

## **Environment of Care**

### **Safety Management Plan - 2014**

**Updated 4.18.2014**

#### **PURPOSE**

The purpose of the Safety Management Plan is to provide a physical environment free of hazards in order to minimize the risk of injury to patients, staff, students, and visitors.

#### **SCOPE**

The Safety Management Plan at TJUH Inc. applies to all facilities as listed below and to all safety processes, activities, departments, structures and grounds as well as patients, staff, students, and visitors. The Safety Management Plan addresses all elements required to provide a safe and healthy environment free of hazards and to collaborate with department management to provide staff training and monitoring in order to minimize the risk of injuries.

TJUH facilities covered by this management plan are as follows:

- Gibbon/Bodine Building, 111 South 11<sup>th</sup> Street - All floors and areas except 1<sup>st</sup> floor leased business occupancies.
- Main Building, 132 South 10<sup>th</sup> Street - All floors and areas.
- Thompson/Tower Building, 1020 Sansom Street - All floors and areas.
- Foerderer Pavilion Building, 117 South 11<sup>th</sup> Street – All floors and areas.
- Jefferson Hospital for Neuroscience, 900 Walnut Street – All floors and areas except for 1<sup>st</sup> floor leased business occupancy and business occupancies on the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> floors. 2<sup>nd</sup> floor Infusion space and 3<sup>rd</sup> floor Surgical Family Waiting are included.
- Medical Office Building (MOB), 1100 - 1104 Walnut Street – 1<sup>st</sup> and 2<sup>nd</sup> floor Surgicenter; 3<sup>rd</sup> and 4<sup>th</sup> floor Breast Care Imaging Center; and 8<sup>th</sup> floor Clinical Lab for Cell Therapy.
- 925 Chestnut Street – 2<sup>nd</sup> floor Infusion Center.
- Clinical Office Building (COB), 909 Walnut Street – Basement and 1<sup>st</sup> floor Radiology space; and 3<sup>rd</sup> floor Oral Surgery suite.
- Methodist Hospital, 2301 South Broad Street – All floors and areas.
- Methodist Hospital, 1300 Wolfe Street – All floors and areas.
- Methodist Hospital, 2422-24 S. Broad Street - All floors and areas.

## OBJECTIVES

The objectives of the Safety Management Plan include:

- Comply with all relevant safety standards and regulations.
- Enforce current safety practices for patients, staff, students, and visitors.
- Provide regular safety education to all staff.
- Monitor the effectiveness of the safety program.
- Identify opportunities and to improve safety performance and develop and implement improvements.

## AUTHORITY

The Chair of the Safety Management Subcommittee is responsible for the program's strategic design and overall plan development, implementation, monitoring, and performance improvement. The Directors of EHS at the respective Center City and Methodist campuses are responsible at an operational level for enforcing all safety practices, monitoring, and reporting. Performance reporting for the program is monitored by the Environment of Care Committee.

## RISK ASSESSMENT

Hazardous physical conditions, potentially hazardous situations, unsafe behaviors, and relative risks are identified and assessed through ongoing facility-wide processes. These processes are designed to proactively evaluate the impact of building, grounds, equipment, materials, operations, and internal physical systems on patient, staff, student, and public safety. The Safety Subcommittee works with the Environment of Care Committee and the Hospital Risk Management department to identify, analyze, and control environmental risks to patient, staff, student, and visitor safety that may contribute to undesirable outcomes. These assessment processes include:

- Annual subcommittee multi-disciplinary Risk Assessment
- Environmental Safety Tours
- Work-related injury assessments
- Patient Safety Net (PSN)
- SAFE Line (955-SAFE; 5-7233)

## PERFORMANCE ELEMENTS:

**Standard EC.01.01.01 – The hospital plans activities to minimize risks in the environment of care.**

### **EC.01.01.01 (1)**

(Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results.

The President appoints Safety Officers responsible for developing, implementing, monitoring, administering and directing an ongoing, organization-wide process to collect

information about opportunities for improvement in the TJUH, Inc. Safety Management program. The Safety Officer has the authority and duty to take immediate and appropriate action in the event that a hazardous condition exists, which poses a threat to life, personal injury /illness, or the threat of damage to property.

The Board of Trustees receives annual reports of the activities of the Safety Management Program from the EOC Committee. The Board of Trustees reviews reports and as appropriate communicates concerns about identified issues and regulatory compliance. The Board of Trustees provides support to facilitate the ongoing activities of the Safety Program.

**EC.01.01.01 (2)**

Leaders identify an individual(s), to intervene whenever environmental conditions immediately threaten life or health or threaten damage to equipment or buildings.

Safety Officers have the delegated the authority to take action when hazardous conditions or potential hazardous conditions exist.

**Standard EC.02.01.01 – The hospital manages safety and security risks.**

**EC.02.01.01 (1)**

The hospital identifies safety and security risks associated with the environment of care that could affect the safety and health of patients, staff and other people coming to the hospital's facilities.

The risk assessment process is designed to proactively evaluate the impact on patient care as it relates to the safety of the buildings, grounds, internal physical systems, and the safe practices of hospital employees.

**EC.02.01.01 (3)**

The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

TJUH, Inc. uses the risks identified to select and implement procedures and controls to achieve the lowest feasible potential for adverse impact for the safety and health of patients, staff, students, and visitors.

**EC.02.01.01 (5)**

The hospital maintains all grounds and equipment.

The Directors of Facilities Services are responsible for supervising the activities of the grounds maintenance crew. The grounds maintenance crew will maintain the property according to the expectations of the hospital. Monitoring of equipment and preventative maintenance and inspection procedures, as well as education and training of users to protect against failure or user error are monitored and maintained by the Directors of Facilities Services.

**EC.02.01.01 (11)**

The hospital responds to product notices and safety recalls.

The Department of Supply Chain Management coordinates with and ensures effective follow up from responsible parties for product safety alerts, hazard notices, and recalls. Facilities Operations Directors assess risk and develop appropriate responses for facilities-related issues. The Department of Biomedical Instrumentation reviews the clinical equipment inventory to screen for equipment matches and will evaluate the severity of the risk. In many cases, the notices will be addressed without removing equipment from service. In the event equipment must be removed from service, the equipment is replaced with a safe effective substitute. The Department of Biomedical Instrumentation will impound equipment removed from use due to recall notices until it can be rendered safe.

**Standard EC.02.01.03 – The hospital prohibits smoking except in specific circumstances.**

**EC.02.01.03 (1)**

The hospital develops a written policy to prohibit smoking in all buildings. Exception for patients in specified circumstances is defined.

TJUH Inc. has developed a policy that prohibits smoking by staff, inpatients, outpatients, visitors, vendors, contractors, and others in all Thomas Jefferson University Hospitals, Inc. buildings and designated outdoor areas.

**EC.02.01.03 (4)**

If the hospital decides that patients may smoke in specific circumstances, it designates smoking areas that are physically separate from care, treatment and services areas if patients are allowed to smoke.

TJUH Inc. does not permit patient smoking. Patients who are in the need for such therapy, through physician orders, will receive alternative treatment.

**EC.02.01.03 (6)**

The hospital takes action to maintain compliance with its smoking policy.

Security rounds are conducted and the rounds checklist includes identifying any smoking in the facility.

**Standard EC.02.06.01 – The hospital establishes and maintains a safe, functional environment.**

**EC.02.06.01 (1)**

Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

**EC.02.06.01 (11)**

Lighting is suitable for care, treatment, and services.

**EC.02.06.01 (23)**

The hospital provides emergency access to all locked and occupied spaces.

**EC.02.06.01 (20)**

Areas used by patients are clean and free of offensive odors.

**EC.02.06.01 (26)**

The hospital keeps furnishings and equipment safe and in good repair.

Facilities Design and Construction designs and constructs spaces in accordance with current FGI Guidelines. Design parameters are reviewed with clinicians, Facilities Operations staff, Infection Control, and Environmental Health and Safety during design as necessary and are reviewed as a part of the Preconstruction Risk Assessment process. As a part of environmental safety tours, Environmental Health and Safety surveys interior spaces, observing whether: Spaces are sufficient to meet the needs of the patient population and are safe and suitable; lighting is suitable; and spaces are clean and free of offensive odors. Any deficiencies are reported to appropriate staff for follow up and correction per EC.04.01.01 EP's 12 and 13 as noted below. Security, Facilities Operations Staff, and Department Managers provide emergency access to all locked and occupied spaces.

**Standard EC.02.06.05 – The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.**

**EC.02.06.05 (1)**

When planning for new, altered, renovated space, the hospital uses the Guidelines for Design and Construction of Health Care Facilities, 2010 edition.

The PA Department of Health requires use of the 2010 edition of the FGI Guidelines. Facilities Design and Construction is responsible for managing project design, approval, and construction and ensures that the FGI Guidelines are used in the design and construction of hospital facilities.

**EC.02.06.05 (2)**

When planning for demolition, construction, or renovation, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.

Facilities Design and Construction manages a preconstruction risk assessment for every demolition, construction, or renovation project. The risk assessment considers air quality, infection control, utility requirements (including shutdowns), noise, vibration, and other hazards that may affect care, treatment, and services. The risk assessment is conducted with a multi-disciplinary team and the results are recorded on a form.

**EC.02.06.05 (3)**

The hospital takes action based on its assessment to minimize risks during demolition, construction, or renovation.

Facilities Design and Construction manages construction activities in such a manner that the results of the preconstruction risk assessment are conveyed to the project team for implementation of established measures to mitigate risk. Permit forms identifying risks and measures are reviewed with contractors and maintained for all projects. Measures are monitored through contractor daily checklists and through weekly project manager observation reports.

**Standard EC.04.01.01 – The hospital collects information to monitor conditions in the environment.**

**EC.04.01.01 (1)**

The hospital establishes processes for continually monitoring, internally reporting, and investigating the following:

- Injuries to patients or others with the hospital’s facilities
- Occupational illnesses and staff injuries

Based on its processes, the hospital reports and investigates the following:

**EC.04.01.01 (3)**

Injuries to patients or others in the hospital’s facilities.

Injuries to patients or others with the hospital’s facilities are continuously monitored by Environmental Health and Safety through accident and injury reports. Each incident is investigated to determine circumstances and causes and is reported. Significant issues are reported at least quarterly to the Environment of Care Executive Safety Committee.

**EC.04.01.01 (4)**

Occupational illnesses and staff injuries.

Occupational illnesses and staff injuries are continuously monitored by Environmental Health and Safety through injury and incident reports. Each incident is investigated to determine circumstances and causes and is reported. Significant issues are reported at least quarterly to the Environment of Care Executive Safety Committee.

**EC.04.01.01 (12)**

The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.

Environmental tours are conducted semiannually in all patient care areas. Surveys are evaluated to determine if trends or patterns are present. A report identifying deficiencies, recommendations, actions taken, and resolutions of the deficiencies is kept on file in the Department of Environmental Health & Safety.

**EC.04.01.01 (13)**

The hospital conducts annual environmental tours in non patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.

Environmental tours are conducted annually in all non-patient care areas of the hospital. All surveys are evaluated to determine if trends or patterns are present. A report identifying deficiencies, recommendations, actions taken, and resolutions of the deficiencies is kept on file in the Department of Environmental Health & Safety.

**EC.04.01.01 (14)**

The hospital uses its tours to identify environmental deficiencies, hazards, and unsafe practices.

Members of a multi-disciplinary Environmental Tour group conduct environmental tours to identify environmental issues, hazards and unsafe practices. Deficiencies are reported

to the department leader for correction and data is aggregated and reported back to the Environment of Care Committee.

**EC.04.01.01 (15)**

Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

The annual evaluation of the Safety Management Plan includes a review of the objectives, scope, performance and effectiveness. The evaluation provides the basis for performance improvement and development of the plan for future risk assessments.

**Standard EC.04.01.03 – The hospital analyzes identified environment of care issues.**

**EC.04.01.03 (1)**

Representatives from clinical, administrative, and support services participate in the analysis of the environment of care data.

The Environment of Care Executive Safety Committee includes representatives from clinical, administrative, and support services. The committee members actively participate in the analysis of Environment of Care data, including quarterly reports from each of the Environment of Care Sub-committees – Safety, Security, Hazardous Materials and Waste, Fire Safety, Medical Equipment, and Utility Systems.

**EC.04.01.03 (2)**

The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues.

Each of the Environment of Care Sub-committees, and the Environment of Care Executive Safety Committee regularly, intentionally, and actively analyze data to determine the effectiveness of processes and procedures, to identify trends and possible causes for safety issues, and to inform action plans developed to foster improvement in safety. As data is trended and reported to the committees, explanations are required for negative trends and for measures that do not meet established goals. The analysis and explanations are then reviewed and further discussed with the focus on improving safety.

**EC.04.01.03 (3)**

Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.

Each of the Environment of Care Sub-committees perform risk assessments and annual evaluations of their respective management plans, including plan performance and effectiveness. Sub-committees are comprised of representatives from clinical, administrative, and support services. Safety issues with significant risk and opportunity for improvement are identified to be monitored through performance measures. Sub-committee recommended performance measures are reviewed and monitored by the Environment of Care Executive Safety Committee.

**Standard EC.04.01.05 – The hospital improves its environment of care.**

**EC.04.01.05 (1)**

The hospital takes action on the identified opportunities to resolve environmental safety issues.

Environmental safety issues are identified through monitoring and analysis of data and incidents. Those safety issues are discussed in Environment of Care Sub-committees and significant issues are discussed and tracked in the Environment of Care Executive Safety Committee. Action items are established for environmental safety issues, responsible persons are identified, and issues are tracked to completion and any required follow up.

**EC.04.01.05 (2)**

The hospital evaluates changes to determine if it resolved environmental safety issues.

Environment of Care Executive Safety Committee and Sub-committee members operate within the rubric of the environment of care risk management cycle of Plan – Teach – Implement – Monitor – Respond – Improve. As such, further evaluation / monitoring of issues is employed to continuously improve the particular environmental safety issue. Further data will typically be obtained and analyzed and additional responses developed to foster continued improvement.

**EC.04.01.05 (3)**

The hospital reports performance improvement results to those responsible for analyzing environment of care issues.

Performance improvement results are reported and discussed at Environment of Care Sub-committees and quarterly at Environment of Care Executive Safety Committee meetings. The committee members analyze the results and recommend further improvement where needed.

**ORIENTATION AND EDUCATION**

Orientation and education for staff is managed and documented through Human Resources and individual departments. This training includes, but is not limited to:

- A. New employee orientation - General Safety training regarding Bloodborne Pathogens, Hazard Communications, and General Safety are given to all new employees during New Employee Orientation. New employee orientation is delivered by a multi-disciplinary team including staff from Environmental Health & Safety.
- B. Annual continuing education - Based on requirements of various healthcare regulatory agencies and internally identified needs, a core curriculum of mandatory continuing education courses are established each year. Computer-based training is utilized as the method to ensure compliance with annual mandatory safety training for all staff.
- C. Department-specific training - Department heads design educational programs for safety that meet their individual department needs. It is the responsibility of each department to:



1. Ensure that each employee is assigned the correct safety curriculum for participation in the computer-based training program.
  2. If the department does not participate in the computer-based training program, designate an individual(s) to be the trainer/educator for the department with regard to safety.
  3. Ensure that all employees within the department receive safety training.
  4. Reassess operations to ensure that any actual or potential safety and/or infection control hazards are identified and reported for inclusion in the educational program.
- D. Contract staff - Contract staff receive annual training on Jefferson Policies regarding safety. Jefferson's Department of Environmental Health & Safety provides safety related information to contractors.

## **PROGRAM EFFECTIVENESS**

Program effectiveness will be regularly monitored using significant incidents as well as trending of performance measures to indicate the effectiveness of the processes and/or systems in place. Performance monitoring and assessments of program effectiveness will be reported to the Safety Subcommittee. Significant events and outcomes of regular trending is reported by the Safety Subcommittee Chair to the Environment of Care Committee monthly meetings at least quarterly or immediately as an exception for serious events.

## **PERFORMANCE MONITORING**

The following safety performance measures are established for 2014:

### **Recordable Workplace Injuries**

Recordable workplace injuries will be monitored and reported monthly. Recordable workplace injury rates will be calculated and reported quarterly using the industry standard of annual injury rate per 100 FTE's (see calculation below). The numerator is the number of recordable workplace injuries. The denominator is the total hours worked for the quarter divided by 200,000. The quarterly rate goal is < 6.0 recordable workplace injuries per 100 FTE's. Results will be reported monthly to the Safety Subcommittee for review and Quarterly to the Environment of Care Committee.

### **Overexertion Workplace Injuries**

Overexertion workplace injuries will be monitored and reported monthly. Overexertion workplace injuries will be calculated and reported quarterly using the industry standard of annual injury rate per 100 FTE's (see calculation below). The numerator is the number of reported overexertion workplace injuries. The denominator is the total hours worked for the quarter divided by 200,000. The quarterly rate goal is < 2.96 overexertion workplace injuries per 100 FTE's. This goal is based on the average rate of overexertion workplace injuries for 2013. Results will be reported monthly to the Safety Subcommittee for review and Quarterly to the Environment of Care Committee.

### **Needlestick Workplace Injuries**

Needlestick workplace injuries will be monitored and reported monthly. Needlestick workplace injuries will be calculated and reported quarterly using the industry standard of annual injury rate per 100 FTE's (see calculation below). The numerator is the number of reported needlestick workplace injuries. The denominator is the total hours worked for the quarter divided by 200,000. The quarterly rate goal is < 1.0 needlestick workplace injuries per 100 FTE's. Results will be reported monthly to the Safety Subcommittee for review and Quarterly to the Environment of Care Committee.

### **Workplace Injuries Rate Calculation**

*Calculated annual injury rate per 100 FTE's =  
(Number of reported injuries x 200,000) / total hours worked*

## **ANNUAL EVALUATION**

The annual evaluation of the Safety Management Program will include a review of the scope according to the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met. The performance and effectiveness of the Safety Management Plan will be reviewed by the Environment of Care Committee.

Reviewed and submitted by

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Safety Subcommittee Chair  
Director of Public Safety