Safety committee – November 20, 2019

Present: Celena Hoey, Paul Beeker, Sarah Gilman, Jen Tate, Lawanda Williams, Kim Riopelle, Tonii Gedin, LaVeda Bacetti and Margaret Flanagan

1. **Review of CAP Procedure (attached)**
    a. Committee reviewed the Conduct Action Plan (CAP) Procedure for consistency in application and to ensure that the Procedure is clear enough for interpretation.
    b. Committee discussed the need to balance swift action to ensure safety plans are in place and the need for the full team to be involved to make treatment decisions. This also includes thinking through the process for longer-term suspensions, where care coordination or care transition needs may occur.
    c. Representatives of the CAP committee felt there is an effort to include the appropriate staff in the meeting, but scheduling can make it difficult.
    d. Continued areas of concern were discussed and a need to clarify the procedure to ensure it appropriately lays out the CAP process:
        i. **Monitoring following a CAP**: need better documentation of the implementation, follow through, and close out of the CAP. Lingering questions:
            1. Where is best to document?
            2. Who should take the lead?
            3. How is the CAP being handled for additional services/sites?
        ii. **How to handle long-term suspensions**: Longer term suspensions (greater than one month) will impact care across the agency. The decision to initiate this must be done with care in order to balance safety and having the least amount of disruption to care as possible. This balance is hard to attain. One idea included to implement a 3rd party facilitator to assist with navigating the CAP discussion and providing an objective lens as well as creating additional criterion to help guide the decision-making process. Lingering questions include:
            1. What is the process to determine the length of a CAP
            2. Who needs to be involved in the decision for a long-term ban (e.g. must the clinical team be involved?
            3. What considerations need to be taken into account?
            4. How is the decision documented and clear?
        iii. **Communication of suspension**: If a long-term suspension is warranted and in place, what is the plan for the communication within HCH and to the client. In addition how are we ensuring the entire clinical team is looped into the plan and able to carry it out to ensure the least disruption to care as possible. Lingering questions include
            1. Is there a more effective way to debrief?
            2. Can we have more visibility for the CAP list such as including it on the public drive?
            3. What is and how is this plan during the suspension for clinical care documented in carried out?
            4. How is this communicated to the client and the treatment team?
        iv. **Documentation of the suspension**: Currently, documentation lives in the GRC with an incident and in the chart following a CAP. However, this can be difficult to check or follow-up on. Lingering items include:
            1. Adding a pop up in PM and within the EMR to alert staff
            2. Making sure it is clear who's responsibility it is to close the loop when it's over
        v. **Clarifying sites affected**: currently, the plan says it applies to all sites. However, there are non-HCH owned sites that may ban a client (WHRC, ODB, and Eastern Family Resource Center) that may impact access to care. We will update the language to state: clients who are suspended by HCH can not receive services at another HCH site. However, if a facility that is non-HCH owned (e.g. WHRC, ODB, or Baltimore County Eastern Family Resource Center) initiates the ban, the client is still able to receive services at another HCH site. Lingering question:
            1. How does this pertain to home visits?

e. **Next steps**: The committee will review changes to the procedure prior to the next meeting, as well as review a document to help clarify the responses to these questions to get clarity. The committee will discuss this at the next safety committee meeting.

2. **EOC plan update** – the final review is occurring with the facilities department. They will finalize these as well as safety and security covered in the previous meeting. These will be finalized and published within the GRC and in the LMS.

   a. Fire
      i. Fire Wardens: updating out-of-date staff persons.
      ii. Wheelchairs: discussing process and/or realities of assistive devices
   b. Hazmat
      i. Ensuring bleach is added to spill kits
      ii. Changed I95 respirators to surgical masks
   c. **Utility**:
      i. Updated titles
      ii. Wheelchairs: same as above.
   d. EM
      i. Removal of code yellow
   e. **Medical equipment**: nothing much changed here, only a few small updates.
   f. **Safety and Security**: already reviewed, no major changes.

Next meeting December 18, 2019 (Agenda items not covered and moved to December meeting: home visits safety and safety committee priorities for 2020)