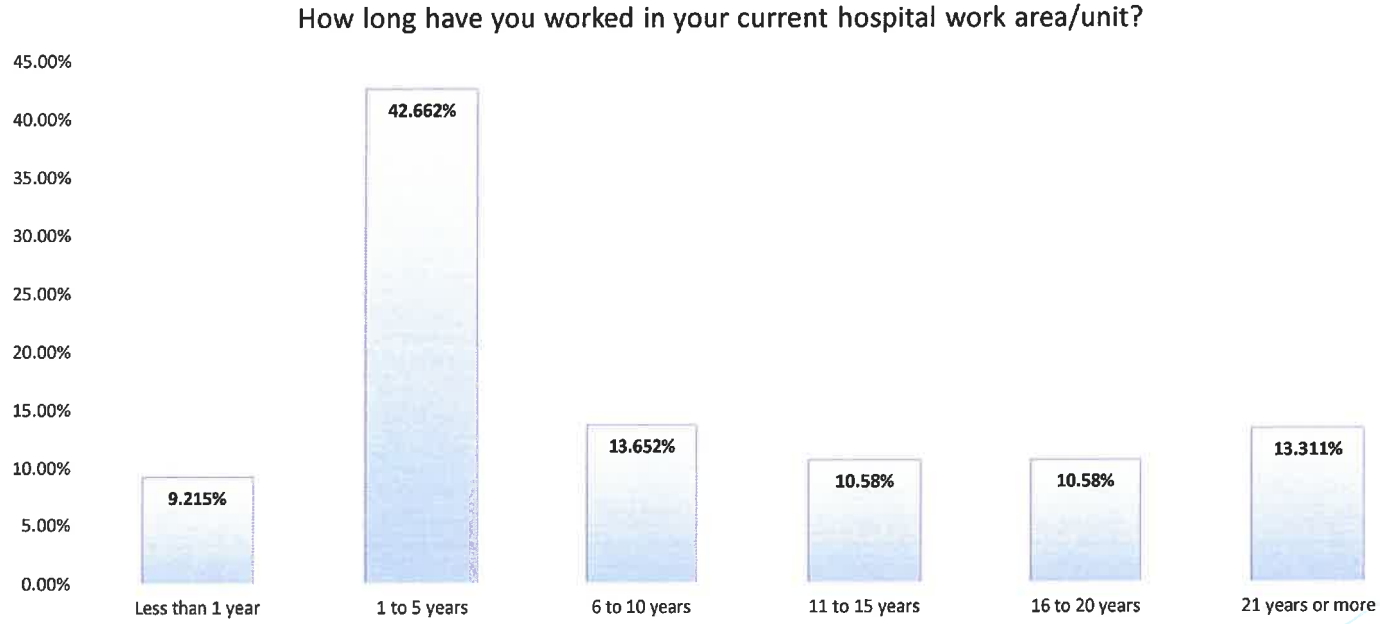
47

Number of Events Reported

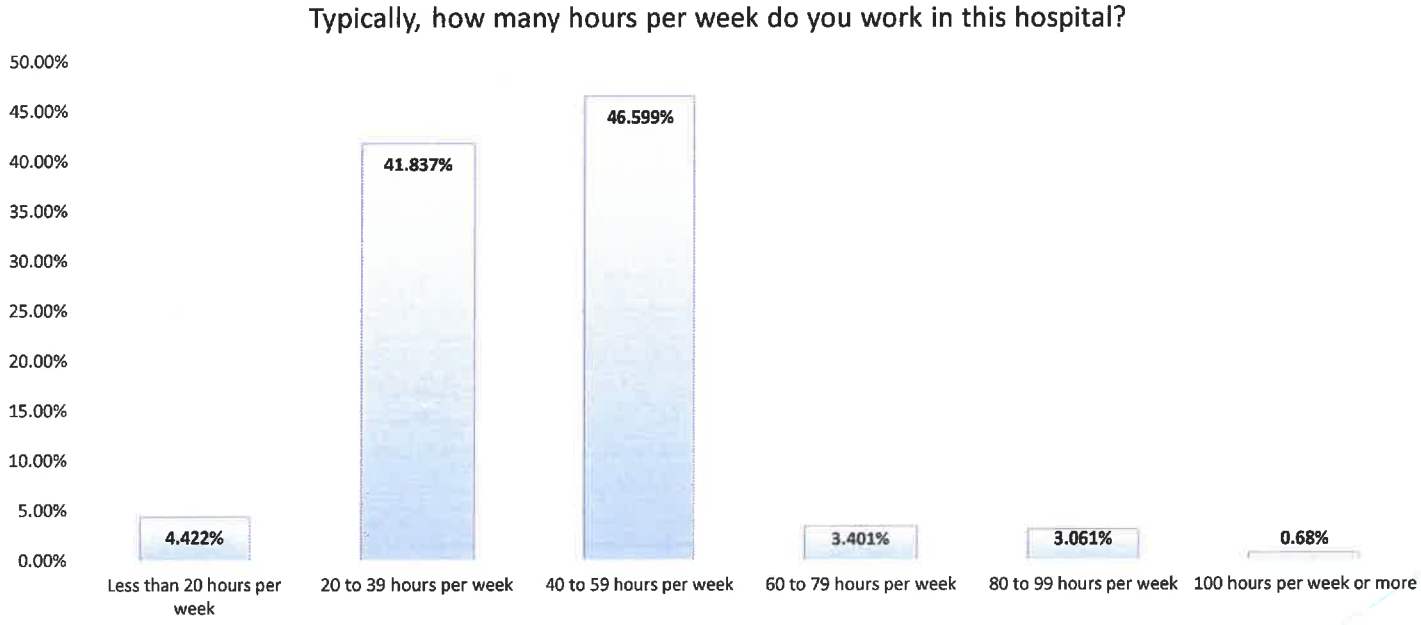


Background Information

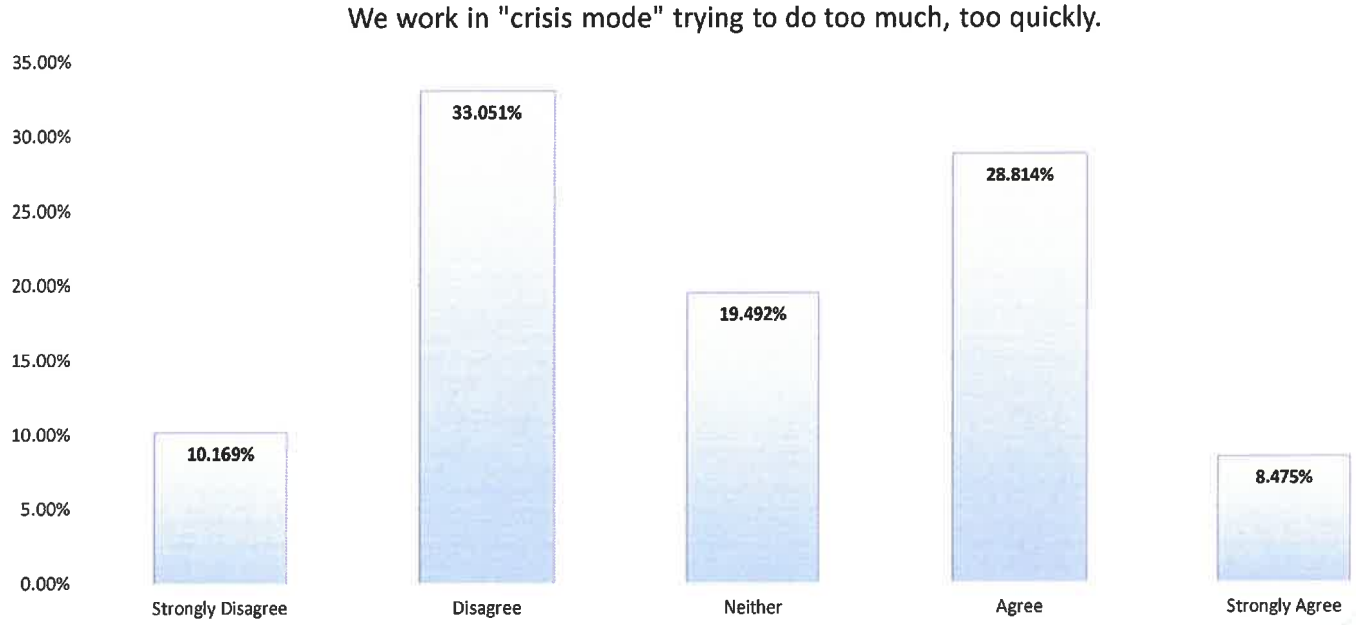


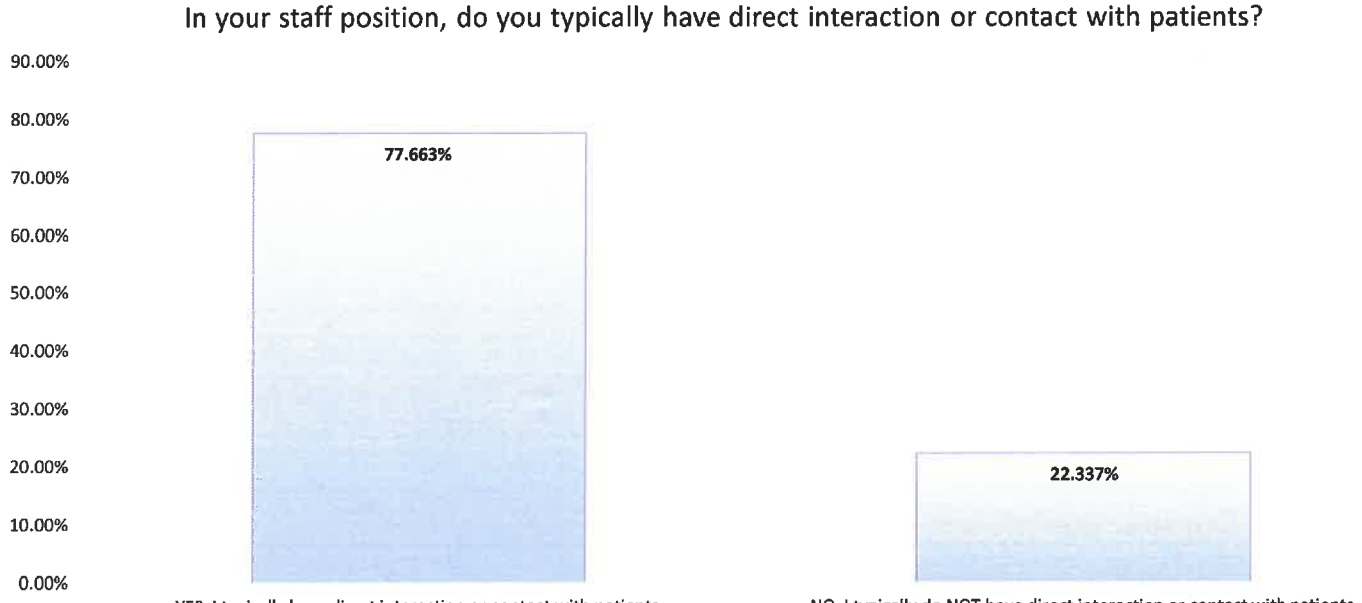

How long have you worked in your current hospital work area/unit?
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
9.215%
42.662%
13.652%
10.58%
10.58%
13.311%
Less than 1 year
1 to 5 years
6 to 10 years
11 to 15 years
16 to 20 years
21 years or more

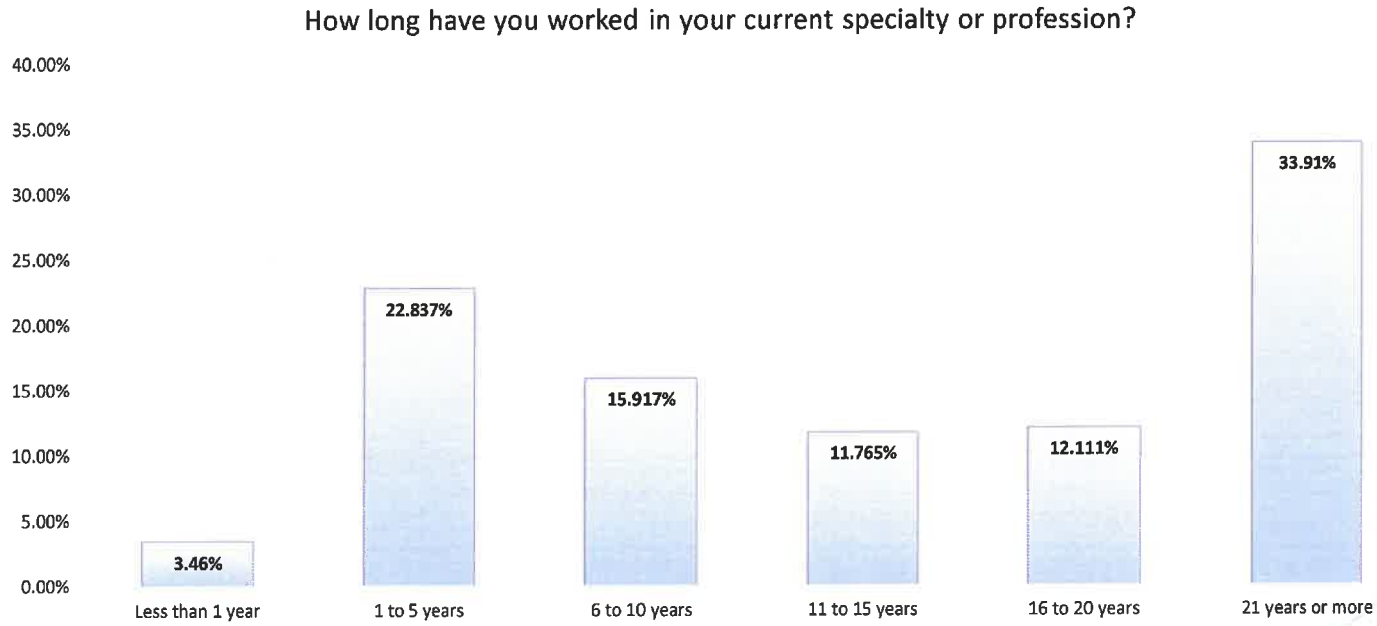
50


Typically, how many hours per week do you work in this hospital?
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
4.422%
41.837%
46.599%
3.401%
3.061%
0.68%
Less than 20 hours per week
20 to 39 hours per week
40 to 59 hours per week
60 to 79 hours per week
80 to 99 hours per week
100 hours per week or more

51


We work in "crisis mode" trying to do too much, too quickly.
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
10.169%
33.051%
19.492%
28.814%
8.475%
Strongly Disagree
Disagree
Neither
Agree
Strongly Agree


In your staff position, do you typically have direct interaction or contact with patients?
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
77.663%
22.337%
YES, I typically have direct interaction or contact with patients.
NO, I typically do NOT have direct interaction or contact with patients.


How long have you worked in your current specialty or profession?
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
3.46%
22.837%
15.917%
11.765%
12.111%
33.91%
Less than 1 year
1 to 5 years
6 to 10 years
11 to 15 years
16 to 20 years
21 years or more

54

Staff Comments (See Attachment)

- 1)HUMAN RESOURCE DEPT IS NOT PROACTIVE TO VISITS/QUESTIONS OF HOSPITAL STAFF.2)WHO GIVES ACLS/BLS CLASSES.MOST OF US HAVE OUR CERTIFICATES EXPIRE NOV/DEC THIS YEAR.3) PCS FD-12 SITTERS COULD HELP IN SHORTAGE STAFFING IF THEY ARE TRAINED EXTRA RESPONSIBILITIES OTHER THAN SITTING LIKE TAKING VITAL SIGNS AND PROVIDING HYGIENIC NEEDS,ETC TO PTS THEY ARE SITTING.IF NOT,REGULAR CNA/MST ON THE FLOOR ARE OBLIGED TO COVER THIS PATIENT WITH SITTER WHEN IT COULD BE DONE BY THE PCS SITTER WITH PROPER TRAINING/CERTIFICATION.
- 1. There are times when there is not enough staff to care for patients
  2. Volume of patients sometimes leads to delay in evaluation
  3. Emphasis on prioritizing FD 12 patients causes delay in caring for other medically critical patient's
  4. Some providers are new to their positions and sometimes make errors in orders and judgement which could cause cascading problems if those orders are executed by nurses that do not question orders critically

- EMPLOYEES DONT HAVE ADVOCATES FOR THEM. ADMINISTRATION DOES NOT GET INVOLVED WITH THE STAFF ONLY IF THERE IS APROBLEM WHEN THE EMPLOYEE HAS TO BE CORRECTED. NO ONE ASKS QUESTIONS THEY JUST SET RULES. STAFF IS OVERWHELMED AND UNDER STAFFED.
- Events rarely happened within the unit . And if so, it was caused by outside departments which were addressed immediately to involved areas for correction and improvement of the hospital. I've seen personally minor and harmless to the patients.
- For the safety of the patients and staff, I am not in agreement with one person transferring a patient on the stretcher or on the bed. We should not wait until problem occurs before action is taken.
- More Root Cause Analysis Meetings should be held after any near miss or actual serious event to ensure we are moving forward with a solid plan. Then implementation and training of all staff should occur to be certain we have made the best attempt to keep the same incident from reoccurring.
- Patient safety errors MUST be seriously dealt with continuous competency testing/re-education specifically in Emergency Department where simple specimen labeling mistakes happen - before it becomes rampant. We have Quality Assurance protocol in the laboratory capable of detecting most mislabeled specimen but I'm afraid that some can still seep thru the process that we're not aware of.

- Some times the departmental managers and supervisors focus on person/employee when some errors which compromises the patient safety occurs. But they don't consider the preconditions which brought that incident. If the problem is procedural, managerial, or process problem; writing up the employee doesn't solve the issue. That only hurts the employee; it does not change/improve the process. Focusing on the problem than making things personal is more better. we all have to create free environment for our employees, when the supervisors or managers are really bossy, that will affect the patient safety indirectly as employees are under pressure. I can moderately witness this.
- THE NURSE PATIENT RATIO IN THE EMERGENCY DEPARTMENT IS UNSAFE, WHICH IS 5:1. THE DEPARTMENT IS ALWAYS UNDERSTAFF WITH INADEQUATE NURSING SUPPORT. THE CHARGE NURSES ARE LAZY AND TRIFLING TO INCLUDE DERRICK CHINGO; ANNETTE STEWART; GINA JAMES AND ROBERTA LENOIR. ALL THEY DO IS SIT IN FRONT OF THE CHARGE NURSE DESK AND GOSSIP AND SOCIALIZE WITH THE DOCTORS AND SCRIBES. THE CHARGE NURSES DO NOT ASSIST WITH PATIENT CARE WHEN NEEDED, NOR DO THEY ASSIGN THEIR FRIENDS PATIENTS. ORDERS ARE LEFT UNCOMPLETED BY DAYSHIFT STAFF WHEN NIGHTSHIFT COMES IN.

- The working environment is the laboratory, specifically the temperature issue, is not safe for the employee and for the patient safety. THE LAB IS TOO HOT with temperature over 80 most of days. Than can compromise patient results.
- The lab management handling of staffing is unacceptable. staffing issue not solved adequately to the extent of compromising patient safety.
- There has to be improvement when communicating with staff on events in my department as well as outside. Also, there is a need for improving work conditions in my area. The unregulated temperature, for example, is one that affects not only the employees but also the equipment that we use to aid in patient care. In some cases, it has hindered the timely reporting of patient results to physicians.
- UNDERSTAFFED! Not enough support, staff to patient ratio is almost always way too short too often. On the off chance we are staffed correctly (2 techs per unit), it's awesome we get some relief. But its almost always only 1 tech per unit (4E/4W) regardless of acuity and census. Holes in the schedule where the unit is technician-less especially between the hours of 1900-2300.

- We do not work alone. In dialysis if there is a patient problem there are other nurses right there to assist and we know immediately what to do from experience and training. Only issue I see is if a patient is admitted from ER, if there is not a room assignment, it is very hard to send back to the emergency room. PT dialysis may be delayed to move to a special room in ER to do pt there.
- When an incident occurs, there is an incidence reporting system in place and it is well utilized in my assessment. Everyone is aware patient safety is a priority and work to make the work place a safe one. However, staff shortage is a real issue here that needs to be addressed, because it is the primary issue that can affect patient safety on the floor the author works.
- WHENEVER SOMEONE DOES SOMETHING WRONG, THAT PERSON ISN'T REPREMANDED, EVERYONE IS.
- ADMINISTRATION DOESN'T CARE ABOUT THE EMPLOYEES SAFETY, ONLY THE PATIENTS.
- THE WHOLE PSYCH ELOPEMENT PROCESS IS OVERKILL. I BELIEVE IN HAVING A SITTER BUT FILLING OUT 3 FORMS THAT LIST THE SAME THING AND CALLING THE OPERATOR WHEN THEY COME AND GO ISN'T NECESSARY.
- ADMINISTRATION IS QUICK TO CRITICIZE AND NEVER GIVES ANY INCENTIVE OR PRAISE FOR THE GOOD JOB THAT IS DONE UNDER VERY STRESSFUL CONDITIONS.
- THERE IS A LOT OF FAVORITISM IN THIS DEPARTMENT WITH THE MANAGER.

(Please see attachment for other staff comments)

References

- Ahrq.gov. (2020). *Patient Safety and Quality Improvement*. [online] Available at: https://www.ahrq.gov/patient-safety/index.html [Accessed 06 Feb. 2020].
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Thank you to all the Staff, Leaders, Quality and IT for assisting and promoting and participating in this Survey.

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Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN
P. 13	High	IC.02.02.01 EP 2	**Standard Text:** The hospital reduces the risk of infections associated with medical equipment, devices, and supplies. **EP Text**: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	During tracer activities in the ED, it was discovered that reusable, sharp instruments are not being transported to the dirty utility room in a closed container, and are hand carried without a closed container. The ED Director and Quality Department scribe were present for the finding. The finding was corrected on site by placing 3 clean closed biohazard containers in the clean supply room for staff to use to transport the instruments from the procedure room to the dirty utility room.	The Infection Preventionist and ED Nurse Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The activities to monitor compliance will include random audits via Infection Control/Environment of Care Rounds on the availability and placement of the biohazard puncture resistant containers in the clean supply room. In addition other activities to ensure compliance will include random interviews of staff to ensure understanding of handling soiled surgical instruments. Review Staff compliance with Education material provided.	100%
P. 12	Moderate	EC.02.06.01 EP 20	**Standard Text**: The hospital establishes and maintains a safe, functional environment. **EP Text:** Areas used by patients are clean and free of offensive odors.	During tracer activities on the BHU, in room 422 there were electrodes found stuck on the bathroom door. Room 422 was not occupied and was ready for a patient admission. The Unit Manager and Quality Department scribe was present for the observation.	The Behavioral Health Manager and ED RN Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Behavioral Health leadership will perform 10 random room inspections audits monthly.	100%
P. 19	Moderate	MM.03.01.01 EP 7	**Standard Text:** The hospital safely stores medications. **EP Text:** All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.	During tour of the Orthopedic clinic, a multi dose vial of lidocaine was used. It was label for opening date. No 28 discard date was present as required by hospital policy: " Medication Administration Policy" dated 2/1/2020. This was witnessed by Ambulatory Director and scribe accompanying the surveyor.	The Director of Ambulatory Rehab Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To ensure proper medication management, labeling of vial monitoring will be put in place for multi-dose vials in specialty/orthopedic clinic in regards to beyond use dates. New and existing medical assistants and providers will have mandatory annual multi-dose vial education in Relias.	100%

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Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN
P. 20	**Moderate**	**NPSG.15.01.01 EP 1**	**Standard Text:** Reduce the risk for suicide. **EP Text:** For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For non-psychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.	During tracer activities on the BHU, in room 422 there was no plastic safety cover on the thermostat, which was identified as a safety risk on the unit risk assessment. Room 422 was not occupied and ready for a patient admission. The Unit Manager and Quality Department scribe were present for the observation. The finding was corrected on site.	The VP of Facilities and Support Services and Behavioral Health Unit is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	A semiannual Ligature Risk assessment will be documented to ensure compliance of safety measures.	**100%**
P. 8	**Low**	**EC.02.02.01 EP 12**	**Standard Text:** The hospital manages risks related to hazardous materials and waste. **EP Text:** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * (See also IC.02.01.01, EP 6)	During tracer activities in the ED it was discovered that dirty instruments were transported to the dirty utility room without a biohazard label. The ED Director and Quality Department scribe were present for the finding.	The Infection Preventionist and ED Nursing Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	UMC purchased additional biohazard puncture resistant containers. Random audits via Infection Control/Environment of Care Rounds to ensure biohazard puncture resistant containers are properly labeled.	**100%**
P. 9	**Low**	**EC.02.04.03 EP 3**	**Standard Text:** The hospital inspects, tests, and maintains medical equipment. **EP Text:** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.	Hydrocollator water changes and cleaning not performed per manufacturer's recommendations. Confirmed by Ambulatory director and QA staff with surveyor.	The VP of Facilities and Support Services and Director of Rehabilitation Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To monitor compliance a monthly review of the hydrocullator cleaning log book will be conducted.	**100%**
P. 9	**Low**	**EC.02.05.05 EP 5**	**Standard Text:** The hospital inspects, tests, and maintains utility systems. **EP Text:** The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented.	Ice machines in the 8th floor Telemetry Unit had an accumulation of white lime scale around the outside and inside of dispensing chute. This was verified by Unit manager and staff accompanying the surveyor.	The VP of Facilities and Support Services and Infection Control is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The procedures identified to monitor compliance with performance will include review of documentation and surveillance of the Preventive Maintenance (PM) of the ice machines during environment of care rounding.	**100%**

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Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN
P. 10	Low	EC.02.05.07 EP 1	**Standard Text:** The hospital inspects, tests, and maintains emergency power systems. **EP Text:** At least monthly, the hospital performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented.	At the time of survey, the documentation of the monthly testing of battery lights and inspection of exit lights did not include an inventory to ensure that each and every one was completed.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The inspection logs will be reviewed on a monthly basis for compliance with battery powered lights and exit light inspections. For instances of non-compliance a corrective action plan will be sent to the VP of Facilities & Support Services.	100%
P. 10	Low	EC.02.05.07 EP 2	**Standard Text:** The hospital inspects, tests, and maintains emergency power systems. **EP Text:** Every 12 months, the hospital performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The test results and completion dates are documented.	At the time of survey, the documentation of the annual functional testing of battery lights did not include an inventory to ensure that each and every light had been tested.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Review the log for functional testing compliance monthly.	100%
P. 11	Low	EC.02.06.01 EP 1	**Standard Text:** The hospital establishes and maintains a safe, functional environment. **EP Text:** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	At the time of survey, there was a stained ceiling tile in the corridor by Radiology room #1030. During environmental tour of Pharmacy, peeled paint on furnace ducts above exposed ceiling was noted over area where medications were being stored. This was confirmed by pharmacy director and VP of Facilities & Support Services. Furnace ducts were repainted and defect corrected and confirmed by surveyor prior to leaving HCO.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	All thermostats will be removed from Behavioral Health Unit patient rooms. Address all stained ceiling tiles within 24 hours of discovery. Address peeling paint in clean areas within 24 hours of discovery.	100%
P. 12	Low	LS.02.01.10 EP 11	**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. **EP Text:** Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012:7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited.	At the time of survey, the door in the 1-hour rated fire wall by OR#9 was in need of adjustment, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8), Other-Deficiency will be promptly corrected. (EP-15)	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform a documented monthly functional test on all fire doors ensuring the self-closer device operates appropriately thus causing the door to latch.	100%

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P. 13	**Low**	**LS.02.01.10 EP 14**	**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. **EP Text:** The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.	At the time of survey, the space around cables within a four-inch conduit sleeve penetrating the floor of the IT closet by room #755 was not properly sealed with an intumescent fire-stop system. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). At the time of survey, the space around cables within two conduit sleeves penetrating the floor of the 3East IT closet were not properly sealed with an intumescent fire stop system. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities and Support Services and Chief Information Officer is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To monitor compliance monthly visual inspections and annually will be monitored for compliance with this element of performance. The vendor will use an approved fire stop material.	**100%**
P. 13	**Low**	**LS.02.01.20 EP 1**	**Standard Text**: The hospital maintains the integrity of the means of egress. **EP Text:** Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3.	At the time of survey, the emergency exit stair door in the kitchen was in need of repair. Neither this surveyor nor members of the hospital team were able to open it, even after multiple tries. The hospital maintenance team immediately repaired it. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform monthly observation of all emergency exit stair doors. The inspection results will be reported to the Hospital's Joint Commission Compliance Committee, as well as the Environment of Care Committee on a monthly basis.	**100%**
P. 13	**Low**	**LS.02.01.20 EP 14**	**Standard Text:** The hospital maintains the integrity of the means of egress. **EP Text:** Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice.	At the time of survey, there were multiple carts and equipment, not in use, located in the egress corridors in ICU. At this point, the area had not been identified as a suite as defined by Life Safety Code. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance(EP-8), Conduct education promoting awareness of deficiencies (EP-13). At the time of survey, there were seven pieces of equipment, not in use, stored in the egress corridor in the Radiology Department. This corridor was not within the area defined as a suite under Life Safety Code. It was adjacent to it. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Annually a vendor will be employed annually to evaluate the Life Safety drawings and make changes as necessary.	**100%**

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P. 15	**Low**	**LS.02.01.20 EP 41**	**Standard Text:** The hospital maintains the integrity of the means of egress. **EP Text:** Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit.	The "dead end" corridor by room #8835 and the "dead end" corridor by room #8803 could both be mistaken for paths to exit but are not. At the time of survey, they lacked the required "NO EXIT" signs. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). The door to the patio in the Healing Garden could be mistaken for a path to exit but is not. At the time of survey, it lacked a "NO EXIT" sign. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The United Medical Center will continue to have their environment of care rounds and will inspect and evaluate the facility for specific doors and pathways that could be mistaken as a path to an exit.	**100%**
P. 16	**Low**	**LS.02.01.30 EP 3**	**Standard Text:** The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke. **EP Text:** All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies.	Supply room #3342 is greater than one hundred square feet. At the time of survey, the door was in need of adjustment, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). At the time of survey, the door to trash room SS91, a storage room greater than one hundred square feet, was in need of maintenance, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform monthly a documented functional test for all doors located at the entrance all fully self-closing and positive-latching. The inspection results will be reported to the Hospital's Joint Commission Compliance Committee, as well as the Environment of Care Committee on a monthly basis.	**100%**
P. 18	**Low**	**LS.02.01.35 EP 6**	**Standard Text:** The hospital provides and maintains systems for extinguishing fires. **EP Text:** There are 18 inches or more of open space maintained below the sprinkler to the top of storage.	At the time of survey, there was storage less than eighteen inches below the sprinklers in EOP Storage Room G072. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8), Conduct education promoting awareness of deficiencies (EP-13).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	All Emergency supply rooms located on the ground floor will be added to the Environment of Care rounding schedule.	**100%**