Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

June 9, 2021 1:00 PM
Zoom Meeting: LINK
Call In Number: 1-669-900-9128
Meeting ID: 925 3694 4207

Attendees

Jeanne Utterback, Board President, Quality Committee Chair
Tom Guyn, Board Secretary

Louis Ward, CEO
Jack Hathaway, Director of Quality

Community Members:
Laura Beyer

1	**CALL MEETING TO ORDER**		Chair Jeanne Utterback			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – May 12, 2021		Attachment A	**Action Item**	2 min.
4	**NO REPORTS FOR: QUALITY FINANCES, FACILTIIES, STAFF**					
5	**REPORTS: QUALITY PATIENT SERVICES**					
	5.1	Skilled Nursing Facility	Shelley Lee	Attachment B	Report	2 min.
	5.2	Emergency Department	Alexis Cureton	Attachment C	Report	2 min.
	5.3	Laboratory	Ulysses Pelew/ Jack Hathaway		Report	2 min.
	5.4	Radiology	Alan Northington	Attachment D	Report	2 min.
	5.5	Blood Transfusion Quarterly	Theresa Overton	Attachment E	Report	2 min.
	5.6	SNF Events/Survey	Candy Detchon		Report	5 min.
	5.7	Infection Control	Dawn Jacobson	Attachment F	Report	5 min.
8	**DIRECTOR OF QUALITY**		Jack Hathaway			
	8.1	Director of Quality Update			Report	5 min.
	8.2	Compliance Quarterly		Attachment G	Report	2 min.

6	**NEW BUSINESS**					
	6.1	Hazard Vulnerability Analysis 2021	Val Lakey	Attachment H	***Action Item***	5 min.
7	**ADMINISTRATIVE REPORT**			Louis Ward	Report	10 min.
8	**OTHER INFORMATION/ANNOUNCEMENTS**				Information	5 min.
9	**ADJOURNMENT:** Next Regular Meeting – July 14, 2021 – Zoom Meeting					

Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes
May 12, 2021 @ 1:00 PM
Fully Remote Zoom Meeting

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1	**CALL MEETING TO ORDER:** Board Chair Jeanne Utterback called the meeting to order at 1:01 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Jeanne Utterback, President Tom Guyn, MD., Secretary		Louis Ward, CEO Candy Detchon, CNO Jack Hathaway, Director of Quality Libby Mee, Director of Human Resources Val Lakey, ED of CR and BD Marina May, Social Services Sondra Camacho, Activities Brigid Doyle, Staff Development Jennifer Levings, Data Analyst Jessica DeCoito, Board Clerk	
	ABSENT: Dawn Jacobson, Infection Control			
	Community Members Present: Laura Beyer			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; committee members accepted the minutes of April 14,2021.	***Guyn, Hathaway***	**Guyn – Y** **Utterback – Y** **Hathaway – Y** **Beyer – Y**
4	**No Reports for: Quality Facilities or Finances**			
5	**REPORTS: QUALITY**			
	5.1	**Marketing:** Intern Interviews are taking place this afternoon which is a part of our Growing Our Own program. More clinic marketing went out today and the heat maps show lots of traffic on our website.		
	5.2	**Safety Quarterly:** Met with Mock Surveyor on Emergency Preparedness and Safety program. Small changes to make. Will have Hazard Vulnerability Assessment brought forward to Quality and then full Board for approval.		
6	**REPORTS: QUALITY STAFF**			
	6.1	**Employee Health:** Will start to combine employee health and worker's comp quarterly reports into the same month. Update: HR met with Mock Surveyor and very impressed with our current programs and tracking. As of Tuesday, May 11th, our employee vaccination rate is at 60%. Continue to track the employees who have yet to get the vaccination and breaking them into categories. Employee Physicals are back up and running and conversations are taking place about moving them down to the Clinic.		
	6.2	**Staff Development: (Written report provided during meeting – copy included in minutes):** Working on the curriculum and lesson plans for the application for the CDPH Training Program Review Unit. This is a 25- day class that is in house and will help		

		with staffing shortages and provide opportunities to the community members who can't make it down to Redding or elsewhere for classes. Relias is no longer informing us of the folks who are not in compliance, so we are making adjustments to our process to keep everyone in compliance.
7	**REPORTS: QUALITY PATIENT SERVICES**	
	7.1	**Social Services:** Most of the report is focused on Long Term Care residents due to COVID presenting challenges to us. With some normalcy coming back, we've seen an uplift in the resident's spirits. Focus is to get our numbers back up into the 80s for LTC. A lot of extra activities have been helpful with moral and social interaction to help boost the wellbeing of our residents. Visitations opening back up has been very nice for residents and their families. Admissions process takes a while and we've been able to use the LEAN process to help streamline.
	7.2	**Activities:** Slowly opening up more opportunities for our residents. Residents took a field trip to Valley Hardware Nursey and purchased items to get gardens ready, took a trip to the Thrift Store and purchased some goods, and picked back up on the Resident Council meetings. We keep moving forward and coming up with activities for the residents to do. Hoping for a trip to the lake can happen soon, and give the residents a chance to throw in a fishing pole. We have also begun a recycling program that the residents are excited about.
	7.3	**SNF Events/Survey:** SNF Mock Survey went well. Currently going through a Mock Survey for the Acute side. So far, very minor issues that have already been solved. Really excited about the CNA program. Kudos to Social Services for their streamlined processes in admission. And thank you to Activities for their creative ideas for the residents.
	7.4	**Infection Control:** Vaccination numbers are decreasing.
8	**DIRECTOR OF QUALITY**	
	8.1	**Director of Quality Update:** Contracting Issue: review of patient service contracts need to be addressed – there is a process in place and most contracts are reviewed and handled but some are slipping through the cracks. A team has met up to discuss process solutions. Quality seems to be going very well hospital wide.
	8.2	**CMS Core Measures:** Patient Experience Measure: always the area we struggle because of volume of patients. 3M is going to be helping us with our coding in our DOG and surveys that will also increase our volume of patient surveys received to help boost our patient experience measure. Mortality Rate: death of heart attack patients and death of heart failure patients – we need to add two more into this measure with some options available, like death from stroke. Safety of Care: NHSN (CDC portal we report infection control through to CMS) is used to report to CMS but not all reporting goes through NHSN. Now that that is identified, we can make adjustments and start reporting out correctly. Discussion took place regarding the difference between JCO accreditation vs. Star Rating. More discussion to take place at the Strategic Planning Session on June 23rd.
	8.3	**5-Star Rating Monitoring – Quarterly Update:** We are at 4 Stars with SNF. CMS has gone back to the Red Hand note on your facility when there is case of abuse. Seamlessly worked with CDPH on all issues in the last 18 months with no deficiencies and solved all issues.
9	**ADMINISTRATIVE REPORT:** COVID Vaccine: 12 to 15 year olds are now able to get vaccine. Working with FRJUSD Superintendent to plan a vaccine clinic at the schools. Working with county on a consent form and how the processes will work, along with picking out dates and times. Siskiyou County is a concern with numbers of COVID positive cases – a recent outbreak of 20 residents coming back positive even after getting the vaccine – turns out it is the South African strain. Watching this closely since Siskiyou neighbors our area. HIPPA retraining will be taking place. Maintenance ticketing system has been set up to help track all the work orders coming through – IT currently uses this program and has been a huge help with tracking all the issues as well as setting up schedules for the Maintenance team. Internet issues have been going on for both campuses – when the line was cut over during the Demo project, Frontier incorrectly connected us to a smaller line than what we need. Huge priority and working on getting this issue resolved ASAP. Outdoor improvements for residents and employees like a gazebo and new seating areas are being implemented. Hospital Week this week – lots of fun activities have already taken place and more to come. Spent time on a radio call in Redding with Shasta Regional CEO – focus was on the vaccinations and opportunities out there. Setting up new Patients for the clinic has been streamlined – online registration, hard copy packet, or call and start the process over the phone to get an appt. set up and during appt. you can finish your registration packet.	
10	**OTHER INFORMATION/ANNOUNCEMENTS**: None	
11	**ANNOUNCEMENT OF CLOSED SESSION**	
	Medical Staff Credentials: Government Code 54962 **STAFF STATUS CHANGE** 1. Scott Zittel, MD – Move to Inactive **Medical Staff REAPPOINTMENT**	

	1. Sean Pitman, MD, Pathology (Shasta Path) 2. Mark Ramus, MD, Pathology (Shasta Path) 3. Michael Dillon, MD, Emergency Med. (Envision) **MEDICAL STAFF APPOINTMENT** 1. Sophie Xu Teng, MD, Neurology (UCD) 2. Robert L. Muller, MD, Radiology (vRad) 3. Anne Marie McLellan, DO, Radiology (vRad) 4. Alap R. Jani, MD, Radiology (vRad) 5. Ronald D. Alexander, DO, Radiology (vRad) 6. Desiree Levyim, MD, Neurology (Telemed2U)
10	**RECONVENE OPEN SESSION – REPORT CLOSED SESSION ACTION:** Medical Staff Credentials were moved, seconded and carried. Unanimous consent to approve credentials.
11	**ADJOURNMENT:** Next Regular Meeting – June 9, 2021

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	May 12, 2021
Department:	Staff Development
Submitted By:	Brigid Doyle MSN, RN

List up to three things that are going well in your department.

1.) Clinical Nurse Educator has created a 2021 Training Plan for CNA staff inclusive of 48 units required for recertification including mandatory dementia training, mandatory abuse training, trauma informed care training and person-centered care. Clinical Nursing Staff are assigned modules in the RMLS to keep licenses and certifications updated until classroom training can be resumed.

2.) Clinical Nurse Educator/Director of Staff Development has worked collaboratively and supported non-nursing clinical staff by creating learning modules in Relias collaboratively with Dietary Manager, Dietician, Safety Officer and Pharmacist by request.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Clinical Nurse Educator/Director of Staff Development is working with Director of Quality and SNF ADON on an application to initiate an in-house CNA training program. Providing a training space in the Intermountain area will ideally support residents who would seek employment at MMH and may not be inclined to travel to community colleges out of the area for this training. The role of the CNE/DSD is to build the training curriculum and schedule for approval by CDPH. Increasing the number of CNA staff to fill open positions and provide staff relief for sick time, vacations and leaves of absence will enable the SNF to maintain quality measures and **** star rating with CMS. Filling open positions contribute to resident and employee satisfaction and drive quality measures.

This is not a LEAN project

How does this impact on patients? Do you think this is acceptable?

Increasing the number of CNA staff, preventing staffing gaps in the event of illness, leaves of absences and PTO ensures the organizations ability to meet the daily staffing ratio, improves resident satisfaction and improves the quality of care.
It is an acceptable, positive and impactful project.

How does this impact on staff? Do you think this is acceptable?

Staff morale and engagement is increased when staffing meets daily ratios and staffing gaps are prevented.
It is an acceptable, positive and impactful project.

What progress has been made on these projects since the last quality committee meeting?
Curriculum and Lesson Plans have been developed for submission to CDPH. Application to CDPH Training Program Review Unit is in process of completion and will be submitted in May.
Has anyone in particular been instrumental in helping to progress/improve the problem?
Candy Vculek and Jack Hathaway
Which Strategic Goal does your quality issue BEST relate to (choose one)?
Have any new quality-related issues arisen? Briefly describe.
Registry staff have fallen below 100% compliance for assessments that previously was achieved. The CNE/DSD is working with HR to identify barriers for compliance. One reason identified was a Relias internal change to notifications of completed assessments. Another factor is that potential registry staff are in the system but never actually follow up or take shift at MMH. The process is being studied and will be revised to include the Relias change. Audits are ongoing and non-active registry staff will be removed from the system, which will bring compliance back to 100%
Are there any other issues to be discussed with the Committee?
ACLS, PALS, NRP certifications are current for all staff required except those on LOA. BLS certifications are 90% complete with ongoing trainings to bring staff up to date due to gap in trainings during Pandemic related cancellation of trainings. ALL CNA, LVN, & RN staff are all current (1 CNA has lapsed due to CDPH error and resolution is imminent)

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	6/09/2021
Department:	Skilled Nursing
Submitted By:	Shelley Lee RN Interim DON

List up to three things that are going well in your department.

1. Teamwork both Facilities along with general staff morale have improved.
2. Annex is almost full. Two male beds open.
3. Remain Covid free at this time, both facilities.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Activity: Resident families are back in the facility visiting regularly.

Not a Lean project.

How does this impact on patients? Do you think this is acceptable?

Positive impact on all residents and families.
Yes acceptable.

How does this impact on staff? Do you think this is acceptable?

Morale has improved. Yes acceptable.

What progress has been made on these projects since the last quality committee meeting?

Began after last quality meeting.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Which Strategic Goal does your quality issue BEST relate to (choose one)?

An outstanding place to work.

Have any new quality-related issues arisen? Briefly describe.

Internet being so slow is causing delay in resident care at the Both facilities.
Increasing medication pass time and resident care.

Are there any other issues to be discussed with the Committee?

Not at this time.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	6/3/2021 completed
Department:	Emergency
Submitted By:	Alexis Cureton

List up to three things that are going well in your department.

1) Transition in practice for smooth operations in the new wing has gone well and staff are now comfortable.
2) ESI is coming along nicely, audits are showing much improvement.
3) Mock Survey results were given to the department and staff is working diligently to achieve these changes.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

ESI triage level – All patients presenting to the ED are assigned a triage level that is a snapshot of their status and needs upon arrival. We have found that our assignment of triage level is not in alignment with standards.

How does this impact on patients? Do you think this is acceptable?

At a facility our size it does not impact patients as we are able to provide care without having to prioritize it to a vast group of "waiting" patients. However, it is regulation and therefore not negotiable.

How does this impact on staff? Do you think this is acceptable?

This process does not increase workload or add steps. It is merely the appropriate application of information

What progress has been made on these projects since the last quality committee meeting?

Official training through Relias was completed including post-tests. Ongoing audit of results and sharing of those results with staff at staff meetings. Providing "New staff" with the same education upon hire.

Has anyone in particular been instrumental in helping to progress/improve the problem?

I am still working on this process by completing all the audits and has been creating emails to the staff to 1) challenge them with different scenarios to apply the new knowledge 2) keep it in staff's forefront. Audit data shows a dramatic improvement in compliance but not yet to the point of target achievement. 2) Education providing them with an explanation in why.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding patient services

Have any new quality-related issues arisen? Briefly describe.

We have implemented protocols for Stroke and Sepsis and need to start audit processes to evaluate our care against those protocols.

Are there any other issues to be discussed with the Committee?

Not at this time

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	June 9, 2021
Department:	Imaging
Submitted By:	Alan Northington

List up to three things that are going well in your department.

1. New permanent Technologist.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

1. Ambra and PCC interface.
2. Lighting in X-ray and CT Suites.
3. Automatic door opener on the CT Suite Door.
4. CD Burner.
5. Additional digital receptor was purchased but installation in the RF room has not been completed.

How does this impact on patients? Do you think this is acceptable?

All projects will have a positive impact on patient care once completed.

How does this impact on staff? Do you think this is acceptable?

Once projects are completed, the level of frustration will decrease.

What progress has been made on these projects since the last quality committee meeting?

Progress has been slow with a few of our projects due to lack of IT resources and shortages in Radiologic Technologists. Adequate staffing continues to be an issue.

Projects completed were the HL7 interface between Ambra and vRad.

Has anyone in particular been instrumental in helping to progress/improve the problem?

No

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Improve workflow and throughput.

Have any new quality-related issues arisen? Briefly describe.

No new issues.

Are there any other issues to be discussed with the Committee?

None at this time.

BLOOD TRANSFUSION CHART
DATE: Jan. 2021

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
1/27/2021	29789	Saborido	2	N-Physician Orders missing	Y	Y	Y	Incomplete
TOTAL			**2**					

BLOOD TRANSFUSION CHART
DATE: Feb. 2021

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
2/12/2021	75311	Watson	1	N-Physician orders missing	Y	Y	Y	Incomplete
TOTAL			**1**					

BLOOD TRANSFUSION CHART
DATE: Mar 2021

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
3/22/2021	56703	Saborido	1	N-Physician Orders missing	Y	Y	Y	Incomplete
TOTAL			**1**					

BLOOD TRANSFUSION REPORT
Quarterly Report/3rd quarter 2021

MD	CHARTS REVIEWED	NUMBER OF UNITS
Saborido	2	3
Watson	1	1
TOTAL	**3**	**4**

Jessica DeCoito

From: Dawn Jacobson
Sent: Wednesday, June 2, 2021 10:02 AM
To: Jessica DeCoito
Subject: Quality Report

There have been no new cases of Covid within the hospital of either employees or patients/Residents.
Vaccine administration is still going well, we are using the state website of My Turn for processing these.

Dawn Jacobson, RN | **Employee Health Nurse/Infection Control**

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MAYERS MEMORIAL HOSPITAL DISTRICT COMPLIANCE REPORT

06/01/2021 FOR Q2- 2021

TRAINING AND EDUCATION

Type	Completion Target	Actual
New Hire Compliance	100%	100%
POC Education	100%	100%

EXCLUDED PROVIDERS

Type	Number
Employees	0
Physicians/Providers	0
Vendors	0

EXPIRED LICENSES

Expired licenses
0

PAYROLL-BASED JOURNAL (PBJ) FOR MOST RECENT AVAILABLE QUARTER

PBJ Issue	Number
Total Nurse Staffing	4 hours 25 minutes – last 5 Star report
Total RN	22 minutes – last 5 Star report
Total CNA	2 hours 42 minutes – last 5 star report
Days No RN Coverage	0 – last PBJ report
Staffing Domain Star Rating	4 star
Overall Star Rating	3 star

INVESTIGATIONS BY INTAKE

Type	Number
Hotline	0
Direct to Compliance	3
RL6	Data unavailable – I am finishing an update for RL6

REPORTS AND INVESTIGATIONS BY TYPE

Issue	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Abuse/Neglect	0	0	0	0	0	0
Code of Ethics/ Policy	0	0	0	0	0	0
Documentation	0	0	0	0	0	0
Elder Justice	0	0	0	0	0	0
False Claims	0	0	0	0	0	0
Gifts	0	0	0	0	0	0
HIPAA	0	0	0	0	0	0
Licensure	0	0	0	0	0	0
OIG Investigations	0	0	0	0	0	0
COVID	0	0	1	0	0	0
Resident Rights	0	0	0	0	0	0
Resident Charges	0	0	0	0	0	0
Non-Monetary	0	0	0	0	0	0
STARK	0	0	0	0	0	0
Total	0	0	0	0	0	0

COMPLAINTS & INVESTIGATIONS

Type	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Professional Liability	0	1	0	0	0	0
Loss of Property	0	0	0	0	0	0
Total	0	1	0	0	0	0

Update on the complaint intake – I have completed the initial work with Zendesk and should have a pilot (or trial) program together by the end of the month.

Thank you,

JH

HAZARD AND VULNERABILITY ASSESSMENT TOOL
NATURALLY OCCURRING EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Hurricane	0	0	0	0	0	0	0	**0%**
Tornado	1	1	1	1	2	2	1	**15%**
Severe Thunderstorm	2	2	2	2	2	2	2	**44%**
Snow Fall	3	1	2	3	1	1	1	**50%**
Blizzard	3	1	2	3	1	1	1	**50%**
Ice Storm	1	1	1	1	3	3	2	**20%**
Earthquake	2	1	1	1	2	2	2	**33%**
Tidal Wave	0	0	0	0	0	0	0	**0%**
Temperature Extremes	2	1	1	1	3	3	2	**41%**
Drought	1	1	1	1	3	3	3	**22%**
Flood, External	1	1	1	1	2	2	2	**17%**
Wild Fire	3	3	3	3	2	2	2	**83%**
Landslide	1	1	1	1	2	2	2	**17%**
Dam Inundation	1	1	1	1	2	2	2	**17%**
Volcano	2	1	2	3	1	1	1	**33%**
Epidemic	3	2	2	2	2	2	2	**67%**
AVERAGE SCORE	**1.63**	**1.13**	**1.31**	**1.50**	**1.75**	**1.75**	**1.56**	**27%**

**Threat increases with percentage.*

RISK = PROBABILITY * SEVERITY		
0.27	**0.54**	**0.50**

HAZARD AND VULNERABILITY ASSESSMENT TOOL
TECHNOLOGIC EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Electrical Failure	2	0	1	2	1	1	2	**26%**
Generator Failure	1	0	3	3	2	1	1	**19%**
Transportation Failure	0	0	0	0	0	0	0	**0%**
Fuel Shortage	1	0	1	2	1	1	1	**11%**
Natural Gas Failure	1	1	1	2	1	1	1	**13%**
Water Failure	2	0	1	2	1	1	1	**22%**
Sewer Failure	1	0	1	2	1	1	3	**15%**
Steam Failure	0	0	0	0	0	0	0	**0%**
Fire Alarm Failure	2	0	1	1	1	1	3	**26%**
Communications Failure	0	0	0	0	0	0	0	**0%**
Medical Gas Failure	1	2	2	3	1	1	1	**19%**
Medical Vacuum Failure	1	0	1	1	1	1	1	**9%**
HVAC Failure	2	0	1	1	1	1	1	**19%**
Information Systems Failure	2	0	0	3	1	1	1	**22%**
Fire, Internal	1	1	3	3	1	1	1	**19%**
Flood, Internal	1	0	2	2	1	1	1	**13%**
Hazmat Exposure, Internal	1	1	0	1	1	1	1	**9%**
Supply Shortage	1	0	0	1	1	1	1	**7%**
Structural Damage	1	1	2	3	1	1	1	**17%**
AVERAGE SCORE	**1.11**	**0.32**	**1.05**	**1.68**	**0.89**	**0.84**	**1.11**	**12%**

**Threat increases with percentage.*

RISK = PROBABILITY * SEVERITY		
0.12	**0.37**	**0.33**

HAZARD AND VULNERABILITY ASSESSMENT TOOL
HUMAN RELATED EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Incident (trauma)	1	1	0	3	2	2	1	**17%**
Mass Casualty Incident (medical/infectious)	1	1	1	1	1	1	1	**11%**
Terrorism, Biological	0	0	0	0	0	0	0	**0%**
VIP Situation	0	0	0	0	0	0	0	**0%**
Infant Abduction	0	0	0	0	0	0	0	**0%**
Hostage Situation	1	1	0	1	1	1	1	**9%**
Civil Disturbance	0	0	0	0	0	0	0	**0%**
Labor Action	0	0	0	0	0	0	0	**0%**
Forensic Admission	0	0	0	0	0	0	0	**0%**
Bomb Threat	1	1	1	1	1	1	1	**11%**
AVERAGE	**0.40**	**0.40**	**0.20**	**0.60**	**0.50**	**0.50**	**0.40**	**2%**

**Threat increases with percentage.*

RISK = PROBABILITY * SEVERITY		
0.02	**0.13**	**0.14**

HAZARD AND VULNERABILITY ASSESSMENT TOOL
EVENTS INVOLVING HAZARDOUS MATERIALS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Hazmat Incident *(From historic events at your MC with >= 5 victims)*	1	1	1	1	1	1	1	**11%**
Small Casualty Hazmat Incident *(From historic events at your MC with < 5 victims)*	1	1	1	1	1	1	1	**11%**
Chemical Exposure, External	1	1	1	1	1	1	1	**11%**
Small-Medium Sized Internal Spill	1	1	1	1	1	1	1	**11%**
Large Internal Spill	1	1	1	1	1	1	1	**11%**
Terrorism, Chemical	0	0	0	0	0	0	0	**0%**
Radiologic Exposure, Internal	1	1	1	1	1	1	1	**11%**
Radiologic Exposure, External	0	0	0	0	0	0	0	**0%**
Terrorism, Radiologic	0	0	0	0	0	0	0	**0%**
AVERAGE	**0.67**	**0.67**	**0.67**	**0.67**	**0.67**	**0.67**	**0.67**	**5%**

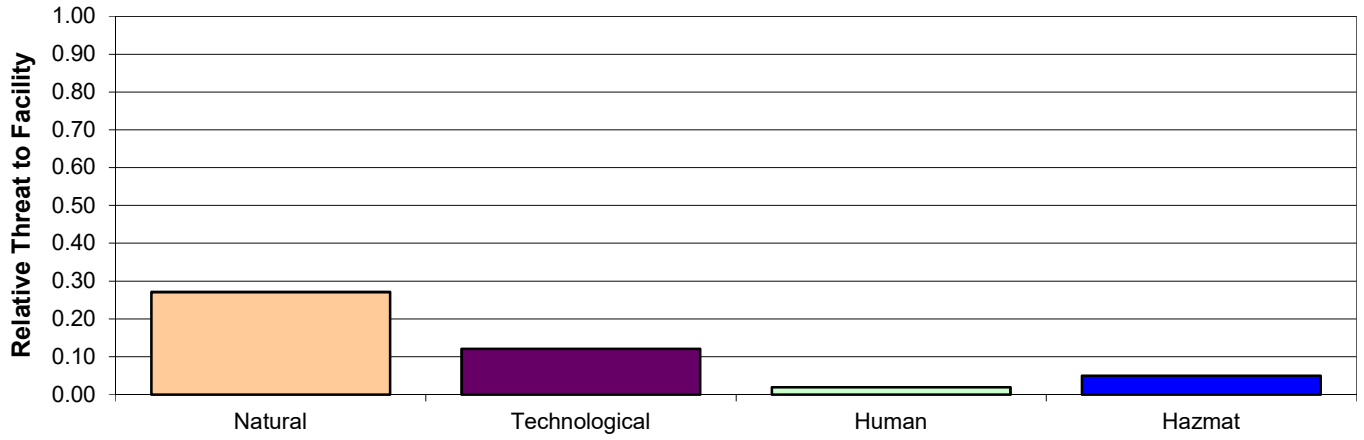
**Threat increases with percentage.*

RISK = PROBABILITY * SEVERITY		
0.05	**0.22**	**0.22**

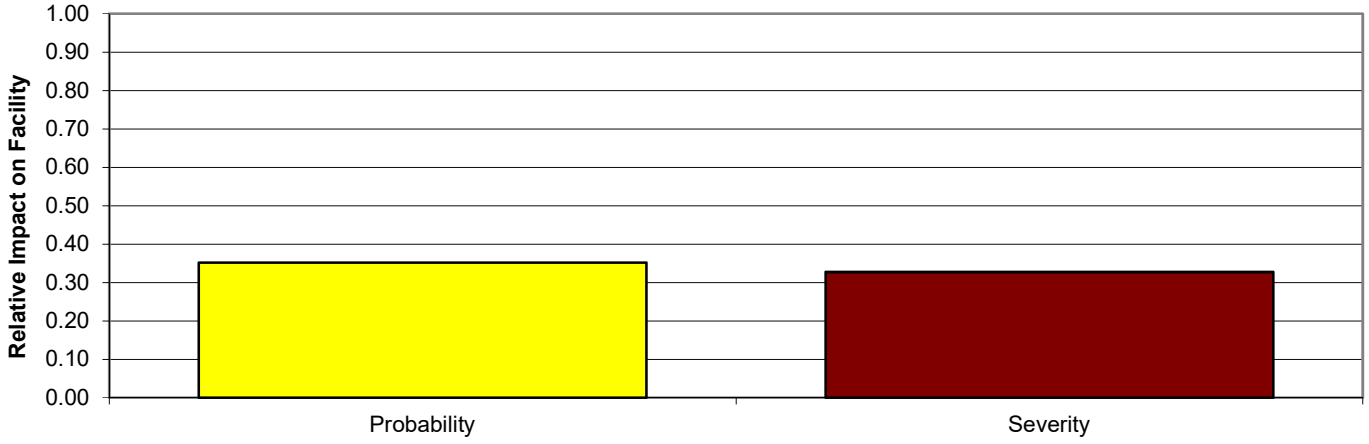
SUMMARY OF MEDICAL CENTER HAZARDS ANALYSIS

	Natural	Technological	Human	Hazmat	Total for Facility
Probability	**0.54**	**0.37**	**0.13**	**0.22**	**0.35**
Severity	**0.50**	**0.33**	**0.14**	**0.22**	**0.33**
Hazard Specific Relative Risk:	**0.27**	**0.12**	**0.02**	**0.05**	**0.12**

Hazard Specific Relative Risk to Medical Center



Probability and Severity of Hazards to Medical Center



This document is a sample Hazard Vulnerability Analysis tool. It is not asubstitute for a comprehensive emergency preparedness program. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.