MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
March 1, 2023
2:00 p.m.
Via Zoom -- Meeting ID: 892 8602 0834 & Passcode: 138656

AGENDA

I.	Call to Order	Barbara Sowada
	A. Roll Call	
	B. Pledge of Allegiance	
	C. Mission and Vision	Kandi Pendleton
	D. Mission Moment	Irene Richardson, *Chief Executive Officer*
II.	Agenda *(For Action)*	Barbara Sowada
III.	Minutes *(For Action)*	Barbara Sowada
IV.	Community Communication	Barbara Sowada
V.	Old Business	Barbara Sowada
	A. Employee Policies *(Remains under review/development, no request for action)*	
	1. Workplace Violence Prevention Policy	
	2. Workplace Violence Prevention Program	
	B. Patient Safety Plan *(For Action)*	Kara Jackson, *Director of Quality Accreditation, Patient Safety & Risk*
VI.	New Business *(Review and Questions/Comments)*	Barbara Sowada
	A. Board Meeting Guidelines *(For Review)*	Marty Kelsey
	B. Board Agenda Annotation Checklist *(For Review)*	Marty Kelsey
	C. Quality Committee Charter *(For Review)*	Taylor Jones
	D. Resolution *(For Action)*	Geoff Phillips, *Legal Counsel*
	E. Credentials Committee Privilege Form *(For Action)*	Kerry Downs, *Director of Medical Staff Services*
	1. Anesthesia	
VII.	Chief Executive Officer Report	Irene Richardson
VIII.	Committee Reports	
	A. Quality Committee	Taylor Jones
	B. Human Resources Committee	Kandi Pendleton
	C. Finance & Audit Committee	Ed Tardoni
	1. Capital Expenditure Requests *(For Action)*	
	2. Bad Debt *(For Action)*	
	D. Building & Grounds Committee	Marty Kelsey
	E. Foundation Board	Taylor Jones
	F. Compliance Committee	Kandi Pendleton
	G. Governance Committee	Barbara Sowada
	H. Executive Oversight and Compensation Committee	Barbara Sowada
	I. Joint Conference Committee	Barbara Sowada

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IX.	Education	Barbara Sowada
	A. iProtean AHA Transformational Talk Series "Social Determinants of Health: Leveraging the Community and Innovation	
X.	Medical Staff Report	Dr. Brianne Crofts, *Medical Staff President*
XI.	Good of the Order	Barbara Sowada
XII.	Executive Session (W.S. §16-4-405(a)(ix))	Barbara Sowada
XIII.	Action Following Executive Session	Barbara Sowada
XIV.	Adjourn	Barbara Sowada

Memorial Hospital

OF SWEETWATER COUNTY

OUR MISSION

Compassionate care for every life we touch.

OUR VISION

To be our community's trusted healthcare leader.

OUR VALUES

Be Kind
Be Respectful
Be Accountable
Work Collaboratively
Embrace Excellence

OUR STRATEGIES

Patient Experience
Quality & Safety
Workplace Experience
Growth, Opportunity & Community
Financial Stewardship

Minutes for February 1 2023 Draft

MINUTES FROM THE REGULAR MEETING
MEMORIAL HOSPITAL OF SWEETWATER COUNTY
BOARD OF TRUSTEES

February 1, 2023

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on February 1, 2023, at 2:00 p.m. with Dr. Barbara Sowada, President, presiding.

CALL TO ORDER

Dr. Sowada welcomed everyone and called the meeting to order. She welcomed Commissioner Robb Slaughter and said we look forward to working together.

Dr. Sowada requested a roll call and announced there was a quorum. The following Trustees were present: Mr. Taylor Jones, Mr. Marty Kelsey, Ms. Kandi Pendleton, Dr. Barbara Sowada, and Mr. Ed Tardoni.

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Dr. Brianne Crofts, Medical Staff President; and Mr. Geoff Phillips, Legal Counsel.

Pledge of Allegiance

Dr. Sowada led the attendees in the Pledge of Allegiance.

Our Mission and Vision

Dr. Sowada read aloud the mission and vision statements.

Mission Moment

Ms. Richardson said she was approached by someone in a local store. The person said they have been so pleased with services at the Cancer Center. The person said the staff are amazing, compassionate, and kind. The person was so happy to be able to stay home and not travel for treatment. Dr. Sowada said we are very fortunate to have the Cancer Center here.

AGENDA

The motion to approve the agenda as presented was made by Mr. Kelsey; second by Mr. Jones. Motion carried.

APPROVAL OF MINUTES

The motion to approve the minutes of the January 4, 2023, regular meeting as presented was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

COMMUNITY COMMUNICATION

Commissioner Slaughter said he is very excited to be the liaison to the Hospital. He said he will be a conduit of information and is very excited about what we can do together. Commissioner Slaughter said we are very fortunate in Sweetwater County to have the people serving on the Board and the people working here. He said he is glad to participate in anything we want him to and asked that we let him know what we want him to participate in regarding committees. Commissioner Slaughter said he wants to maintain open communication. Ms. Richardson said we appreciate Commissioner Slaughter and all of the Commissioners. Dr. Sowada said we are very grateful to the Commissioners for their generosity and helpfulness. She said we appreciate the relationship.

OLD BUSINESS

Employee Policies

The motion to table action on the Workplace Violence Prevention Policy and Program while discussions continue at the Committee level was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

Finance and Audit Committee Charter

The motion to approve the updates to the Finance and Audit Committee as presented was made by Mr. Tardoni; second by Mr. Jones. Motion carried.

NEW BUSINESS

Patient Safety Plan

Dr. Sowada said the Plan has been approved by the Quality Committee and Medical Executive Committee. Mr. Kelsey said he thought the Plan was well done. The Plan will be brought back to the Board with a request for approval at the March meeting.

Credentials Committee Privilege Forms

Ms. Kerry Downs, Director of Medical Staff Services, said we are working on revising credentials to standardize the format for all specialties. The forms presented have been approved by the specialties, department chairs, and the Medical Executive Committee. She said all are subject to peer review. The motion to approve the forms as presented was made by Mr. Tardoni; second by Mr. Kelsey. Motion carried.

Ms. Downs said our current reappointment timeframe is two years. The Joint Commission updated their requirement to three years. The three years timing meets with Wyoming requirements. The proposed change has been approved by the Credentials Committee and the Medical Executive Committee. Ms. Downs said we will need to change the Medical Staff Bylaws to incorporate the change following Board approval. The motion to approve the reappointment timeframe change as presented was made by Mr. Tardoni; second by Mr. Kelsey. Motion carried.

CHIEF EXECUTIVE OFFICER REPORT

Ms. Richardson thanked Commissioner Slaughter for being at the meeting and said she has extended an invitation to provide a hospital orientation overview to Commissioner Slaughter, Commissioner West, and Commissioner Richards in their new roles. Ms. Richardson provided an update on the strategic plan areas of patient experience, quality and safety, community and growth, workplace experience, and financial stewardship. Dr. Sowada thanked Ms. Richardson for the report and said Ms. Richardson will be presenting at the American Hospital Association Rural Healthcare Conference in San Antonio later in February.

COMMITTEE REPORTS

Quality Committee

Mr. Jones said the information is in the meeting packet.

Human Resources Committee

Ms. Pendleton said the information is in the meeting packet.

Finance and Audit Committee

Mr. Tardoni said the information is in the meeting packet. He noted we are on-track with our financial goals.

Bad Debt: The motion to approve the net potential bad debt of $1,504,537.11 as presented was made by Mr. Tardoni; second by Mr. Kelsey. Motion carried.

Building and Grounds

Mr. Kelsey said the information is in the meeting packet. He said staff and architects are busy getting our lab project off the ground. Mr. Kelsey said this is a big, exciting project. Mr. Jones asked about the lightning project status. Mr. Kelsey said we hope to know more within the next month. Ms. Pendleton asked about the timing of the current Foundation area grant work. Ms. Richardson said the lab project and Foundation area project will be happening at the same time.

Foundation

Mr. Jones said our community has been incredible in their support of the upcoming Red Tie Gala. He thinks it will be a record-setting event. Mr. Jones thanked the Board of Trustees for contributing to the live auction item. Ms. Richardson expressed appreciation to the large number of volunteers.

Compliance Committee

Ms. Pendleton said the information is in the meeting packet. She said the Committee will not meet in February.

Governance Committee

Dr. Sowada said information will be in the March packet due to timing of the Committee meeting.

Executive Oversight and Compensation Committee

Dr. Sowada said there is nothing to report.

Joint Conference Committee

Dr. Sowada said the Committee has not met.

CONTRACT REVIEW

The motion to approve the First Amendment to Agreement for Physician Professional Services for the Emergency Department as presented was made by Mr. Kelsey; second by Mr. Jones. Motion carried. Mr. Phillips commended Ms. Richardson for the very good job she did representing the Hospital and negotiating on our behalf.

EDUCATION

Ms. Stevie Nosich, Environmental Safety Officer, and Ms. Amber Fisk, Human Resources Director, provided an overview of M.O.A.B. (Management Of Aggressive Behavior) training. The M.O.A.B. program is endorsed by The Joint Commission. Ms. Fisk said it is de-escalation training. Ms. Nosich said OSHA put out an updated list with healthcare moving higher on the list for potential violence in the workplace. She reported we have educated 154 employees and have plans to offer training to more moving forward. The Trustees are invited to participate. Ms. Nosich said we have received great feedback from staff. M.O.A.B. information is also included in our annual education program.

MEDICAL STAFF REPORT

Dr. Crofts provided an update of medical staff meetings and education.

GOOD OF THE ORDER

Mr. Kelsey said he heard the Covid emergency may be declared ended in May. He said when Covid first hit, the Board granted some additional financial authority for expenses to the CEO on an emergency basis. He asked what staff and the Board are thinking regarding that remaining in place indefinitely and said if we want to continue, we should codify in policy. Dr. Sowada suggested discussing the topic at the next Governance Committee meeting. Mr. Phillips offered to draft a document for the Committee.

EXECUTIVE SESSION

The motion to go into executive session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

RECONVENE INTO REGULAR SESSION

At 4:18 p.m., the motion to leave executive session and return to regular session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

Approval of Privileges

The motion to approve the list of clinical privileges and granting appointments to the Medical Staff as reviewed in executive session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

Credentials Committee Recommendations to the Board of Trustees for Granting Clinical Privileges and Granting Appointment to the Medical Staff from January 11, 2023

1. Initial Appointment from Locum Tenens to Active Staff (2 years)
   - Dr. Preetpal Grewal, OB/GYN
   - Dr. Razvan Ducu, Hospitalist
2. Initial Appointment to Associate Staff (1 year)
   - Dr. Brahmananda Koduri, Pediatrics
3. Reappointment to Active Staff (2 years)
   - Dr. Michael Bowers, Family Medicine
   - Dr. Steven Croft, Anesthesia
   - Dr. Kurt Hunter, Family Medicine
   - Dr. Weston Jones, Pediatric Dentistry
   - Dr. Peter Jensen, Ophthalmology

The motion to approve the contract presented by the CEO and authorize the CEO to sign the contract as discussed in executive session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 4:20 p.m.

_____
Dr. Barbara Sowada, President

Attest:

_____
Ms. Kandi Pendleton, Secretary

Minutes for February 9 2023 Special Meeting Draft

MINUTES FROM THE SPECIAL MEETING
MEMORIAL HOSPITAL OF SWEETWATER COUNTY
BOARD OF TRUSTEES

February 9, 2023

The Board of Trustees of Memorial Hospital of Sweetwater County met in a special meeting on February 9, 2023, at 3:30 p.m. with Dr. Barbara Sowada, President, presiding.

CALL TO ORDER

Dr. Sowada called the meeting to order. The following Trustees were present: Mr. Taylor Jones, Mr. Marty Kelsey, Dr. Barbara Sowada, and Mr. Ed Tardoni.
Excused: Ms. Kandi Pendleton.

Officially present: Ms. Irene Richardson, Chief Executive Officer; Mr. Geoff Phillips, Legal Counsel.

EXECUTIVE SESSION

The motion to go into executive session was made by Mr. Jones; second by Mr. Kelsey. Motion carried.

RECONVENE INTO REGULAR SESSION

At 5:39 p.m., the motion to leave executive session and return to regular session was made by Mr. Kelsey; second by Mr. Jones. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 5:39 p.m.

_____
Dr. Barbara Sowada, President

Attest:

_____
Ms. Kandi Pendleton, Secretary

Patient Safety Plan-Draft Clean February 2023

Status Draft PolicyStat ID 12325926

Approved N/A
Review Due N/A

Document Area: General - Housewide
Reg. Standards: APR 09.01.01, APR 09.02.01, TJC EC.04.01.01, TJC IC.01.03.01, TJC LD.02.01.01, TJC LD.03.01.01, TJC LD.03.02.01, TJC LD.03.03.01, TJC LD.03.04.01, TJC LD.03.05.01, TJC LD.03.07.01, TJC LD.03.09.01, TJC LD.04.01.01, TJC LD.04.01.09, TJC LD.04.01.10, TJC MM.07.01.03, TJC MM.08.01.01, TJC MS.09.01.01, TJC NR.02.01.01, TJC PI.01.01.01, TJC PI.02.01.01, TJC PI.03.01.01, TJC RI

Patient Safety Plan

Introduction

Memorial Hospital of Sweetwater County (MHSC) is committed to providing compassionate, high-quality care with a strong culture of safety for the best patient outcomes. Our objective is to support a culture of safety for our patients and staff, as well as to support an unrelenting commitment to safety and to do no harm. This culture allows our organization to consistently identify opportunities to improve performance and safety, while maintaining a commitment to responsible stewardship of resources by aligning with MHSC's mission, vision, values, and strategic objectives. The Patient Safety Plan cultivates an organization-wide approach and provides a coordinated, collaborative effort to patient safety.

Purpose

MHSC strives for staff to feel supported, safe and empowered in speaking up about errors, Good Catches/near misses, and related opportunities for improvement. The Patient Safety Plan provides guidelines for collecting, analyzing, and using data to identify, address, and monitor performance to continually improve the quality and safety of care provided by the hospital, please see the Performance Improvement and Patient Safety Plan for more details.

The Patient Safety Plan provides a systematic, organization wide program that minimizes hazards and patient harm by improving processes of care. The purpose of MHSC's Patient Safety Plan is to build a framework for the delivery of safe care, perpetuate a culture of safety, improve patient safety and reduce risk to patients by reducing variability in care processes, increase reporting of occurrences, and reduce preventable adverse events.

Scope

The Patient Safety Plan is organization wide and encompasses patients, visitors, volunteers, medical staff, and staff. The plan integrates all services and departments impacting patient care including contracted services. The plan addresses maintenance and improvement of patient safety in all

departments throughout the organization.

Objectives

I. To promote patient safety through effective management of identified risks and prevention of adverse events

II. To reduce the opportunity for harm and improve safety mechanisms and processes

III. To encourage reporting of errors, occurrences, and risks to patient safety without judgment or placement of blame

IV. To collect and analyze data to ensure proper prioritization of process improvements

V. To identify risk through trending of confidential patient safety occurrence information from individual event reports and aggregate data reports

VI. To investigate and analyze occurrences with a focus on process and system improvements to reduce risk

VII. To integrate patient safety priorities into the design and redesign of all relevant organizational processes, functions, and services

VIII. To provide open communication regarding patient safety risks, events, and system-based improvements

IX. To facilitate organizational learning about patient safety occurrences

X. To incorporate recognition of patient safety as an integral job responsibility

XI. To use education as a key strategy for prevention of patient safety issues based on needs specific to the organization

XII. To involve patients in decisions about their health care and promote open communication with patients and families about medical errors that occur

XIII. To identify at least one high-risk patient safety process selected at a minimum of every 18 months for proactive risk assessment. The following may be considered, but not limited to, when selecting a proactive risk assessment:

    A. The Joint Commission Sentinel Event alerts
    B. Core Measure performance data
    C. Occurrence reporting information
    D. Information from external sources: state, federal and current literature
    E. National Patient Safety Goals

XIV. To support initiatives that promote person-centered care and involvement

XV. To identify patient perception of safety issues using patient satisfaction survey data

XVI. To regularly evaluate staffs' perception of the organizational culture of safety using a valid and reliable survey tool, and to implement improvements identified from survey results

Definitions

Adverse event: An occurrence with an unplanned, unexplained negative event that reaches the patient and results in no harm, harm (minimal to severe), or death

Good Catch/ near miss: An event that could have caused harm, but was prevented from reaching the patient

Hazard: A potential source of harm or adverse effect

Just Culture: A value supported system of accountability that allows the individual to report adverse events, Good Catches, and hazards in an atmosphere of trust. See also Just Culture

Occurrence: Any happening that is not consistent with routine operation of the facility. See also Occurrence Reporting

Patient harm: Unintended physical or psychological injury or damage resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that results in death

Patient safety: The prevention of errors and adverse effects to patients that are associated with health care

Patient safety event: An event, occurrence, or condition that could have resulted or did result in harm to a patient

Performance improvement: The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement

Safety culture: The product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety

For further definitions please refer to these documents: Occurrence Reporting, Adverse Drug Reactions, Medication Errors, Fall Prevention Program, Just Culture, Disclosure of Adverse Medical Event, Performance Improvement and Patient Safety Plan, and Sentinel Event Policy

Organization and Accountability

MHSC recognizes that all staff have an impact on patient safety. All staff are expected to participate in patient safety activities and to offer suggestions and recommendations for improvement through their involvement in occurrence reports, patient safety initiatives, department meetings, and other formal and informal means.

Board of Trustees

I. Hold CEO accountable for promoting and modeling behaviors consistent with a Just Culture, as well as overseeing actions to improve patient safety throughout the organization
II. Review and approve Patient Safety Plan annually
III. Review annual written report provided by Patient Safety Committee

IV. Oversee that quality and safety are at the core of the organization's mission

V. Oversee that quality and safety values are embedded in guiding the organization's strategic plan

VI. Oversee that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement

VII. Oversee the Hospital's ongoing monitoring, maintenance, and improvement efforts for safe, high quality, and efficient medical care

Senior Leadership Team

I. Promote and model behaviors consistent with a Just Culture, as well as oversee actions to improve patient safety throughout the organization

II. Create and maintain a culture of safety at the hospital that supports effective implementation of the Patient Safety Plan

III. Provide the resources necessary for the effective implementation of the Patient Safety Plan

IV. Define, in writing, the following terms:

A. Occurrence

B. Patient safety event

C. Adverse events

D. Adverse drug events

E. Medication errors

F. Sentinel events

G. Good Catch/ near miss

V. Disseminate above definitions throughout the organization

VI. Set expectations for improvement work based on results from the Culture of Safety survey and additional safety data

VII. Prioritize and ensure that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement

VIII. Participate in regular safety rounds

IX. Encourage communication of ongoing efforts to improve safety in the organization

Leadership Team

I. Create and maintain a culture of safety that supports effective implementation of the Patient Safety Plan

II. Establish that safety occurrences are not commonly the result of individual misconduct, but rather a failure of the systems or processes of the organization, see the Just Culture policy for more information

III. Inform staff of patient safety initiatives

IV. Encourage participation in patient safety principles and initiatives, performance improvement,

and problem-solving processes

V. Participate in the collection and analysis of relevant departmental data

VI. Ensure completion of performance improvements and action plans

VII. Foster a climate of continuous improvement through measurement, data analysis, identification, and implementation of changes needed to improve safety of care and ensure sustainment

VIII. Provide the foundation for an environment that supports Just Culture and patient safety by:

A. Acknowledging that most safety events are process failures and monitoring processes to mitigate the risk of patient harm

B. Promoting learning

C. Motivating staff to uphold a fair and Just Culture of safety

D. Providing a transparent environment in which quality measures and patient harms are freely shared with staff

E. Modeling professional behavior by adopting and promoting the MHSC Code of Conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety

F. Addressing intimidating behavior that undermines the safety culture so as not to inhibit others from reporting safety concerns

G. Educating staff and holding them accountable for professional behavior

IX. When a patient safety event occurs, provide resources and mechanisms for support as necessary following a patient safety event

A. Examples include but are not limited to, debriefing, counseling, and resources provided through the employee assistance program

X. Disseminate lessons learned from safety events

Medical Staff

I. Provide effective mechanisms to measure, assess, and improve the quality and appropriateness of patient care, and the clinical performance of all individuals with delineated clinical privileges, accomplished through Ongoing Professional Practice Evaluations (OPPE), Focused Professional Practice Evaluations (FPPE), and Peer Review Process (refer to Professional Practice Review Process – Medical Staff Peer Review)

II. Know and understand the culture of safety, the role of occurrence reporting in the culture of safety, and their responsibilities under the culture of safety

III. Report occurrences (both events that do and do not reach the patient, and do or do not cause harm to the patient) immediately, and document events through the hospital's occurrence reporting platform

IV. Participate in any investigative activities including but not limited to the following:

A. Describe, in writing, the situation and event

B. Any clinical data related to the event (for example, patient’s vital signs, medication

name and dosage, and so on)
Identify any other staff members who were present during the event

C. Answer questions from the individual(s) investigating the event

D. Collaborate with Quality department, department directors and others as appropriate, to design and implement corrective actions and monitor the results

V. Provide the foundation for an environment that supports a Just Culture and patient safety by:

A. Modeling professional behavior by adopting and promoting the Medical Staff Code of Conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety.

B. Addressing intimidating behavior that undermines the safety culture so as not to inhibit others from reporting safety concerns

VI. Act upon identified areas for improvement

Quality Department

I. Facilitate education about patient safety principles to the Board of Trustees

II. Coordinate and provide patient safety education at new employee orientation and to staff annually

III. Collaborate with department directors to determine whether a reported patient safety event is likely to be repeated

IV. Conduct Root Cause Analyses - see Sentinel Event Policy for more information

V. Serve as a resource for performance improvement, patient safety, patient experience, and regulatory information

VI. Educate MHSC staff about the performance improvement process, patient safety, and patient experience

VII. Support staff, including Medical Staff, Leadership, and project leaders in the development and implementation of performance improvement activities, including team building and data analysis

Patient Safety Committee

The Patient Safety Committee is a standing interdisciplinary group that manages the Patient Safety Plan through a systematic, coordinated, continuous approach. Please see the Patient Safety Committee Charter for details on the responsibilities of the Patient Safety Committee (attached).

Staff and Volunteers

I. Know and understand the organizational definitions of the following terms, as provided by leadership:

A. Occurrence

B. Patient safety event

C. Adverse events

D. Adverse drug events

E. Medication errors
F. Sentinel events
G. Good Catch/near miss

II. Comply with all hospital policies and procedures related to patient safety that apply to their position and job duties
III. Know and understand the culture of safety, the role of occurrence reporting in the culture of safety, and their responsibilities under the culture of safety
IV. Improve the culture of safety and accountability by employing a “see something, say something, do something” approach
V. Report occurrences (both events that do and do not reach the patient, and do or do not cause harm to the patient) to their department manager or supervisor immediately, and document events through the hospital's occurrence reporting platform
VI. Participate in any investigative activities including but not limited to the following:
    A. Describe, in writing, the situation and event
    B. Any clinical data related to the event (for example, patient’s vital signs, medication name and dosage, and so on)
    C. Identify any other staff members who were present during the event
    D. Answer questions from the individual(s) investigating the event
    E. Collaborate with Quality department, department directors and others as appropriate, to design and implement corrective actions and monitor the results
VII. Participate in data collection and analysis activities as well as performance improvement activities
VIII. Identify and utilize approaches for improving processes and outcomes to continuously improve the quality and safety of patient care
IX. Participate in improvement activities related to the Patient Safety Plan
X. Constantly hold patient safety at the forefront and continue to advocate for changes where opportunities are identified
XI. Encourage patients and their family members to speak up when they observe or suspect a patient safety event or if they have questions about the safety of a system or process
XII. For further information, please refer to the following policies: Occurrence Reporting, Adverse Drug Reactions, Medication Errors, Fall Prevention Program, Just Culture, Disclosure of Adverse Medical Event, and Sentinel Event Policy

Data

The Patient Safety Committee will monitor data that is further specified and defined in the PIPS Plan and Patient Safety Committee Charter. Information from data analysis is used to make changes that improve performance and patient safety and reduce the risk of adverse and sentinel events. Please see Patient Safety Committee Charter "Data" heading for details.

Communication

Patient safety initiatives, lessons learned, and patient safety improvement work will be communicated as appropriate throughout the organization. Communication will occur through:

I. Quality Committee of the Board
II. PIPS Committee
III. Patient Safety Committee
    A. Monthly Patient Safety Newsletters
    B. Monthly Key Takeaway Information
IV. Leadership meetings
V. Medical Staff meetings
VI. Staff meetings
VII. Department white boards, electronic communication, patient safety rounding, and communication books

Confidentiality

I. WY Stat 35-2-910. Quality management function for health care facilities; confidentiality; immunity; whistle blowing; peer
II. All quality and patient safety data, materials, and information are private and confidential, shall be considered the property of Memorial Hospital of Sweetwater County, and as such is protected by state and federal health care quality statutes.
III. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with hospital policy and state and federal regulations governing the confidentiality of quality and patient safety work.
IV. Information, data results, reports and minutes generated by all quality management activities will be handled in a manner ensuring strict confidentiality
V. Confidential information may include but is not limited to: Medical Staff committee minutes, organizational quality improvement committee minutes, electronic data gathering and reporting, and incident/occurrence reporting
VI. Quality improvement activities will occur in ways that preserve confidentiality of information consistent with policy and established law
VII. The Joint Commission is an independent contractor. Any event reported to The Joint Commission is performed under the auspice of the Quality Committee.

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Reviewed and Approved:
Patient Safety Committee: October 27th, 2022
Medical Executive Committee: November 29th, 2022
Quality Committee of the Board: January 18th, 2023
Board of Trustees:

Attachments

Patient Safety Committee Charter.docx

Approval Signatures

Step Description	Approver	Date

Patient Safety Plan-Draft-Changes February 2023

Status **Draft** PolicyStat ID **12325926**

Approved N/A
Review Due N/A

Document Area: General - Housewide
Reg. Standards: APR 09.01.01, APR 09.02.01, TJC EC.04.01.01, TJC IC.01.03.01, TJC LD.02.01.01, TJC LD.03.01.01, TJC LD.03.02.01, TJC LD.03.03.01, TJC LD.03.04.01, TJC LD.03.05.01, TJC LD.03.07.01, TJC LD.03.09.01, TJC LD.04.01.01, TJC LD.04.01.05, TJC LD.04.01.10, TJC MM.07.01.03, TJC MM.08.01.01, TJC MS.09.01.01, TJC NR.02.01.01, TJC PI.01.01.01, TJC PI.02.01.01, TJC PI.03.01.01, TJC RI

Patient Safety Plan

Introduction

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Purpose

MHSC strives for staff to feel supported, safe and empowered in speaking up about errors, Good Catches/near misses, and related opportunities for improvement. The Patient Safety Plan provides guidelines for collecting, analyzing, and using data to identify, address, and monitor performance to continually improve the quality and safety of care provided by the hospital, please see the Performance Improvement and Patient Safety Plan for more details.

~~MHSC strives for staff to feel supported~~The Patient Safety Plan provides a systematic, ~~safe and empowered in speaking up about errors, Good Catches/near misses, and related opportunities for improvement~~organization wide program that minimizes hazards and patient harm by improving processes of care. ~~MHSC promotes a "Just Culture" of safety which balances a non-punitive learning environment with an equally important need to hold people accountable for their actions. Just Culture is a value supported system of accountability that allows individuals to report occurrences in an atmosphere of trust.~~ The purpose of MHSC's Patient Safety Plan is to build a framework for the delivery of safe care, perpetuate a culture of safety, improve patient safety and reduce risk to patients ~~through~~by reducing variability in care processes, ~~increasing~~increase reporting of ~~safety events~~occurrences, and ~~overall reduction of~~reduce preventable adverse events.

Scope

The Patient Safety Plan is organization wide and encompasses patients, visitors, volunteers, medical staff, and staff. The plan integrates all services and departments impacting patient care including contracted services. The plan addresses maintenance and improvement of patient safety ~~issues~~ in all departments throughout the organization.

Objectives

~~To acknowledge risks to patient safety such that medical and human errors will occur in a complex environment~~

~~To recognize and report errors and risks to patient safety within a Just Culture~~

~~To engage staff in internal reporting by:~~

~~A. Ensuring a non-punitive approach to patient safety event reporting~~

~~B. Educating staff on identifying patient safety events that should be reported~~

~~C. Providing timely feedback regarding actions taken on patient safety events~~

I. To promote patient safety through effective management of identified risks and prevention of adverse events

II. To reduce the opportunity for harm and improve safety mechanisms and processes

III. ~~To minimize blame or unfair treatment for reporting or involvement in errors~~To encourage reporting of errors, occurrences, and risks to patient safety without judgment or placement of blame

IV. To collect and analyze data to ensure proper prioritization of process improvements

V. To identify risk through trending of confidential patient safety occurrence information from individual event reports and aggregate data reports

VI. To investigate and analyze occurrences with a focus on process and system improvements to reduce risk

VII. To integrate patient safety priorities into the design and redesign of all relevant organizational processes, functions, and services

~~To create an accountable Culture of Safety~~

~~To investigate and analyze with a focus on process and system improvements~~

~~To utilize a standardized tool which offers a clear, equitable and transparent process for recognizing and separating blameless errors from unsafe or reckless act (Appendix A-Just Culture Algorithms).~~

VIII. To provide open communication regarding patient safety risks, events, and system-based improvements

~~To provide open communication with patients and families about medical errors that occur (See Disclosure of Medical Events Policy)~~

IX. To facilitate organizational learning about patient safety occurrences

X. To incorporate recognition of patient safety as an integral job responsibility

XI. To use education as a key strategy for prevention of patient safety issues based on needs specific to the organization

XII. To involve patients in decisions about their health care and promote open communication with patients and families about medical errors that occur

XIII. To identify at least one high-risk patient safety process selected at a minimum of every 18 months for proactive risk assessment. The following may be considered, but not limited to, when selecting a proactive risk assessment:

A. The Joint Commission Sentinel Event alerts

B. Core Measure performance data

C. Occurrence reporting information

~~Performance Improvement Priority Matrix (see Performance Improvement and Patient Safety (PIPS) Plan)~~

D. Information from external sources: state, federal and current literature

E. National Patient Safety Goals

XIV. To support initiatives that promote person-centered care and involvement

XV. To identify patient perception of safety issues using patient satisfaction survey data

XVI. To regularly evaluate staffs~~'~~ perception of the ~~organizations'~~organizational culture of safety using a valid and reliable survey tool, and to implement improvements identified from survey results

Definitions

Adverse event: An occurrence with an unplanned, unexplained negative event that reaches the patient and results in no harm, harm (minimal to severe), or death

Good Catch/ near miss: An event that could have caused harm, but was prevented from reaching the patient

Hazard: A potential source of harm or adverse effect

Just Culture: A value supported system of accountability that allows the individual to report adverse events, Good Catches, and hazards in an atmosphere of trust. See also Just Culture

Occurrence: Any happening that is not consistent with routine operation of the facility. See also Occurrence Reporting

Patient harm: Unintended physical or psychological injury or damage resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that results in death

Patient safety: ~~Is the~~The prevention of errors and adverse effects to patients that are associated with health care~~.~~

~~Patient harm: Unintended physical or psychological injury or damage resulting from or contributed to by~~

~~medical care that requires additional monitoring, treatment, or hospitalization, or that results in death.~~

Patient safety event: An event, occurrence, or condition that could have resulted or did result in harm to a patient

Performance improvement: The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement

Safety culture: ~~Is the~~The product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the ~~organizations~~organization's commitment to quality and patient safety~~.~~

~~Non-punitive reporting: A reporting system where individuals are not punished for reporting adverse events, close calls and hazards, and shall not incur repercussions for sharing details of an event.~~

~~Hazardous or unsafe conditions: A circumstance (other than a patient's own disease process or condition) that increases the probability of and adverse event, as it relates to patient safety.~~

~~Zero tolerance for reckless behavior: MHSC will not tolerate any reckless behavior or willful violations that may place a patient, provider or staff at risk, or results in abuse. These behaviors will result in disciplinary action or termination, please see the Employee Corrective Action policy for further information.~~

~~Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care. Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, including the following:~~

I. ~~Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)~~
II. ~~Shaming others for negative outcomes~~
III. ~~Unjustified negative comments or complaints about another provider's care~~
IV. ~~Refusal to comply with known and generally accepted practice standards, the refusal of which may prevent other providers from delivering quality care~~
V. ~~Not working collaboratively or cooperatively with other members of the interdisciplinary team~~
VI. ~~Creating rigid or inflexible barriers to requests for assistance or cooperation~~
VII. ~~Not returning pages or calls promptly~~

For further definitions please refer to these documents: ~~Occurrence Reporting~~Occurrence Reporting, ~~Sentinel Event Policy~~Adverse Drug Reactions, ~~Disclosure of Adverse Medical Event~~Medication Errors, Fall Prevention Program, Just Culture, Disclosure of Adverse Medical Event, Performance Improvement and Patient Safety Plan, and Sentinel Event Policy

Organization and Accountability

MHSC recognizes that all staff have an impact on patient safety. All staff are expected to participate in patient safety activities and ~~encouraged~~ to offer suggestions and recommendations for improvement through their involvement in occurrence reports, patient safety initiatives, department meetings, and other formal and informal means.

Board of Trustees

I. Hold ~~Senior Leadership~~CEO accountable for promoting and modeling behaviors consistent with a Just Culture, as well as overseeing actions to improve patient safety throughout the organization
II. Review and approve Patient Safety Plan annually
III. Review annual written report provided by Patient Safety Committee
IV. ~~Ensure~~Oversee that quality and safety are at the core of the organization's mission
V. ~~Ensure~~Oversee that quality and safety values are embedded in guiding the organization's strategic plan
VI. Oversee that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement
VII. Oversee the Hospital's ongoing monitoring, maintenance, and improvement efforts for safe, high quality, and efficient medical care

Senior Leadership Team

I. Promote and model behaviors consistent with a Just Culture, as well as oversee actions to improve patient safety throughout the organization
II. Create and maintain a culture of safety at the hospital that supports effective implementation of the Patient Safety Plan
III. Provide the resources necessary for the effective implementation of the Patient Safety Plan
IV. Define, in writing, the following terms:
    A. Occurrence
    B. Patient safety event
    C. Adverse events
    D. Adverse drug events
    E. Medication errors
    F. Sentinel events
    G. Good Catch/~~close call/~~ near miss
V. Disseminate ~~these~~above definitions throughout the organization
VI. Set expectations for improvement work based on results from the Culture of Safety survey and additional safety data

VII. Prioritize and ensure that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement

VIII. Participate in regular safety rounds

IX. Encourage communication of ongoing efforts to improve safety in the organization

Leadership Team

I. Create and maintain a culture of safety that supports effective implementation of the Patient Safety Plan

II. Establish that safety occurrences are not commonly the result of individual misconduct, but rather a failure of the systems or processes of the organization, see the Just Culture policy for more information

III. Inform staff of patient safety initiatives

IV. Encourage participation in patient safety principles and initiatives, performance improvement, and problem-solving processes

V. Participate in the collection and analysis of relevant departmental data

VI. Ensure completion of performance improvements and action plans

VII. Foster a climate of continuous improvement through measurement, data analysis, identification, and implementation of changes needed to improve safety of care and ensure sustainment

VIII. Provide the foundation for an environment that supports Just Culture and patient safety by:

A. Acknowledging that most safety events are process failures and monitoring processes to mitigate the risk of patient harm

B. Promoting learning

C. Motivating staff to uphold a fair and Just Culture of safety

D. Providing a transparent environment in which quality measures and patient harms are freely shared with staff

E. Modeling professional behavior by adopting and promoting the MHSC Code of Conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety.

F. Addressing intimidating behavior that undermines the safety culture so as not to inhibit others from reporting safety concerns

G. Educating staff and holding them accountable for professional behavior

IX. When a patient safety event occurs, provide resources and mechanisms for support as necessary following a patient safety event

A. Examples include but are not limited to, debriefing, counseling, and resources provided through the employee assistance program

X. Disseminate lessons learned from safety events

Medical Staff

I. Provide effective mechanisms to measure, assess, and improve the quality and appropriateness of patient care, and the clinical performance of all individuals with delineated clinical privileges, accomplished through Ongoing Professional Practice Evaluations (OPPE), Focused Professional Practice Evaluations (FPPE), and Peer Review Process (refer to Professional Practice Review Process – Medical Staff Peer Review)

II. Know and understand the culture of safety, the role of occurrence reporting in the culture of safety, and their ~~rights and~~ responsibilities under the culture of safety

III. Report ~~all observed or suspected patient safety events~~occurrences (both events that do and do not reach the patient, and do or do not cause harm to the patient) immediately, and document events through ~~designated~~the hospital's occurrence reporting ~~software~~platform

IV. Participate in any investigative activities including but not limited to the following:

   A. Describe, in writing, the situation and event

   B. Any clinical data related to the event (for example, patient's vital signs, medication name and dosage, and so on)
   Identify any other staff members who were present during the event

   C. Answer questions from the individual(s) investigating the event

   D. Collaborate with Quality department, department directors and others as appropriate, to design and implement corrective actions and monitor the results

V. Provide the foundation for an environment that supports a Just Culture and patient safety by:

   A. Modeling professional behavior by adopting and promoting the ~~MHSC~~Medical Staff Code of Conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety.

   B. Addressing intimidating behavior that undermines the safety culture so as not to inhibit others from reporting safety concerns

VI. Act upon identified areas for improvement

Quality Department

I. Facilitate education about patient safety principles to the Board of Trustees

II. Coordinate and provide patient safety education at new employee orientation and to staff annually

III. Collaborate with department directors to determine whether a reported patient safety event is likely to be repeated

IV. Conduct ~~a~~ Root Cause ~~Analysis~~Analyses - see ~~Sentinel Event Policy~~Sentinel Event Policy for more information

V. Serve as a resource for performance improvement, patient safety, patient experience, and regulatory information

VI. Educate MHSC staff about the performance improvement process, patient safety, and patient experience

VII. Support staff, including Medical Staff, Leadership, and project leaders in the development and implementation of performance improvement activities, including team building and data

analysis

Patient Safety Committee

The Patient Safety Committee is a standing interdisciplinary group that manages the Patient Safety Plan through a systematic, coordinated, continuous approach. Please see the Patient Safety Committee Charter for details on the responsibilities of the Patient Safety Committee (attached).

Staff and Volunteers

I. Know and understand the organizational definitions of the following terms, as provided by leadership:
    A. Occurrence
    B. Patient safety event
    C. Adverse events
    D. Adverse drug events
    E. Medication errors
    F. Sentinel events
    G. Good Catch/~~close call/~~near miss

II. Comply with all hospital policies and procedures related to patient safety that apply to their position and job duties

III. Know and understand the culture of safety, the role of occurrence reporting in the culture of safety, and their ~~rights and~~ responsibilities under the culture of safety

IV. Improve the culture of safety and accountability by employing a "see something, say something, do something" approach

V. Report ~~all observed or suspected patient safety events~~occurrences (both events that do and do not reach the patient, and do or do not cause harm to the patient) to their department manager or supervisor immediately, and document events through ~~designated~~the hospital's occurrence reporting ~~software~~platform

VI. Participate in any investigative activities including but not limited to the following:
    A. Describe, in writing, the situation and event
    B. Any clinical data related to the event (for example, patient's vital signs, medication name and dosage, and so on)
    C. Identify any other staff members who were present during the event
    D. Answer questions from the individual(s) investigating the event
    E. Collaborate with Quality department, department directors and others as appropriate, to design and implement corrective actions and monitor the results

VII. Participate in data collection and analysis activities as well as performance improvement activities

VIII. Identify and utilize approaches for improving processes and outcomes to continuously improve the quality and safety of patient care

IX. Participate in improvement activities related to the Patient Safety Plan

X. Constantly hold patient safety at the forefront and continue to advocate for changes where opportunities are identified

XI. Encourage patients and their family members to speak up when they observe or suspect a patient safety event or if they have questions about the safety of a system or process

XII. For further information, please refer to the following policies: Occurrence Reporting ~~and/or~~, Adverse Drug Reactions, Medication Errors, Fall Prevention Program, Just Culture, Disclosure of Adverse Medical Event, and Sentinel Event Policy~~.~~

Data

~~Monitor~~The Patient Safety Committee will monitor data that is further specified and defined in the PIPS Plan and Patient Safety Committee Charter. Information from data analysis is used to make changes that improve performance and patient safety and reduce the risk of adverse and sentinel events. Please see Patient Safety Committee ~~charter~~ Charter "Data" heading for details.

Communication

Patient safety initiatives, lessons learned, and patient safety improvement work will be communicated as appropriate throughout the organization. Communication will occur through:

I. Quality Committee of the Board

II. PIPS Committee

III. Patient Safety Committee

   A. Monthly Patient Safety Newsletters

   B. Monthly Key Takeaway Information

IV. Leadership meetings

V. Medical Staff meetings

VI. Staff meetings

VII. Department white boards, electronic communication, patient safety rounding, ~~the patient safety newsletter,~~ and communication books

Confidentiality

I. WY Stat 35-2-910. Quality management function for health care facilities; confidentiality; immunity; whistle blowing; peer

II. All quality and patient safety data, materials, and information are private and confidential, shall be considered the property of Memorial Hospital of Sweetwater County, and as such is protected by state and federal health care quality statutes.

III. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with hospital policy and state and federal regulations governing the confidentiality of quality and patient safety work.

IV. Information, data results, reports and minutes generated by all quality management activities will be handled in a manner ensuring strict confidentiality

V. Confidential information may include but is not limited to: Medical Staff committee minutes, organizational quality improvement committee minutes, electronic data gathering and reporting, and incident/occurrence reporting

VI. Quality improvement activities will occur in ways that preserve confidentiality of information consistent with policy and established law

VII. The Joint Commission is an independent contractor. Any event reported to The Joint Commission is performed under the auspice of the Quality Committee.

REFERENCES

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Reviewed and Approved:
Patient Safety Committee: October 27th, 2022
Medical Executive Committee: November 29th, 2022
Quality Committee of the Board: January 18th, ~~2021~~
~~MEC: November 23rd, 2021~~
~~Quality Committee of the~~2023
Board~~: February 16th, 2022~~
~~Board~~ of Trustees: ~~April 6th, 2022~~

Attachments

Patient Safety Committee Charter.docx

Approval Signatures

Step Description	Approver	Date

DRAFT

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

BOARD OF TRUSTEES MEETING GUIDELINES

MARCH, 2023

Introduction

These Guidelines are intended to provide a framework for the preparation, notification, and operation of meetings of the Board of Trustees (Board) concerning topics not otherwise addressed in the Wyoming Statutes, the By-Laws of the Board, or in the Board Governance Committee Charter. These Guidelines are prepared by the Governance Committee of the Board and are approved by the Board. They may be amended at any time by the Board.

Agenda Preparation

The Board President, the Chief Executive Officer (CEO), and the Executive Assistant to the CEO meet at least a week before each regular monthly meeting of the Board to prepare the agenda for the meeting. Typically, a less formal meeting is required for the preparation of an agenda for special meetings of the Board.

Public Access to the Meeting Packet

The meeting packet associated with regular monthly meetings of the Board should be published on the Hospital's website at least two days before the date of the meeting.

When possible, the meeting packet for special meetings of the Board should also be published on the Hospital's website in advance of the meeting. It is noted that a meeting packet may not be prepared for every special meeting.

Orientation Memo Associated with New and Old Business Agenda Items

Prefacing each agenda item under the Old and New Business section of the meeting agenda, staff should prepare a brief "Orientation Memo" designed to orient Board members concerning the agenda item. To ensure consistency, the Executive Assistant to the CEO should develop a template that would be used each time so that the memo format is standardized for every meeting and for each agenda item. The following content for the Memo must include:

(1) Date of the Board Meeting
(2) Topic for old and new business items
(3) If a policy or other document…is it a revision or a new policy/document?
(4) Brief Senior Leadership comments (if any)
(5) Board Committee action (if applicable)
(6) Is the agenda item for review only or for Board action?
(7) Legal Counsel (In House & Board) review (and comments if any)
(8) Senior Leadership recommendation

Review and Approval of Hospital Policies & Program Documents

As a general practice, new policies & program documents being recommended for Board approval and existing policies & program documents being recommended for material or substantive revision should be presented for "review only" the first time they are brought before the Board for consideration. This practice helps ensure that Board members have sufficient time to review the proposals prior to voting and provides time for questions which may be posed by Board members and/or others to be addressed by staff.

As a general practice, minor, non-substantive revisions to existing policies or program documents may be voted upon at the first meeting they are brought before the Board.

As a general practice, new or revised Medical Staff forms, etc. approved by the Medical Executive Committee (MEC) may be voted upon the first time they are brought before the Board.

Board Committee Reports

Board Committee reports to the Board may be presented by the Committee Chair either in writing or verbally at the discretion of the Committee Chair.

Executive Sessions

Invitations to attend Executive Sessions of the Board are extended by the Board President. The CEO should always be in attendance unless excused for a period of time by the Board President when his/her regular performance evaluation is being conducted or for other reasons associated with his/her performance or compensation. The Executive Assistant to the CEO is typically in attendance to document the discussion. If absent, an Acting Executive Assistant may be present to document the discussion or, alternatively, a taped recording may be substituted.

APPROVED BY THE BOARD OF TRUSTEES THIS _____DAY OF _____, 20___

_____

President, Board of Trustees

ORIENTATION MEMO

Board Meeting Date: March 1, 2023

Topic for Old & New Business Items:

Orientation Memo Procedure for Items Presented to the Board of Trustees

Policy or Other Document:

_____ Revision
___X__ New

Brief Senior Leadership Comments:

Irene Richardson reviewed the procedure with the Governance Committee on 1/30/2023 and agreed this is a good idea.

Board Committee Action:

On January 30, 2023, the Governance Committee agreed to forward a draft orientation memo to the Board of Trustees for review at the March 1, 2023 meeting.

Policy or Other Document:

____X__ For Review Only
_____ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:

Status Draft PolicyStat ID 12449187

Approved N/A
Review Due N/A

Document Area General - Housewide

Board Quality Committee Charter

STATEMENT OF PURPOSE:

The purpose of the Quality Committee (Committee) is to assist the Board of Trustees (Board) in its fiduciary and oversight duties regarding the delivery of safe, quality, patient-centered care with the expectation of continuous improvement as set forth below.

TEXT

I. **Definition of Quality:** Quality at Memorial Hospital of Sweetwater County (Hospital) is a patient-centered commitment to excellence, consistently using best practices for process improvement to achieve the best outcomes for our patients.

A. The Institute of Medicine (IOM) defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The IOM defines the six (6) dimensions of quality as:

1. **SAFE**, does not harm
2. **TIMELY**, delivered without unnecessary delays
3. **EFFECTIVE**, based on the best scientific knowledge currently available
4. **EFFICIENT**, does not waste resources
5. **EQUITABLE**, based health needs not personal characteristics
6. **PATIENT-CENTERED**, respectful and customized according to patients needs and values

II. **Authority:**

A. The committee has no expressed or implied power or authority.

III. **Responsibilities:**

A. In fulfilling its charge, the Committee is responsible for the following activities and functions.

1. Monitors the monthly quality, safety, and patient experience reports of the Hospital against national benchmarks and other standards.
2. Monitors priority-focus data as identified by the Performance Improvement and Patient Safety (PIPS) Committee.
3. Monitors the summary quality, safety, and patient experience reports provided pursuant to provisions of clinical service contracts.
4. Monitors the summary quality, safety, patient experience reports of the Hospital's medical directors and department chairs.
5. Reviews all Serious Safety Events, as defined by the Hospital, the National Quality Forum, Wyoming Department of Health, and The Joint Commission, and subsequent improvement plans made in connection therewith.
6. Monitors the effectiveness of project and committee leaders' improvement plans with regard to negative variances and serious errors.
7. Reviews the Hospital's annual PIPS Plan, Patient Safety Plan, and Environment of Care Plans, and recommends the Plans to the Board for its approval.
8. Advocates that quality and cost are appropriately inter-related and that the Hospital's culture and resources are sufficient to support efforts to improve quality, safety, and patient-centered care.
9. Recommends organizational strategy regarding the delivery of safe, patient-centered, quality care as aligned with the Hospital's strategic plan.
10. Works with Senior Leadership to help assure that major new programs, service additions, or enhancements have met specific quality-related performance criteria, including, but not limited to, volume, staffing and accreditation requirements.
11. Recommends Board level policies regarding the delivery of safe, patient-centered, quality care, as needed.
12. Recommends education programs to the Board.

IV. **Composition:**

A. The composition of the Committee shall be as follows: two (2) Board members, one of whom to serve as Chair, Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Chief Nursing Officer, Chief Clinical Officer, Clinic Director, Quality Director, and not more than two physicians as appointed by the Board President. Each of these members shall have voting privileges.

1. The Chair may invite any director, officer, staff member, expert or other advisor who is not a member of the Committee to attend, but these individuals have no voting privileges.
2. **Meetings should be attended by** the staff of the Quality Department and

the Infection Prevention, Risk and Compliance Director. These individuals shall not have voting privileges.

V. **Meeting Schedule:**

A. The committee shall meet monthly and as needed.

VI. **Reports:**

A. The Committee will regularly receive and review the following reports.

1. The monthly quality, safety, and patient experience reports of the Hospital
2. Centers for Medicare and Medicaid quarterly and annual reports
3. Serious Safety Events, as they occur
4. Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA) reports
5. Environment of Care Plan Evaluation, semi annually
6. Progress on performance improvements and/or safety goals as aligned with identified priority areas in the PIPS Plan and/or other priorities identified by the PIPS Committee in action plan format
7. The annual PIPS Plan
8. The results of the biennial Culture of Safety survey
9. Accreditation reports when received
10. Infection Prevention Program Annual Evaluation
11. Performance Improvement and Patient Safety (PIPS) Plan Annual Evaluation and Performance Improvement (PI)and Patient Safety Report
12. Summary of clinical contract reviews annually
13. Audits of credentialing process at least every two (2) years
14. Audits of peer review, ongoing professional practice evaluations (OPPE), focused professional practice evaluations (FPPE) monitoring, annually

VII. **Confidentiality:**

A. WY Stat 35-2-910. Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A.

B. WY Stat 35-2-910 (d)

C. All quality and patient safety data shall be considered the property of the Hospital.

D. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy and State and Federal Regulations governing the confidentiality of quality and patient safety work.

E. Only aggregated data will be reported to the Committee, with two exceptions. These exceptions are Serious Safety Events and events that triggered Root Cause Analysis and/or Failure Mode Effects Analysis. De-identification of protected health information will be used for these reports.

Approved: The Board Quality Committee 2/15/2023

Board Charter: The Quality Committee

Category: Board Committees & Committee Charters

Title: Quality Committee

Original Adoption: 7/4/2018

Revision: 7/25/2018; 1/29/2020; 4/1/2020

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 12449187

Approved N/A
Review Due N/A

Document Area General - Housewide

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II. **Authority:**

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III. **Responsibilities:**

A. In fulfilling its charge, the Committee is responsible for the following activities and functions.

1. Monitors the monthly quality, safety, and patient experience reports of the Hospital against national benchmarks and other standards.
2. Monitors priority-focus data as identified by the Performance Improvement and Patient Safety (PIPS) Committee.
3. Monitors the summary quality, safety, and patient experience reports provided pursuant to provisions of clinical service contracts.
4. Monitors the summary quality, safety, patient experience reports of the Hospital's medical directors and department chairs.
5. Reviews all Serious Safety Events, as defined by the Hospital, the National Quality Forum, Wyoming Department of Health, and The Joint Commission, and subsequent improvement plans made in connection therewith.
6. Monitors the effectiveness of project and committee leaders' improvement plans with regard to negative variances and serious errors.
7. Reviews the Hospital's annual PIPS Plan ~~(~~, Patient Safety Plan~~)~~, and Environment of Care Plans, and recommends the ~~Plan~~Plans to the Board for its approval.
8. Advocates that quality and cost are appropriately inter-related and that the Hospital's culture and resources are sufficient to support efforts to improve quality, safety, and patient-centered care.
9. Recommends organizational strategy regarding the delivery of safe, patient-centered, quality care as aligned with the Hospital's strategic plan.
10. Works with Senior Leadership to help assure that major new programs, service additions, or enhancements have met specific quality-related performance criteria, including, but not limited to, volume, staffing and accreditation requirements.
11. Recommends Board level policies regarding the delivery of safe, patient-centered, quality care, as needed.
12. Recommends education programs to the Board.

IV. **Composition:**

A. The composition of the Committee shall be as follows: two (2) Board members, one of whom to serve as Chair, Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Chief Nursing Officer, Chief Clinical Officer, Clinic Director, Quality Director, and not more than two physicians as appointed by the Board President. Each of these members shall have voting privileges.
~~The Chair may invite any director, officer, staff member, expert or other advisor who is not a member of the Committee to attend, but these individuals have no voting privileges.~~
~~**Meetings should be attended by** the staff of the Quality Department and the Infection Prevention, Risk and Compliance Director. These individuals shall not have~~

~~voting privileges.~~

1. The Chair may invite any director, officer, staff member, expert or other advisor who is not a member of the Committee to attend, but these individuals have no voting privileges.
2. **Meetings should be attended by** the staff of the Quality Department and the Infection Prevention, Risk and Compliance Director. These individuals shall not have voting privileges.

V. **Meeting Schedule:**

A. The committee shall meet monthly and as needed.

VI. **Reports:**

A. The Committee will regularly receive and review the following reports.

1. The monthly quality, safety, and patient experience reports of the Hospital
2. Centers for Medicare and Medicaid quarterly and annual reports
3. Serious Safety Events, as they occur
4. Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA) reports
5. Environment of Care ~~reports~~Plan Evaluation, ~~biannually and~~semi annually
6. Progress on performance improvements and/or safety goals as aligned with identified priority areas in the PIPS Plan and/or other priorities identified by the PIPS Committee in action plan format
7. The annual PIPS Plan
8. The results of the biennial Culture of Safety survey
9. Accreditation reports when received
10. Infection Prevention Program Annual Evaluation
11. Performance Improvement and Patient Safety (PIPS) Plan Annual Evaluation and Performance Improvement (PI)and Patient Safety Report
12. Summary of clinical contract reviews annually
13. Audits of credentialing process at least every two (2) years
14. Audits of peer review, ongoing professional practice evaluations (OPPE), focused professional practice evaluations (FPPE) monitoring, annually

~~Audits of clinical contract quality and safety review, annually~~

~~Audits of medical directors' quality review initiatives annually~~

VII. **Confidentiality:**

~~WY Stat 35-2-910. Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A. "Each licensee (hospital, healthcare facility and health services) shall implement a quality management function to evaluate and improve patient and resident care and services in accordance with the rules and regulations promulgated by the division.~~

~~Quality management information relating to the evaluation or improvement of the quality of health care services is confidential. Any person who in good faith and within the scope of the functions of a quality management program participates in the reporting, collection, evaluation, or use of quality management information or performs other functions as part of a quality management program with regards to a specific circumstance shall be immune from suit in any civil action based on such functions brought by a health care provider or person to whom the quality information pertains. In no event shall this immunity apply to any negligent or intentional act or omission in the provision of care."~~
~~Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy and State and Federal Regulations governing the confidentiality of quality and patient safety work. All quality and patient safety data shall be considered the property of the Hospital.~~
~~Only aggregated data will be reported to the Committee, with two exceptions. These exceptions are Serious Safety Events and events that triggered Root Cause Analysis and/or Failure Mode Effects Analysis. De-identification of protected health information will be used for these reports.~~

A. WY Stat 35-2-910. Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A.
B. WY Stat 35-2-910 (d)
C. All quality and patient safety data shall be considered the property of the Hospital.
D. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy and State and Federal Regulations governing the confidentiality of quality and patient safety work.
E. Only aggregated data will be reported to the Committee, with two exceptions. These exceptions are Serious Safety Events and events that triggered Root Cause Analysis and/or Failure Mode Effects Analysis. De-identification of protected health information will be used for these reports.

~~WY Stat 35-2-910 (d)~~

Approved: The Board ~~Compliance~~Quality Committee ~~4/1/2020~~2/15/2023

Board Charter: The ~~Compliance~~Quality Committee

Category: Board Committees & Committee Charters

Title: ~~Compliance~~Quality Committee

Original Adoption: 7/4/2018

Revision: 7/25/2018; 1/29/2020; 4/1/2020

Approval Signatures

Step Description	Approver	Date

RESOLUTION NO. ____

Comes now the Board of Trustees of Memorial Hospital of Sweetwater County and hereby adopts the following Resolution:

WHEREAS, the Board of Trustees has determined that it is in the best interests of Memorial Hospital of Sweetwater County to become certified as a Medicare Critical Access Hospital (CAH), and;

WHEREAS, the Board of Trustees has determined that a CAH designation will reduce the financial vulnerability of Memorial Hospital of Sweetwater County by providing certain benefits, such as cost-based reimbursement for Medicare services; and improve access to healthcare by keeping essential services in Sweetwater County.

NOW THEREFORE, be it resolved by the Board of Trustees of Memorial Hospital of Sweetwater County that the President of the Board of Trustees and the Chief Executive Officer of Memorial Hospital of Sweetwater County are hereby directed and authorized to submit application for Memorial Hospital of Sweetwater County to receive a CAH designation to the necessary Wyoming state agencies, the CMS regional office and any other necessary governmental agencies.

BE IT FURTHER RESOLVED that the President of the Board of Trustees and the Chief Executive Officer of Memorial Hospital of Sweetwater County are fully authorized and empowered to execute in the name of Memorial Hospital of Sweetwater County any and all documents necessary for the application to receive a CAH designation as described herein.

BE IT FURTHER RESOLVED that the President of the Board of Trustees and the Chief Executive Officer of Memorial Hospital of Sweetwater County are fully authorized and empowered to retain the services of any experts necessary to submit the application to receive a CAH designation.

BE IT FURTHER RESOLVED that this authority given to the President of the Board of Trustees and the Chief Executive Officer of Memorial Hospital of Sweetwater County to submit application to receive a CAH designation shall be continuing and shall be binding upon Memorial Hospital of Sweetwater County until the authority given herein is revoked or superseded by another resolution of the Board of Trustees.

BE IT FURTHER RESOLVED that the designation of Memorial Hospital of Sweetwater County as a CAH hospital shall be subject to final approval by the Board of Trustees of Memorial Hospital of Sweetwater County.

DATED: _____

_____
Chairman, Board of Trustees of Memorial Hospital of Sweetwater County

ATTEST: _____
CLERK/SECRETARY

Name: _____

Delineation of Privileges
ANESTHESIOLOGY PRIVILEGES

☐ Initial appointment ☐ Reappointment ☐ Modification of Privileges

Applicant
Check the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

To be eligible to request privileges in Anesthesiology, a practitioner must meet the following minimum threshold criteria:

LICENSURE / PROFESSIONAL LIABILITY INSURANCE	MD or DO Licensed to practice medicine in the State of Wyoming Current Wyoming designated DEA Registration and current Wyoming Controlled Substance Registration Professional liability insurance in the amounts of at least: Per Claim: $1,000,000.00 Aggregate: $3,000,000.00.
EDUCATION / TRAINING	Completion of an approved residency in Anesthesiology by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
CERTIFICATION	Certification by the applicable Anesthesiology specialty board for any clinical privileges for which applicant has applied, or be eligible for certification by such board. Once physician is board certified, Maintenance of Board Certification is required.
CLINICAL EXPERIENCE (INITIAL)	Applicants for initial appointment must be able to demonstrate the performance of at least 250 hospital anesthesiology cases during the last 12 months or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship, or research. Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications, and for resolving any doubts.
CLINICAL EXPERIENCE (REAPPOINTMENT)	To be eligible to renew core privileges in Anesthesiology, the applicant must meet the following Maintenance of Privilege criteria: Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
FPPE	FPPE criteria will be assigned by the Department Chair during the approval process.
OTHER REQUIREMENTS	• Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy. • This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Memorial Hospital OF SWEETWATER COUNTY

Name: _____

ANESTHESIOLOGY CORE PRIVILEGES - This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/ privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/ procedures/privileges requiring similar skill sets and techniques.		
Requested	**CHECK ALL PRIVILEGES/PROCEDURES YOU ARE REQUESTING**	**Approved**
☐	Administration of anesthesia, including general, regional, and local, and administration of all levels of sedation to patients of all ages. Care is directed toward patients rendered unconscious or insensible to pain and the management of emotional stresses during surgical, obstetrical, and certain other medical procedures, including pre-, intra-, and postoperative evaluation and treatment and the support of life functions and vital organs under the stress of anesthetic, surgical, and other medical procedures.	☐
☐	Assessment of, and consultation for, and preparation of patients for anesthesia	☐
☐	Monitoring and maintenance of normal physiology during the perioperative period	☐
☐	Sedation or anesthesia for patients outside the OR, including those undergoing radiologic studies and treatment and acutely ill and severely injured patients in the ER	☐
☐	All types of neuraxial analgesia (including epidural, spinal, combined spinal and epidural analgesia) and different methods of maintaining analgesia (e.g., bolus, continuous infusion, patient-controlled epidural analgesia)	☐
☐	Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation and uterine curettage, postpartum tubal ligation, cervical cerclage, and assisted reproductive endocrinology interventions	☐
☐	Management of normal and abnormal airways	☐
☐	Perform history and physical exam	☐
☐	Interpretation of laboratory results	☐
☐	Management of both normal perioperative fluid therapy and massive fluid or blood loss	☐
☐	Mechanical ventilation	☐
☐	Placement of venous and arterial catheters	☐
☐	Image guided procedures	☐
☐	Clinical management and teaching of cardiac and pulmonary resuscitation	☐
☐	Management of critically ill patients in special care units pertinent to the practice of anesthesiology	☐
☐	Evaluation of respiratory function and application of respiratory therapy	☐
☐	Consultation for medical and surgical patients	☐
☐	Diagnosis and treatment of acute pain	☐

Memorial Hospital OF SWEETWATER COUNTY

Name: _____

ACKNOWLEDGEMENT OF APPLICANT
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that: a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents. Applicant's Printed Name: _____ Applicant's Signature: _____ Date: _____

DEPARTMENT CHAIR REVIEW	
I have reviewed the requested clinical privileges and supporting documentation and make the following recommendations:	
☐	Recommend all privileges as requested
☐	Recommend privileges with conditions/modifications (describe):
☐	Do not recommend the following requested privileges (rationale for recommendation):
☐	I assign _____ to complete the initial FPPE evaluations on this Practitioner.
Department Chair's Printed Name _____ Department Chair's Signature: _____ Date: _____	

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee approval ***Date:*** _____

Medical Executive Committee approval ***Date:*** _____

Board of Trustees approval ***Date:*** _____

Privileges Effective From: _____ To: _____

Date Form Approved by Specialty: 01/27/2023
Date Form Approved by Department Chair: 01/27/2023
Date Approved by Credentials Committee: 02/07/2023
Date Approved by MEC: _____
Date Approved by Board of Trustees: _____

QUALITY COMMITTEE REPORT TO THE BOARD

February 2023 meeting

The Quality Committee met in Zoom format this month. Taylor Jones was excused. Barbara Sowada sat in for Taylor and Ed Tardoni acted as chair of the meeting. All other voting members were present.

Committee Charter

The Committee, by unanimous vote, sent a revised charter to the Board for their consideration. The revision involves improved consistency of language with no change in duties or activity.

Environment of Care Management Plan

Mr. Horan made the annual presentation of this plan to the committee. The plan covers fire, security, safety, utility, medical equipment, hazardous materials, and waste management. A copy may be found in the February Quality Packet on Board Advantage

End Stage Renal Disease Quality Incentive Program Review

Mr. Rodriquez made a presentation of the status of this quality measure. A copy of the presentation may be found in the February Quality Packet on Board Advantage

Standard Quality Measure Reports

Staff directed Committee attention to several items in this month's data. Considerable progress has been made with scanning and overrides this month. Other items in which control has been maintained were discussed. The data package is available to Board Members on Board Advantage.

March Meeting

The Quality Committee will meet by zoom at 8:15 hours, Wednesday, March 15th.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Human Resources Committee Meeting Minutes - Draft
Monday – February 20, 2023
Zoom

Trustee Members Present by Zoom: Kandi Pendleton, Barbara Sowada
Voting Members Present by Zoom: Suzan Campbell, Amber Fisk, Irene Richardson
Non-Voting Members & Guests Present by Zoom: Tami Love, Kari Quickenden, Amy Lucy, Shawn Bazzanella, Ruthann Wolfe, Eddie Boggs, Cindy Nelson

Kandi called the meeting to order and welcomed everyone.

APPROVAL OF AGENDA

The motion to approve the agenda as presented was made by Barbara, second by Irene. Motion carried.

APPROVAL OF MINUTES

The motion to approve the January meeting minutes as presented was made by Barbara, second by Suzan. Motion carried.

ROUTINE REPORTS

Turnover

Amber provided the 2023 turnover data through the end of January. She said we are at a 23% turnover rate which is good compared to the national average still at 26%. The Committee discussed job abandonment numbers as well as the jobs with the highest turnover. Kandi asked if we ever checked on pay related to local employers vs. hospitals in the area. Amber said Amy called around to a few places and found we are in-line with local industry. Amber said we gather information from various resources to make sure we are on the right track.

Open Positions

Amy reported we have 60 open positions. She said we are organizing a dinner in March to recruit nursing students preparing to graduate. Amber said our goal is to generate some excitement. Kandi asked if we have a number or goal for recruitment from the event. Irene said Ann has a goal and can provide that number.

Contract Staffing

The Committee reviewed the current contract staff report and said it is continually looking better. Barbara commented it is nice to see the number going down.

Employee Injury & Illness Reporting

Amber said we do not have an updated illness and injury log. Nicole Burke in Employee Health is working on an update.

Old Business

Employee Policies - Workplace Violence Policy & Workplace Violence Plan

Amber said this is tabled.

New Business

Employee Policies – Drug & Alcohol-Free Policy

Suzan reviewed the reasons for the update. She said we currently have a policy and a process. The update pulls the process HR uses within the policy itself. Suzan said she based this update on another hospital's policy and feels it fits better for our hospital. The Committee discussed the section on searches. Suzan will work on that section following discussion.

Next Meeting

The next meeting is scheduled Monday, March 20 at 3:00 p.m.

Human Resources Committee Meeting
Monday, February 20, 2023 @ 3:00pm
Zoom meeting

AGENDA

1. Approval of Agenda
2. Approval of Minutes:
    - January 2023 meeting minutes
3. Routine Reports:
    a. Turnover
    b. Open Positions
    c. Contract Staffing
    d. Employee injury & illness reporting – 02-2023 – No update
4. Old Business
    - Employee Policies – Workplace Violence Prevention Policy & Plan
        - Tabled at January 2023 Board Meeting
5. New Business
    - Employee Policies – Drug & Alcohol-Free Policy
6. Executive Session as needed
7. Next meeting—03/20/2023

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Human Resources Committee Meeting Minutes - Draft
Monday – January 16, 2023
Zoom

Trustee Members Present by Zoom: Kandi Pendleton, Barbara Sowada
Voting Members Present by Zoom: Suzan Campbell, Amber Fisk, Irene Richardson
Non-Voting Members & Guests Present by Zoom: Tami Love, Kari Quickenden, Amy Lucy, Cindy Nelson

Kandi called the meeting to order and welcomed everyone.

APPROVAL OF AGENDA

The motion to approve the agenda as presented was made by Barbara, second by Irene. Motion carried.

APPROVAL OF MINUTES

The motion to approve the November meeting minutes as corrected was made by Barbara, second by Irene. Motion carried. Amber said she will make the correction to show Kandi was not in attendance and Barbara conducted the meeting. The motion to approve the December meeting minutes as presented was made by Barbara, second by Irene. Motion carried.

ROUTINE REPORTS

Turnover

Amber provided the 2022 turnover data and reviewed highlights. Kandi asked if Human Resources has a goal around the numbers. Amber said our focus is on retention. We want to stay below the national hospital average for turnover.

Open Positions

Amy reported we have 54 open positions and has 6 offers on her desk so there is a lot of movement going on. Amber said we continue to see the number of open positions go down.

Contract Staffing

Amber said we currently have contract staff in ED, ICU, Lab, Respiratory, and Surgical Services. The report shows the total number of contract staff. Kandi noted the numbers are going down. Amber talked about recruitment activities including contingent offers to current students, recruitment events, and sponsorship opportunities. She said we want to grow our own and our efforts will not be limited to nursing.

Employee Injury & Illness Reporting

Amber reviewed the reports she sent to the Committee.

Old Business

Workplace Violence Policy:

Suzan said she and Amber met with Ed Tardoni. She reviewed the changes in the update. Suzan said she will send out the original and what has changed with this current draft. The Committee discussed potential confusion and agreed we can always amend in the future as needed. The motion to send the policy to the Board for third reading and approval was made by Barbara, second by Irene. Motion carried.

Workplace Violence Plan:

Suzan reviewed the one change to the plan regarding leadership responsibilities. The motion to send the plan to the Board for approval was made by Barbara, second by Irene. Motion carried.

New Business

Staffing Levels Report:

Irene reviewed the report and said it starts with 2017. The group agreed this is a good starting point. Kandi thanked Tami for putting this together following her request and requested the report be included in the February board meeting packet.

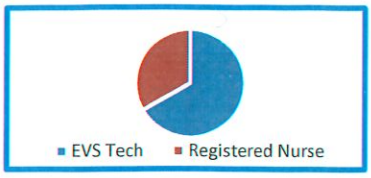
Next Meeting

The next meeting is scheduled Monday, February 20 at 3:00 p.m.

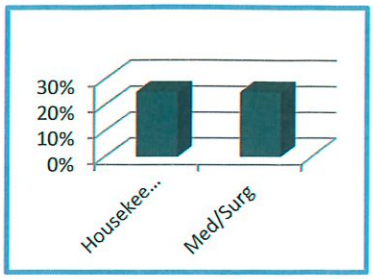
MEMORIAL HOSPITAL OF SWEETWATER COUNTY

2023 Turnover Data (as of 01/31/2023)

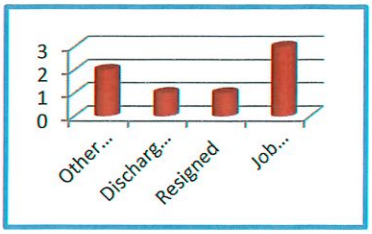
Top Position(s) / Turnover	2023	% of All	% of Pos
EVS Tech	2	25%	8%
Registered Nurse	1	13%	1%



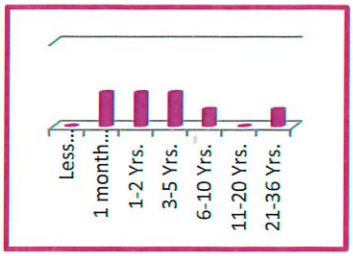
Top Department(s) / Turnover	2023	% of All	% of Dept
Housekeeping	2	25%	7%
Med/Surg	2	25%	7%



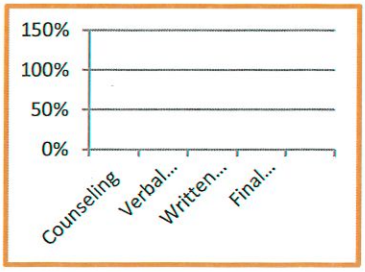
Top Reason(s) / Turnover	2023	%
Other Employment	2	25%
Discharged	1	13%
Resigned	1	13%
Job Abandonment	3	38%
Retired	0	0%



Length of Service	2023	%
Less than 30 days	0	0%
1 month - 1 Yr	2	25%
1-2 Yrs.	2	25%
3-5 Yrs.	2	25%
6-10 Yrs.	1	13%
11-20 Yrs.	0	0%
21-36 Yrs.	1	13%
Total	8	

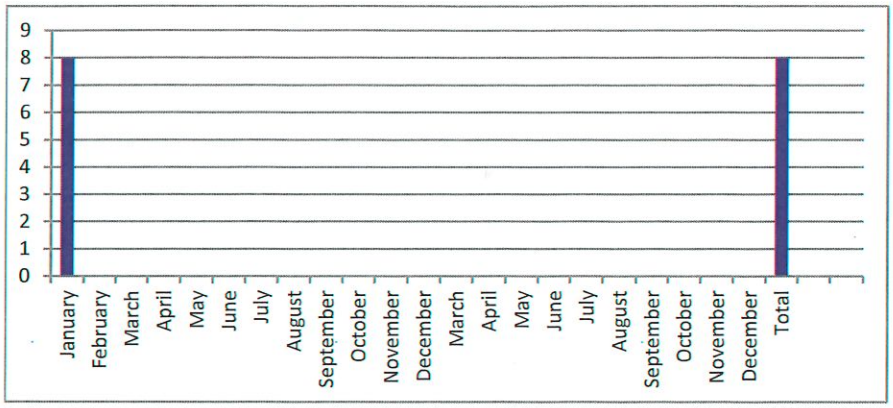


Corrective Action
Counseling
Verbal Warning
Written Warning
Final Written Warning



2023 Separations	Separations	New Employees	Total Employees
			537
January	8	12	541
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
Total	8		

Overall Turnover	
2009	96
2010	98
2011	79
2012	104
2013	113
2014	88
2015	97
2016	86
2017	116
2018	96
2019	93
2020	67
2021	129
2022	102
2023	541



Involuntary	1
Voluntary	7
Total	8

Classifications

RN	1
Classified	7
Total	8

Rolling 12	Separations	
Jan 22 - Jan 23	123	23%

Requisition Number	Job Title	Schedule	Shift	Department
Clinical				
3175	C.N.A.	Regular Part Time	Days	MED/SURG
3168	C.N.A.	PRN	Rotating	MED/SURG
3157	C.N.A.	Regular Full Time	Variable	POST PARTUM
3083	Central Sterile Tech	Regular Part Time	Variable	CENTRAL STERILE
3189	Clinical Coordinator	Regular Full Time	Days	MEDICAL ONCOLOGY
2995	Lab Asst / Phlebotomst I	Regular Full Time	Variable	LABORATORY
3036	Med. Tech	Regular Full Time	Rotating	LABORATORY
2838	Med. Tech	Regular Full Time	Variable	LABORATORY
3199	Med. Tech	Regular Full Time	Variable	LABORATORY
2689	Med. Tech	Regular Full Time	Variable	LABORATORY
3148	Medical Assistant	Regular Full Time	Variable	CLINIC
3156	Medical Assistant	Regular Full Time	Variable	CLINIC
3145	Medical Assistant	Regular Full Time	Variable	CLINIC
3159	Nurse Practitioner	Regular Full Time	Days	CLINIC
3021	Nurse Practitioner	Regular Full Time	Days	CLINIC
3176	Rad. Tech. I (ARRT)	Regular Full Time	Variable	MEDICAL IMAGING
3111	Rad. Tech. II (ARRT)	Regular Full Time	Variable	MEDICAL IMAGING
2902	Reg. Resp. Therapist	Regular Full Time	Variable	CARDIOPULMONARY
2903	Reg. Resp. Therapist	Regular Full Time	Variable	CARDIOPULMONARY
2743	Reg. Resp. Therapist	Regular Part Time	Variable	RESPIRATORY THERAPY
2744	SLP Lab T-Gist/Rpsgt	Regular Full Time	Nights	SLEEP LAB
3061	Social Worker	Regular Full Time	Variable	CARE MANAGEMENT

Filters

All Active Facility; All Active Department; All Active ; Recruiters:All; Hiring Manager:All; JobStatus:Active - Posted; Optimize To Print:No; Display Job Summary:No; Custom Fields:No Custom Fields; Dates:6/1/

3194	Speech Therapist	Regular Full Time	Days	PHYS, OCC & SPEECH THERAPY
2962	Student Radiographer - Medical Imaging	Regular Full Time	Variable	MEDICAL IMAGING
3201	Ultrasound Tech	PRN	Variable	MEDICAL IMAGING
Non-Clinical				
2958	Collections Clerk	Regular Full Time	Days	PATIENT FINANCIAL SERVICES
3151	EVS Technician	Regular Part Time	Variable	HOUSEKEEPING
3191	Laundry Worker	Regular Full Time	Variable	LAUNDRY & LINEN
3172	Laundry Worker	Regular Part Time	Variable	LAUNDRY & LINEN
3081	Maint Mech/Groundskeeper	PRN	Days	MAINTENANCE
3186	Patient Access Specialist I	Regular Full Time	Days	ADMITTING
2796	Patient Access Specialist I	PRN	Variable	ADMITTING
2851	Patient Access Specialist I	PRN	Variable	ADMITTING
2861	Patient Access Specialist I	PRN	Variable	ADMITTING
2832	Patient Access Specialist I	PRN	Variable	ADMITTING
3178	Patient Access Specialist I	PRN	Variable	ADMITTING
Nursing				
2830	Clinical Coordinator	Regular Full Time	Days	SURGICAL SERVICES
3193	Clinical Coordinator	Regular Full Time	Days	CLINIC
2985	LPN - Hospital	PRN	Variable	MED/SURG
3107	Registered Nurse	Regular Full Time	Days	MED/SURG
3183	Registered Nurse	Regular Full Time	Days	MED/SURG

Filters

All Active Facility; All Active Department; All Active ; Recruiters:All; Hiring Manager:All; JobStatus:Active - Posted; Optimize To Print:No; Display Job Summary:No; Custom Fields:No Custom Fields; Dates:6/1/

3144	Registered Nurse	Regular Full Time	Nights	MED/SURG
2885	Registered Nurse	Regular Full Time	Nights	MED/SURG
2887	Registered Nurse	Regular Full Time	Nights	ICU
3106	Registered Nurse	Regular Full Time	Nights	ICU
3190	Registered Nurse	Regular Full Time	Nights	ICU
2879	Registered Nurse	Regular Full Time	Nights	ICU
2880	Registered Nurse	Regular Full Time	Nights	ICU
3013	Registered Nurse	PRN	Variable	ICU
3137	Registered Nurse	Regular Full Time	Days	ICU
3068	Registered Nurse	Regular Full Time	Days	ICU
3105	Registered Nurse	Regular Full Time	Days	ICU
3141	Registered Nurse	Regular Full Time	Variable	RECOVERY ROOM
3197	Registered Nurse	Regular Full Time	Variable	SURGICAL SERVICES
3076	Registered Nurse	Regular Full Time	Variable	EMERGENCY DEPARTMENT
3077	Registered Nurse	Regular Full Time	Variable	EMERGENCY DEPARTMENT
3090	Registered Nurse	Regular Full Time	Nights	EMERGENCY DEPARTMENT
3188	Registered Nurse	PRN	Variable	EMERGENCY DEPARTMENT
3165	Registered Nurse	Regular Part Time	Variable	POST PARTUM
3131	Registered Nurse - Clinic	Regular Full Time	Variable	CLINIC

Filters
All Active Facility; All Active Department; All Active ; Recruiters:All; Hiring Manager:All; JobStatus:Active - Posted; Optimize To Print:No; Display Job Summary:No; Custom Fields:No Custom Fields; Dates:6/1/

Department	Position	Shift	Start Date	End Date	Filled by Perm or Open	Neg. Rate
ED	RN	Nights	10/24/2022	4/22/2023	**OPEN #3092**	after 1/21 extend $131
ED	RN	Nights	12/5/2022	3/4/2023	**OPEN #3075**	
ED	RN	Days	10/3/2022	4/1/2023	**OPEN #3076**	After 12/30 $128
ED	RN	Nights			**OPEN #3077**	Back filled Sinclair leaving early
ED	RN		8/28/2022	5/8/2023	**OPEN #3090**	$215 prior 7/22, 150 prior 11/7
ED	RN		10/11/2021	4/8/2023	**Filled #2889 6/20**	$150 prior 7/9, 1/7 @ $131
ED	RN	Mids	9/12/2022	3/18/2023	**Filled #2916 9/12**	
ED	RN	12p - 12a	1/30/2023	4/29/2023		
ICU	RN	Nights	1/16/2023	7/15/2023	**OPEN #2879**	
ICU	RN	Nights	2/13/2023	5/13/2023	**OPEN #3106**	
ICU	RN	Days	5/16/2022	4/29/2023	**Closed**	$150 prior 8/6 , $130 prior 11/12
ICU	RN	Nights	8/1/2022	4/29/2023	**OPEN #2887**	130 prior to 10/29
ICU	RN	Days	1/3/2022		**OPEN #3137**	
ICU	RN	Days	8/29/2022		**OPEN #3068**	
Med/Surg	RN	Changed to **Nights** since B.P. took a days position	12/27/2022	3/25/2023	**OPEN #3144**	
Laboratory	MT	Days	2/13/2023	5/13/2023	**OPEN #2649**	
Respiratory	RRT		5/9/2022	5/8/2023	**OPEN #2743 (PT)**	$140 prior to 8/5 - $120 prior 11/5
Respiratory	RRT	Variable	1/3/2023	4/1/2023	**OPEN #2903**	
Respiratory	RRT	Variable	1/30/2023	4/29/2023		
Surgical Services	RN		11/28/2022	2/25/2022	**Open #3109**	

Status Draft PolicyStat ID 12989080

Approved N/A
Review Due N/A

Document Area Employee Policies

EMPLOYEE POLICIES - DRUG AND ALCOHOL FREE WORKPLACE AND TESTING POLICY with Substance Abuse Checklist

STATEMENT OF PURPOSE

Memorial Hospital of Sweetwater County (MHSC) is a drug and alcohol free workplace. As such, MHSC prohibits the use of non-prescribed drugs or alcohol during work hours. If an employee comes to work under the influence of drugs or alcohol or uses drugs or alcohol during work time, the employee will be subject to drug or alcohol testing as outlined in this policy.

This policy applies to all employees including employed physicians, part-time employees and traveling and/or contract employees. The policy is applicable in all MHSC facilities and wherever MHSC employees are performing duties for the Hospital. It is also applicable while operating any hospital vehicle or equipment at any time, or any personal, rental or other vehicle while on Hospital business. This policy will be under the purview of the Human Resources Department.

ADA Compliance

Consistent with MHSC's general policy against discrimination, the Hospital recognizes that disabled individuals should be protected from discriminatory treatment. Under the Americans with Disabilities Act, a disabled person is someone who has a medical or psychological condition that materially impairs a major life activity. However, also in accordance with the Americans with Disabilities Act, disability does not include any condition resulting from alcohol or other drug abuse which prevents a person from performing essential functions of the job or which creates a direct threat to property or the safety of individuals.

As MHSC is a drug and alcohol free workplace, the Hospital may notify the appropriate law enforcement agency when it believes that an employee may have illegal drugs in his/her possession or is involved in other illegal conduct involving drugs at MHSC facilities.

Employees who wish to undertake rehabilitation for drug or alcohol abuse may make a request to the

Human Resources Director to participate in a rehabilitation program (see MHSC's EAP). The Hospital may grant the employee an unpaid leave of absence for this purpose if the employee seeks help before the drug or alcohol abuse adversely affects the employee's work performance or before the employee tests positive under this or any other applicable testing policy. An "introductory period" employee is not eligible for unpaid leave to attend a rehabilitation program.

ALCOHOL AND DRUG TESTING POLICY

All current and prospective employees are subject to this drug testing policy. Prospective employee's will be asked to submit to a test once a conditional offer of employment has been extended and accepted. An offer of employment by MHSC is conditioned on the prospective employee testing negative for illegal substances. MHSC's policy is intended to comply with all state and federal laws governing drug testing and is designed to safeguard employee privacy rights to the fullest extent of the law.

If there is reasonable cause to suspect that an employee is working while under the influence of drugs or alcohol, the employee will be suspended with pay until the results of a drug and alcohol test are made available to the HR Department by the testing laboratory. Whenever an employee is operating machinery at the Hospital or driving a Hospital vehicle and is involved in an accident the employee will be suspended with pay until the results of a drug and alcohol test are made available to the HR Department by the testing laboratory. *Where drug or alcohol testing is part of a routine physical there will be no adverse employment action or suspension taken until the test results are returned and reviewed by the HR department.*

Before being asked to submit to a drug test, the employee will receive written notice of the request or requirements. The employee must also sign a testing authorization and acknowledgement form confirming that he or she is aware of this policy and the employee's rights. Any drug testing required or requested by MHSC will be conducted by a laboratory licensed by the state. All expenses related to the test will be incurred by the hospital.

If the employee receives notice that the employee's test results were confirmed positive, the employee will be given the opportunity to explain the positive result to HR. In addition, the employee may have the same sample retested at a laboratory of the employee's choice as a confirmatory test.

The Hospital may discipline an employee up to and including termination of employment if the employee tests positive on the first test (if the positive test is not requested by the employee to be sent for a confirmatory test) or upon a positive confirmatory test. An employee who has a positive confirmatory test, but is not terminated, will be required to participate in and complete a drug or alcohol treatment program. Refer to the Employee Assistance Plan (EAP).

All testing results will remain confidential and will be maintained in a separate employee file. Employee must sign a consent form prior to the release of results to a third party. Test results may be used in arbitration, administrative hearings and court cases arising as a result of the employee's drug testing. Results will be sent to federal agencies as required by federal law. If the employee is to be referred to a treatment facility for evaluation, the employee's test results will also be made available to the employee's counselor at the facility.

I. In order to carry out the Hospital's commitment to be an alcohol and drug-free workplace, the

Hospital reserves the right to conduct:

A. **Reasonable Cause Drug and Alcohol Testing** Any employee who is reasonably suspected of using alcohol or illegal drugs or of abusing controlled substances in the workplace or of performing official duties while under the influence of alcohol, illegal drugs, or abused controlled substances will be required to undergo an alcohol and/or drug test. "Reasonable cause" exists when an employee exhibits patterns of behavior that suggest impairment from drug or alcohol use. (See Attachment A)

B. **Post-Accident Testing** Whenever an employee is operating machinery at the Hospital or driving a Hospital vehicle and is involved in an accident he/she will be required to submit to a drug test. Test will be performed as soon as possible after the accident.

Refusal to Participate. An employee has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with the Hospital policy and will result in disciplinary action up to and including termination of employment.

APPROVED: MHSC Board of Trustees 3/6/2019

Attachments

SUBSTANCE ABUSE POLICY - Attachment A.pdf

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 12994251

Approved N/A
Review Due N/A

Document Area Human Resources

DRUG AND ALCOHOL FREE POLICY

POLICY

Memorial Hospital of Sweetwater County (MHSC or Hospital) is an alcohol and substance free workplace. As such, MHSC prohibits being under the influence of illegal or non-prescribed controlled substances and/or alcohol during work hours.

This policy applies to all employees including employed providers, part-time employees and traveling and/or contract employees. The policy is applicable in all MHSC facilities and wherever MHSC employees are performing duties for the Hospital. It is also applicable while operating any Hospital vehicle or equipment at any time, or any personal, rental or other vehicle while on Hospital business.

Shared Responsibility

- A safe and productive workplace free of inappropriate alcohol or drug use is achieved through cooperation and shared responsibility.
- It is the responsibility of each employee and student to:
    1. Adhere to this policy
    2. Notify his or her supervisor at the Hospital of any arrest or conviction involving drugs or alcohol prior to his or her next scheduled shift.
    3. Cooperate fully with any investigation related to alleged violations of this policy.
    4. Investigate, report, and/or intervene in the event of reasonable suspicion of violations of this policy.
    5. Safeguard Controlled Substances from unauthorized access.
- It is the responsibility of Hospital management to:
    1. Inform employees and students of this policy.
    2. Make the policy easily accessible to employees and students.
    3. Periodically conduct substance abuse awareness training for supervisors.

4. Promote employee awareness of the Hospital's assistance programs, including the Employee Assistance and Rehabilitation Assistance Programs.
5. Investigate reports of reasonable suspicion of violations of this policy.
6. Take action with respect to violations of this policy. Such action could include counseling with respect to professional help, referral to the Employee Assistance Program, disciplinary action or termination.
7. If required by accreditation, certification, licensure, or legal requirements or if management believes it to be appropriate, timely notify the appropriate authorities of any such action.
8. Maintain all documents pertaining to reports and investigations filed or conducted pursuant to this policy.

Prohibited Behavior

- The following activities are strictly prohibited and may lead to discipline, up to and including immediate discharge:
    1. The sale, manufacture, distribution, purchase, use or possession of alcohol, alcoholic beverages, illegal substances, non-prescribed controlled substances, or drug paraphernalia by an employee or student on Facility premises or during his or her working hours.
    2. Reporting to work, or being at work, while under the influence of or while impaired by alcohol, alcoholic beverages, illegal substances, prescribed or non-prescribed controlled substances.
    3. Reporting to work, or being at work, with the smell of alcohol on one's breath or person, or a measurable quantity of non-prescribed Controlled Substances in one's blood or urine.
    4. A conviction for sale or possession with intent to distribute any drugs, including prescription drugs.
    5. Theft or diversion of Hospital medications.
    6. Refusal for any reason to submit or consent to a drug/alcohol screen requested by any management personnel at MHSC.
    7. Participation in any act that would create or allow false documentation of security and/or safety practices.
    8. Tampering with or otherwise altering drug testing samples or security equipment or systems.
- Prescription medications are not prohibited under this policy when taken as prescribed under the direction and monitoring of a physician.

Duty to report, Detection and Reasonable Suspicion

- An employee or student must notify his or her supervisor whenever he or she is taking a prescribed or over the counter drug that the employee or student has been advised will or based upon the drug profile is likely to, impair job performance (e.g. drowsiness or diminished

ability to focus)

- An employee or student must notify his or her supervisor if the employee or student has reasonable concerns that another employee or student has violated this policy.

Searches

If a supervisor has a reasonable suspicion that an employee or student has violated this policy, the supervisor may require the employee or student to submit to a search or inspection. By entering Hospital property, each employee or student consents to such searches and inspections. Searches can be conducted of pockets, clothing, lockers, wallets, purses, briefcases, lunch boxes, backpacks, duffel bags, desks, work stations, equipment, and other areas.

Drug and Alcohol Testing

- To ensure the accuracy and fairness of our testing program, all collection and testing will be conducted pursuant to guidelines established Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines which may include a confirmatory test; the opportunity for a split sample and; review by an Medical Records Officer (MRO), including the opportunity for employees or students who test positive to provide a legitimate medical explanation, such as a physician's prescription, for the positive result; and a documented chain of custody.
- All drug-testing information will be maintained in separate confidential records.
- Employees and students will be required to participate, at a minimum, in testing as follows:
    1. post offer, pre-employment;
    2. upon reasonable suspicion;
    3. after a reportable accident; and
    4. after an on-the-job injury to any person (e.g., another employee, student, a patient, the person to be tested) when it is possible that the acts or omissions of the employee or student to be tested may have caused or been partially responsible for the injury.
- Substances tested for at hire must at a minimum include amphetamines, barbiturates, benzodiazepines, opiates, marijuana, codeine, and cocaine. Reasonable suspicion and reportable accident testing should include amphetamines, barbiturates, benzodiazepines, carisoprodol, opiates, fentanyl analogues, methadone, meperidine, marijuana, and cocaine.
- Testing for the presence of alcohol will be conducted by analysis of breath, saliva, blood or other accepted testing methodology. For the purpose of the Policy, an employee or student is presumed to be under the influence of alcohol if a blood test or other scientifically acceptable testing procedure shows a blood alcohol level of .01 or more. A test result which shows a blood alcohol limit of .01 or more will result in corrective action up to and including termination.
- Testing for the presence of the metabolites of drugs will be conducted by the analysis of urine, blood, saliva, or other accepted testing methodology. A positive test result for non-prescribed or illegal drugs will result in corrective action up to and including termination.
- The MRO will review all non-negative reports. Any non-negative drug test result due to a physician-approved medication will be reported as a negative result. If it appears that the

person tested is impaired by the use of medications for which the employee or student has a valid prescription, the report should note that fact. Medications that could affect an applicant's ability to perform his or her job may result in restrictions or recommendation for accommodation with respect to those tasks.

Violations of Policy

Employees or students will be subject to corrective action, including termination, for violations of this policy.

Pre-Employment Tests

With respect to a person who has been offered employment, if the person refuses to take the pre-employment drug tests described above, or tests positive for any non-prescribed Controlled Substances or Illegal Substances, the offer of employment will be withdrawn.

Definitions

Controlled Substances: any drug or chemical substance whose possession and use are regulated under the Controlled Substances Act.

Illegal Substances: any drug the possession or sale of which violates federal law (in the U.S.) or the country, state or local law of the jurisdiction in which the Facility is located.

Impairment: Practitioner impairment occurs when a substance-related disorder interferes with his or her ability to engage in professional activities competently and safely.

Medical Review Officer (MRO): A licensed physician not employed by MHSC who oversees the medical aspects of this policy. The MRO could be affiliated with the reference lab contracted with by the Facility. The MRO should have appropriate medical training to interpret and evaluate an individual's positive test results, medical history and any other relevant medical information.

Reportable Accident: Any employee or student involved in an on-the-job accident which involves injury requiring medical treatment or evaluation to the employee, student, or another person, property damage, or lost time from the job will be required to be tested for drugs and alcohol. An exception may be made provided it is immediately apparent to management that the employee or student is not at fault.

PROCEDURES

- If an employee suspects another employee of being under the influence of drugs or alcohol the suspecting employee should immediately contact his/her supervisor and/or Human Resources to report his/her suspicions.
- If HR Director is unavailable, please contact the Administrator On Call (AOC) or a member of Senior Leadership. Please DO NOT contact the House Supervisor. If, after an initial investigation by the Supervisor or HR, there appears to be some credibility to the suspicion, the Hospital shall take whatever action necessary to protect patients, students, and employees, including, if the circumstances indicate that it is appropriate, immediately removing the employee or student from his or her work area and escorting him/her to a designated testing location, and conducting a search of the work area. The employee or student will be asked to sign a consent form prior to testing.

- Any employee or student whose blood alcohol content exceeds the maximum set forth in this policy, or tests positive for non-prescribed Controlled Substances or illegal substances, will be immediately placed on administrative leave/suspension. The Hospital shall then seek legal review by the Legal Department.
- During a suspension for violation of this policy, the employee or student shall not be allowed access to the Hospital with the exception for medical treatment.
- The Hospital will provide employees and students who test positive for substances and for alcohol in their system with contact information for substance abuse resources including Employee Assistance Program.

Voluntary Self-Reporting

An employee or student who voluntarily self-reports substance abuse may, in the Hospital's sole discretion, be offered an opportunity to participate in a rehabilitation program. In such cases, the Facility may require, as a condition of continued employment, that the employee or student abide by the terms set forth by the Facility.

Confidentiality

All information received by the Hospital through compliance with this policy is confidential. Access to this information is limited to those who have a legitimate need to know within the Hospital or in some situations, law enforcement agencies.

Communication and Training

Communicating this policy is critical to the Hospital's success. To ensure all employees or students are aware of their role in supporting this policy, the Hospital shall prepare a plan for ensuring:

- The policy will be reviewed in orientation sessions for all employees and students.
- The policy will be reviewed annually by all employees and students.
- Leadership/designee will discuss the policy and organizational procedure during orientation of staff managers.

Approval Signatures

Step Description	Approver	Date

MEMORANDUM

To: Board of Trustees
From: Wm. Marty Kelsey
Subject: Chair's Report…February Building & Grounds Committee Meeting
Date: February 23, 2023

Pharmacy Chemo Mixing Room…Drawings and Specs are 95% complete. Estimated base cost is in the mid-$600K range and staff recommends the project be paid for with County maintenance funds. Finance Committee approval will be sought on February 28th and Board approval to proceed with bidding will be sought on March 1st. Barring very high bids, there should be enough County maintenance funds to complete this project. The project will bid out competitively.

Dr. Sulentich Office…the project did not pass State inspection due to issues with the smoke alarms. Another state inspection is expected in the next few weeks. The staff is working in the area, however, and this delay regarding the State inspection will not impact their operations.

Building Automation System…System balancing still needs to be done and valves need to be replaced in the radiant heating system.

Bulk Oxygen/Landscaping Project…Work will not resume until warmer weather. A backup plan discussion occurred regarding the temporary tank owned by Air Gas.

Laboratory Renovation/Expansion Project…Staff and Plan One Architects are continuing their work. In connection with this project, a discussion occurred regarding the current Foundation and Legal space. Irene mentioned that staff should be able to present options for the renovation of this space at the April Building and Grounds Committee meeting.

Lightning Arrest System…MHSC still has no proposal from WyoElectric. It was emphasized that a cost proposal needs to be presented no later than at the March B & G meeting.

Buildings and Grounds Annual Plan…Staff has been working hard on the plan. The current draft is in the portal for review. B & G Committee members are to review the Plan and submit any suggestions, concerns, etc. to Jim Horan prior to the March B & G meeting. Mr. Kelsey and Mr. Tardoni desire to have staff present this to the full Board of Trustees this spring. It will be an excellent tool for capital renewal and capital construction planning and also for budgeting.

Medical Imaging Core and X Ray…a portion of the Medical Imaging area was not renovated during the last round of work. This area needs to be renovated. Plan One Architects is working with staff to come up with a plan.

As usual, for more detail please see the meeting minutes in the packet.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Building and Grounds Committee Meeting
February 21, 2023

The Building and Grounds Committee met in regular session via Zoom on February 21, 2023, at 3:00 PM with Mr. Marty Kelsey presiding.

In Attendance: Mr. Marty Kelsey, *Trustee - Chair*
Mr. Ed Tardoni – *Trustee*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. James Horan, *Director of Facilities*
Mr. Gerry Johnston, *Facilities Supervisor*

Mr. Kelsey called the meeting to order.

Mr. Kelsey asked for a motion to approve the agenda. Mr. Tardoni made a motion to approve the agenda. Ms. Love seconded; motion passed.

Mr. Kelsey asked for a motion to approve the minutes from the January 17, 2023 meeting. Mr. Horan made a motion to approve the minutes. Mr. Tardoni seconded; motion passed.

Maintenance Metrics

Mr. Johnston presented the current maintenance metrics. He said they have been very busy and ended the month with 88 open maintenance work orders. They were able to get a lot kicked out an completed this month.

Old Business – Project Review

Pharmacy Chemo Mixing Room

Ms. Love said they have received the 95% drawings and estimate and shared the updated cost estimate. She said she has also reached out to Mr. Beattie, Director of Pharmacy, to start getting quotes for the new hood. Mr. Kelsey asked for a recommendation on next steps from the committee. Ms. Richardson asked about the regulatory requirements of this project. Mr. Johnston said the project is to make us compliant with the State Board of Pharmacy USP 797 and 800. Ms. Love recommended moving forward with the State approval and bid process. She said the plan has been to use the remaining County maintenance funds for this project. Mr. Kelsey confirmed we would go through the traditional bid out process. Mr. Tardoni recommended we present to the Finance committee and Board next week so we can get the process moving quickly. Mr. Tardoni made a motion to approve the Chemo Mixing Room project to move forward to the Finance Committee and full Board approval. Ms. Love seconded: motion passed.

Dr. Sulentich Office

Mr. Johnston said they had issues with the smoke alarms and they did not pass inspection. We have had Johnson Controls and Simplex working on the issue. Pat Davis, from the State, was supposed to be here again this week but rescheduled for next week due to the weather. Dr. Sulentich and staff are in the space currently.

Building Automation System

Mr. Johnston said they are still waiting on final balancing from Harris. He said we are having issues in some areas that will be addressed with balancing. There have been some air flow and wind tunnels in some places.

Bulk Oxygen

Mr. Kelsey asked if the team had thought about a backup plan for the temporary tank. Mr. Johnston looked at the contract and there isn't anything regarding the removal of the tank. Mr. Tardoni is concerned about what happens if there is a failure. Mr. Johnston the temporary tank does have a backup tank on the trailer. We do have oxygen bottles onsite but are not sure how long they would last in an emergency. Mr. Johnston said the other oxygen service company in our area is Praxair. He will investigate a possible backup plan.

Laboratory Renovation

Mr. Horan said we have been working with Plan One and Lab leadership on fine tuning the plans. Ms. Love shared the most recent drawings with the notes from Plan One. They will then send over the revised plans from these meetings for final approval. Mr. Tardoni had a question about the second floor and what will happen with the current Foundation and Legal spaces. There was discussion regarding the plans for the other grant we received for the current Foundation Lab area. The grant for the Foundation Lab area is on the same timeline as the Lab renovation grant. Ms. Richardson said we should be able to present options for that space by the April committee meeting.

Lightning Arrest System

Mr. Horan said Wyoelectric has been onsite the last week and they have had some discussion with him and Mr. Johnston on what the project entails. They will need to place 43 ground rods and will need roof access, lifts and underground plans. They said they would have a proposal today but he had not received anything yet. They said they would be able to do it this summer. Mr. Kelsey said we need to have a proposal next month.

Building and Grounds Annual Plan

Mr. Horan presented the revised plan. He said they had added language about estimated costs, removed some projects that were already in progress, and added some others that have come up. Ms. Love said the revised plan is in the Board portal for their review. Mr. Kelsey said we can use this as a guide for our FY2024 capital improvements. He would like to review the plan and then take to the Board for review in the Spring. It was discussed the committee will review over the next month and we will finalize the plan at the next meeting. Mr. Tardoni said this will serve as a basis for staff to work on the capital budget for next year. Mr. Horan said to let him know if they find any discrepancies or other issues prior to the next meeting. Mr. Kelsey thanked him for all the work he has put into this plan.

New Business

Medical Imaging Core and X-ray

Ms. Love said we have had Plan One come up and look at the last area in Medical Imaging that needs to be renovated. Our two current x-ray machines are both at end of life and need to be replaced. Ms. Soller, Director of Imaging, is looking at proposals now for the equipment. It was decided with the replacement of the equipment, the x-ray rooms and core area should be renovated also. Ms. Love shared the current drawings of the space. Plan One did a walk through with imaging staff, facilities and management and are working on the design.

Other

No other business was presented.

The next meeting is scheduled for Tuesday, March 21, 2023.

Mr. Kelsey adjourned the meeting at 3:58 pm.

Submitted by Tami Love

Governance February

Minutes
Governance Committee Meeting
February 15, 2023

Present: Barbara Sowada, Marty Kelsey, and Irene Richardson
Guest: Cindy Nelson

Call to Order: Barbara Sowada called the Zoom meeting to order at 2:00 pm

Agenda was approved as amended to add discussion of need for policy regarding Delegation of Authority in Absence of CEO

Minutes had been previously approved.

Old Business –

1. Board agenda annotation check list. Cindy presented draft for review. Suggested changes made during meeting. Draft is attached. To be brought to Board at March meeting with recommendation to approve.
2. Board policy regarding authority and oversight of Board discussed. Committee agreed that the policy is not needed. Authority and oversight responsibilities of the Board are detailed in the Board Bylaws.
3. Board policy re types of Hospital policies that require Board review and approval discussed versus those that require Hospital approval. Agreed that Hospital policy does not specify Board requirements. Action: Irene will assign staff to work on Board policy. Draft to be brought to March Governance meeting.
4. Update on Patient/Staff Workplace Safety policy. Update provided by Irene. Action: Irene will discuss the need for policy and seek input from County Commissioner liaison. Telephone update on 2/16/23 from CEO to Board President: Liaison sees need for policy and recommend that the Hospital pursue the policy.

New Business

1. Board policy re Emergency Authority of CEO. Discussion indicated multiple perspectives regarding discussion during February meeting of the Board of Trustees. Questioned as to whether authority was limited to financial activities or included broader range of emergency responsibilities. Discussion tabled until minutes from February Board meeting are reviewed.
2. Policy re Delegation of Authority in Absence of CEO was discussed. Need for policy was questioned. Action: Irene will bring Chain of Command Policy for review at the March Governance meeting.
3. iProtean for March will either be video on board-legal counsel relationships or on Population Health Management with representatives from Case Management and Quality sharing their perspectives on how this relates to MHSC.

The meeting was adjourned at 4:15 pm.

Next meeting is Monday, March 20, 2023, at 2:00 pm by Zoom.

Respectfully submitted,

Barbara J. Sowada, Ph.D.

ORIENTATION MEMO

Board Meeting Date: March 1, 2023

Topic for Old & New Business Items:

Orientation Memo Procedure for Items Presented to the Board of Trustees

Policy or Other Document:

_____ Revision
___X__ New

Brief Senior Leadership Comments:

Irene Richardson reviewed the procedure with the Governance Committee on 1/30/2023 and agreed this is a good idea.

Board Committee Action:

On January 30, 2023, the Governance Committee agreed to forward a draft orientation memo to the Board of Trustees for review at the March 1, 2023 meeting.

Policy or Other Document:

____X__ For Review Only
_____ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:

Governance January 2023

Minutes
Governance Committee Meeting
January 30, 2023

Present: Barbara Sowada, Marty Kelsey, and Irene Richardson
Guest: Cindy Nelson

Call to Order: Barbara Sowada called the Zoom meeting to order at 2:00 pm

Agenda was approved as amended to eliminate discussion of Workplace Patient/Staff Safety policy and associated documents.

Minutes had been previously approved.

Old Business – None

New Business

1. Discussed attached document proposed by Marty, Meeting Guideline:
    a. Purpose of document is to bring more structure to Board meetings. Included in the document is a specific recommendation for a template or coversheet to orient board regarding the purpose of document brought forward, the committee or department recommending the document, recommendations of senior leadership, reviewed by Board legal counsel, etc.
    b. Cindy will draft the template to be reviewed at the February Governance meeting.
    c. Plan to bring the Meeting Guideline and template to March Board meeting. Irene will assign staff member to draft a written document for board orientation.
2. Discussion regarding Board policies, hospital policies, and what types of hospital policies need Board approval.
    a. Irene reviewed 2020 policy titled "Policies, Standards, Plans, Procedures, etc.," which is in policy stat.
    b. Marty requested Cindy research Board minutes as to whether this policy was discussed during a Board meeting. No Board member signed policy that is in Policystat.
    c. Will review policy at February Governance meeting with intention to bring it to Board at its March meeting.
3. Marty expressed concerns that Policystat does not allow for review of changes made over time to policies. Irene will investigate whether Policystat does allow for historical review of changes to policies and whether hospital keeps electronic file of changes that are available for review. Goal is to be able to review changes over time.
4. Marty suggested that anytime a policy is brought to Board, the policy, if appropriate, has been reviewed by the Board's legal counsel. The need for outside counsel review is the CEO's discretion. This opportunity for review will be included in the template that is part of Meeting Guideline document.
5. Standing Governance meeting will be changed from the 4th Monday of the month to the 3rd Monday of the month. This allows for adequate time for Governance meeting material to be included in upcoming Board meeting.

The meeting was adjourned at 2:50 pm.

Next meeting is Monday, February 15, 2023, at 2:00 pm by Zoom.

Respectfully submitted,

Barbara J. Sowada, Ph.D.

DRAFT

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

BOARD OF TRUSTEES MEETING GUIDELINES

MARCH, 2023

Introduction

These Guidelines are intended to provide a framework for the preparation, notification, and operation of meetings of the Board of Trustees (Board) concerning topics not otherwise addressed in the Wyoming Statutes, the By-Laws of the Board, or in the Board Governance Committee Charter. These Guidelines are prepared by the Governance Committee of the Board and are approved by the Board. They may be amended at any time by the Board.

Agenda Preparation

The Board President, the Chief Executive Officer (CEO), and the Executive Assistant to the CEO meet at least a week before each regular monthly meeting of the Board to prepare the agenda for the meeting. Typically, a less formal meeting is required for the preparation of an agenda for special meetings of the Board.

Public Access to the Meeting Packet

The meeting packet associated with regular monthly meetings of the Board should be published on the Hospital's website at least two days before the date of the meeting.

When possible, the meeting packet for special meetings of the Board should also be published on the Hospital's website in advance of the meeting. It is noted that a meeting packet may not be prepared for every special meeting.

Orientation Memo Associated with New and Old Business Agenda Items

Prefacing each agenda item under the Old and New Business section of the meeting agenda, staff should prepare a brief "Orientation Memo" designed to orient Board members concerning the agenda item. To ensure consistency, the Executive Assistant to the CEO should develop a template that would be used each time so that the memo format is standardized for every meeting and for each agenda item. The following content for the Memo must include:

(1) Date of the Board Meeting
(2) Topic
(3) If a policy or other document…is it a revision or a new policy/document?
(4) Brief Leadership comments (if any)
(5) Board Committee action (if applicable)
(6) Is the agenda item for review only or for Board action?
(7) Staff recommendation

Review and Approval of Hospital Policies & Program Documents

As a general practice, new policies & program documents being recommended for Board approval and existing policies & program documents being recommended for material or substantive revision should be presented for "review only" the first time they are brought before the Board for consideration. This practice helps ensure that Board members have sufficient time to review the proposals prior to voting and provides time for questions which may be posed by Board members and/or others to be addressed by staff.

As a general practice, minor, non-substantive revisions to existing policies or program documents may be voted upon at the first meeting they are brought before the Board.

As a general practice, new or revised Medical Staff forms, etc. approved by the Medical Executive Committee (MEC) may be voted upon the first time they are brought before the Board.

Board Committee Reports

Board Committee reports to the Board may be presented by the Committee Chair either in writing or verbally at the discretion of the Committee Chair.

Executive Sessions

Invitations to attend Executive Sessions of the Board are extended by the Board President. The CEO should always be in attendance unless excused for a period of time by the Board President when his/her regular performance evaluation is being conducted or for other reasons associated with his/her performance or compensation. The Executive Assistant to the CEO is typically in attendance to document the discussion. If absent, an Acting Executive Assistant may be present to document the discussion or, alternatively, a taped recording may be substituted.

APPROVED BY THE BOARD OF TRUSTEES THIS _____DAY OF _____, 20___

_____

President, Board of Trustees