EYE SURGERY CENTER OF NORTHERN NEVADA:

QUALITY AND PATIENT SAFETY PLAN

This plan was created and reviewed by ESCNN Patient Safety committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and/or preventable events.

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Commitment to Patient Safety

ESCNN is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

ESCNN will make reasonable modifications to ensure that people with disabilities have an equal opportunity to participate in services benefitting them.

Mission, Vision, and Values

In support of our mission, vision, and values, ESCNN Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in ESCNN are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, ESCNN has developed this Patient Safety plan.

This plan protects patients, families, and visitors by ensuring ADA requirements are followed at all times. This includes providing wheelchair access, alternate communication options, and any reasonable modifications required so patients, families, and visitors can participate in the services offered at ESCNN. There will be no discrimination against people with disabilities at ESCNN.

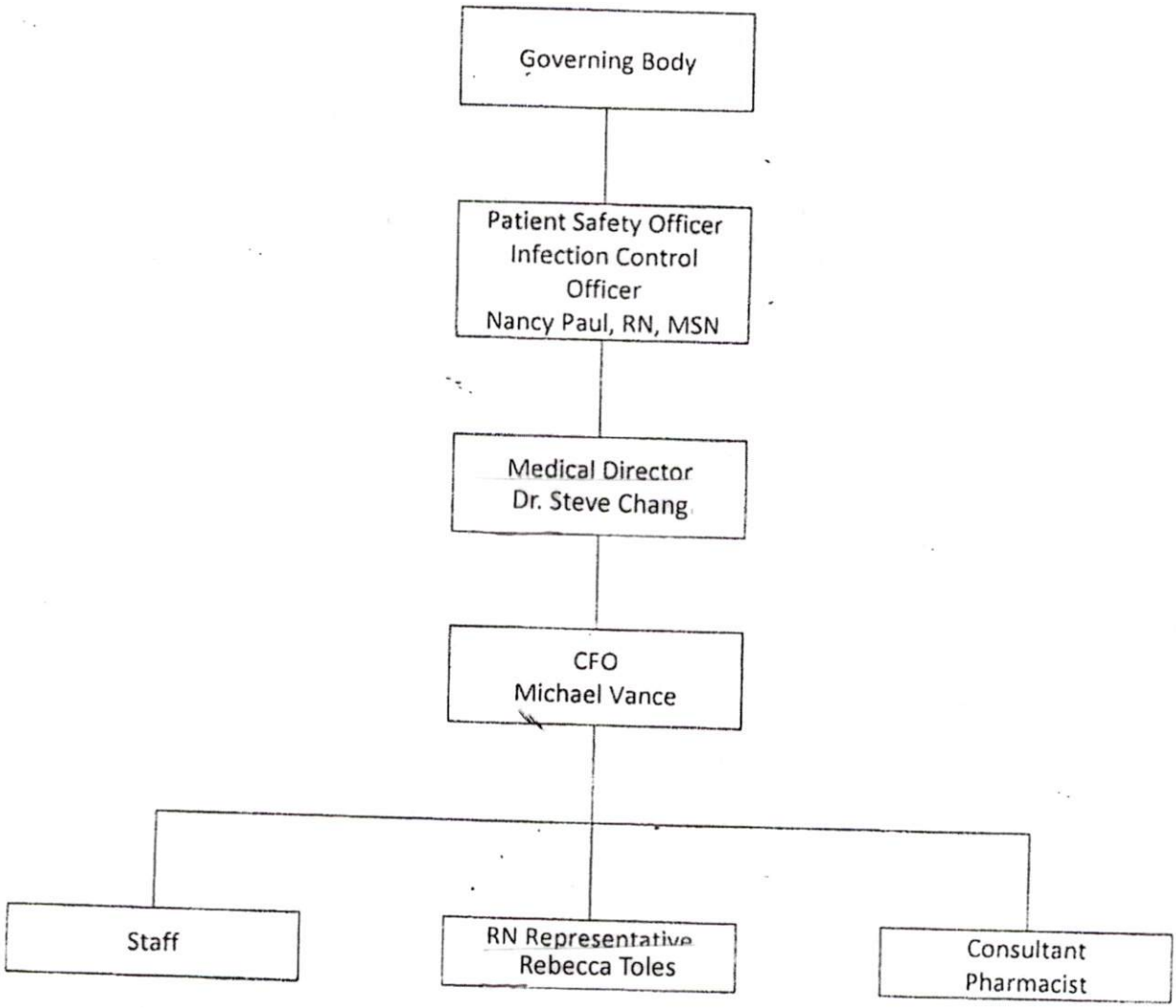
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- Americans with Disabilities Act will be followed which prohibits discrimination against people with disabilities.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- Receive reports from the patient safety officer pursuant to NRS 439.870.
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:

  (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

  (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

  (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) :

- Conduct RCA as needed utilizing members of the Patient Safety Committee.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- Make policy changes as needed based on RCA results.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

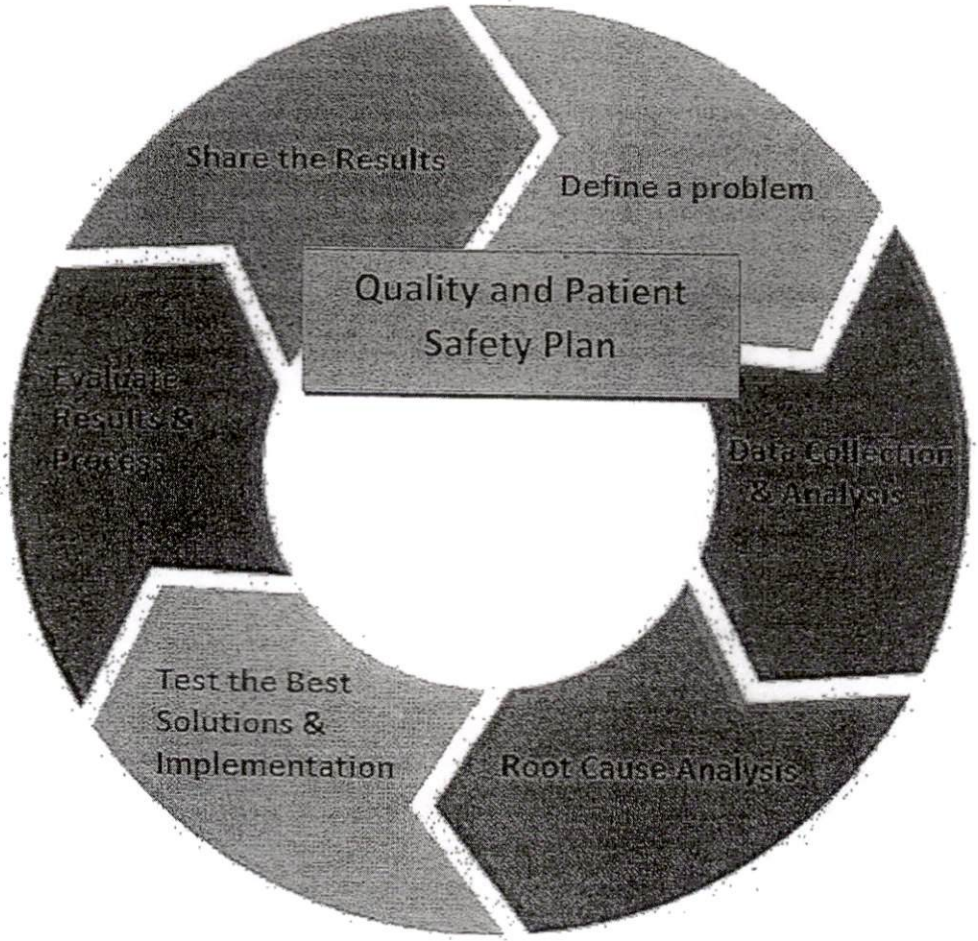
The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

Components and Methods

Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

ESCNN will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



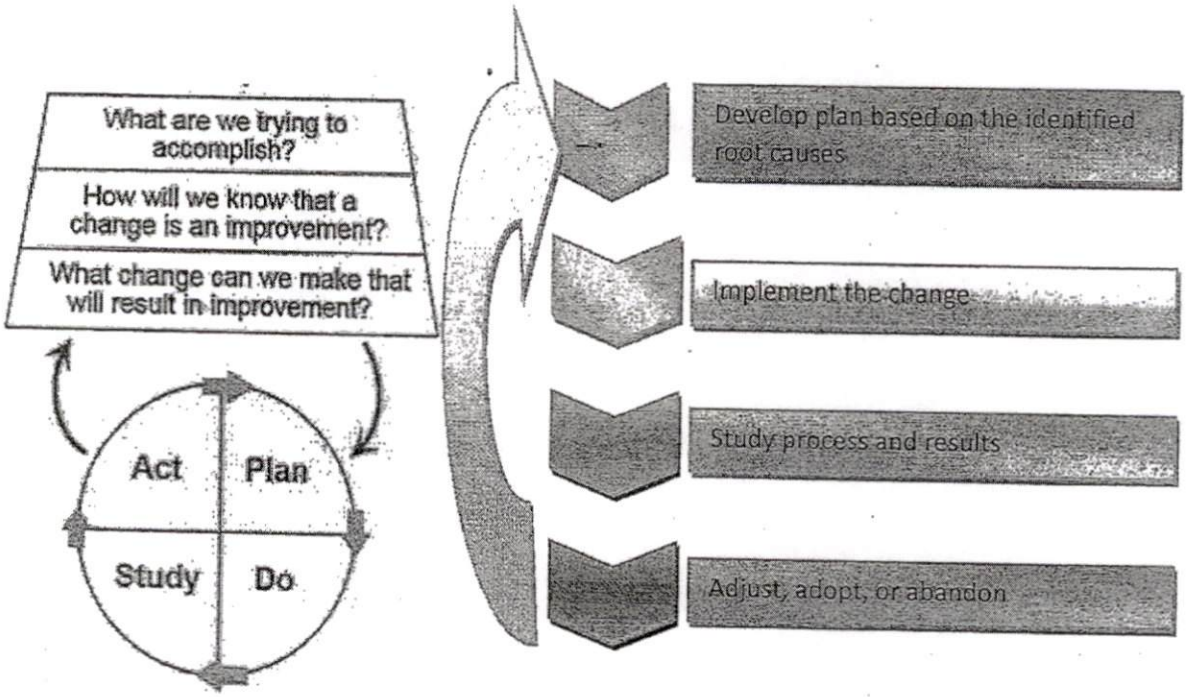
Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. ESCNN is tracking sentinel events and healthcare infection data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
    - Proper instructions concerning prescription medications;
    - Instructions concerning aftercare;
    - Any other instructions concerning his or her care upon discharge.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA).

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

EYE SURGERY CENTER OF NORTHERN NEVADA

QUALITY IMPROVEMENT RISK MANAGEMENT PLAN

ESCNN maintains an active, integrated, organized, peer-based continuous quality improvement program. The program is based on the AAAHC "Quality Management and Improvement Guide" and "Building a strong ASC QI program" document from OR Manager Inc (both of these documents are attached). The ASC utilizes a systematic approach for Performance Improvement through multidisciplinary cooperation. Quality Improvement activities demonstrate the systematic, "closing the loop" process. This process incorporates an improvement model that includes design, identification of problems/concerns in the care of patients; (evaluation) of the identification of problems/concerns; (resolution measures); re-evaluation; reporting. The plan will address clinical, administrative, cost-of-care issues and patient outcomes. The focus will be activities that affect the majority of patients serviced and consider high-risk, high-volume, and problem-prone patients. The plan is an integral part of the ASC's overall goal of continually improving organizational performance and patient health outcomes.

Objectives:

The Quality Improvement activities are designed to evaluate several parameters of quality. Continuous quality improvement, meets several main objectives:

1. Prompt attention to high-priority access of clinical care.

2. An increased likelihood of desired health outcomes through the facility's participation in performance measurement and quality improvement activities.

3. Stimulate analysis of the appropriateness and effectiveness of clinical care.

4. Findings of QI activities are incorporated into the organization's educational process.

5. Mechanisms are in place for designing, measuring, assessing, improving, and redesigning organizational functions-knowing that performance can be improved when high standards appear to be met.

6. Leaders of the organization are held accountable for setting priorities and providing needed resources to achieve the highest quality of care possible.

7. Patient and organizational focused functions are maintained in the process.

8. Dimension of performance aspects are considered:

   A. Efficiency
   B. Availability
   C. Timeliness
   D. Safety
   E. Respect and caring
   F. Continuity

9. Consideration is given to needs of patients, surgeons, vendors, payors, and staff in the process.

10. A Surveillance Plan for the prevention of infections and communicable disease for patients and staff.

11. Design improvement functions which affect the majority of patients serviced and consider high-risk, high-volume and problem-prone patients.

12. Tracking surgical procedures that result in unplanned patient admission to a hospital within 72 hours of a procedure due to post-op complication.

13. Consideration is given to the mission, philosophy, and scope of service of the ASC organization.

14. Results of peer review information are used as part of the basis for granting continuation of privileges.

15. The implementation of a consistent process for the identification, reporting, analysis, and prevention of adverse incidents/occurrences.

Process:

1. The Center utilizes the systematic "closing the QI loop" process to promote continuous quality improvement throughout the facility.

2. This process provides for a planned, systematic, organization-wide, prioritized, approach that is inter-disciplinary and uniform.

3. QI activities conducted by specific clinical disciplines within the organization are consistent with the characteristics of the overall CQI program.

4. The improvement activities are on-going and part of the Center's planning process.

5. The improvement activities take into consideration patient, surgeon, and staff needs and expectations as well as others; i.e. payers, community.

6. The improvement activities take into consideration patient and organizational functions as well as dimensions of performance.

7. Improvement activities consider:

   A. Scope of service
   B. Mission and philosophy
   C. Important aspects of care
   D. High-volume, high-risk, problem-prone patients
   E. Contracted services, if appropriate
   F. Patient, surgeon, staff satisfaction
   G. Incident reports
   H. Standards of practice
   I. Identifying unacceptable or unexpected trends that influence patient outcomes

8. Improvement activities are re-designed as appropriate.

9. Individual performance is addressed as necessary and appropriate.

Characteristics:

Quality improvement activities have the following characteristics:

1. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to:

   A. Unacceptable or unexpected results of on-going monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal tests results, prescribing errors for medications, specific diagnoses, and so forth
   B. The clinical performance and practice patterns of health care practitioners

C. Medical record review for quality of care and completeness of entries
D. Quality controls for and use of pharmaceutical services
E. Other professional and technical services provided
F. Assessment of patient satisfaction
G. Direct observation
H. Staff concerns
I. Accessibility
J. Medical/legal issues
K. Wasteful practices
L. Over-utilization and under-utilization

2. The frequency, severity, and source of suspected problems or concerns are evaluated. Healthcare practitioners participate in the evaluation of identified problems or concerns.

3. Measures are implemented to resolve important problems or concerns that have been identified. Healthcare practitioners, as well as administrative staff, participate in the resolution of the problems or concerns that are identified.

4. The problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternative corrective actions are taken as needed to achieve and sustain improvement.

5. Through the organization's designated mechanisms, quality improvement activities are reported, as appropriate, to the proper personnel, the administrator, and the governing body.

6. The facility has a process in place to review key indicators in comparison with other similar organizations.

7. Benchmarks used will be based on state, local, or national standards. Participation in performance benchmarking activities will allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. These activities may include:

   A. Selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served
   B. Systematically collecting and analyzing data related to the selected performance measures
   C. Ensuring the validity and reliability of data

D. Measuring changes in performance related to the performance measures
E. Demonstrating and sustaining performance improvement over time
F. Using benchmarks that are based on local, state, or national standards, i.e. performance measures

The results of benchmarking activities are incorporated into other quality improvement activities of the ASC and reported to the governing body and throughout the organization.

Quality Committee:

The Governing Body of the Center retains overall responsibility for the design, implementation and evaluation of the Plan. The Governing Body delegates direct responsibility for development and implementation of the Plan to the Clinical Director and/or Administrator of the Center.

1. The Governing Body creates and oversees a Quality Improvement/Risk Management Committee that consists of the following individuals:

   A. The Medical Director of ESCNN, who shall serve as the committee chairperson
   B. The Clinical Director of the Center
   C. The Administrator of Eye Surgery Center of Northern Nevada, and
   D. The designated Risk Administrator, who may be one of the individuals delineated above

2. The Committee reports administratively to the President of the Center. Individual members of the Committee oversee QI/RM activities within the purview of their existing administrative responsibilities and may delegate specific aspects of the Plan implementation to other employees of ESCNN, as appropriate.

3. It is the responsibility of the Committee to conduct, at least quarterly, a comprehensive assessment of risks and quality improvement issues that might affect the life and/or welfare of the Center patients or employees, the quality of care delivered by the Center, and the effectiveness and efficiency with which the Center utilizes and safeguards its facilities and services. In order to provide independent review, a second physician will participate in QI activities relating to each physician employee of the Center. Outside physicians may be contracted on an as needed basis to provide this service.

4. This review should specifically address the objectives listed in the plan as well as the impact of peer-review and patient satisfaction surveying

on the QI/RM process. A result of this review includes updating and reissuing of this Plan and submittal of the revised Plan to and the approval thereof by the Governing Body of the Center.

5. The purpose of the committee is to monitor important aspects of care and to encourage communication about the ASC operations which will provide maximum opportunities to implement continuous quality improvement and to aid in quality assurance. The following will be reviewed at each meeting:

    A. All incident/occurrence reports related to patient and employee safety
    B. All patient evaluation cards and surveys
    C. All direct hospital admissions and transfers
    D. All complication data generated by chart review
    E. Medical chart audit studies (at least one per quarter)

6. A permanent record will be kept of each meeting.

7. Important patient care problems or concerns are identified. These problems or concerns may arise from clinical, administrative, or cost-of-care issues, as well as actual or potential problems affecting patient outcomes.

8. The frequency, severity, and source of suspected problems or concerns are evaluated.

9. Effective measures are developed and implemented by appropriate personnel to resolve important problems or concerns that have been identified.

10. Problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If not, alternative corrective measures are developed and implemented as needed to resolve the problem or concern.

11. Quality improvement and risk management activities and the results thereof, are reported to the Governing Body on a quarterly basis or more often as required.

The Committee has identified three major areas of risk/study. These areas are Quality Improvement, Risk Management and Patient Satisfaction. Separate risk analysis and program definition has been performed for each area and is summarized herein.

1. Quality Improvement consists of three significant components: Quality of Care (including Peer Review), Cost of Care, and Administrative issues. These are discussed in turn.

   A. Quality of Care. Within this component, numerous aspects of care exist which require regular and consistent review and evaluation. The Committee has designated the following elements as requiring daily attention:

      a. Verify equipment function within proper limits for: Refrigerators, Defibrillator, and Surgical Lasers. Confirm cleanliness of all equipment.
      b. Nursing care is appropriate with respect to IV starts, medication administration, patient preparation, and turnover time.
      c. Medical records are complete and accurate, physically present in the operating suite and legible. Ascertain that the surgeon and/or anesthesiologist verifies all laboratory results, if applicable.
      d. Patient condition and care is documented with respect to:

         i. Proper placement of bed side-rails in the up position.
         ii. Any ambulation problems post-operatively.
         iii. Nausea or vomiting.
         iv. Maintenance of continuity of surgery.
         v. Glucose testing performed on all known diabetic patients.
         vi. Blood oxygen levels below 90 percent are properly documented and evaluated prior to surgery.

      e. Anesthesia care is documented as to the success of conscious sedation (when utilized), local or regional blocks (when utilized),), volume of medication administered, and mixture of anesthetic utilized. Additional indicators include existence of:

         i. Tooth damage
         ii. Stridor, laryngospasm, obstruction
         iii. Prolonged respiratory depression
         iv. Pulmonary aspiration

v. Cardiac arrhythmia
vi. Hypertension
vii. Prolonged sedation
viii. Orbital bleed
ix. Vomiting > 3 episodes
x. Perforation of globe
xi. Retrobulbar hemorrhage
xii. Adequate sedation
xiii. Documentation of controlled drug administration
xiv. Related complications
xv. Other unexpected outcomes as recognized

f. This data is collected daily and compiled quarterly or more often if needed. Following quarterly compilation, the data is reviewed by the Clinical Director of ESCNN to identify any adverse trends or real or potential problems or concerns that may affect the quality of patient care.
g. Issues so identified will be considered quality improvement opportunities and the appropriate study methodology, as described in the plan, should be applied.
h. Other elements of the operation of the Center designated by the Committee for periodic review include:

i. Monitoring nursing staff to insure that current licensure is maintained and professional development activities are adequate to insure skills remain sharp. When required, ACLS status is ascertained and appropriate levels of productivity are achieved. Current copies of licenses are to be obtained and maintained in each individual's personnel file. Annual performance evaluations will be conducted.
ii. Patient care concerns in this category include comfort of medications administered, safety issues (including falls), all required transfers to a hospital, all unplanned vitrectomies, treatment of pathology specimens, and all nosocomial infections.
iii. An additional concern to be addressed at least annually is adequate documentation of the appropriateness of the surgical decision.

i. The final element designated by the Committee, as a required element of quality improvement monitoring is peer review. It is the responsibility of the Clinical Director of ESCNN to establish appropriate peer review relationships in the areas of surgical care and anesthesia

care. Further, appropriate peer review of the medical records and procedures of the Center shall be performed at least annually.

j. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of ESCNN.

k. Cost of Care. These issues are critical to the continued successful operation of the Center. The Committee notes the relationship of these issues to quality of care and the following elements are believed to exhibit significant cost of care concerns:

   i. New equipment purchases. Scope for mandatory study is established as $15,000.00
   ii. Cost of existing or planned new services, including the impact of new regulatory requirements.
   iii. Change or replacement of equipment. Scope for mandatory study is established as $15,000.00
   iv. Purchasing methods, particularly as they relate to regulatory compliance (e.g., "bundling").
   v. Monitoring and control of cost per case for surgery and other procedures as their significance warrants.
   vi. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of ESCNN.

l. Administrative. This set of issues includes operational, financial and personnel management elements. Specific concerns of the Committee include:

   i. Operational – adequate staffing, repair and maintenance of plant and equipment, and establishment and implementation of operating procedures for non-medical employees.
   ii. Financial – control of financial assets (particularly cash and inventory), review system of internal accounting control for appropriateness and efficacy, preparation of periodic financial statements on a timely and consistent basis, regular analysis of collections and accounts receivable and profitability of the company.
   iii. Personnel Management – training and supervision of staff, continuing education of medical staff and key non-medical employees, regular program of career counseling and salary administration and compliance with regulatory requirements affecting

employees (e.g., OSHA, COBRA, Fair Labor Standards, etc.).

iv. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of the Center.

B. Risk Management reflects concerns that affect the lives and welfare of the patients and employees of the Center. The Committee has identified the following elements of physical security, patient care, and corporate liability for study. Each element so identified must be addressed at least annually, or more frequently as circumstances warrant:

i. Physical Center maintenance and security, including control of ingress and egress.
ii. Life safety systems and procedures, including alarms, drills, and disaster planning.
iii. Regulatory compliance, particularly OSHA and DEA requirements.
iv. All patient or employee incident reports involving safety, injury, or misconduct.
v. Adequacy and completeness of insurance coverage, including property and casualty, medical malpractice, general corporate liability, business overhead, group health, and group disability, if applicable.
vi. Procedures involving acquisition, utilization and disposal of controlled substances.
vii. Disposal of medical waste.
viii. Exposure control and other staff health issues.
ix. The Clinical Director and designated Risk manager will share responsibility for the implementation of this segment.

C. Patient Satisfaction. The Clinical Director will be responsible for the design, implementation, and evaluation of an ongoing system to monitor patient satisfaction with various aspects of the care and services provided by the Center.

i. It is anticipated that this program will be conducted by the Center, will provide both qualitative and quantitative data and will annually cover the performance of all health care providers, specifically including all licensed physicians individually. The performance of other employees may be addressed

as a group, e.g., nursing care, reception personnel, etc.

ii. The results of all such studies will be communicated to the Governing Body, President and Staff of the Center during regular staff meetings as soon as such data is available.

The Committee is responsible for dissemination of QI/RM data to the Governing Body, President, management and staff of the Center. The available meeting and training schedule should be utilized to the maximum extent possible.

1. This schedule includes the scheduled staff meetings that are available for both the reporting of results and findings and also for in-service training. The Governing Body will meet quarterly in accordance with their procedures and written minutes of these meetings will be maintained in the corporate records.

2. It is the intent of the Committee to formally present the QI/RM plan to the Governing Body for approval on an annual basis. Further, the Governing Body will review the results of QI/RM activities on a quarterly basis. These activities will be documented in the minutes of the meeting of the Governing Body.

3. Finally, the Governing Body will periodically review the composition of the Committee. Appointments and reappointment to the Committee shall be approved by the Governing Body and appropriately documented in the minutes.