University of Arkansas for Medical Sciences

Part I - Safety Management Plan

FY27

I. MISSION STATEMENT

The mission of UAMS is to improve the health, health care and well-being of Arkansans and of others in the region, nation and the world by:

- Educating current and future health professionals and the public.
- Providing high-quality, innovative, patient- and family-centered health care while providing specialty expertise not routinely available in community settings.
- Advancing knowledge in the areas of human health and disease translating and accelerating discoveries into health improvements.

Consistent with the UAMS mission, values and philosophy, the Safety Coordinating Committee, Medical Staff, and Administration has established and provides ongoing support for the Safety Management Program described in this plan.

The purpose of the Safety Management Plan is to define methods/processes for the identification and management/minimization of the inherent safety risks associated with our healthcare operations. The plan establishes the parameters within which a safe environment of care is developed, maintained and improved. This plan also addresses specific responsibilities and employee education programs.

II. SCOPE

The Safety Management Plan addresses specific responsibilities and employee education programs. These and other elements of the Safety Management Plan are all directed toward managing the activities of the employees so the risk of injuries to patients, visitors and employees are reduced, and employees can respond appropriately in emergencies.

III. AUTHORITY / REPORTING RELATIONSHIPS

The Safety Coordinating Committee (SCC), its members and Chairman are appointed by the Chancellor and shall act as the administrative body for coordination and/or implementation of the Safety Management Program campus wide. Four sub-committees to the SCC are also appointed by the Chancellor to facilitate the activities of the Safety Committee. (Appendix I) One of the most critical functions of the SCC is the coordination of the programs involved with Joint Commission Physical Environment Chaptercompliance. The Safety Coordinating Committee shall meet at least quarterly or by call of the Safety Coordinating Committee chairman appointed by the Chancellor. The Safety Coordinating Committee shall evaluate recommendations of the four sub-committees and act as the recommending body through the Chancellor to the University of Arkansas Systems Board of Trustees for final approval.

The standing members of the SCC shall consist of the chairman of each Safety sub-committee or a representative, the Director of Occupational Health and Safety and a representative of each of the campus colleges. Other members serve as permanently invited guests. The Safety Coordinating Committee shall be multidisciplinary in that the colleges and hospital shall have representation on the committee.

The written Safety Management Plan is maintained and updated as needed with the approval of the SCC. The Plan's purpose is to effectively manage the environmental safety of patients, staff, and other people coming to the UAMS Hospital and campus.

The Environmental Health and Safety Executive Director has been appointed by the Chancellor as Safety Officer (Appendix II) and in that capacity has the authority to inspect, review, and recommend for correction any discrepancies noted in the safety and health codes and standards set forth by the authorities having jurisdiction. (UAMS Medical Center Policy A.4.01). As per that policy the Director or his or her designee may take appropriate action, including evacuation of facilities and terminating hazardous operations, whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings. The Safety Officer participates in the three Emergency Preparedness Committees for the campus.

SAFETY SUB-COMMITTEES AND FUNCTIONS

A. RADIATION SAFETY COMMITTEE

1. PURPOSE AND FUNCTION

The Radiation Safety Committee meets at least quarterly and is charged with the responsibility of evaluating, approving, monitoring, and correcting hazards associated with the use of ionizing radiation from any source.

2. ORGANIZATION AND RESPONSIBILITY

The Chancellor, in conformity with the requirements specified in Arkansas radiation control regulations, appoints at least three members. The Committee membership represents an authorized user of each type of radioactivity as well as representatives from administration and nursing.

The Radiation Safety Officer(s) (RSO) derives authority from the Chancellor and is directed by actions taken by the Radiation Safety Committee. The RSO(s) reports within the Department of Environmental Health & Safety.

All magnetic resonance imaging (MRI) operations fall under the purview of the Department of Radiology and their policies. The Department of Radiology's procedures define how the hospital manages MRI safety risks associated with patients. The Department of Radiology also ensures that the hospital manages the MRI safety risks by restricting access to everyone not trained in MRI safety or screened by staff trained in MRI safety.

The responsibilities of the Radiation Safety Committee are:

- Review and grant or deny permission for the use of radiation sources within this institution from the standpoint of radiological health and safety of patients, personnel and other factors, which the committee may wish to establish.
- Prescribe special conditions that will be required during a proposed use of radiation sources, such as requirements for bioassays and physical examinations of users, and minimum level of training and experience of users.
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- Formulate and review the institutional training programs for the safe use of radiation sources.
- Review and approve all changes to procedures related to the Radiation Safety Program prior to implementation, and ensure that procedures satisfy regulatory requirements, do not change exiting license conditions, and do not decrease the effectiveness of the Radiation Safety Program.

- Review records and reports from the RSO, or other individuals delegated responsibility for radiation safety practices in this institution. This includes, but not limited to findings identified on lab audits, quarterly program audits, or annual audits of the radiation safety program, ALARA dose reports, fluoroscopy patient doses over 3Gy, etc.)
- Take actions when noncompliance is identified, including analysis of the cause, corrective actions, and actions to prevent recurrence.
- Maintain a written record of actions taken by the committee.
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- Monitor the Institutional program to ensure occupational and public doses are as low as reasonably achievable (ALARA).
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The responsibilities of the Radiation Safety Officer(s) are:

- Provide assistance on all aspects of radiation protection.
- Oversee all uses of ionizing radiation to ensure radioactive material and radiation producing machines are used safely and in compliance with federal and state rules and Joint Commission standards.
- Perform audits of use and individuals who are authorized to use ionizing radiation.
- Maintain radiation exposures at the lowest possible level by the supervision or operation of an effective and appropriate radiation safety and control program.
- Develope and maintain procedures for personnel and area monitoring and maintain the records attending these actions.
- Conduct educational programs for instructing employees and students in the proper procedures and the type of equipment necessary for the safe use of radiation sources.
- Establish and maintain procedures for the safe receipt and disposal of radioactive materials.
- Ensure radioactive material is properly secured from unauthorized use or access.
- Make available to all radiation workers, a copy of the Radiation Safety Manual and State rules, and inform them of relevant sections of the rules as well as periodic changes.
- Evaluate any incidents involving ionizing radiation and notify proper authorities if required.
- Reviewing all safety incidents in MRI with the Department of Radiology.

B. INSTITUTIONAL BIOSAFETY COMMITTEE

1. PURPOSE AND FUNCTION

The Institutional Biosafety Committee shall meet at least quarterly or as called to review and evaluate investigator-generated safety protocols for the proposed use of biological materials that entail a potential risk to humans, animals, plants, or the environment. This includes, but is not limited to, studies involving recombinant or synthetic nucleic acid molecules (r/sNA), infectious agents, and biological toxins. The IBC fulfills the functions set forth in Secction IV of the *NIH Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules (NIH Guidelines).* The IBC periodically reports to the Safety Coordinating Committee and makes recommendations regarding biohazards that may exist or arise on the UAMS campus.

2. ORGANIZATION AND RESPONSIBILITY

The IBC shall be composed of faculty, biological safety officers (BSOs), at least two non-affiliated community members, the Institutional Safety Officer, and *ex officio* members, per *NIH Guidelines Section IV*. Members may be appointed for their expertise in infectious agents, toxicology,

recombinant DNA, animals, and gene-drive modified organisms (GDMOs) and/or human gene therapy. The committee members and its chairperson shall be appointed by the Chancellor. The committee chairperson, or designee, shall be empowered to sign for the committee to approve biohazard safety protocols on appropriate institutional forms.

Agents to be reviewed shall include, but are not limited to:

- Recombinant or synthetic nucleic acid molecules, including human gene therapy and human subject research, unless exempt from the *NIH Guidelines*
- Gene-drive modified organisms (GDMOs)
- Non-human cells and cell culture, organs or tissues, or biological materials that are recombinant, unless exempt from the *NIH Guidelines*
- Vertebrate and invertebrate animals that are recombinant (transgenic), exotic, or grown in association with recombinant materials, unless exempt from the *NIH Guidelines*

The IBC may also be asked to review research that is not subject to the *NIH Guidelines* but involves:

- Infectious agents at biosafety level 2 (BSL-2) or higher, including bacteria, viruses, mycotic agents, parasites, prions, or virus shedding cells that are not recombinant
- Highly toxic compounds, biological toxins, hazardous chemicals, and/or drugs

Responsibilities of the Institutional Biosafety Committee chair include, but are not limited to:

- Manage membership of the committee and ensure members are appropriately trained to review r/sNA research in accordance with the *NIH Guidelines*
- Act as a liaison between the IBC and University administrators, federal and state officers involved in the practices of institutional biosafety committees, and spokespersons representing committees from other institutions
- File an annual report with NIH Office of Science Policy (OSP) which includes a roster of all members that lists their role and expertise, and a biographical sketch of each member, and make regular updates as necessary.

Responsibilities of IBC members include, but are not limited to:

- Review research involving recombinant or synthetic nucleic acid molecules for compliance with the *NIH Guidelines*
- Notify the PI of IBC review and approval
- Set containment levels and modify containment levels for ongoing experiments as warranted
- Review safety protocols and verify applicable sections and subsections of the NIH Guidelines
- Report to OSP and institutional officials any substantial problems or violations of the *NIH Guidelines* or significant research-related accidents or illnesses

Responsibilities of the principal Investigator include, but are not limited to:

- Full compliance with the *NIH Guidelines* in the conduct of recombinant or synthetic nucleic acid molecule research or biosafety level 2 or 3 containment research
- Submit the initial safety protocol and any subsequent amendments or renewals for review and approval prior to initiating research activities
- Make an initial determination of the required levels of physical and biological containment in accordance with the *NIH Guidelines* and select the appropriate laboratory practices and techniques to be used
- Include all persons who use hazardous materials in their work in the safety protocol and ensure these persons receive appropriate laboratory-specific training in addition to all required biosafety training

- Report any problems, research-related accidents or illnesses, spill of biohazardous material, exposure or potential exposure, and any other injury or incident or near misses to the Biological Safety Officer
- Make available to all laboratory personnel the protocols that describe the potential hazards and the precautions to be taken
- Ensure the integrity of the physical containment and biological containment equipment and procedures
- Adhere to approved emergency response procedures for handling accidental spills and personnel contamination
- Comply with shipping requirements for biological material or recombinant or synthetic nucleic acid molecules

C. LASER SAFETY COMMITTEE

1. PURPOSE AND FUNCTION

The Clinical Laser Committee has joint responsibility to the UAMS Medical Board and the UAMS Safety Coordinating Committee, and is charged with the responsibility of evaluating, approving, monitoring, and correcting hazards associated with the use of all lasers on campus. The Laser Safety Committee (LSC) meets as needed and reports activities to the SCC.

2. ORGANIZATION AND RESPONSIBILITY

The committee members are appointed by the Chairman of the LSC. The UAMS Laser Safety Officer (LSO) is a member of both the LSC and the SCC and reports at least quarterly to the SCC on activities.
The LSO derives authority from the Chairman of the LSC, who is appointed by the Chancellor, and is directed by actions taken by the Interventional Services Committee.

The responsibilities of the LSC are:

- Advising the credentialing committee when questions arise regarding applications for laser credentialing within this institution from the standpoint of health and safety of patients and personnel.
- Prescribing special conditions that will be required during the proposed use of a laser source such as requirements for protective equipment and minimum level of training and experience of users.
- Receiving and reviewing records and reports from the Laser Safety Officer or other individuals delegated responsibility for laser safety practices.
- Recommending remedial action to correct safety infractions.
- Formulating and reviewing the institutional training programs for the safe use of laser sources.
- Maintaining written records of actions taken by the committee.
- Reviewing requests for new lasers.

The responsibilities of the Laser Safety Officer are:

- Providing consulting services on all aspects of laser protection.
- Acting as liaison to SCC and reporting laser related activities quarterly to SCC.

D. ENVIRONMENT OF CARE COMMITTEE

1. PURPOSE AND FUNCTION

This committee is charged with the responsibility of evaluating, approving, monitoring, and correcting hazards associated with the environment of care for patients, staff members and other individuals.

2. ORGANIZATION AND RESPONSIBILITIES

Committee membership will be composed of the Directors and/or their representatives of each area in the environment of care and other critical areas: Safety, Engineering & Operations, Clinical Engineering, Design and Construction, Clinical Environmental Services, Technology Services and Support and the Police. The committee chairman will be appointed by the Chancellor. The committee will meet as often as necessary, but at least quarterly, and will report all pertinent indicators through the Safety Coordinating Committee structure.

The Environment of Care (EOC) Committee will receive and review reports pertaining to Clinical Environmental Services, Fire Prevention and Life Safety, Hazardous Materials and Waste Management, Utilities, Security Management, Medical Equipment Management Committee, and the Worker Safety Committee. In addition to reports from these areas, Management Plans also maintained for Security (Part II), Hazardous Materials and Waste (Part III), Fire Prevention and Life Safety (Part IV), Medical Equipment (Part V), and Utilities Systems (Part VI).

Effective management of the Physical Environment includes using processes and activities to:

- Reducing and controlling environmental hazards and risks
- Preventing accidents and injuries
- Maintaining safe conditions for patients, visitors and staff
- Maintaining an environment which is sensitive to patient needs for comfort, social interaction, positive distraction, and self-control;
- Maintaining an environment which minimizes unnecessary environmental stress for patients, visitors and staff

IV. OBJECTIVES

1. Develops and implements department specific safety policies and education.

2. Monitors, tracks and trends employee injuries throughout the medical center and campus.

3. Effectively utilizes building and laboratory audits and environmental tour data to maintain a safe working environment for staff, students, patients and visitors.

4. Develops and implements employee and contractor knowledge of the Safety Management Program.

V. INTENT PROCESSES

A. Risk Assessments - UAMS pro-actively performs risk assessments to evaluate the impact of proposed changes to new or existing areas of the organization. The goal of performing risk assessments is to reduce the likelihood of future incidents or other negative experiences that have the potential to result in injury, an accident, or other loss to patients, employees, or hospital assets. Potential safety issues are reported and discussed in the Safety Committee

meetings, along with all-pertinent data and alternatives. Based on the committee's evaluation of the situation, a decision by management of the issue is reached.

Results of the risk assessment process are used to create new or revise existing safety policies and procedures, environmental tour elements in the area affected, safety orientation and education programs, or safety performance improvement standards.

B. Incident Reporting and Investigation- The Safety Management Program documents patient and visitor incidents, employee incidents, and property damage. Patient and visitor incidents are reported in the Press Ganey Reporting System. Reports on patient and visitor incidents are directed to the Department of Patient Safety and are reported through the Adverse Event Review and Evaluation Committee and the Quality, Experience, Safety Team (QUEST) Committee.

Reports on employee injuries and incidents are directed to the Occupational Health & Safety Department and the Workers Compensation Department in Human Resources. Reports on property damage are directed to the Chief of Police and Occupational Health & Safety.

Occupational Health & Safety and/or the Police Department perform an analysis of these incidents. The findings of this analysis are reported to the Safety Committee. The incident analysis is intended to provide an opportunity to identify trends or patterns that can then be used to identify necessary changes to the Safety Management Program to control or prevent future occurrences.

C. Environmental Tours- The Safety Officer or designee actively participates in the management of the environmental tour process. Environmental Tours are conducted to evaluate employee knowledge and skill, observe current practice, and evaluate environmental conditions. Results from environmental tour activities serve as a tool for improving safety policies and procedures, orientation and education programs, and employee performance. The Safety Officer or designee provides the SCC Committee through the Environment of Care Committee with summary reports on activities related to the environmental tour process.

Environmental Tours at UAMS are conducted every six months in all areas where patients are served and at least annually in all areas where patients are not served.

Individual department managers are responsible for initiating appropriate action to address the findings of the environmental tour process. Environmental Tours are used to monitor employee knowledge of safety. Answers provided during random questioning of employees during the survey, are analyzed and reports submitted to the Environment of Care Committee (EOC), and as appropriate to the SCC Committee.

D. Product/Medication/Equipment Safety Recalls- Information regarding a recalled product, medications or equipment is distributed to all user departments in a timely manner. It is the responsibility of the Environment of Care Committee and SCC to review recall and alert compliance.

E. Examining Safety Issues- The SCC membership consists of the chairman of each Safety sub-committee or a representative, the Director of Occupational Health and Safety and a representative of each of the campus colleges. Other members serve as permanently invited guests. The SCC is multidisciplinary in that the colleges and hospital shall have representation on the committee to share progress, ideas and successes and evaluate/plan improvements in the program.

F. Policies and Procedures- The Safety Officer is responsible for coordinating the development of general safety policies and procedures. Individual department managers are responsible

for managing the development of departmental specific safety policies and procedures. Departmental specific safety policies and procedures address safe operations, use of hazardous equipment, and use of personal protective equipment. The Safety Officer assists department managers in the development of new department safety policies and procedures.

System-wide safety policies and procedures are distributed to all departments. Department Directors and/or Managers are responsible for distribution of department level policies and procedures to their employees. The Safety Officer and department managers are responsible for ensuring enforcement of safety policies and procedures. Each employee is responsible for following safety policies and procedures.

System-wide and departmental safety policies and procedures are reviewed at least every two years or as necessary. Some policies/procedures will be reviewed more often if driven by a requirement of a regulatory standard (i.e., BBP, TB Control Plan, Hazard Communication, etc.). Additional interim reviews may be performed on an as needed basis.

G. Safety Officer Appointment- The UAMS Chancellor is responsible for managing the Safety Officer appointment process.

If the Safety Officer position should become vacant, the Chancellor is responsible for selecting a qualified individual capable of overseeing the development, implementation, and monitoring of the Safety Management Program. By appointment, the incumbent Safety Officer is assigned overall operational responsibility for the Safety Management Program. The Safety Officer performs those functions normally associated with a Safety Officer and is guided by a written job description.

H. Intervention Authority- The SCC Chairperson and Safety Officer or their designee has been given authority by the Chancellor to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings. Any suspension of activity shall immediately be reported to the Chancellor or his representative.

I. Grounds and Equipment- The Operational Support Services and Engineering and Operations Departments are responsible for scheduling and performing maintenance of hospital grounds and external equipment. Policies and procedures for this function are located in the respective department.

VI. EMPLOYEE HEALTH AND WELFARE

A. Department Directors and Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the Safety Program, and to ensure its effective implementation within their department. Each employee is responsible for attending safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the safety guidelines set forth in the Safety Program.

B. Employees complete the Injury and Incident report. Reports on employee incidents are directed to the Occupational Health and Safety and the Human Resources Worker Compensation Department for trending and reporting to the EOC.

C. Historical data will allow UAMS to review and analyze the following indicators:

1. Number of OSHA recordable injuries.
2. Injuries by cause.
3. Injuries by body part.

4. Needlestick and body fluid exposures.

VII. ORIENTATION AND EDUCATION

A. New Employee Orientation: The Safety Education/Orientation and Training program begins with the New Employee Orientation program for all new employees and continues on an ongoing basis with departmental-specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis.

B. Annual Continuing Education: The Annual Continuing Education Program for UAMS includes self-directed computer-based learning modules and departmental specific in-service training sessions. These modules contain learning materials and tests. These modules can be used by individual employees or as a guide for group presentations. Directors or Managers determine the most appropriate method of instruction for employees in their department or unit. Modules are reviewed and/or revised as necessary. New modules are developed when the need is identified.

C. Department Specific Training: Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job-related hazards

D. Contract Employees: Assessment and education are done at the time of assignment regarding safety management.

VIII. INFORMATION COLLECTION & EVALUATION (ICES) - Performance Monitoring

A. At UAMS, ongoing performance monitoring is conducted. The following performance monitors have been established as follows:

1. Measure compliance identified during environmental tour inspections. The goal for FY23 is 90% compliance on environmental rounds audit. This is an ongoing measure of environmental tours.
2. Measure compliance for annual safety education for employees and staff. The goal for compliance will be 90%.

B. The Safety Officer oversees the development of performance monitors for the Safety Coordinating Committee. Data from these performance monitors are reported at least quarterly to the SCC. Performance Indicators are reported annually to the Chancellor, Vice Chancellor for Clinical Programs, Board of Trustees, Medical Director and other department managers as appropriate. Annually, the data from all the environment of care performance monitors are analyzed and prioritized to select at least one recommendation to be made to the leadership of UAMS for a performance improvement activity in the environment of care.

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IX. ANNUAL EVALUATION

A. The Safety Officer has overall responsibility for coordinating the annual evaluation process with each of the five functions associated with managing the Environment of Care. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Safety Management Program.

B. The annual evaluation is presented to the SCC by the end of the first quarter of each year. The SCC reviews and approves the report. The deliberations, actions, and recommendations of the SCC Committee are documented in the minutes. The annual evaluation is distributed to the Chancellor, Vice Chancellor for UAMS Health, Board of Trustees, and other department managers as appropriate. This finalizes the evaluation process.

X. SMOKING POLICIES-

Administrative Guide, Policy Number: 3.1.01, Policy Title: Smoking/Tobacco Use
UAMS Medical Center Policies and Procedures, Policy Number: PS.1.09, Policy Title: Patient Smoking and Tobacco Use

The University of Arkansas for Medical Sciences (UAMS) is committed to promoting health, wellness, prevention and the treatment of diseases within the community as well as to providing a safe, clean and healthy environment for our patients, visitors, employees and students. It is UAMS's policy to provide a totally tobacco free work environment. UAMS is committed to providing helpful intervention strategies and treatment resources in addressing this issue and to offering programs to assist patients, students, current employees to reduce their dependence on tobacco products.

Appendix I

Safety Committee Data Information Flow

