Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96913
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

June 4, 2018

GU# 34-18-1951

Speaker Benjamin J.F. Cruz

JUN 04 2018

Time: 313 [ ] AM [ ] PM File No.

Received By:

VIA HAND DELIVERY
Honorable Benjamin J. F. Cruz
Speaker of I Minatrentai Kuattro Na Liheslaturan Guåhan
163 Chalan Santo Papa
Hagåtña, GU 96910

RE: Reporting Requirements for Boards and Commissions

Dear Speaker Cruz:

Hafa Adai! In accordance with Ch. 8 of Title 5 GCA, Section 38, §8113.1, Reporting Requirements for Boards and Commissions, enclosed is a compact disc containing electronic copies of all materials presented and discussed at the GMHA Board of Trustees meeting held on May 31, 2018 at 6:00 p.m. in the Daniel L. Webb Conference Room.

Please contact Mr. Theo Pangelinan from our Board Office at 647-2104 if you have any questions.

2018 JUN -4 PM 4:19

Regards,

PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

1951

Guam Memorial Hospital Authority

Board of Trustees Meeting

May 31, 2018

Copy to: I Liheslaturan Guahån

CD*

GUAM MEMORIAL HOSPITAL AUTHORITY
TAMUNING, GUAM

REVIEW AND APPROVAL

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws

☐ Rules & Regulations

☒ Policy & Procedure

Submitted by
Department/Committee: _____

Title: _____

Evaluation for 2017 Equipment Management Plan

	Date	Signature
Reviewed	2.10.18	
Approved		
Title	Zaldy Tugade, Acting Hospital Facilities Maintenance Manager	
Reviewed	2/22/18	
Approved		
Title	Gordon Mizusawa, Chairperson, Environment of Care Committee	
Reviewed	03/26/18	
Approved		
Title	PeterJohn D. Camacho, MPH, Chairperson, Executive Management Council	
Reviewed		
Approved	4/25/18	
Title	James P. Last, M.D., Chairperson, Medical Executive Committee	
Reviewed		
Approved		
Title	Eloy S. Lizama, Chairperson, Board of Trustees	
Reviewed		
Approved	5/31/18	
Title		

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE MEDICAL EQUIPMENT MANAGEMENT PROGRAM Calendar Year 2017

I. OBJECTIVES

The program is designed to protect all GMHA patients, staff, equipment, property, and the environment by promoting the safe and reliable operation of medical equipment and related components. The primary objectives of this plan of action are as follows:

- Ensuring continued compliance with applicable regulatory requirements, industry standards, guidelines, and equipment manufacturer's recommendations.
- Selecting and acquiring safe medical equipment.
- Carrying out an effective preventive maintenance program.
- Providing equipment technician and end user training.
- Ensuring back-up equipment and plans are readily available in the event of equipment failure or malfunction.
- Monitoring all hazard notices/product recalls and providing related information to equipment users.

These objectives are accomplished and completed through the following processes.

A. Criteria and Inventory.

The Biomedical Shop utilizes the antiquated MP2 equipment management software program to maintain a current up to date and accurate inventory of all medical equipment covered under this plan. Before any medical equipment is placed into patient use, it is evaluated based on Risk Factors (function, clinical application, equipment incident history, maintenance frequencies and requirements, environmental use) a determination is made whether to include a particular equipment under the equipment management database. All medical equipment determined and included under this database is assigned a unique Biomedical Shop control number for tracking and preventative maintenance purposes.

B. Preventative Maintenance Strategies.

- Technical inspections on new medical equipment to include pre-operational verification and safety checks are performed prior to patient/ staff use.
- Routine Safety inspections are constantly being conducted monthly, quarterly, semi-annually and annually on all medical equipment that are included under the Medical Equipment Management Program (MEMP) and always after any repairs have been made to the equipment's electrical or electronic circuitry.
- Preventive maintenance checks, routine safety and operational checks are performed by GHMA Biomedical electronic technicians in accordance with the equipment manufacturer's recommendations or based on the outcome of the (MEMP) five (5) point risk assessment which is conducted prior to equipment utilization.
- Calibration, system operational verification and certifications are consistently being performed in accordance with the equipment manufacturer's recommendations or based on the outcome of the MEMP five (5) point risk assessment which ~~is~~ conducted prior to equipment utilization.

C. Hazard Notices and Product Recalls:

Refer to MEMP outlining procedures and guidelines to follow in the event Hazard Notices and Product Recall Alerts are received from the Food and Drug Administration (FDA) or equipment or product manufactures.

D. Equipment Failures:

The Acting Biomedical Electronics Superintendent (BES), and Acting Hospital Facilities Maintenance Manager (AHFMM) review equipment problems, failures, user errors, and submit monthly summary reports to the Environment of Care (EOC) Committee for review and corrective action.

What are the results of the review and evaluations of the objectives of the Medical Equipment Management Program?

During the calendar year 2017 the following objectives were established under the MEMP.

Develop written procedures related to the MEMP outlining procedures to address Hazard Notices and Product Recalls on medical equipment, supplies and related devices.

Hazard Notices and Product Recalls covering medical equipment, supplies and related devices are provided to FM – Biomedical Shop through the Materials Management Department (MMD) who is the primary responsible party for monitoring all Hazard Notices and Product Recall Alerts from the FDA or directly from the manufacturer. The Acting BES and the AHFMM or designee review each notice/recall, and take immediate corrective action as needed and document them into the MP2 equipment management software program and also notify MMD of findings regarding notice/ recall received.

This objective has been met:

- Develop written procedures related to the MEMP outlining methods and criteria on the proper selection while acquisitioning new medical equipment.

  Through development of Policy No. A-LD1320 Product Standardization Evaluation Committee (PSEC) under the Materials Management Manual. The policy needs to be reviewed and revisited as Physicians and end users would insist on a preferred equipment brand, type, or manufacturer.

  This issue is deferred to PSEC.

- Provide more in depth training to clinical users on the existing Medical Equipment Failure Intervention (MEFI) Policy (EM6480-004) to address the following:

  - ✓ What to do in the event of equipment malfunction, disruption or failure.
  - ✓ When and how to perform emergency clinical intervention when medical equipment fails.
  - ✓ Availability and location of Back-up Equipment.
  - ✓ How to correctly report all equipment failures using the Equipment and Utility Failure report.
  - ✓ NOTE: For the current Hemodialysis machines no contract for continuous maintenance by manufacturer or technical support has been provided after warranty has expired.

  Through on-going in-service training conducted by the Biomedical staff on the safe and proper operation and function of medical equipment to include failures of medical equipment during the new employee's general orientation.

This objective has been met:

The following represents goals of the Medical Equipment Management Program for Calendar Year 2018:

- Continue that all medical equipment are inspected within their preventive maintenance schedules and ensure services and repairs are in accordance with manufacturer's recommendation.
- Continue monitoring all hazard notices/product recalls and providing related information to equipment users.
- Continue to ensuring back-up equipment is readily available in the event of equipment failure.
- Continue to provide technician and end user training for all covered equipment.
- Continue to assist in outlining correct and compliant methods and criteria on the proper selection while acquisitioning new medical equipment.
- Ensuring compliance with applicable regulatory requirements, standards, guidelines, and manufacturers' recommendation.
- Continue to monitor and work to minimize the Unable to Locate (UTL) medical equipment in close coordination with end users.

New Acquisitions: Acquired 63 new Medical Equipment for 2017.

				Training Provided to Biomedical Electronic Technicians		
Item	Equipment Description	Qty	End User	Local	Manufacturer	Recommended
1	Weight Scale (Lab)	1	X			X
2	Vital Signs Monitor	5	X			X
3	Vascular Doppler	3	X			X
4	PH Meter	4	X			X
5	Humidifier	2	X			X
6	Cryostat	1	X			X
7	Sure Temp Elect. Thermometer	6	X			X
8	Philips Sure sign VSM	12	X			X
9	Treadmill	1	X			X
10	Zoll AED Defibrillator	3	X			X
11	Ultrasound	1	X			X
12	Fluid/ Blanket Warming Cabinet	1	X			X
13	Bladder Scanner	1	X			X
14	AccuCut Microtome	1	X			X
15	Bed Scale	2	X			X
16	Glidescope	1	X			X
17	Diaper Scale	2	X			X
18	Infant Ventilator	2	X			X
19	Info Vac Therapy Unit	1	X			X
20	Infant Resuscitation Machine	2	X			X
21	Pulse Oximeter	8	X			X

22	ACT Plus Machine	1	X			X
23	Nu Step Cross Trainer	2	X			X
	TOTAL EQUIPMENT	**63**				

Upgrade PICU and Medical Telemetry CMS (Central Monitoring System) was completed in 2017.

SCOPE

What are the results of the review and evaluation of the scope of the MEMP?

The MEMP is facility wide and plans to address all medical equipment utilized on patients for Life Support, Diagnostic and Therapeutic treatment and monitoring are inspected and tested regularly to minimize the clinical and physical risks of equipment failure.

Biomedical personnel were **unable to locate** all scheduled preventive maintenance equipment to conduct the required preventive maintenance. Another reason for not consistently meeting the monitoring activities threshold is the **lack of assistance and cooperation** of the end users/operators and Department Managers/Supervisors to look for these unable to locate equipment.

In service trainings were readily scheduled and provided to end users as requested or during the newcomer's staffing orientation.

For local maintenance services for this year, end users were task to implement, inventory, monitor, and make necessary amendment of their equipment and preventive maintenance contracts.

III. PERFORMANCE

Medical Equipment Failures, User/Operator Errors - Reports are maintained and submitted to the EOC Committee monthly through the following procedures:

The MEMP collects hospital wide information via work orders and equipment failure reports channeled to the Biomedical Shop. The Acting BES and Biomedical staff conducts detailed review and summarization of these problems, failures, user errors, and relevant published reports of hazards. These findings, recommendations, actions taken, and results of measurement gathered are continually reported to the EOC Committee on a monthly basis.

Corrective action taken to prevent recurrence – Following equipment evaluation by Biomedical personnel it is determined that these failures are due to the operator errors. Biomedical staff conducts refresher in-service trainings to all end users on the function and operation of the affected medical equipment especially to new employee/staff.

Were problems or opportunities for improvement identified?

- In Calendar 2017, Biomed severe staffing shortage is still a major factor that resulted **to not** meeting established PM threshold in the month of April. However, month following till end of the year threshold has been modestly met as required.
- Biomedical Electronics Superintendent resigned in May of 2017.
- In Calendar Year 2017 there were no medical equipment failures that directly impacted or affected patient care.
- It has been noted that company or manufacturer trainings for BIOMED staff for new acquisitions has been severely limited, if not withdrawn from the current provisions.

- Continue to monitor the Unable to Locate (UTL) medical equipment. Partially met and will defer to the end users coordination for appropriate actions.

Has the facility selected processes for monitoring that need the most attention? Please explain.

The monthly Unable to Locate (UTL) scheduled preventive maintenance medical equipment list for various wards/areas is continuously being monitored and communicated to all Department Heads and Supervisors, to minimize current UTL numbers.

What are the results of performance improvement projects selected for the year? How did these projects affect patient care delivery?

There are no performance improvements selected and affected patient care delivery.

Equipment Management 2017	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JUL 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017
No. of Equipment Failures	76	69	77	38	74	63	85	92	74	69	38	77
No. of Equipment Failures due to Operator Errors	8	6	3	6	6	10	8	5	0	4	0	4
No. of Equipment Failures that Impacted Patient Care	0	0	0	0	0	0	0	0	0	0	0	0
No. of Equipment w/PM Completed	50	309	265	193	324	198	48	277	268	315	330	51
No. of Equipment Scheduled for PM	52	344	292	327	335	199	51	311	281	318	331	51

There were no revision in the MEMP performance improvement indicators/measures for FY2017.

IV. PLAN/PROGRAM EFFECTIVENESS

Identify the MEMP strengths and weaknesses (What has been accomplished, what opportunities for improvement were identified?):

Strengths of the MEMP – Continue to be monitoring, correcting, and reporting equipment failures as hospital wide information is collected through submission of work orders and equipment failure reports. The Biomedical Shop/Staff led by the Acting BES and the AHFMMA or designee conduct continuous reviews and compilation of summaries identifying problems, failures, findings and corrective actions taken. GMHA continues to retain BRS (Biomedical Repair Service) a local contract Biomedical Equipment Service provider to augment the technical and miscellaneous needs in line with the intent of complying with the accreditation requirements.

Weakness of the MEMP – The Biomedical Shop with the presence of acting BES is still in the process of continuously updating and inputting all those completed scheduled preventive maintenance work orders in the MP2 database.

The antiquated MP2 equipment management software program is proprietary software not belonging to GMHA and therefore needs an upgrade (costing to $25K to $30K) that will allow multiple FM personnel to simultaneously enter, close, and access work orders. Immediate replacement and upgrade is strongly recommended to prevent any MP2 software corruption, glitches, and crashes. Logging of work orders and reports are still a big challenge due to ongoing staffing shortages and limitations to single person entry of work orders.

As always Financial capacity and proper budgeting must be stable to assure prompt payment to service providers and ongoing parts purchasing so services can continue to be provided as needed and scheduled.

What are the goals for the MEMP for Calendar Year 2018?

- Focus on resolving current weaknesses identified and Continue to maintain and build on strengths to improve the overall effectiveness and performance of the program.
- Address the severe staffing shortages in BIOMED Shop by hiring at least 2 more Biomedical Electronic Technicians. Biomedical Electronics Superintendent position needs to be filled.
- Continue to provide refresher in-service trainings on proper use and care of medical equipment to all end users in an effort to minimize user/operator errors.
- Provision of manufacturer's trainings requested to update and re-certify qualifications of biomedical staffs is imperative and highly recommended to continue meeting the required trainings for the electronic technicians.
- Acquisition, replacement and planned procurement by end users of equipment that has past or is nearing its life expectancy.
- Monitor other outsourced service maintained and repaired equipment when severe staffing shortage is adequately addressed.
- Acquisition of BIOMED Shop's new testing and maintenance equipment, tools, bench/es, furniture, adequate equipment repair parts and Preventive Maintenance (PM) kits especially for critical and life supporting equipment.
- Enforce and increase coordination by Department Heads and Supervisors adherence, cooperation, and active participation to take ownership and responsibility of their equipment along with end user accountability due to neglect and especially those missing or unable to locate (UTL) equipment during scheduled Preventive Maintenance (PM).
- Further reduce the numbers of missing or unable to locate medical equipment during scheduled PM.

What resources have been allocated toward these goals? Budget request for 2018 review and will show increase. The following are requested.

- Budget for training is requested and included yearly.
- Increased budget for Tools, Test and Calibration Equipment, and replacement equipment parts.

The following as part of the 2018 goal is recommended for consideration is forwarded to the EOC Committee, Performance Improvement (PI) Committee and to Administration.

- Technical training for the biomedical staff provided by the manufacturer at the manufacturer's training facility for life support and diagnostic equipment.
- Procurement and calibration of all testing and calibration equipment and replacement of antiquated and obsolete test equipment and maintenance tools for BIOMED Shop.

NOTE: This report is based on data gathered for Calendar year 2017.

Prepared by: Keith A. Jesser and Michael G. Morta for Eloise LG Manglona
Maintenance Workers for Acting BES

Reviewed, Concurred and Submitted by:

Zaldy S. Tugade **Date: 01/19/2018**
Acting Hospital Facilities Maintenance Manager

Approved by : Gordon Mizusawa **Date: 02/22/2018**
Chairperson, Environment of Care Committee

GUAM MEMORIAL HOSPITAL AUTHORITY
TAMUNING, GUAM

REVIEW AND APPROVAL

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws

☐ Rules & Regulations

☒ Policy & Procedure

Submitted by
Department/Committee: _____

Title: _____

Evaluation for 2017 Life Safety Management Plan

	Date	Signature
Reviewed	01.06.18	
Approved		
Title	Zaldy Tugade, Acting Hospital Facilities Maintenance Manager	
Reviewed	1-25-18	
Approved		
Title	Gordon Mizusawa, Chairperson, Environment of Care Committee	
Reviewed		
Approved	03/27/18	
Title	PeterJohn D. Camacho, MPH, Chairperson, Executive Management Council	
Reviewed		
Approved	4/25/18	
Title	James P. Last, M.D., Chairperson, Medical Executive Committee	
Reviewed		
Approved	5/31/18	
Title	Eloy S. Lizama, Chairperson, Board of Trustees	
Reviewed		
Approved		
Title		

ANNUAL EVALUATION OF THE EFFECTIVENESS OF GMHA'S LIFE SAFETY MANAGEMENT PROGRAM
Calendar Year 2017

I. OBJECTIVES

What are the results of review and evaluations of the objectives for the life safety management program?

The program is established to ensure continuous upkeep and maintenance of all life safety systems and related equipment throughout the facility to assure the patients, staff and visitors are in a safe environment. The Life Safety Management responsibilities are shared amongst multi-disciplines. The Facilities Management and Safety Management group work cohesively with the Environment of Care Committee to establish objectives for each calendar year. The six (6) primary objectives of this plan are:

1. To ensure the building structure and its components are in compliance with applicable NFPA 101 (2012) – Life Safety Code standards and local fire regulations.
2. To provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire.
3. To assure that staff competency training related to the Life Safety Management Program are effective.
4. To inspect, test, maintain (ITM), repair and certify the fire alarm system (FAS) devices, detection systems and fire suppression systems (FSS) in accordance with NFPA 101 (2012) – Life Safety Code standards, NFPA 10, 13, 14, 25 & 72, as well as applicable federal and local fire regulations.
5. To inspect and maintain the integrity of the fire barrier/smoke compartmentalization and fire exit doors.
6. To institute Interim Life Safety Measures (ILSM) alongside with the ICRA (Infection Control Risk Assessment) during construction or fire alarm or detection systems failures or impairments and ensure staff and contractors are well versed on ILSM and ICRA.

Evaluation of the objectives established under the Life Safety Management Program:

Throughout the course of the year these objectives in line with improving the Plan were assessed to the degree to which they were met:

1. The building structure and its components are in compliance with applicable NFPA 101 – Life Safety Code standards and local fire regulations.

   Minor renovations were made to relocate personnel. New area/s of relocation site are within an existing compartmentalized area. Awaiting plan and construction for new structure to relocate back Business, Accounting, and Social Welfare offices.

   Elevators unit 3 & 4 were modernized in 2016. Partially met as there is a need Modernization of units 1 & 2 is needed and slated for approval and implementation in 2108.

This objective has been partially met.

2. Provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire.

   Yearly Fire and Life Safety on line and fair were conducted.

   This objective has been met.

3. Assure that staff competency training related to the Life Safety Management Program are effective.

   Facility wide training conducted this year.

   This objective has been met.

4. Test and maintain the fire alarm devices, detection systems and fire suppression systems in accordance with applicable federal and local fire regulations.

   Thorough inspection, assessment and testing in progress this last quarter of 2017 as system reached its 10 year of useful life expectancy. System needs to be refurbished and upgraded.

   This objective has not been met.

5. Inspect and maintain the integrity of the fire barrier/smoke compartmentalization and fire exit doors.

   Inspection, testing and maintenance (ITM) and risk assessments were conducted to determine the extent of fire barrier/smoke compartmentalization breaches throughout the facility and corrections were made as deficiencies are encountered. Number of doors inspected increased from 200 to 205 each.

   This objective has been met.

6. There were no ILSM during renovation/construction of Medical Surgical Ward. Construction was done in house and no FAS failures or impairments at the time.

   This objective has been met.

Goals of the Life Safety Management Program for Calendar Year 2018:

Continue its six (6) primary objectives as stated above.

These objectives are accomplished through the following processes:

A. Criteria and Inventory:

- The Environmental Maintenance Shop at present uses hard copy checklist for its PM of all Fire Rated Door Assemblies. Transition to the use of the MP2 management software program to maintain a current, accurate inventory of all Fire rated door assemblies has been futile as the program became unstable.
- The Main Fire Alarm System with its integral software system maintains a current inventory of all devices and components being monitored. All devices are assigned with unique nomenclature and control numbers for ease of identification of devices and related components.

B. Maintenance Strategies:

- Inspection, Testing, Maintenance (ITM) and Certification – Fire alarm devices and fire suppression equipment are tested in accordance with the NFPA 101 (2012)– Life Safety Code standards, NFPA 10, 13, 14, 25 & 72 as well as applicable federal and local fire regulations .
- Inspection and Preventive Maintenance – Fire Rated Door Assemblies, Fire Barrier/Smoke Compartments are inspected and serviced in accordance with the NFPA 80 standards. Established frequencies for fire rated doors is monthly while inspection of wall partitions is quarterly covering each floor.
- Fire Rated Door Assembly Failures – The Maintenance Supervisor reviews fire rated door problems, type of failures and submits a summary report identifying discrepancies to the Environment of Care Committee for review and corrective action on a monthly basis.

C. Continuous Education:

Staff training and development is a continuous process in which staff learn how to respond to fires, learn general fire safety guidelines specific to their departments and/or worksites, learn proper use and location portable fire extinguishers, learn and familiarization for the location of oxygen shut-off valves and who is authorized to turn off these valves, location and use of evacuation chairs, plans/routes and how to properly evacuate by moving horizontally to the nearest smoke compartment and then vertically as needed. Keeping egress free from obstructions and maintaining combustible items at low inventory levels at normal times and while construction or renovation works are on-going.

II. SCOPE

What are the results of the Safety / Environment of Care Committee's review and evaluation of the scope covering the Fire Safety and Life Safety Management Plan / Program?

The Hospital Safety and Security Administrator focuses on the human aspects of Fire Safety such as safe work practices and emergency response/ evacuation while the Facilities Maintenance Manager focuses on the physical aspects of Life Safety such as operability of fire alarm/fire suppression equipment, facility design and construction, and maintenance of building systems and components. Based on TJC & CMS standards and other applicable regulations, there have been no other changes to the organization and/or its mission that would necessitate further changes to the scope of the operation in 2017 and thereby in 2018.

The scope of the Life Safety Management Plan / Program for the upcoming year include: (Has something changed? i.e., added new services/responsibilities, physician practices)

The Life Safety Management Plan will remain the same for 2018.

List any items under consideration for addition to the plan/program at this time:

As previously mentioned, the Life Safety Management responsibilities are shared among multi-disciplines. The Facilities Maintenance and Safety Management group work cohesively with the Environment of Care Committee to establish objectives while conducting various activities to address current standards and practices.

Although there are no immediate changes suggested for addition to the plan at this time, the organization will continue to focus on enforcement and improvement of the plan/program by the following methods:

- Continue to ensure regulatory compliance through review of departmental fire safety and life safety standard operating procedures for compliance with newer OSHA and applicable NFPA codes
- Continue to track emergency response and incident reporting while conducting fire drills in accordance with frequencies as required
- Continue to conduct environmental risk assessments, hazardous surveillance risk assessments and infection control risk assessments to improve overall program goals and objectives
- Continued enforcement and documentation of ICRA / ILSM requirements during periods construction, renovation, maintenance activities or impairment of fire alarm systems
- Continue regular review and updates to the eSOC, BBI and PFI while tracking percentage of PFI's completed on time as deemed necessary reference to the implementation of newer applicable codes.
- Continue to provide new employee orientation and annual refresher training and development to elevate staff competency as it relates to Fire Safety and Life Safety programs

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III. PERFORMANCE

Are Fire Safety and Life Safety Management reports maintained and reported to Safety/Environment of Care Committee at least quarterly? Please explain:

Yes, reports are submitted to the Environment of Care Committee on a monthly basis and to the Performance Improvement Committee on a quarterly basis.

Have there been any user errors/accidents over the course of the past year? Please explain and include actions taken to prevent recurrence:

No significant errors or accidents related to the Life Safety Program in 2017.

When problems or opportunities for improvement have been identified have actions been taken, documented and evaluated for effectiveness? Please explain:

Problem#1 – FAS has reach its 10 year useful life expectancy so a thorough assessment is ongoing and that refurbishment and upgrade needs to follow in 2018.

Problem #2 – Submission of work orders and failure reports. As identified end users are not submitting timely all failure reports and works orders. Policy has been modified and reinstated use of work orders and failure reports. Reminders sent out in advance to all departments to identify problems.

What are the results of performance improvement projects selected for the year? How did these projects affect patient care delivery?

The matrix below reflects Performance Improvement monitoring activities and indicators detailing them into specific categories.

LIFE SAFETY	Jan	Feb	Mar		Apr	May	Jun		Jul	Aug	Sep		Oct	Nov	Dec	
EMERGENCY GENERATOR TESTING	100%	100%	100%	**100%**	100%	100%	100%	**100%**	100%	92%	83%	**92%**	83%	83%	83%	**83%**
# of testing completed	24	24	30		24	24	30		24	22	25		20	20	25	
# of testing scheduled	24	24	30		24	24	30		24	24	30		24	24	30	
FIRE DOOR MAINTAINED	100%	100%	100%	**100%**	100%	100%	100%	**100%**	100%	100%	100%	**100%**	100%	100%	100%	**100%**
# of fire doors maintained	205	205	205		205	205	205		205	205	205		205	205	205	
# maintenance scheduled	205	205	205		205	205	205		205	205	205		205	205	205	
FIRE ALARM DEVICES TESTED	100%	100%	100%	**100%**	100%	100%	100%	**100%**	100%	100%	100%	**100%**	100%	100%	100%	**100%**
# of fire alarm devices tested	1	32	1		1432	54	1		10	1	25		1	1	1118	
# of testing scheduled	1	32	1		1432	54	1		10	1	25		1	1	1118	

a. Number of Emergency Generator Testing Scheduled and Completed

We failed to maintain 100% compliance with our average at 94% attributed to the downed unit for the MRI building. However, this only affects the MRI Building. It is recommended that this unit be removed from being monitored. This year the replacement of the older 1.6 Meg was slated but to no avail. Pushing forward is the major refurbishing of the two 1.6 Meg and the 650 KW this first quarter of 2018.

b. Number of Fire Rated Doors Scheduled and Completed Maintenance

Monthly inspection continues. Total increased from 200 each to 205 each. At the same time an annual inspection is also of the walls above these fire rated doors are also inspected. Any discrepancies noted are corrected the same month.

c. Number of Fire Alarm Devices Tested as Scheduled and Completed

Testing are done as scheduled. More system troubles are experienced due to the systems age. It has met its useful life expectancy of 10 years. At the end of 2017 a thorough assessment was conducted and that a system refurbishment is recommended by system provider. Repairs and upgrades is sought for 2018.

Has the facility selected processes for monitoring that need the most attention? Please explain.

None selected but emphasized for those that did not meet as all testing requirements and frequencies as required are all monitored and treated the same attention or importance.

Any revisions in the Fire Safety and Life Safety Management Plan / Program Performance Improvement Indicators / Measures for the upcoming year?

No revisions done for 2017. However, forthcoming 2018 removal of the MRI unit from the on for emergency testing needs to be considered. The organization continues with the current number of performance improvement monitoring activities and measures for 2018.

IV. PLAN/PROGRAM EFFECTIVENESS

Identify the Fire Safety and Life Safety Management Plan's / Program's strengths and weaknesses (What has been accomplished, what opportunities for improvement were identified?):

Strengths

- 100% Attendance to all Continuing Education and cross training for involving the entire organization.
- Weaknesses
  - Late attendance by personnel on leave or for one reason or another.
  - Staff shortage is due to other projects other than those allocated for PM. Projects like in house construction to address immediate Life Safety issues.

What resources have been allocated toward these goals?

No specific funding sources allocated this year that would positively impact the overall operations of the Life Safety Management Program.

The following as part and parcel to performance improvement activity is considered as a priority for improvement and will be forwarded to the Safety/ Environment of Care Committee, Performance Improvement Committee and to administration.

- Track ITM for Damper and AHU Shutdown this year and follow thru 2018.

Submitted by : Zaldy S. Tugade — Date: 01/06/2018
Acting Facilities Maintenance Manager

Concurred by : Jeffrey Ventura — Date :01/17/2018
Hospital Safety & Security Administrator

Approved by : Gordon M Mizusawa
Chairperson, Environment of Care Committee — Date: 01/25/2018

GUAM MEMORIAL HOSPITAL AUTHORITY
TAMUNING, GUAM

REVIEW AND APPROVAL

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws

☐ Rules & Regulations

☒ Policy & Procedure

Submitted by
Department/Committee: _____

Title: _____

Evaluation for 2017 Utilities Management Plan

	Date	Signature
Reviewed	1-31-18	
Approved		
Title	Zaldy Tugade, Acting Hospital Facilities Maintenance Manager	
Reviewed		
Approved	1/31/18	
Title	Gordon Mizusawa, Chairperson, Environment of Care Committee	
Reviewed		
Approved	03/27/18	
Title	PeterJohn D. Camacho, MPH, Chairperson, Executive Management Council	
Reviewed		
Approved	4/25/18	
Title	James P. Last, M.D., Chairperson, Medical Executive Committee	
Reviewed		
Approved	4/25/18	
Title	Eloy S. Lizama, Chairperson, Board of Trustees	
Reviewed		
Approved	5/31/18	
Title		

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE UTILITY SYSTEMS MANAGEMENT PLAN/PROGRAM
Calendar Year 2017

OBJECTIVES:

What are the results of the Environment of Care Committee's review and evaluations of the objectives of the utility systems management plan/program?

The objectives of the Utilities Management Program is to establish a safe, comfortable patient care and treatment environment by managing the risks associated with safe operation and the functional reliability of the hospital's utility systems to include inventory of critical operating components and systems.

The Utilities Management in a concerted effort with the Environment of Care Committee and Planning Department established 10 (ten) objectives for the calendar year. The intent of these objectives are in line with improving the overall capability of the Utilities Management Plan, these bulleted objectives listed below are followed by an assessment of the degree to which they were met.

- Electrical Power Distribution System Upgrade: Project design and Specification completed. However, no funds to support the whole project instead opted for replacement of the older 1.6 Meg Generator. Generator Procurement not done in 2017 but will proceed in 2018.

  This objective has not been met.

- Vertical Transportation Elevator Modernization Project: Plan refurbishment for 2017 not done. Carried over to 2018.

  This objective has not been met.

- Nurse Call/Clock and Paging System Replacement/Upgrade: This project to cover the replacement of the Nurse Call System for the whole hospital except for the OB Ward, NICU and L&D which are included in the proposed MCH "Maternal Child Healthcare" Project. Project was completed.

  This objective has been met except the Clock and Paging System.

- Boiler and Steam Line Replacement: Project intent is to remove and replace the oldest boiler unit and its distribution lines in time with the acquisition of two sterilizer units for CSR. Still on hold and awaiting residual funding from DOI/CIP

  This objective has not been met.

- Water Softener Upgrade Project is to refurbish and Upgrade existing Water Softener System. Completed in 2017.

  This objective has been met

- Damper Upgrade. Project is to remove and replace all smoke and fire dampers found to be inoperable. All dampers assessed for replacement were replaced and subsequent inspection and testing conducted. Met the 6 years interval for inspection, testing and maintenance (ITM). New assessment and ITM this year will take place to assure completeness.

  This objective has been met.

- FAS (Fire Alarm System) Upgrade. Project is to refurbish /Upgrade existing system. Assessment completed in last quarter of 2017.

  This objective has not been met.

- Energy/Lighting Conservation Project: Intent to gain 100% facility wide LED. 4 foot Lamp on corridors and 24 hours offices/areas including administration, and patient room lights completed. Overall facility wide we are 25% LED. Replacement continues forward to next year 2018.

This objective has been met.

- AutoClave Refurbishment. Project is to remove and replace components of the existing Autoclave to refurbish and commission it like new. Completed in 2017.

  This objective has been met.

- Shredder Replacement. Remove and replace old shredder to render bio-waste less recognizable prior to its final disposition. Procurement did not prosper in 2017 and now carried over to 2018

  This objective has not been met.

The objectives for the utility systems management plan/program for the upcoming year include:

Eleven (11) objectives have been lined up for the 2018 calendar year. Details of these bulleted objectives are as follows:

- Electrical Power Distribution System Upgrade: Procurement of a new 1.6 generator to replace the older 1.6 generator.
- Vertical Transportation Elevator Modernization Project: Upgrade of #1 and #2 (public elevators).
- Boiler and Steam Line Replacement: Remove and replace the oldest boiler unit and its distribution lines.
- FAS (Fire Alarm System) Upgrade. Refurbish /Upgrade existing system. (Existing system has reached its 10 years old useful life expectancy.)
- Energy/Lighting Conservation Project: Lamp replacement is continuous replacement of old lamps to LED lamps for year 2017.
- Shredder Replacement. Remove and replace old shredder to render bio-waste less recognizable prior to its final disposition.
- Underground Water Storage System Control Remove and replace control system and upgrade mechanical and electrical system.
- Vacuum System Controls Remove and replace manual control with automated control system.
- LOX (Liquid Oxygen) Tank Removal and replacement/repair.
- Reinsulation of Chilled water lines. Removal of old and ineffective insulations.
- Fresh Air and Ventilation System Project Repair/Replacement of all fresh air intakes and Ventilation System.
- Public Address (PA) and Clocking System Upgrade/ Repair/ Replacement of Responder Type Paging and clocking System. PA front end is presently out of commissioned in December 2017.
- Pharmacy HVAC (Heat , Ventilation and Air Conditioning System) Upgrade and re-engineering (Design and construction) to effectuate and conform to upcoming USP 800.

SCOPE:

What are the results of the Environment of Care Committee's review and evaluation of the scope of the utility systems management plan/program?

- Detailed monitoring for frequency of indoor air quality testing, pressure differential, temperature and humidity needs is carried through continuously forward.

The scope of the utility systems management plan/program for the upcoming year include: (Has something changed? i.e., added new services/responsibilities, physician practices)

- There are 11 (eleven) objectives set for 2018 five of which are carry overs.

Please list any items under consideration for addition to the plan/program at this time:

The following bulleted items are under consideration for addition to the Utilities Management Plan:

- As built drawings are revised constantly as needed to reflect actual site conditions. This will be carried through continuously.
- Utility system revamp or change out those equipment/s that are beyond or have passed its useful life due to obsolescence and discontinuation of support.
- Procurement to replace MP2 software.

PERFORMANCE:

Are Utility System Failure/User Error Reports maintained and reported to Environment of Care Committee at least quarterly? Please explain:

Yes. Monthly Utility Management Reports are submitted to the Environment of Care Committee. These reports reflect failure trends, operator errors, component failures, parameter failures and impact to patient care services, biological indicator testing, indoor air quality and medical infectious waste processing.

Have there been any user errors/accidents over the course of the past year? Please explain and include actions taken to prevent recurrence:

The majority of errors were directly related to clogged sinks and water closets caused by stuffing excessive or foreign objects into drainage systems. In most all cases, these failures are reported immediately and technicians respond rather quickly to correct the situation thereby eliminating potential Infection Control issues. End Users are reminded to dispose of foreign objects in proper disposal bins or containers. There were no serious errors or accidents throughout the course of the year.

What problems or opportunities for improvement have been identified? Have actions been taken, documented and evaluated for effectiveness? Please explain:

Focused to improve the overall use of Failure Reports and Work Orders by End Users, and Interim Life Safety Measures (ILSM) / Infection Control and Risk Assessment (ICRA) Program implementation and adherence as it relates to Utilities Management. Refresher training covering the area of ILSM's is an ongoing measure and informational circulars are generated to staff at all levels and contractors. Areas of focus remains on failure and action plans covering air conditioning; elevators; water softener; water; LP Gas; diesel fuel; steam boiler liquid oxygen; nitrous oxide; medical air; medical vacuum; fire alarm; autoclave and isolation systems and carried through 2018. Generator repairs for the MRI unit has been dismal as none would provide. It is recommended that this unit be taken out on the monitoring list. Scheduled services by off island providers has been slow due to procurement processes and issues. To address other short falls it is recommended that other maintenance contracts are to be outsourced same as in previous past years. ***These are the Fire Alarm System (FAS), Fire Suppression System (FSS), Chemical Treatment Program, Kitchen equipment, chiller and condenser maintenance, medical air and vacuum system and Sterilizer System maintenance. Retainage of off island generator, Air quality, trace gas inspection, verifier and service and repair providers.***

What are the results of performance improvement projects selected for the year? How did these projects affect patient care delivery?

Completion of the Nurse Call System, Refurbishment of the Autoclave and Water Softeners, progress in the LED lighting upgrade reduced the relative failure. Projects slated for 2018 should further reduce failures. The performance improvement initiative remains the same which is carried through forward to 2018.

The matrix below reflects Performance Improvement monitoring activities and indicators detailing them into specific categories.

UTILITIES MANAGEMENT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Volume of Regulated Waste	18,834	17,101	17,006	17,630	19,091	16,244	17,531	16,487	15,839	19,550	20,850	22,890
No. of Emergency Generator Testing Completed	24	24	30	24	24	30	24	22	25	20	20	25
No. of Emergency Generator Testing Scheduled	24	24	30	24	24	30	24	24	30	24	24	30
No. of Elevator Failures	3	3	11	5	5	7	9	4	7	11	10	5
No. of Utility Failures	51	86	78	138	146	75	83	69	62	141	76	101
No. of Utility Failures Due to Operator Errors	4	0	0	2	0	0	0	0	0	0	0	0
No. of Utility Failures that Impacted Patient Care	0	0	0	0	0	0	0	0	0	0	0	0
No. of Utilities with PM Completed	569	652	543	544	577	781	573	697	854	776	996	985
No. of Utilities Scheduled for PM	574	678	560	564	753	787	579	1016	1149	813	1006	1006
No. of Completed Sterilizer Testing	67	71	84	79	75	77	77	79	76	70	66	76
No. of Sterilizer Testing Scheduled	67	71	84	79	75	77	77	79	76	70	66	76

a. Volume of Regulated Waste

Monitoring activities reflect a steady stream of medical infectious waste generated. This year monthly average is slightly less than last year. 2017 (18,219 lbs.) < 2016 (18,873lbs)

b. No. of Emergency Generator Testing Scheduled/Completed

Testing average to same as last year at 94 %. This year it is expected that this will translate to 100% reliability due to service providers due late last year is now scheduled to come in mid of this first quarter to conduct their ITM.

c. No. of Elevator Failures

Elevator failures averaged 6.7 per month higher than the goal. This will improve if the modernization of units #1 and #2 will be implemented hopefully early this year.

d. No. of Utility failures

Though there was 1,106 utility failures this year none impacted patient care.

e. Utility Failures due to operator errors

Low number at 6 (six) eliminating potential Infection Control issues or patient impact.

f. Utility failures that impacted patient care

No failures directly impacting patient care.

g. No. of Utilities with Preventive Maintenance Scheduled/Completed

92% ration garnered this year meets and exceeded expectation.

h. Biological Growth Testing on Sterilizers Scheduled/Completed

All Biological Integrator tests conducted reflected negative results throughout the course of the year.

Has the facility selected processes for monitoring that need the most attention? Please explain.

Regulatory Monitors:

These tests are sole responsibility of the Operating Room staff to include inventory replenishment.

Indoor Air Quality Testing to include positive and negative air movement relationships will continue to be monitored to ensure compliance with CDC, OSHA and AIA guidelines.

Chemo waste generation and disposition is resolved.

Performance Monitors:

The number of elevator failures and elevator entrapments will continue to be monitored in an effort to identify opportunities to improve and minimize failure rates.

Fire Alarm/Fire Suppression System ITM will be pursued vigorously in conjunction with the intent or program for its upgrade and repair as it reached its useful life expectancy.

Any revisions in the utility systems management plan/program performance improvement indicators/measures for the upcoming year?

Proposed to drop under testing of generators, the MRI unit as it provides only for the MRI building which is separate from the main facility.

PLAN/PROGRAM EFFECTIVENESS:

Identify the utility systems management plan's/program's strengths and weaknesses (What has been accomplished, what opportunities for improvement were identified?):

Strengths identified under the Utilities Management Plan lie primarily with completing objectives as scheduled. However, weakness as in late payments to service providers has led to discontinuation of services at the time that they are supposed to be provided.

Weakness.

Our utilities are old, aging and therefore fragile.

Restricted by financial resources coupled with limited human resources hinders provisions of timely services and replacement of needed components. On the personnel note FM personnel are aging and leadership has been dismal. Though new personnel was acquired succession needs to be in place to provide continuity.

Strength

Though the organization, in most cases, manages to overcome financial restraints through support of federally funded projects and recent bond proceeds,

Facilities Maintenance Department (FM) must receive support from Leadership to increase or fill all its & identified vacancies of seven (7) Full Time Employees.

FM has implemented coverage of at least 2 personnel 24/7 during holidays, weekends, before and after normal working hours of 8 am to 5 pm. Leadership should revisit the recall and standby policies to

effectuate a more stable program to respond to trouble calls as FM Department seems to loose moral compared to how other departments are compensated for standby calls.

Personnel cross training is in effect which is an affirmative note as personnel readily accepts their assigned task..

What are the goals for the utility systems management plan/program for the upcoming year?

Focus will remain the same to improve effectiveness of the program design as outlined for 2018 and upcoming year and implementation can be measured on a number of dimensions:

- Continued performance improvement monitoring activities
- Achievement of objectives outlined for the upcoming year
- Development and implementation of procedures and controls to minimize risks
- Identification of risks as they relate to utilities
- Continuous cross training development and staff education programs
- Adherence to the implementation and completion of the 11 (eleven) objectives.

What resources have been allocated toward these goals?

- Continued financially benefit from the Hospital Preparedness Program (HPP) Cooperative Agreement federally administered by the US Department of Health and Human Services (HHS) / Assistant Secretary for Preparedness and Response (ASPR) to partially fund ongoing improvement efforts to support the Utilities Management Program/Plan.

- Receipt of other funding, such as federal Compact Impact Funding from the U.S. Department of the Interior (DOI); and local General Obligation Bond (GOB) proceeds. These funding sources enable the organization to improve, replace or maintain its critical infrastructure and key resources that positively impact the overall operations of the Utility Management Program.

The following performance improvement activities are recommended for consideration by the organization as a priority for improvement and will be forwarded to the Environment of Care Committee, Performance Improvement Committee and to Leadership.

- Continue updating of as built plans.
- Risk assessment to ensure labeling controls for emergency shutdown
- Continuous efforts placed in obtaining and reinstating emergency repair and maintenance services.

Submitted by : Zaldy S. Tugade — Date: 01/23/2018
Acting Facilities Maintenance Manager

Approved by : Gordon M. Mizusawa — Date: 01/31/2018
Chairperson, Environment of Care Committee

Firefighters serve lunch, mark World Hunger Day

By Alana Chargualaf
alana@postguam.com

The firemen initially sought to do a voluntary weeknight feeding, but gladly answered the call to serve a wholesome lunch for up to 150 individuals in observance of the World Hunger Day movement for the first time, according to fireman Nicolas Garrido, who was also the event's coordinator.

Once Guam Fire Department leadership learned of the opportunity to serve, close to $1,000 was raised during a 24-hour shift through the personal generosity of many supportive firemen.

GFD's feeding team, gathered from their Northern and Rescue commands, as well as those from the Fire Prevention Bureau, provided a lunch of red rice, fried chicken, pot roast, ham, corn, fresh fruits and cake – all of which had been prepared beginning at 5 a.m. that morning.

Garrido explained how firemen, aside from their shift work, are agents of public safety who work 24 hours a day and 365 days a year despite the holidays, birthdays and wedding celebrations that may come along.

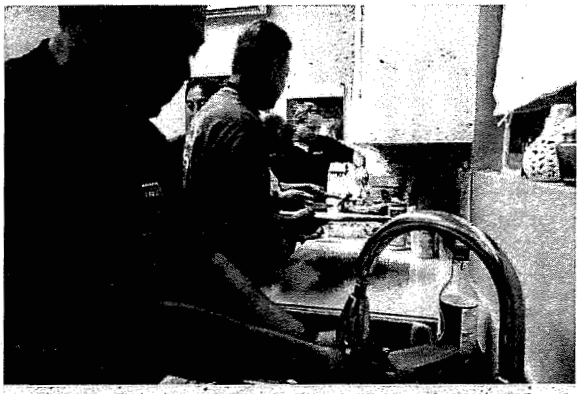
'From the heart'

He highlighted how service events heighten the firemen's sense of morale and how it enhances the work that they do as first responders.

"Here we are today, serving the community from the hearts of the individuals within the local department," Garrido said. "To come out here on their days off definitely shows the mindset of everyone, as well as the true meaning of 'from the heart.' At the end of the day, we come in together and we're here to give to the community."

Despite this being the department's first time to host such an event, Capt. John Aguon said it was easy to round up the volunteers, raise the funding, and cook and serve the meals.

"We have a lot of good firefighters that want to ... do something for the community, so if we can do it, and there's a need, then we try to fill the need," Aguon said. "We know that some people need help, so we'll help. No problem."



KITCHEN DUTY: *Members of the Guam Fire Department prepare food in the kitchen of Kåmalen Karidåt on Monday in Hagåtña in observance of World Hunger Day.*
Norman M. Taruc/The Guam Daily Post

Justice patches unveiled for Guam Girl Scouts



By Alana Chargualaf
alana@postguam.com

Guam's Girl Scouts will soon have the opportunity to earn their Justice patch after two patch designs were unveiled Saturday at the Agana Heights Mayor's Office, for the upcoming Guam Girl Scouts Justice Patch Program.

The unveiling was held at the closing of a month-long Law Day celebration – the 60th Anniversary: "Separation of Powers: Framework for Freedom."

According to Chief Judge Frances Tydingco-Gatewood of the District Court of Guam, the Girl Scouts of Greater Los Angeles discussed their Justice Patch program, as well as their program's blueprint, at a 9th Circuit community and educational outreach event last year in San Francisco.

The Los Angeles program inspired the Giri Scout affiliates of the Judiciary of Guam to foster the program on island – a team including former Girl Scout Tydingco-Gatewood; District Court community and educational outreach director and former Girl Scout troop leader Stacy McDonald-Flores; and Danielle Rosete, Judiciary of Guam clerk of court and current Giri Scout troop leader for Troop 406 – in coordination with Guam Girl Scouts Executive Director Melissa Lamorena-Fernandez.

"Being a part of a great organization of girls that promotes character, outdoor activities, good citizenship and service to others inspired our Guam courts to present the Justice Patch program to Guam," Tydingco-Gatewood said.

As members of the Girl Scout family, Tydingco-Gatewood believed their ideas came naturally in the designing of the Justice patches.

Guam-exclusive designs

These ideas were shared with local artist Ricky Perez Catindig, designer and owner of W5 Productions Inc., who created the two Guam-exclusive designs. Tydingco-Gatewood described them as cohesive, meaningful and beautiful, with an island style.

"The two patches that you will see today are especially made for the Guam Girl Scouts," Tydingco-Gatewood told the event's attendees on Saturday. "I hope that you girls and the troop leaders will appreciate them."

The patches will be embroidered and available at the Guam Giri Scouts center in several weeks when the program is launched.

Until then, Tydingco-Gatewood, Mcdonald-Flores, Rosete and Lamorena-Fernandez will continue their collaboration to bring the Justice Patch program to fruition.

Present at the unveiling were Tydingco-Gatewood; Rosete; McDonald-Flores; Chief Justice Katherine Maraman; Judge Elyze Iriarte; Guam Bar Association Vice President Minakshi Hemlani; District Court of Guam 9th Circuit lawyer representative Cynthia Ecube; Law Week Committee member attorney Dana Gutierrez; Law Week Committee member and assistant public defender Annie Gayle; and District Court of Guam Law Clerk Judith Hattori.

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 Governor Carlos G. Camacho Road
Tamuning, Guam 96913

PUBLIC NOTICE

BOARD OF TRUSTEES MEETING

Date: Thursday, May 31, 2018
Time: 6:00 p.m.
Place: 1st Floor, Daniel L. Webb Conference Room

You may contact Toni Tenorio at 647-2218, Monday through Friday from 8:00 a.m. to 5:00 p.m. for special accommodations, auxiliary aids, or other services.

/s/ PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO
This advertisement was paid for with government funds.



GUAM ELECTION COMMISSION

Kumision Ileksion Guåhan

2nd Floor, Suite 200 GCIC Building
414 West Soledad Avenue, Hagåtña, Guam 96910
Tel: (671) 477-9791 • Fax: (671) 477-1895
E-Mail: vote@gec.guam.gov Website: www.gec.guam.gov

GUAM ELECTION COMMISSION SPECIAL MEETING

The Guam Election Commission has scheduled a special meeting for **Tuesday, May 29, 2018, 5:30 p.m.,** to discuss a complaint received from Mr. Troy Torres filed on May 11, 2018, at the Guam Election Commission Conference Room 200, 414 W. Soledad Ave., GCIC Building, Hagåtña, Guam.

The public is invited. For individuals requiring special accommodations, auxiliary aids or services please contact the Guam Election Commission. For more information, you may call Helen M. Atalig at (671) 477-9791 or send an email to vote@gec.guam.gov.

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Cougar kills mountain biker, mauls another; later shot

(Reuters) – A mountain lion killed one mountain biker and mauled another in Washington state on Saturday when they rode into its territory, and authorities later shot the animal dead, police said.

The mountain bikers were riding together down a remote, backwoods trail at 11 a.m. in an area near North Bend, Washington state, around 30 miles east of Seattle, when the two men encountered the animal.

In the ensuing attack, the first rider received deep scratches and the other was dragged away by the cougar to its den, King County Sheriff's Office spokesman Sgt. Ryan Abbot said.

The 31-year-old survivor rode 2 miles out of the area and called 911.

Police drove up the trail, found the victim's bike and went into the woods where they came across the cougar standing over the victim's body, Abbott said.

"He or she, I don't know if the cougar was a male or female, had the body of the victim down in his den," said Ryan.

A deputy took a shot at the animal, sending it fleeing into the woods. Officers of the Washington Department of Fish and Game tracked the cat with dogs and killed it, Abbott said.

The survivor was taken to hospital in Seattle with serious but none-life-threatening injuries, he said.

Fatal cougar attacks are extremely rare in North America, with only about two dozen recorded in the last 100 years, most of them involving children.

It was only the second deadly attack by a mountain lion in Washington state in the last 100 years, Abbott said.

Trump demands DOJ look into 'political' infiltration of campaign

(Bloomberg) – President Donald Trump said he'll "demand" an investigation into possible infiltration of his campaign for political purposes by the Obama administration or others.

"I hereby demand, and will do so officially tomorrow, that the Department of Justice look into whether or not the FBI/DOJ infiltrated or surveilled the Trump Campaign for Political Purposes - and if any such demands or requests were made by people within the Obama Administration!" Trump said Sunday on Twitter.

His comment comes after House intelligence Chairman Devin Nunes said U.S. spy agencies crossed a "red line" if they planted a paid informant inside Trump's campaign.

In an interview on Fox News Channel, Nunes said he and Republican colleagues have yet to determine whether there was such an informant, because the Justice Department and FBI continue to withhold documents from them.

But the California lawmaker pointed to what he said were "leaks" behind news reports in recent days that the Federal Bureau of Investigation had used an "informant" to get information regarding the Trump campaign early in its counterintelligence investigation of possible ties to Russia.

"You can't do this to political campaigns," Nunes said.

This week marked the one-year anniversary of Robert Mueller's appointment as special counsel to lead a probe into election meddling by Russia. Trump and some Republicans are increasingly pressing the argument that the inquiry should be shut down because it was irreversibly tainted by improper actions well before Mueller was appointed.

The president and his allies on Capitol Hill have been trying to undercut the probe by exposing the role of a confidential source who helped the FBI. Democrats, including Sen. Mark Warner of Virginia, as well as the Justice Department and intelligence leaders, have warned that identifying the source may put lives in danger.

Warner, top Democrat on the Senate intelligence committee, said Sunday that exposing the source would be illegal.

"If any individual, elected official or otherwise, knowingly reveals a classified piece of information about an FBI source, you are breaking the law and should be fully prosecuted," he said on

INFILTRATION continued on page 15



DEMANDING AN INVESTIGATION: *President Donald Trump gestures as he delivers remarks during the Prison Reform Summit at the White House in Washington, D.C., May 18. Reuters*

Hawaii faces new threat from volcano: gassy, glassy laze

PAHOA, Hawaii (Reuters) – Hawaii residents dealing with Kilauea's volcanic eruption faced a potentially deadly new challenge on Sunday as lava that reached the Pacific Ocean threatened to send up laze, a hazardous mix of glass particles and noxious gas.

The new challenge came when a stream of lava from the volcano cut through Highway 137 on the south coast of Hawaii's Big Island late on Saturday and then poured into the sea, authorities said.

The mix of erupting lava, which can reach 2,000 degrees Fahrenheit, and sea water could send up plumes of laze, a mix of hydrochloric acid, steam and volcanic glass particles, Hawaii County Civil Defense said in a statement.

"Be aware of the laze hazard and stay away from any ocean plume," the agency said, warning that potential hazards include lung damage.

Laze – a combination of "lava" and "haze" – killed two people in 2000 when a lava flow reached the coast, and even a wisp can irritate eyes and lungs and make it hard to breath, the U.S. Geological Survey said.

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850 Governor Carlos G. Camacho Road
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PUBLIC NOTICE

BOARD OF TRUSTEES MEETING

Date: Thursday, May 24, 2018
Time: 6:00 p.m.
Place: 1st Floor, Daniel L. [illegible] Conference Room

You may contact [illegible] at 64[illegible]218, Monday through Friday from 8:00 a.m. to 5[illegible] accommodations, auxiliary aids, or other services.

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/s/ PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

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Calvo signs letter endorsing Trump for Nobel Prize

Gov. Eddie Calvo is among seven Republican governors who have signed a letter supporting the nomination of President Donald Trump for the Nobel Peace Prize.

The letter praises Trump for his "unprecedented victory for global peace and security" in his negotiations with North Korea.

"After nearly two decades of gridlock and global anxiety surrounding North Korea's nuclear program, we are now, at last, on the precipice of peace," reads the letter, which hails Trump's "successful policy of security through strength."

'No one more deserving'

"There is no one more deserving of the Nobel Peace Prize," concludes the letter. It was sent on Monday to Berit Reiss-Andersen, the chair of the Nobel Committee in Oslo, Norway.

In addition to Calvo, the letter was signed by Alabama Gov. Kay Ivey, Kansas Gov. Jeff Colyer, Mississippi Gov. Phil Bryant, Maine Gov. Paul LePage, West Virginia Gov. Jim Justice and South Carolina Gov. Henry McMaster, who recruited the other governors to sign on.

Earlier this month, 18 House Republicans, led by Rep. Luke Messer, also wrote a letter nominating Trump for the award.

President Trump is expected to meet with North Korean leader Kim Jong Un in Singapore in June.

The North Korean regime Wednesday threatened to cancel the Trump-Kim summit, saying it won't be pushed into abandoning its nuclear weapons program.

Promoting peace, brotherhood

On Nov. 27, 1895, Alfred Nobel signed his last will and testament, giving the largest share of his fortune to a series of prizes, the Nobel Prizes, according to the official website of the Nobel Prize.

The peace prize is dedicated to "the person who shall have done the most or the best work for fraternity between nations, for the abolition or reduction of standing armies and for the holding and promotion of peace congresses."

The honor has been awarded to four U.S. presidents: Theodore Roosevelt, Woodrow Wilson, Jimmy Carter, and Trump's predecessor, Barack Obama.

(Daily Post Staff)

$42K donation gifts GMH upgraded life-support machine

By Alana Chargualaf
alana@postguam.com

By way of a substantial donation, the Guam Memorial Hospital staff recently acquired one of the most up-to-date models of life-support machines to serve their patients.

A donation in excess of $42,000 – made by Ho Eun, chairman of Core Tech International Corp., and his wife, He Eun – allowed for the purchase of the AVEA Ventilator, and the clinical and biomedical training necessary for the machine's operation.

The Guam Daily Post is an affiliate of Core Tech International.



DONATION: *Ho Eun, second from left, and wife He Eun chat with Dr. Kazue Shimabukuro, the Guam Memorial Hospital pediatric intensive care unit medical director, right, and Joyce Crisostomo, president of the GMH Volunteers Association, on May 16 at the GMH Education Classroom. The Euns donated more than $42,000 so the hospital could acquire an AVEA Ventilator – a life-support system – and the clinical and biomedical training to operate the machine.*

Norman M. Taruc/The Guam Daily Post

Greater safety for patients

According to GMH Chief Respiratory Therapist Angela Gaminde, the new ventilator is very much an upgrade to what the hospital currently operates, and is gentle and powerful enough to provide support to all demographics of newborns, children and adults.

GMH Neonatologist Dr. Ben Numpang said the new machine is "definitely superior" to the old ventilators and hopes the new machine ensures greater safety for patients, especially the premature infants, as older machines can potentially damage a baby's lungs.

Dr. Kozue Shimabukuro, assistant associate medical director, echoed Numpang's hopes and explained how the machine's various attachments can be used for babies' and adults' safety. Shimabukuro is also the hospital's pediatric intensive care unit medical director. She noted that the machine's monitor display means more accurate readings.

Ho Eun said he hopes to continue assisting the hospital in the years to come.

"I'm honored that I can participate in this," he said. "Bottom line: We all need help. Let's just try to help each other."

Meeting the hospital's demands

GMH has 14 operable life-support units, which Gaminde said is an appropriate amount for the hospital's size and meets the hospital's demands. Her concern, however, is that the machines are upgraded every eight to 10 years as recommended.

According to GMH Volunteers Association President Joyce Crisostomo, the GMH administrator and CEO provides a wishlist of needed equipment submitted by the hospital's department managers.

For this year, the association is working to provide three pieces of equipment: an echocardiogram, blood analyzer, and anesthesia and gas analyzer monitor. Together, the equipment cost at least $200,000.

The association's treasurer, Toni Pecon, invites others to assist in the hospital's needs for equipment, upgrades and sustainability.

"We ask the community to help us," Pecon said. "Everything we do and everything we make goes directly to purchasing whatever the hospital needs."

MICRONESIAN ARCHAEOLOGICAL RESEARCH SERVICES, INC.
(A scientific and educational non-profit corporation)
Balance sheet—December 31, 2017

ASSETS

Cash in bank and on hand	$106,483
Accounts receivable	6,729
Assets	$113,212

LIABILITIES AND NET ASSETS

Liabilities	0
Net Assets	$113,212

Statement of Revenues, Expenditures and Changes in Net Assets

Net Assets, December 31, 2016		$49,920
2017 Project Revenues		$180,230
Total Revenues		$180,230
Expenditures		
Employee wages and benefits	$81,889	
Consultants	18,938	
Rent, utilities, phone	12,122	
Other operational expenses	2,464	
Insurance	1,525	
Total expenditures	$116,938	
Excess of revenues over expenditures		$63,292
Net Assets, December 31, 2017		**$113,212**

Certified to be true and correct
Signed by Darlene R. Moore, President

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 Governor Carlos G. Camacho Road
Tamuning, Guam 96913

PUBLIC NOTICE

BOARD OF TRUSTEES MEETING

Date: Thursday, May 24, 2018
Time: 6:00 p.m.
Place: 1st Floor, Daniel L. Webb Conference Room

You may contact Toni Tenorio at 647-2218, Monday through Friday from 8:00 a.m. to 5:00 p.m. for special accommodations, auxiliary aids, or other services.

/s/ PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO
This advertisement was paid for with government funds.

GMHA Board of Trustees
AGENDA

Thursday, May 31, 2018 | 6:00 p.m. | Daniel L. Webb Conference Room

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I. CALL MEETING TO ORDER AND DETERMINATION OF QUORUM

Five (5) members establish a quorum.

II. ACCEPTANCE OF REGULAR SESSION MINUTES

A. April 19, 2018

III. OLD BUSINESS

IV. NEW BUSINESS

A. 2017 Equipment Management Plan Evaluation
B. 2017 Utilities Management Plan Evaluation
C. 2017 Life Safety Management Plan Evaluation

V. BOARD SUBCOMMITTEE REPORTS

A. Joint Conference and Professional Affairs
    1. Resolution No. 2018-40, Relative to the Reappointment of Active Medical Staff Privileges
    2. Resolution No. 2018-41, Relative to the Appointment of Provisional Medical Staff Privileges
    3. Policy No. A-MS400, Focused Professional Practice Evaluation

B. Quality and Safety
    1. Patient Safety Committee Team Charter
    2. Performance Improvement Committee Team Charter

C. Human Resources
D. Facilities, Capital Improvement, and Information Technology
E. Governance, Bylaws, and Strategic Planning
F. Finance and Audit

VI. ADMINISTRATORS REPORTS

A. Hospital Administrator/CEO
B. Associate Administrator of Medical Services
C. Acting Associate Administrator of Professional Support Services
D. Assistant Administrator of Nursing Services
E. Chief Financial Officer
F. Medical Staff President

VII. PUBLIC COMMENT

VIII. ADJOURN MEETING

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

□ Bylaws Submitted by Department/Committee: **Medical Staff Office**

□ Rules & Regulations Policy No.: A-MS400

■ Policies & Procedures Title: **FOCUSED PROFESSIONAL PRACTICE EVALUATION**

	Date	Signature
Reviewed/Endorsed	4/16/18	
Title		Vincent A. Duenas, MD Associate Administrator of Medical Services
Reviewed/Endorsed	4/24/18	J Cruz, MD
Title		Jeff Cruz, MD Chairperson, MEC Credentials Committee
Reviewed/Endorsed	4/28/18	M.D.
Title		James P. Last, MD President, Medical Executive Committee
Reviewed/Endorsed	5/3/18	
Title		Ricardo Terlaje, MD Chairperson, Joint Conference & Professional Affairs
Reviewed/Endorsed	5/31/18	
Title		Eloy Lizama Chairperson, Board of Trustees
Reviewed/Endorsed		
Title		
Reviewed/Endorsed		
Title		

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Administrative Office.**

GUAM MEMORIAL HOSPITAL AUTHORITY
MEDICAL STAFF OFFICE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Medical Staff	October 22, 2012	A-MS400	1 of 9
TITLE: FOCUSED PROFESSIONAL PRACTICE EVALUATION				
LAST REVIEWED/REVISED: __/____				
ENDORSED: CREDENTIALS: __/____; MEC __/____; EMC: __/____;JCPAC __/____; BOT __/____				

OVERVIEW:

Focused Professional Practice Evaluation (FPPE) is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

Initial competency of practitioners new to the Guam Memorial Hospital Authority (GMHA) Medical Staff shall have privileges specific competency evaluated by review of competency information obtained from current and former institutions, where privileged, followed by a focused review during the provisional period.

FPPE will occur under the following circumstances:

1. The practitioner is new to GMHA (during the provisional period, as defined by the GMHA Medical Staff Bylaws), or the practitioner is requesting new/additional privilege(s) and does not have documented evidence of competently performing the requested privilege
2. When there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

PURPOSE:

To establish a systematic proctoring process to ensure that there is sufficient information available to confirm the current competence of practitioners who initially request privileges at GMHA, as part of a FPPE.

SCOPE:

This policy applies to all practitioners who request initial privileges, including initial applicants for Medical or Allied Staff appointment and current members of the Medical or Allied Staff who request new or additional clinical privileges.

Practitioners requesting membership but not exercising specific privileges do NOT need to be proctored.

The scope of the proctoring plan shall be as indicated above. However, each department shall define the appropriate proctoring method to determine what constitutes a practitioner's current specialty specific competency.

FPPE METHODOLOGY:

Proctoring may utilize a combination of the following methods to obtain the best understanding of the care provided by the practitioner. The appropriate methods for proctoring for each individual practitioner will be determined by the Credentials Committee (CC) based on recommendations from the Department Chairperson or his/her designee for a specific practitioner situation. The hospital's proctoring forms must be utilized.

Proctoring includes one or more of the following as part of a FPPE:

- *Prospective Proctoring:* presentation of cases with planned treatment outlined for treatment concurrence or review of case documentation for treatment concurrence.

- *Concurrent Proctoring:* Direct observation of the procedure being performed or medical management either through real-time observation of practitioner interactions with patients and staff or review of clinical history and physical and review of treatment orders during the patients hospital stay.

- *Retrospective Proctoring:* review of a case after care has been completed, which may include interviews with personnel directly involved in the care of the patient.

In situations where a practitioner has skills that are needed at GMHA on an occasional basis, where the skills and reputation the practitioner in question are known to members of the medical staff of GMHA and in situations where practitioners are needed from healthcare organizations to provide occasional coverage at GMHA Reciprocal Evaluation (documented evidence of proctoring from an area hospital) may be used. The practitioner is responsible for providing such evidence to Guam Memorial Hospital.

Evaluation by an External Source may be used in situations where a proctor is unavailable (for example, when there is no available proctor with privileges at GMHA in the specialty area relative to the privileges(s) to be evaluated).

OVERSIGHT/RESPONSIBILITIES:

The Credentials Committee (CC) is charged with the responsibility of monitoring departmental compliance with this policy. It accomplishes this oversight by submitting regular reports related to the progress of each practitioner, who is required to be proctored, as well as any issues or problems involved in implementing this policy to the Medical Staff Office. This report will then be made a part of the Medical Staff Office's standing report at the Joint Conference and Professional Affairs Committee.

The Department Chairperson, or his/her designee, will determine changes to improve performance based on results of FPPEs, including proctoring, and implementation of practitioner-specific performance improvement plans, if appropriate, for practitioners who complete the FPPE. Practitioner specific improvement plans will be submitted to the CC for review and approval.

The hospital's QI Coordinator involved with Ongoing Physician Performance Evaluation (OPPE) will provide the CC with data that is systematically collected through the OPPE processes for those practitioners, as appropriate, to confirm current competence during the FPPE period.

SELECTION OF PROCTOR(S):

The Department Chairperson shall be responsible for selecting the proctor(s). Proctors must be members in good standing of the active GMHA Medical Staff and must have unrestricted privileges in the specialty area relative to the privilege(s) to be evaluated.

SOURCES OF DATA:

FPPE data may include any of the following:

- Documented personal interaction with the practitioner by proctor
- Documented discussion(s)/interview(s) with other individuals interacting with the practitioner
- Chart audits by non-medical staff personnel based on defined criteria
- Detailed medical record review by proctor
- Monitoring clinical practice patterns
- Proctoring as described above
- Simulation
- External source evaluation

The data obtained by the proctor will be recorded on the approved proctoring form for consistency and inter-rater reliability.

PROCTORING PERIOD:

Proctoring shall begin when a practitioner is informed of appointment to the medical or allied health staff or upon being granted a new privilege. Based on the specialty of the practitioner, newly granted privileges shall be considered under FPPE for either a specific period of time (no less than six months) or for a specific number of patients/procedures.

The proctoring period may be extended for a period not to exceed a total of 12 months from the granting of the privilege(s) that require proctoring if either initial concerns are raised that require further evaluation or if there is insufficient activity during the initial period.

The provider will remain on Provisional Status until successful completion of proctoring requirements. Provisional Status will not last beyond two years.

The medical staff may take into account the practitioner's previous experience in determining the approach and extent of proctoring needed to evaluate and confirm current competency.

RESPONSIBILITIES OF PROCTORS:

A. The proctor's role is that of an evaluator, to review and observe cases, not of a supervisor or consultant. The practitioner who is serving solely as a proctor is an agent of the hospital. The proctor receives no compensation directly or indirectly from any patient for this service.

B. Proctors will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested. The performance of a specific procedure shall be reviewed, or in the situation that the privilege encompasses cognitive care, then the relative components of the patients chart must also be reviewed for that aspect of care.

C. Proctors will ensure the confidentiality of the proctoring results and forms. The proctor will deliver the completed proctoring form(s) to the CC.

D. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor should promptly notify the respective Department Chairperson. One of the following may be recommended:

1. The Department Chairperson will intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for the patient.
2. The QI Coordinator will review the case for possible peer review at the next department meeting.
3. Additional or revised proctoring requirements may be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.

E. If during the initial period of proctoring the proctor feels there may be imminent danger to the health and safety of any individual, the continuation of the privilege(s) requested and proctoring are subject to being discontinued by Hospital Administrator/Chief Executive Officer at the recommendation from the Department Chairperson or Associate Administrator of Medical Services.

F. All members of the medical staff with relevant privileges, within each department, must serve as proctors when asked to do so.

G. In addition to specialty and privilege specific issues, proctoring also will address the general competencies.

RESPONSIBILITIES OF THE PROCTORED PRACTITIONERS:

A. For concurrent proctoring, the practitioner shall make every reasonable effort to be available to the proctor including notifying the proctor of each patient where care is to be evaluated in sufficient time to allow the proctor to concurrently observe or review the care provided. For elective surgical or invasive procedures where direct observation is required, and the department requires proctoring be completed before the practitioner can perform the procedure without a proctor present, the practitioner must secure agreement from the proctor to attend the procedure.

B. The practitioner shall provide the proctor with information about the patient's clinical history, pertinent physical findings, pertinent lab and radiology results, the planned course of treatment or management and direct delivery to the proctor of a copy of all histories and physicals, operative reports, consultation reports and discharge summaries documented by the proctored practitioner.

C. The practitioner shall have the prerogative of requesting from the Department Chairperson a change of proctor if disagreements with the current proctor may adversely affect his or her ability to satisfactorily complete the proctorship timely and satisfactorily. The Department Chairperson will keep the CC informed about changes in proctors.

D. Inform the proctor of any unusual incident(s) associated with his/her patients.

E. It is the responsibility of the practitioner to ensure documentation of the satisfactory completion of his/her proctorship, including the completion and delivery of proctorship forms to the CC. The proctoring period will be automatically extended if the summary proctor report is not completed and submitted at the end of the initial proctoring period. The automatic extension under this section shall be until the date that is 3 months from the expiration of the initial period.

F. If the summary proctor report is not completed and submitted to the CC when due, or if the practitioner fails to complete the proctoring requirements prior to the expiration of the proctoring period, the additional or new privileges that are the subject of proctoring shall be deemed to be voluntarily relinquished by the practitioner and the practitioner shall immediately stop performing these privileges.

RESPONSIBILITIES OF DEPARTMENT CHAIRPERSONS:

Each medical staff depat1ment chairperson shall be responsible for:

A. Assignment of proctors as noted above.

B. Assist in establishing a minimum number of cases/procedures to be proctored and determining when the proctor must be present. The minimum number of cases to be proctored and type of proctoring required shall be made at the time privileges are recommended. When there are interdepartmental privileges, the CC shall determine the minimum number of cases/procedures to be reviewed.

C. Identifying the names of practitioners eligible to serve as proctors as noted above.

D. If at any time during the proctoring period, the proctor notifies the Department Chairperson that he/she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the Department Chairperson shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall:

1. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient;
2. Review the case for possible referral to the peer review committee;
3. Recommend to Medical Executive Committee that:
    a. Additional or revised proctoring requirements be imposed upon the practitioner;
    b. Corrective action be undertaken pursuant to applicable corrective action procedures.

E. The Department Chairperson will review both the case-specific and aggregate data and provide the CC with an interpretation as to whether a practitioner's performance was acceptable, in need of further data to complete the evaluation or unacceptable.

RESPONSIBILITIES OF MEDICAL STAFF OFFICE:

Medical Staff Office shall assure that the following steps are taken.

A. Direct correspondence to the practitioner being proctored and to the assigned proctor containing the following information:

1. A copy of the privilege form of the practitioner being proctored

2. The name, address and telephone numbers of the practitioner being proctored and the proctor
3. A copy of this FPPE Policy and Procedure
4. Proctoring forms to be completed by the Proctor

B. Provide information to appropriate hospital units/departments about practitioners being proctored including the name of the proctor and a supply of proctoring forms as needed.

C. Contact both the proctor and practitioner being proctored on a monthly basis to ensure that proctoring and chart reviews are being conducted as required.

D. Submit a report to the CC and EMC related to proctorship activity for all practitioners being proctored every six months.

RESPONSIBILITIES OF THE CREDENTIALS COMMITTEE:

The Credentials Committee shall:

A. Have the responsibility of monitoring compliance with this policy and procedure.

B. Receive regular status reports related to the progress of all practitioners required to be proctored as well as any issues or problems involved in implementation of this policy and procedure.

C. Make recommendations to the MEC regarding clinical privileges based on information obtained from the proctoring process.

PROCEDURE:

The specifics steps needed to perform proctoring by the proctor and practitioner undergoing proctoring are outlined in table below:

TASK	ACTIVITY	TIMEFRAME	RESPONSIBILITY
Determination of Proctoring Period/Volume and Methods	Applicant's FPPE plan based on his/her experience and available data and trending	At the time privileges are recommended by the Department Head	Department Head and Credentials Committee
Proctor Assignments	Members from appropriate specialty are contacted	Prior to privileges granted by Board	Department Head
Initiation of proctoring	Proctor and practitioner informed of proctoring plan	At orientation and activation of privileges	Department Head and Medical Staff Office
Scheduling of proctoring sessions	Proctor and practitioner determine schedule if concurrent methods are used	Within one week following privilege activation	Proctor and Practitioner
Distribution of proctoring forms	Forms for proctoring sent to proctor	Prior to or at the time privileges are activated	Medical Staff Office
Completion of proctoring forms	Proctor submits completed forms to Medical Staff Office	Monthly for duration of proctoring period	Proctor
Notify Department Head of any evolving issues	Medical Staff Office reviews proctoring forms and alerts the Department Head if there are negative ratings or	As needed for the duration of the proctoring period	Medical Staff Office

	comments		
Proctoring Chart Audits	Staff performs audits required by proctoring plan and submits data to Medical Staff Office (and to the Department Head if negative information is identified during audits)	Monthly for duration of proctoring period	Appropriate staff
Department Head Recommendation	Department Head provide Medical Staff Office (MSO transmits to the Credentials Committee) with assessment of proctoring data and recommendation to end or extend proctoring or terminate privileges	Any time for during initial proctoring plan proctor's raise substantial concerns or proctor reports as submitted raise concerns, Medical Staff Office will contact Department Head to develop action plan	Department Head and Medical Staff Office
Final Recommendations and Decision-making	Credentials Committee reviews proctor data and Department Head recommendation and submits recommendation to Medical Executive Committee. Medical Executive Committee submits recommendation to the Joint Conference and Professional Affairs Committee	At next scheduled meetings of the Medical Executive Committee and the Joint Conference and Professional Affairs Committee	Medical Staff Office, Credentials Committee, Medical Executive Committee, and Joint Conference and Professional Affairs Committee

REFERENCES:

I. Medical Staff Rules and Regulations, Section IX, Proctorship and FPPE/OPPE

RECISION(S):

I. 6170-16, Focused Practitioner Practice Evaluation, Effective 10/22/2012

ATTACHMENTS:

I. <u>FOCUSED PROFESSIONAL PRACTICE EVALUATION PLAN</u>
II. <u>DEPARTMENT REVIEW AND MEDICAL STAFF COMMITTEE APPROVAL FORM</u>

ATTACHMENT I

FOCUSED PROFESSIONAL PRACTICE EVALUATION PLAN

Practitioner: _____ Dates Privileges Assigned: _____

Department: _____ Specialty: _____

PLANNED TIME PERIOD[1]	SOURCES OF DATA[2]	WHAT IS TO BE EXPECTED[3]
	☐ Documented personal interaction with practitioner ☐ Documented discussion(s)/interview(s) with other individuals interacting with practitioner ☐ Chart audit(s) by non-medical staff ☐ Chart review by proctor ☐ Monitoring clinical practice patterns ☐ Proctoring ☐ Simulation ☐ External review	
	☐ Documented personal interaction with practitioner ☐ Documented discussion(s)/interview(s) with other individuals interacting with practitioner ☐ Chart audit(s) by non-medical staff ☐ Chart review by proctor ☐ Monitoring clinical practice patterns ☐ Proctoring ☐ Simulation ☐ External review	
	☐ Documented personal interaction with practitioner ☐ Documented discussion(s)/interview(s) with other individuals interacting with practitioner ☐ Chart audit(s) by non-medical staff ☐ Chart review by proctor ☐ Monitoring clinical practice patterns ☐ Proctoring ☐ Simulation ☐ External review	
	☐ Documented personal interaction with practitioner ☐ Documented discussion(s)/interview(s) with other individuals interacting with practitioner ☐ Chart audit(s) by non-medical staff ☐ Chart review by proctor ☐ Monitoring clinical practice patterns ☐ Proctoring ☐ Simulation ☐ External review	

[1] Insert time period for evaluation (e.g., 1 month, 3 months, 6 months)

[2] Check all sources of data to be used

[3] Insert number of cases and types of cases (BE SPECIFIC: e.g. first 10 admissions; 2 major or high risk procedures such as….)

FPPE Plan Developed by Department Chairperson: _____
(PRINT NAME)

Signature: _____ Date: _____

ATTACHMENT II

DEPARTMENT REVIEW AND MEDICAL STAFF COMMITTEE APPROVAL
FOCUSED PROFESSIONAL PRACTICE EVALUATION

Practitioner: _____ Dates Privileges Assigned: _____

Department: _____ Specialty: _____

SOURCES OF DATA USED (*check all that apply)*

- ❑ Documented personal interaction with practitioner
- ❑ Documented discussion(s)/interview(s) with other individuals interacting with practitioner
- ❑ Chart audit(s) by non-medical staff
- ❑ Stimulation
- ❑ Chart review by proctor
- ❑ Monitoring clinical practice patterns
- ❑ Proctoring
- ❑ External review

DEPARTMENT EVALUATION *(check one box)*

❑ **Satisfactory Completion**
Based on utilization of the method(s) indicated above and review of the proctor and departmental report(s), the practitioner demonstrated the ability and competency to perform effectively and has satisfactorily completed the FPPE Plan. The practitioner may continue privileges.
Comments:_____
_____

❑ **NOT Satisfactorily Completed**
Based on utilization of the method(s) indicated above and review of the proctor and departmental report(s), the practitioner has not demonstrated the ability and competency to perform effectively and has not satisfactorily completed the FPPE Plan.

The following is recommended *(select one):*
- ❑ Satisfactory completion of supplementary FPPE Plan *(attached)*
- ❑ Voluntary relinquishment of privileges for failure to comply with FPPR Plan
- ❑ Restriction of privileges _____
- ❑ Revocation of privileges _____

Comments: _____
_____

_____ _____ _____
PRINT: Department Chairperson **Signature** **Date**

CREDENTIALS COMMITTEE *(Check one box)* Meeting Date: _____

- ❑ Concur with department evaluation
- ❑ Do NOT concur with department evaluation _____

_____

_____ _____ _____
PRINT: Credentials Chairperson **Signature** **Date**

MEDICAL EXECUTIVE COMMITTEE *(Check one box)* Meeting Date: _____

- ❑ Approve Credentials Committee recommendation
- ❑ Do NOT approve Credentials Committee recommendation _____

_____

_____ _____ _____
PRINT: MEC President **Signature** **Date**

GMHA Board of Trustees
ATTENDANCE SHEET
Thursday, May 31, 2018 | 6:00 p.m. | Daniel L. Webb Conference Room

NAME	TITLE	SIGNATURE
Board Members:		
Eloy S. Lizama	Chairperson	
Lillian Perez-Posadas	Vice-chairperson	
Melissa Waibel	Secretary	
	Treasurer	
Sharon Davis	Trustee	
Sonia L. Siliang	Trustee	
Ricardo M. Terlaje	Trustee	Excused
Hospital Management:		
PeterJohn D. Camacho	Hospital Administrator/CEO	
Benita A. Manglona	Chief Financial Officer	
Zennia C. Pecina	Assistant Administrator of Nursing Services	
Vincent A. Duenas, MD	Associate Hospital Administrator of Medical Services	
James Last, MD	Medical Staff President	
Guests:		

Minutes of the Regular Meeting of the Guam Memorial Hospital Authority Board of Trustees

April 19, 2018 | 6:00 p.m.
Daniel L. Webb Conference Room

ATTENDANCE

Board Members:
Eloy Lizama
Lillian Posadas
Sharon Davis
Dr. Ricardo Terlaje
Sonia Siliang

Melissa Waibel – Excused

Executive Management:
PeterJohn Camacho
Benita Manglona
Dr. Vincent Duenas
Zennia Pecina – Excused
Dr. James Last – Excused
Dr. Kozue Shimabukuro – Excused

ISSUE/TOPIC/DISCUSSIONS	DECISION(S)/ACTION(S)	RESPONSIBLE PARTY	REPORTING TIMEFRAME	STATUS
I. CALL MEETING TO ORDER AND DETERMINATION OF QUORUM				
	After notices were duly issued pursuant to *Title 5 Guam Code Annotated, Chapter 8 Open Government Law, Section 8107(a)* and with a quorum present, Trustee Lizama called to order the regular meeting of the GMHA Board of Trustees at 6:06 p.m. on Thursday, April 19, 2018 in the Daniel L. Webb Conference Room of the GMHA located in Tamuning, Guam.	Trustee Lizama	None	None
II. EXECUTIVE SESSION				
	At the written request of legal counsel, Trustee Lizama called for a motion to go into executive session. At 6:06 p.m. Trustee Posadas motioned and it was seconded by Trustee Davis to convene into executive session. The motion carried with all ayes. *Note: The minutes of the Executive Session are confidential and kept under separate cover in accordance with Title 5 Guam Code Annotated, Chapter 8 Open Government Law, Section 8111(c)(7).* Note: At 6:35 p.m. the Board went into regular session.	All Board members	None	None
	Trustee Posadas motioned and it was seconded by Trustee Terlaje to accept legal counsel's recommended action relative to two settlements. The motioned carried all ayes.	All Board members	None	Approved

III. ACCEPTANCE OF REGULAR SESSION MINUTES				
A. <u>March 28, 2018</u>	A draft of the March 28, 2018 meeting minutes was distributed and reviewed. Trustee Posadas motioned and it was seconded by Trustee Davis to approve the minutes as printed. The motion carried with all ayes.	All Board members	Within five business after the meeting.	Approved
IV. OLD BUSINESS				
There were no old business matters for discussion.	No decisions or actions taken.	None	None	None
V. NEW BUSINESS				
There were no new business matters for discussion.	No decisions or actions taken.	None	None	None
VI. BOARD SUB-COMMITTEE REPORTS				
A. <u>Joint Conference and Professional Affairs (JCPA) Subcommittee</u> 1. Resolution No. 2018-35, Relative to the Reappointment of Active Medical Staff Privileges (exp. 03/31/20) for: • Jerry Castro, MD • Golda Sol Fernandez, MD • William Graf, MD • Miran Ribati, MD • David Weingarten, MD	Trustee Posadas motioned and it was seconded by Trustee Siliang to approve Resolution No. 2018-35 as presented. The motion carried with all ayes.	All Board members	None	Approved
2. Resolution No. 2018-36, Relative to the Appointment of Allied Health Provisional Staff Privileges (exp.03/31/20) for: • Bradley Patrick, CRNA	Trustee Waibel motioned and it was seconded by Trustee Posadas to approve Resolution No. 2018-17 as presented. The motion carried with all ayes.	All Board members	None	Approved
B. <u>Quality and Safety Subcommittee</u> 1. Policy No. A-PS810, Disclosure of Unanticipated Outcomes	Trustee Posadas informed the Board that the purpose of this policy was to provide guidance on the procedure for informing patients and their families about results of a treatment or procedure that differ significantly from what was anticipated. She mentioned that it was a way of mitigating potential lawsuits. Trustee Davis motioned and it was seconded by Trustee Terlaje to approve policy no.A-PS810 as presented. The motion carried with all ayes.	All Board members	None	Approved

2. Policy No. A-PS820, Just Culture Response to Patient Safety Events	Trustee Posadas informed the Board that this policy was intended as a tool for open and free communication and to improve patient safety. Trustee Davis motioned and it was seconded by Trustee Terlaje to approve policy no. A-PS820 as presented. The motion carried with all ayes. <u>Other discussions</u>: Trustee Posadas informed the Board that a conference call with the Joint Commission took place on 04/05/18 to discuss the Hospital's appeal. At that point in time, there was no change of accreditation status. A written response to the conference call was expected within 2 to 3 weeks.	All Board members Trustee Posadas	None Updates to be provided at the next scheduled meeting.	Approved Informational
C. <u>Human Resources Subcommittee</u> 1. Resolution No. 2018-37, Relative to Approving the Decrease of the Total Number of Vacant Budgeted FTE Physician Positions for FY-2018 in the Unclassified Service for the Guam Memorial Hospital Authority	The board was informed that this action was necessary to clean up the Hospital's staffing pattern by converting certain part-time physician positions to independent contractors. Mrs. Manglona informed the Board that this action will decrease the hospital's liabilities because these individuals will no longer be entitled to certain employee benefits. Trustee Davis motioned and it was seconded by Trustee Posadas to approve Resolution No. 2018-37 as presented. The motion carried with all ayes.	All Board members	None	Approved
2. Resolution No. 2018-38, Relative to the Guam Memorial Hospital Authority Furlough Plan A and Plan B of 2018	The Board and management thoroughly discussed the Hospital proposed furlough plans A and B. Plan A, the "no furlough" plan, would be made possible by identifying and implementing measures in order to achieve a cost-savings of about $2,634,077 of the $2.7M in reductions needed to take the hospital through the end of FY-2018.			

	On the other hand, if the implementation of Plan B was necessary, the Hospital intended on preserving the clinical staff. The furlough of all other positions would be determined based on retention points as per the Department of Administration Personnel Rules and Regulations. Trustee Davis motioned and it was seconded by Trustee Posadas to approve Resolution No. 2018-38 as presented. The motion carried with all ayes.	All Board members	None	Approved
D. <u>Facilities, Capital Improvement Projects (CIP), and Information Technology Subcommittee</u>	Trustee Davis reported the following: • a policy was being developed to address the issue of loss and damages to hospital property; • the design phase for the communications system upgrade was 50% completed; • installations of VOIP phones were 85% completed; • the project for the design of the automatic transfer switches was ongoing; • the bid for the 64-slice CT scanners was still under protest; • the 1.6Meg Genset was well beyond its life expectancy and needed to be replaced; • the steam boiler system went down, but the staff worked with a vendor to service the units affected; • the upgrade of the main electrical distribution system and roof upgrade projects were among critical projects that required funding; • the rooftop solar panel installations were completed; • the biometric clocking system was under testing.	Trustee Davis	Updates to be reported at the next scheduled meeting.	Informational
E. <u>Governance, Bylaws and Strategic Planning Subcommittee</u>	Ms. Siliang informed the Board that the subcommittee had met on Apr. 16, 2018 and continued reviewing the 2018-2020 Strategic Plan, particularly sections II through IV. She mentioned that the committee members	Trustees Siliang and Terlaje	Updates to be reported at the next scheduled meeting.	Informational

	were asked to provide any further recommendations for revisions to the Chief Planner to incorporate into the draft, which would then be disseminated to the Board members for their review and recommendations. Ms. Siliang mentioned that the subcommittee decided to change the validity from 3 to 5 years. The Board may hold a working session to allow an opportunity for clarifications and further discussions.			
F. <u>Finance and Audit Subcommittee</u> 1. <u>Resolution No. 2018-39, Relative to Approving 98 New Fees and Updating 8,608 Professional Fees</u>	Trustee Posadas motioned and it was seconded by Trustee Siliang to approve Resolution No. 2018-39 as printed. The motion carried with ayes. Trustee Lizama deferred the financial report to the Chief Financial Officer.	All Board members	None	Approved
VI. ADMINISTRATORS' REPORTS				
A. <u>Hospital Administrator/CEO</u>	Mr. Camacho provided his written report to the Board for reference. In summary, he had informed the Board of the following: • the Hospital submitted its FY-2019 Budget proposal to Speaker Cruz's office timely. An error was found in the copying of documents, but was corrected and resubmitted. A hearing date was pending; • testimony was submitted in support of Bill 260-34 that proposed an increase in taxes for alcohol and tobacco; however, Speaker Cruz advised that the bill may not be reported out of committee because he believed that not enough votes would be garnered for the bill to pass into law; • a hearing on the three bills (262-34, 263-34, and 264-34) introduced to repeal or add exemptions to P.L. 34-87 that would	Mr. Camacho	Updates to be reported at the next scheduled meeting.	Informational

	provide the Hospital with a dedicated funding source was scheduled for May 2, 2018 from 1 to 5 p.m. Management's attendance and testimonies were expected. • meetings took place with representatives from the Non-Communicable Disease Consortium, DPHSS, and Guam Cancer Trust and the Bureau of Statistics and Plans took place to discuss data sharing on alcohol and tobacco related illnesses and a grant that would fund the opioid crisis and its impact on the forensic science community respectively; • GEDA had approved the Hospital's request for GRMC's Community Contribution of $600K to go toward the purchase of equipment for radiology, laboratory, dietary, and bariatric beds; • the Hospital was informed that the USDA is not waiving the requirement to secure interim funding for the Family Birth Center project. GEDA would need to issue a third RFP for that purpose. He mentioned that this project was included in the Hospital's FY-2019 Budget.			
B. <u>Associate Administrator of Medical Services</u>	Dr. Duenas reported the following: • physician charge vouchers via the computerized physician order entry (CPOE) system was being piloted in the internal medicine department; • the contract with UCDavis health for telemedicine services was under review; • there was a need for an additional angio suite due to the increase of coronary care services (e.g., cardiac catheterizations, percutaneous coronary interventions (PCIs), and pacemakers)	Dr. Duenas	Updates to be reported at the next scheduled meeting.	Informational
C. <u>Associate Administrator of Professional Support Services</u>	Dr. Duenas informed the Board that he would be overseeing the Professional Support Division moving forward. He mentioned that Dr. kozue had been detailed to clinical duties.	Dr. Duenas	Updates to be reported at the next scheduled meeting.	Informational

	The Board was invited to attend the proclamation signing on Apr. 20, 2018 at 2:00 p.m. for Laboratory Week. He commended the Laboratory for achieving CAP accreditation.			
D. <u>Assistant Administrator of Nursing Services</u>	Ms. Pecina was not present to provide her report.	Ms. Pecina	Updates to be reported at the next scheduled meeting.	Informational
E. <u>Chief Financial Officer</u>	Mrs. Manglona informed the Board that the Hospital continued experiencing challenges with respect to funding, and that the Hospital continued working with CMS on rebasing its TEFRA reimbursements. She mentioned that the hospital anticipated $4.3M in adjustments for fiscal years 2014 & 2015, and that adjustment requests for FY-2016 would be submitted by the end of the month and FY-2017 by May 2018. She informed the Board that the fiscal team would be looking at revising the pricing model, increasing fees for room and board, and bundling services.	Mrs. Manglona	Updates to be reported at the next scheduled meeting.	Informational
F. <u>Medical Staff President</u>	Dr. Last was not present to provide his report.	Dr. Last	Updates to be reported at the next scheduled meeting.	Informational
VII.PUBLIC COMMENT				
	None	None	None	None
VIII. ADJOURNMENT				
	There being no further business matters for discussion, Chairman Lizama declared the meeting adjourned at 8:18 p.m., motioned by Trustee Posadas and seconded by Trustee Davis. The motion carried with all ayes.	Chairman Lizama	None	Approved

Transcribed by: _____
Theo M. Pangelinan
Administrative Assistant

Submitted by: _____
Melissa Waibel
Secretary, Board of Trustees

CERTIFICATION OF APPROVAL OF MINUTES: The minutes of the April 19, 2018 regular session meeting was accepted and approved by the GMHA Board of Trustees on this 31st day of May 2018.

Certified by: _____
Eloy S. Lizama
Chairman, Board of Trustees

COMMITTEE CHARTER

Name of Committee: PERFORMANCE IMPROVEMENT COMMITTEE

Date Template Completed: May 23, 2018

Purpose of Committee:
The Performance Improvement Committee (PIC) is formed to have oversight over hospital-wide Quality Assessment and Performance Improvement (QAPI) activities. The overall goal of this Committee is to ensure that the oversight provided is aligned with the Hospital's mission of providing quality patient care in a safe environment. Moreover, it includes ensuring that we are compliant with all standards and regulations of our regulatory bodies via continuous monitoring of performance indicators and measures.

Specific Committee Functions and Responsibilities:
Each member has a significant function that has an equal weight of duties for this Committee. The expectation of PIC members includes the following:

- Attend each monthly meeting no less than 83% of the time each calendar year. If a member is not able to attend, an identified representative shall act on his/her behalf. Notice to the Chairperson of the PIC shall be in writing or at least by e-mail prior to the meeting date.
- Provide each member general courtesy and respect. Discussion that deviates from the current topic and objectives are considered avoidable. The Chairperson is responsible to re-focus discussion back to the pertinent item on the agenda of the meeting.
- Be responsible for his/her roles and responsibilities (refer to Committee Member and Selection of Committee section).
- Direct the request for information or action items from the Committee to the appropriate hospital teams/committees.
- Ensure that the working committees/taskforces are committed to its delegated tasks and responsibilities. Whereas if it is identified that the working committee/taskforce is not functioning as planned, a review of the effectiveness of its leadership shall be conducted. If it is determined that the leader of the working committee/taskforce is ineffective, the Committee will request for a change in leadership, and the overseeing member shall conduct further personnel actions based on the Human Resources policy and procedure.
- Review and prepare to report to the PIC and Board of Trustees Quality & Safety Subcommittee, his/her responsible indicators/measures, contract-related QAPI, and staffing adequacy analyses, which he/she has oversight for.
    - Significant indicators/measures, contract-related QAPI, and staffing adequacy analyses, shall be discussed by the members during the meeting, wherein improvement actions and recommendations can be brought forth and as necessary, redirected to the respective working committee/taskforce by the overseeing member.
- The Committee shall vote on the recommendations when it has been identified that a decision needs to be made. A majority vote indicates that the recommendation shall be approved. The approved recommendation shall be forwarded to the working committee/taskforce.
- Set annual goals for the patient and staff satisfaction surveys, analyze the results and strategize on the action plan for improvement, in conjunction with the appropriate responsible department(s).
- Discussions shall be documented in the meeting minutes (done by an Administrative Assistant or designated Scribe), wherein action plans, responsible party and completion date shall also be documented and followed up at each meeting (as an open item) until the members determine that the task has been completed.
- Complete and submit QAPI reports a week prior to the committee meetings. Members' QAPI reports will then be presented at subsequent Board of Trustees (BOT) Quality and Safety (Q&S) Subcommittee meetings.
- Complete and submit an annual QAPI evaluation to the BOT-Q&S Subcommittee (for the area which the member is responsible for/overseeing), to include recommendations for the following calendar year's QAPI improvement opportunities/QAPI projects, etc.
- Conflicts that arise amongst members of the Committee shall be addressed outside the scheduled meeting with the Chairperson as a mediator. Should it be identified that the conflict is directly related to a concern of quality

Approved: PIC 05/25/18 – [illegible]

[illegible]

and safety within our Hospital, the concern/issue shall be immediately addressed by the working committee/taskforce wherein a risk assessment shall be provided to the PIC as soon as possible.

Committee Authorized By:
This team is authorized by the BOT, which has overall authority and responsibility over the operational functions of our Hospital. The BOT Q&S Subcommittee shall have direct oversight over the PIC. This BOT Subcommittee authorizes the PIC to take appropriate actions on concerns that contradicts our mission and strategic plan initiatives.

Date Implemented:
This Committee has been in effect since 1995.

Committee Chair: Hospital Administrator/CEO, or designee

Committee Recorder: Transcriptionist / Administrative Assistant or Designated Scribe

Location of Minutes and Committee Documents/Reports: All minutes, its attachments and other documents/ reports discussed in the Committee's meeting shall be (1) placed in a 4" Binder, (2) stored in the Administration Office, and (3) maintained by the Committee Recorder. One binder will include a calendar year's documents. These documents shall have a retention period of five years.

Alignment of Committee to System Processes: *See attached reporting pathway and reporting process*

Alignment of Committee to strategic initiatives:
QAPI indicators/measures are aligned with the standards and regulations of our regulatory bodies, our Hospital's Mission and Vision, Core Values and strategic plan. Thus, the Committee shall provide oversight to QAPI activities that meet the following Strategic Initiatives: (1) achieve financial stability, (2) leadership team development, (3) establish and sustain safety and quality culture, (4) training and education assessment and implementation, (5) capital improvement planning and implementation.

Committee Members:

POSITION TITLE	NAME	Contact Info (email/ telephone number)
Hospital Administrator/CEO	**PeterJohn Camacho, MPH**	**peterjohn.camacho@gmha.org 647-2203**
Duties & Responsibilities: • Provide effective leadership (as Chairperson of the Committee), ensuring that the purpose of the Committee, its operational function and responsibility is met. • Ensure that members of the Committee meet the required expectations. Ensure that the respective division administrators and/or chairpersons of individuals/committees/task forces provide an action plan for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100). • Ensure that the QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives. • Provide the BOT Q&S Subcommittee with monthly/quarterly and annual executive summaries (verbal and written) of significant indicators/measures, contract-related QAPI, and staffing adequacy analyses from the PIC.		
Associate Administrator of Operations	**Oversight by PeterJohn Camacho, MPH**	**peterjohn.camacho@gmha.org 647-2203**
Duties & Responsibilities: • Schedule monthly meetings with the directors/department managers/supervisors of the division and the Environment of Care (EOC) Committee, who will report his/her QAPI activities.		

COMMITTEE CHARTER

POSITION TITLE	NAME	Contact Info (email/ telephone number)

- Have oversight of the departments of the Operations (OPS) Division and the EOC Committee.
  - Report to the PIC and BOT-Q&S Subcommittee significant indicators from the departments of the OPS Division, and the EOC Committee.
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Ensure that the directors/department managers/supervisors and members of the working committees provide action plans for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology - the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of indicators/measures, contract-related QAPI, and staffing adequacy analyses from his/her respective area.

Associate Administrator of Medical Services **Vincent Duenas, MD** **vincent.duenas@gmha.org 647-2330 (via GMH operator)**

Duties & Responsibilities:

- Schedule monthly meetings with the directors/department managers/supervisors of the division who will report his/her QAPI activities.
- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of the significant indicators/measures, contract-related QAPI, staffing adequacy analyses and PI activities related to his/her respective area and as it deals with medical staff, medical staff committees, and any other quality and safety concerns. *Note: the Medical Executive Committee (MEC) and its underlying Medical staff departments and committees maintain their QAPI responsibilities per the Medical Staff Bylaws and report directly to the BOT Q&S Subcommittee via the MEC Chairperson.*
- Ensure that any significant indicators/measures that have a negative trend (fail to meet goals) have an action plan and follow up with its respective working medical staff department/committee. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Have concurrent oversight of the QAPI activities of the Medical Staff Departments, Medical Staff Committees, and the departments of Medical Services Division.

Associate Administrator of Clinical Services **VACANT** **VACANT**

Duties & Responsibilities:

- Schedule monthly meetings with the directors/department managers/supervisors/assistant administrators of the divisions who will report his/her QAPI activities.
- Have oversight of the departments of Nursing Services and Professional Support Services
  - Report to the PIC significant indicators/measures from the departments.
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Ensure that the directors/department managers/supervisors and members of the working committees provide an action plan for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of indicators/measures, contract-related QAPI, and staffing adequacy analyses from his/her respective area.

COMMITTEE CHARTER

POSITION TITLE	NAME	Contact Info (email/ telephone number)
Assistant Administrator of Nursing Services	**Zennia Pecina, MSN, RN, CCHP**	**zennia.pecina@gmha.org 647-2400**
Deputy Assistant Administrator, Nursing Services (Acting)	**Rhodora Cruz, MSN, RN, CEN**	**rhodora.cruz@gmha.org 647-2310**

Duties & Responsibilities:

- Schedule monthly meetings with the directors/department managers/supervisors of the division who will report his/her QAPI activities.
- Have oversight of the departments of Nursing Services
    - Report to the PIC significant indicators/measures from the departments.
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Ensure that the directors/department managers/supervisors and members of the working committees provide an action plan for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of indicators/measures, contract-related QAPI, and staffing adequacy analyses from his/her respective area.

Assistant Administrator of Professional Support Services	**Oversight by Vincent Duenas, MD**	**vincent.duenas@gmha.org 647-2330 (via GMH operator)**

Duties & Responsibilities:

- Schedule monthly meetings with the directors/department managers/supervisors of the division who will report his/her QAPI activities.
- Have oversight of the departments of Professional Support Services
    - Report to the PIC significant indicators/measures from the departments
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Ensure that the directors/department managers/supervisors and members of the working committees provide an action plan for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of indicators/measures, contract-related QAPI, and staffing adequacy analyses from his/her respective area.

Chief Financial Officer	**Benita Manglona, CPA, CGMA**	**benita.manglona@gmha.org 647-2828**

Duties & Responsibilities:

- Schedule monthly meetings with the directors/department managers/supervisors of the division who will report his/her QAPI activities.
- Have oversight of the departments of Fiscal Services
    - Report to the PIC significant indicators/measures from the departments.
- Ensure that these QAPI activities are aligned with the Hospital's Mission, Vision, Core Values and Strategic Initiatives.
- Ensure that the directors/department managers/supervisors and members of the working committees provide an action plan for and follow up with negative trends (indicators/measures failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).

POSITION TITLE	NAME	Contact Info (email/ telephone number)

- Provide the Committee and BOT Q&S Subcommittee with monthly/quarterly and annual QAPI reports (verbal and written) of indicators/measures, contract-related QAPI, and staffing adequacy analyses from his/her respective area.

Risk Management Program Officer	**Aurora Cabanero**	**aurora.cabenero@gmha.org 648-6763**

Duties & Responsibilities:

- Be involved in the development of the root cause analysis for adverse events, sentinel events, and other incidents warranting deeper analysis (e.g. near misses occurring frequently).
- Report monthly/quarterly and annually to the PIC and BOT-Q&S (verbal and written), occurrences/incidents/ events reported within the Hospital and significant trends/patterns, analyses, improvements, lessons learned, feedback provision and information dissemination to hospital staff, and proactive measures implemented.
- Communicate with members any involved risk or ethical concerns that may cause the Hospital future litigations.

Administrator of Quality, Patient Safety and Regulatory Compliance	**Danielle Manglona, MSN, MBA-HCM, RNC-OB, CPPS, CPHRM**	**danielle.manglona@gmha.org 648-6769**

Duties & Responsibilities:

- Have oversight of the Compliance Office and collaborate with individuals/committees/task forces on quality, patient safety, and regulatory compliance.
- Provide guidance and resources, as needed, to individuals/committees/task forces on quality, patient safety, and regulatory compliance.
- Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Provide the Committee and BOT-Q&S with quarterly and annual status reports (verbal and written) of the significant activities from his/her respective area.
- Communicate with the members any updates/changes with the standards and regulations of the Joint Commission and the Centers for Medicare & Medicaid Services (CMS).

Performance Improvement Coordinator	**Veronica Cruz, BSN, RN**	**veronica.cruz@gmha.org 648-6711**

Duties & Responsibilities:

- Attend hospital working groups' meetings periodically, to assist the Committee with evaluating QAPI program effectiveness.
    - Provide additional guidance and educational resources as needed, to hospital working groups, to assist with compliance with QAPI requirements.
- Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan - Administration Policy# A-PI100).
- Create/develop a dashboard for the BOT Q&S Subcommittee.
- Assist the Committee with the written annual evaluation of the QAPI program's effectiveness (reporting pathway, reporting process of monthly rotation, reporting templates, and any QAPI-related education).

Transcriptionist / Administrative Assistant or Designated Scribe	**Jacqueline Taitano**	**jacqueline.taitano@gmha.org 647-2367**

COMMITTEE CHARTER

POSITION TITLE	NAME	Contact Info (email/ telephone number)

Duties & Responsibilities:

- Schedule PIC meetings (in accordance with the Chairperson's approval) and send notices to the members via email, indicating date, time, and location.
- Record meeting minutes and prepare the minutes and agenda for members' review a week prior to the next scheduled meeting.
- Maintain and update the PIC binder, which shall contain all the approved minutes, agenda and its attachments (records/reports).

Membership Selection Process:
As stated in the Quality Assessment and Performance Improvement Plan (Administration Policy# A-PI100), the members of the PIC include the Executive Management Council (EMC) and the Performance Improvement Coordinator.

Should it be identified by majority of the Committee that a member has not abided to the expectations as stated in this Committee Charter; the Chairperson/Hospital Administrator shall determine further actions towards that specified member with reference to respective Human Resources policy and procedures.

Should it be identified by the members that an additional member is needed based on the ongoing discussions of issues and concerns, the members can elect for that additional member and request for approval from the Hospital Administrator to formally include that individual to the PIC via a memorandum.

Committee Process to manage its own Internal Continuous Quality Improvement:
The overall goal of this Committee is to ensure that a quality and safe environment is provided to our patients, staff and visitors. At the end of the meeting, a recap of the significant discussions will take place, with the identified responsible member, who will ensure that an action plan is in place with an indicated completion date. These significant findings will remain an open item on the agenda until the members decide that the item has been resolved, and that the improvement process is sustaining a positive outcome.

Committee Process to Communicate Activities to others:
The members of the PIC will communicate with one another through various means. Electronic and telephone communication are the best used modes outside the meeting. Each member is expected to respond to inquiries of other members in a timely manner. Should a member be unable to provide a response, he/she should advise the group immediately, so that completion dates are not delayed.

The staff of the Hospital shall be informed of the status of overall hospital QAPI activities through a quarterly newsletter. Furthermore, staff should be informed (by their department manager/supervisor) of their unit's QAPI indicators through monthly staff meetings.

Meeting Schedule:

- Committee meetings shall be held on every third Wednesday of each month.
- The location of the meetings shall take place in the Boardroom. If the Boardroom is unavailable, logistical information shall be provided (by the Transcriptionist / Administrative Assistant or Designated Scribe) to the members via email notification.

COMMITTEE CHARTER

Signatures: By signing below, you acknowledge and accept the functions and responsibilities of the Committee and your individual roles and responsibilities.

Name & Position	Signature	Date
PeterJohn Camacho, MPH Hospital Administrator/CEO		05/29/18
Oversight by PeterJohn Camacho, MPH Associate Administrator of Operations		05/29/18
Vincent Duenas, MD Associate Administrator of Medical Services		5/29/18
Vacant Associate Administrator of Clinical Services		
Zennia Pecina, MSN, RN, CCHP Assistant Administrator of Nursing Services		5/29/18
Rhodora Cruz, MSN, RN, CEN Deputy Assistant Administrator of Nursing Services (Acting)		5.29.18
Oversight by Vincent Duenas, MD Assistant Administrator of Professional Support Services		5/29/18
Benita Manglona, CPA, CGMA Chief Financial Officer		5/29/18
Aurora Cabanero Risk Management Program Officer		5/29/2018
Danielle Manglona, MSN, MBA-HCM, RNC-OB, CPPS, CPHRM Administrator of Quality, Patient Safety & Regulatory Compliance		29 May 18
Veronica Cruz, BSN, RN Performance Improvement Coordinator		5/29/18
Jacqueline Taitano Administrative Assistant		05/29/18

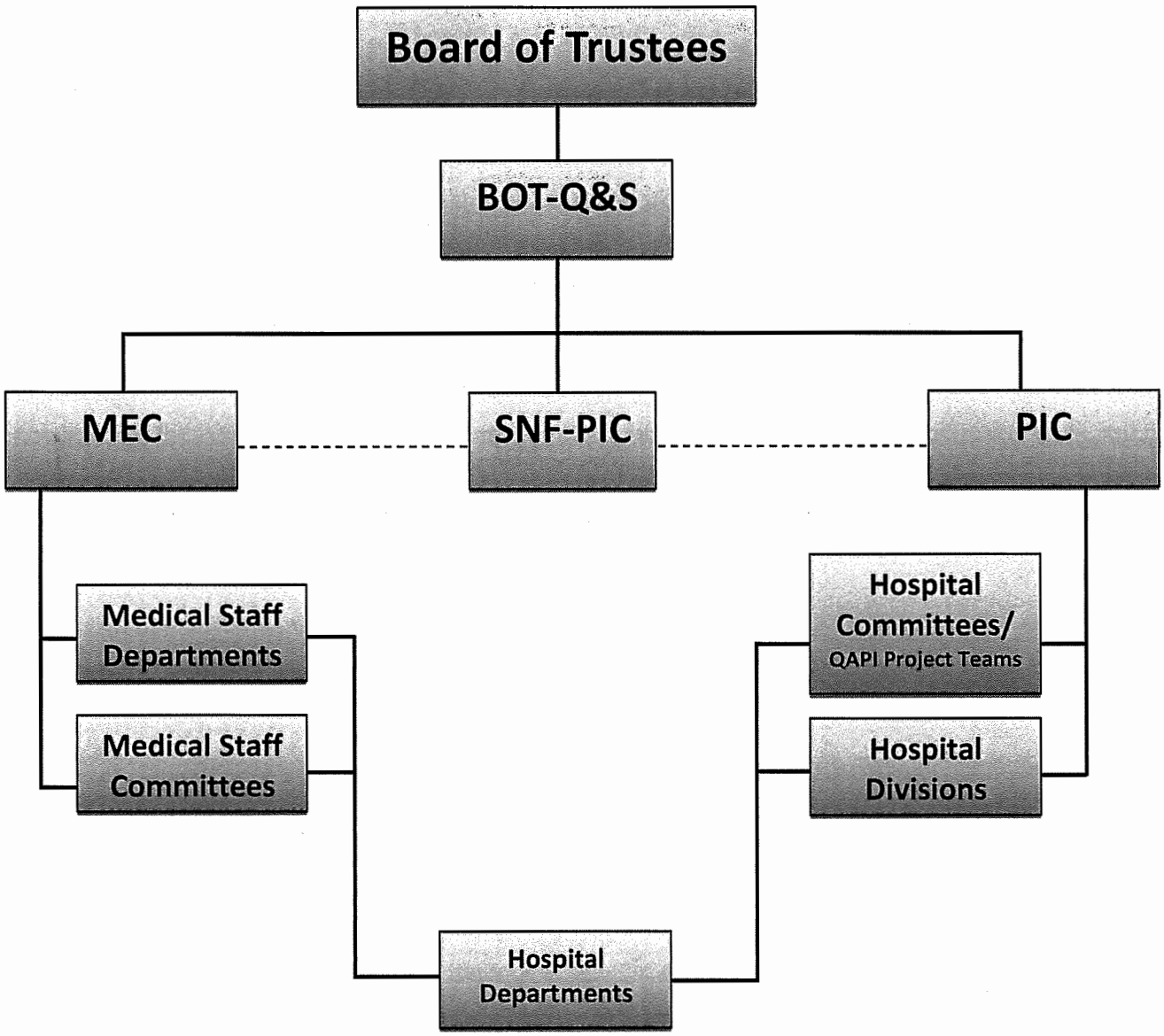
Approval:

Name & Position	Signature	Date
Lillian Perez-Posadas, MSN, RN **BOT - Q&S-Subcommittee, Chairperson**		5/30/18
Eloy Lizama **BOT Chairperson**		5/31/18

COMMITTEE CHARTER

Quality Assessment and Performance Improvement Reporting Pathway

Revised September 2017



Quality Assessment and Performance Improvement Reporting Process – Monthly Rotation

Revised December 2017

NOTE: ***ALL Rotation Months must submit written PI reports per the deadlines specified in the QAPI Schedule and Deadlines. This Rotation schedule specifies when Departments'/Units' verbal reports must be done at monthly Division PI meetings.***

MONTH 1

Verbally reports at Division PI meetings: January, April, July, October

- **NURSING**
  ICU, Med-Surg, Surgical, Tele-PCU
- **FISCAL**
  Pt. Registration, Medical Records
- **OPERATIONS**
  Comm. Center, Human Resources, IT Dept., Guest Relations
- **Patient Satisfaction Survey, Patient Complaints & Grievances**
- **PRO-SUPPORT**
  Special Services, Urgent Care, Education Dept., Laboratory Dept.
- **MEDICAL SERVICES**
  Employee Health Svcs., Infection Control
- **ENVIRONMENT OF CARE COMMITTEE**

MONTH 2

Verbally reports at Division PI meetings: February, May, August, November

- **NURSING**
  OR, ER, Hemodialysis, Patient Education
- **FISCAL**
  Patient Affairs
- **OPERATIONS**
  Environmental Services, Facilities Maintenance, Planning Dept.
- **PRO-SUPPORT**
  Pharmacy Dept., Radiology Dept., Dietary Dept.
- **MEDICAL SERVICES**
  Utilization Review, Medical Staff Office
- **SKILLED NURSING FACILITY PI COMMITTEE**

MONTH 3

Verbally reports at Division PI meetings: March, June, September, December

- **NURSING**
  Pediatrics-PICU, OB Ward, Nursery-NICU, Labor & Delivery
- **FISCAL**
  Finance & Payroll
- **OPERATIONS**
  Safety Dept., Security Dept., Materials Management
- **EEO Report (Staff Satisfaction Survey, Exit Interview)**
- **PRO-SUPPORT**
  Respiratory Dept., Rehabilitative Svcs., Social Services
- **MEDICAL SERVICES**
  Risk Management
- **PATIENT SAFETY COMMITTEE**

COLOR KEY:

GMH DIVISIONS ■ STANDING REPORTS ■ COMMITTEE REPORTS ■ SKILLED NURSING FACILITY ■

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96913
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

May 25, 2018

MEMORANDUM

FROM: PeterJohn D. Camacho, MPH
Hospital Administrator/CEO and Performance Improvement Committee (PIC) Chairperson

TO: Loressa Melegrito, BSN, RN, Skilled Nursing Facility-Performance Improvement Committee (SNF-PIC) Chairperson and Acting SNF Administrator

CC: PIC Members, BOT Q&S Subcommittee Chairperson

SUBJECT: PERFORMANCE IMPROVEMENT COMMITTEE - MEMBER APPOINTMENT FOR CY2018

The PIC hereby appoints you as a member of the committee, for CY2018, to serve as the reporting representative on behalf of the SNF-PIC. Your responsibilities to the PIC are as follows:

- Regularly meet with the members of the SNF-PIC to receive SNF-related QAPI information/reports.
- Report to PIC the significant indicators from the SNF-PIC's QAPI monitoring and activities.
- Ensure that QAPI monitoring and activities support and demonstrate the fulfillment of all CMS Long Term Care requirements.
- Ensure that SNF-PIC members provide action plans for and follow up with negative trends (indicators/measure failing to meet goals) identified in their reports. Ensure the use of the SNF's chosen improvement methodology.
- Provide the PIC with quarterly and annual QAPI reports (verbal and written) of indicators/measures from the SNF-PIC.
- Provide the PIC with a quarterly SNF-PIC Dashboard.

If you are unable to represent the SNF-PIC at PIC meetings, please ensure that an appropriate alternate attend on your behalf.

Thank you very much.

PETERJOHN D. CAMACHO, MPH

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96913
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

May 25, 2018

MEMORANDUM

FROM: PeterJohn D. Camacho, MPH
Hospital Administrator/CEO and Performance Improvement Committee (PIC) Chairperson

TO: Gordon Mizusawa, Environment of Care (EOC) Committee Chairperson and Chief of Environmental Services

CC: PIC Members, BOT Q&S Subcommittee Chairperson

SUBJECT: PERFORMANCE IMPROVEMENT COMMITTEE - MEMBER APPOINTMENT FOR CY2018

The PIC hereby appoints you as a member of the committee, for CY2018, to serve as the reporting representative on behalf of the EOC Committee. Your responsibilities to the PIC are as follows:

- Regularly meet with the members of the EOC Committee to receive EOC-related QAPI information/reports.
- Report to PIC the significant indicators from the EOC Committee's QAPI monitoring and activities.
- Ensure that QAPI monitoring and activities support and demonstrate the fulfillment of all EOC management requirements.
- Ensure that EOC Committee members provide action plans for and follow up with negative trends (indicators/measure failing to meet goals) identified in their reports. Ensure the use of the QAPI methodology – the Model for Improvement (refer to Quality Assessment and Performance Improvement Plan – Administration Policy# A-PI100).
- Provide the PIC with quarterly and annual QAPI reports (verbal and written) of indicators/measures from the EOC Committee.
- Provide the PIC with a quarterly EOC Committee Dashboard.

If you are unable to represent the EOC Committee at PIC meetings, please ensure that an appropriate alternate attend on your behalf.

Thank you very much.

PETERJOHN D. CAMACHO, MPH

Patient Safety Committee Team Charter FY 2018

Name of Team:

Patient Safety Committee (PSC)

Date Template Completed:

January 26, 2018

Purpose of Team:

To support and engage Guam Memorial Hospital Authority leadership, staff, physicians, patients, and visitors in patient safety efforts to create a safety culture that improves patient outcomes and the hospital, by:

- Increasing awareness of patient safety issues;
- Providing education regarding patient safety issues;
- Developing and providing tools for providers, patients, and visitors regarding patient safety issues;
- Fostering transparent systems that promote patient care improvement and education; and
- Thinking, speaking, and functioning with one voice and language to foster a consistent and clear message on patient safety initiatives.

To work collaboratively with the community to make GMHA a safe hospital. We will achieve this by educating the community and advocating in concert with others in the community regarding patient safety initiatives, practices, and outcomes.

Specific Team Functions and Responsibilities:

We value the concepts of:

- Collaborating;
- Sharing information and listening;
- Celebrating success;
- Being proactive and visible;
- Using lessons learned and reflective learning to facilitate improvement and growth; and
- Involving patients and family in our deliberations and products.

We will:

- Use evidence-based patient safety activities;
- Remain patient centered;
- Focus on improving outcomes;
- Share information, and ideas with each other to improve patient safety, i.e., health care education (incorporate patient safety into health care curriculum as standard);
- Develop and disseminate best practices and evidence based information across the hospital and to the community where applicable;
- Share responsibility/accountability within the committee;

- Work with a sense of urgency;
- Use system thinking.

Scope of Work:

1. Present an annual quality patient safety plan to the Quality and Safety Committee for review, input, and approval;
2. Recommend to the Performance Improvement Committee and the Quality and Safety Committee the appropriate patient safety and quality measures and outcomes to be collected and reported internally;
3. Oversee and evaluate patient safety and quality measures and outcomes to include those regulatory and accreditation-related elements of performance. The committee will collect and analyze information on National Patient Safety Goals and ensure that departments receive feedback regarding the effectiveness of their improvement activities;
4. Collect and analyze reports of patient safety risks, ranging from "no-harm", and frequently occurring "near misses" to sentinel events with serious adverse outcomes;
5. Identify individuals/groups best situated to perform root cause analysis and action plans for identified areas of improvement in patient safety;
6. Ensure the hospital's participation in national quality improvement activities focuses on nationally agreed-upon priorities and those that are critical to GMHA. The committee shall approve all such participation;
7. Establish priorities for hospital-wide patient safety initiatives and standardization as it applies and make recommendations to hospital leadership and others;
8. Ensure the hospital's understanding of patient safety initiatives, and ensure that leadership, staff, and physicians receive adequate training in patient safety and quality-related content;
9. Communicate committee recommendations for actions to department heads/chairpersons;
10. Provide direction, feedback and recommended educational offerings on patient safety;
11. Communicate best practices;
12. Increase hospital leadership involvement in patient safety by providing information that demonstrates a sound business case for the highest quality and safest care.
13. Pursue collaborative relationships with other interested community organizations and individuals to enhance current patient safety initiatives;
14. Communicate and promote key initiatives to the general public;
15. Work with the hospital's leadership to promote a culture and climate of non-punitive reporting of errors and endorse continuous patient safety improvement. Mitigate unresolved issues, which may impact the quality or safety of patient care.
16. Recognize and celebrate achievements and improvements of patient safety by hospital physicians and staff;
17. Identify grant opportunities to support the initiatives;
18. Annually review and reassess the adequacy of this charter and recommend any proposed changes to the Performance Improvement Committee and the Quality and Safety Committee;
19. Ensure that the committee conducts and annual self-evaluation to determine whether it is functioning effectively. The outcomes of the assessment process will be discussed with the committee and a plan for improvements for the following year will be developed.

Operations:

1. Appointment of members shall be subject to approval by the Hospital Administrator/CEO;
2. The committee shall recommend a chair and other officers as the committee deems appropriate;
3. Members shall meet a minimum of 12 times per year, and at least once a month. Members shall attend no less than eight meetings per year, and must send a proxy for those meetings they are unable to attend;
4. A special meeting may be called at any time by the committee chairperson to address an urgent issue(s);
5. The agenda of each meeting shall be prepared, approved by the committee chairperson and circulated to each member two days prior to the meeting date;
6. Notices for regularly scheduled meetings shall be sent out one week prior to the meeting;
7. Unless the committee adopts other procedures, the provision of Robert's Rules of Order shall govern meetings of the committee;
8. Members serve as expert resources in guiding patient safety projects and activities;
9. Members are expected to assist in developing committee priorities and support the implementation of adopted initiatives. In addition to attending meetings, members may be called upon to provide leadership, and assist with other committees, special projects, studies, events, and other related activities.

Team Authorized by:

The Patient Safety Committee is authorized by the hospital's governing body.

Team Authority:

The Patient Safety Committee has the ultimate authority to establish patient safety policies for the hospital with approval of the Board of Trustees Quality and Safety Committee. The Patient Safety Committee will maintain a close working relationship with Nursing Management, Professional Support, and the Medical Executive Committee to ensure integrated communication occurs regarding patient safety policies and initiatives. The Patient Safety Committee has the authority, in its discretion, to conduct any investigation it deems necessary or appropriate to enable it to carry out its duties, to include, but not be limited to, medical record audits, root cause analysis, etc. Investigations conducted by the Patient Safety Committee are not to be confused with Administrative Investigations which are completely separate in purpose and nature.

Date Implemented:

January 26, 2018

Team Chairperson:

Patient Safety Officer or designee

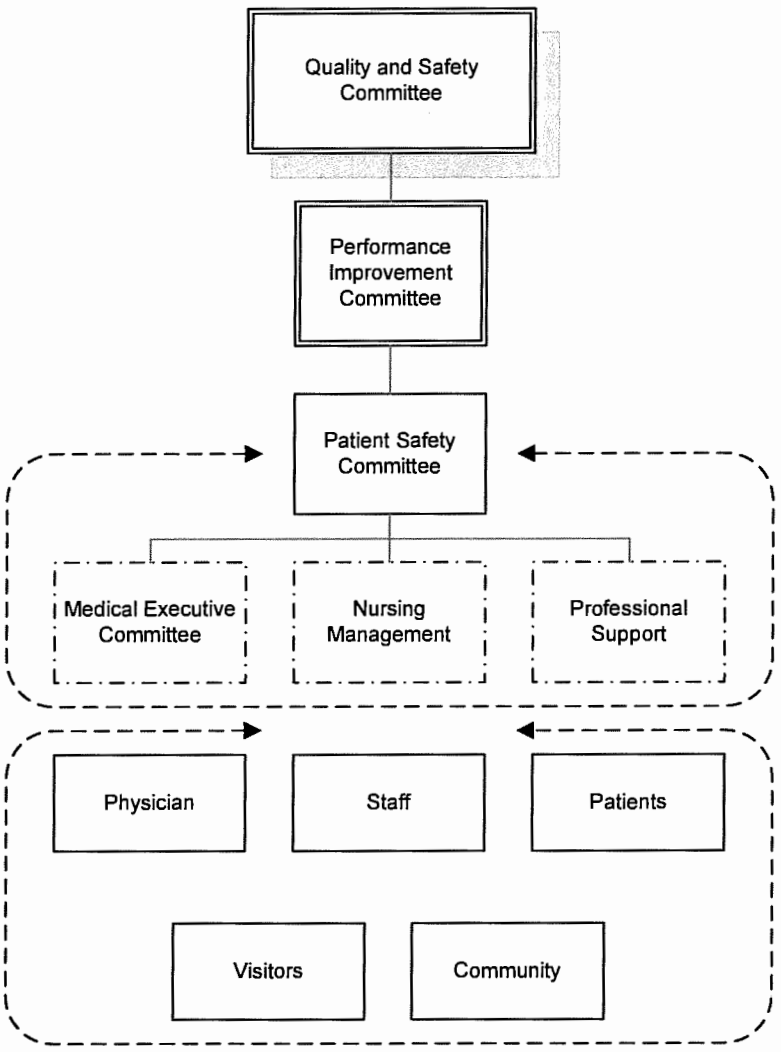
Team Recorder:

The function of Team Recorder will be assigned by the Hospital Administrator/CEO. Any person serving in this role is responsible for creating a packet for the minutes (to include the agenda, the minutes, any supporting documentation (i.e.; policies, memorandums written, etc., that were a part of that particular meeting for filing). Packets will be sent out electronically prior to the meeting. No paper copies of the packet will be provided.

Location of Minutes and Team Documents:

All minutes and team documents shall be kept organized and secure by the Team Recorder.

Alignment of Team to System Processes:



Alignment of Team to Strategic Initiatives:

The Patient Safety Committee plays a vital role in the hospital's strategic plan with regard to the following:

Goal 3: Establish and Sustain Safety and Quality Culture

Team Members:

See Attachment I.

Membership Selection Process:

The overall membership is based on approved appointment by the Hospital Administrator/CEO. Failure to attend meetings, provide a proxy, and/or complete assigned tasks shall result in progressive disciplinary action.

Team Process to Manage its Own Internal Continuous Quality Improvement*:

Measurable changes that positively impact patient safety outcomes hospital-wide by:

- Identifying key initiatives for hospital-wide activity;
- Increasing awareness;
- Providing education;
- Sharing information;
- Using evidence-based patient safety activities and dissemination of best practices;
- Pursuing collaborative relationships for strategic alliance;
- Communicating to the community regarding patient safety; and
- Identifying funding opportunities

*For annual use by the Patient Safety Committee to self-evaluate effectiveness.

Team Process to Communicate Activities to Others:

Copies of minutes will be provided to the following:

- Performance Improvement Committee
- Quality and Safety Committee

Support Needed:

Funding as needed for communications, education, guest speakers, and staff and leadership support.

Attachment I: Team Members

Name	Roles and Responsibilities
Compliance Officer, Patient Safety Committee Chairperson, Acting Signature 23 Feb 2017 Date	Provides leadership in the promotion of patient safety and oversees proper implementation of patient safety initiatives; Interprets and recommends policies and procedures, Presents to the committee procedures to be reviewed from time to time and modifies the policies and methods as indicated; Oversee and measure compliance with The Joint Commission regulations and standards; Assist in obtaining and maintaining accreditation/ licensure; Seeks opportunities to influence policymaking bodies ; Communicates changes in regulations and standards; Provides an annual evaluation of the hospital's patient safety program to leadership; and Other duties as identified.
Risk Management Program Officer Signature 1/26/2018 Date	Lead the event reporting process; Report to the committee patient safety events reported within the hospital and significant trends related to these reports; and Other duties as identified.
Assistant Administrator of Nursing Services Signature 1/26/18 Date	Act as a liaison between the committee and Nursing Management in addressing identified issues as relevant to nursing staff and units; Communicate PSC-NPSG standards and requirements to Nursing Administrator and Nursing Management Committee; Assist in coordinating PSC activities within nursing units and assign nursing personnel as needed to ensure compliance with relevant NPSG requirements; Collect and communicate data and findings regarding this monitoring of NPSG to the PI Coordinator and bring identified issues to the committee; and Carry out other responsibilities as assigned during meetings; and Other duties as identified.
Chief of Radiology Signature 1.26.18 Date	Responsible for radiation safety for patients, visitors, and hospital personnel; Collect data on radiation events and communicate this to the committee and risk management; Ensure the NPSGs are being met and complied with; Ensure opportunities are taken for improvement of processes and outcomes for Critical Test Reporting; Ensure the hospital is following federal radiation safety guidelines as defined by the Nuclear Regulatory Commission (NRC); Ensure all credentials, competencies, requirements, and licenses are met and current to ensure quality of care and patient safety; and Other duties as identified.

Chief of Respiratory Signature 01/26/2018 Date	Provide expertise on Respiratory Care issues pertaining to patient safety; Report incidents involving life support to the committee; Provide a Respiratory Care perspective to any Rapid Response Team issues; and Other duties as identified.
Infection Control Practitioner Signature 01/26/2018 Date	Provides information on current cases of HAIs, associated risks and possible causes; Provides expertise based on knowledge of IC processes in the hospital; Provides input on policies and procedures; Identifies risks for disease transmission based on aspects of the provision of patient care and the patient care environment; Identifies IC risks associated with work practice; Confers with the PSC on actions implemented (via direct care personnel) and as a result of noted occurrences/increase in HAIs/outbreak investigation/ exposure, etc. ; and Other duties as identified.
Chief of Rehabilitative Service Signature 1/26/2018 Date	Reports to committee on compliance, implementation, and enforcement of Patient Safety Management Issues; Provide reporting of PSMC data collection as necessary; Provide consultative role in developing new patient care strategies involving safety and quality; Play a supportive role in administrative aspects of the committee; and Perform other duties as necessary.
Assistant Administrator of Laboratory Services Signature 1/26/2018 MA. Date	Collect monthly indicator study data on Laboratory staff compliance of timeliness of reporting critical tests/critical results for submission to PI Coordinator; Observe and collect monthly data of laboratory staff compliance with NPSGs: Hand hygiene, Use of 2 patient identifiers, and Specimen labeling; Identify , define, and implement opportunities to improve processes/outcomes based on indicator studies; Identify any patient safety concerns within laboratory or hospital, in general, and bring it to the attention of the committee; Recommend indicators for PI monitoring; and Other duties as identified.
Performance Improvement (PI) Coordinator Signature 1/26/18 Date	Assist members of the committee in coordination of quality/performance improvement activities; Assist the committee with communicating improvement activities and patient safety performance measures internally via a dashboard; Collect some NPSG-related data for the committee and utilize data analysis tools such as flowcharts and graphs as needed; Provide knowledge on current clinical practice to the members of the committee in the absence of its respective member; And other duties as needed

Special Services Department Supervisor Signature 01/26/2018 Date	Provide expertise on outpatient Neurology, Cardiology and Orthopedic services pertaining to patient safety; Provide assistance in maintaining compliance with JC regulations and standards pertaining to the Heart Program; and Other duties as identified.
Operating Room/PACU Nursing Unit Supervisor Signature 1/26/2018 Date	Provide a safe environment for all patients and staff; Provide continuous education for staff as it relates to the National Patient Safety Goals and ensuring complete compliance; and Other duties as needed.
Rapid Response Team Coordinator Signature 1/26/18 Date	Ensure that NPSG in regards to Rapid Response Team is met and patient safety is maintained at all times; Provide quarterly statistics of RRT to PI coordinator for Quality Improvement; Collaborates with all Patient Safety Committee (PSC) members to ensure that NPGS's and JC standards are met; and Other duties as needed.
Skilled Nursing Unit Hospital Nursing Supervisor Signature 01-26-2018 Date	Coordinate Skilled Nursing Unit patient safety plan in accordance with the Center for Medicare & Medicaid and The Joint Commission's National Patient Safety Goals; Communicate patient safety issues in the Skilled Nursing Unit to the committee; Oversee the patient safety quality improvement process in the Skilled Nursing Unit and reports it to the committee; Head the Resident Safety Program sub- committee; Conduct inter-departmental safety meetings regularly and as needed; and Other duties as needed.
Chief of Pharmacy Signature 1/26/18 Date	Report the incident cases relating to all mediation errors and medication issues that occur in the pharmacy; Submit a report once a month for Medication Errors, Adverse Drug Reactions, and Drug-related Incompatibilities monitoring; Submits monthly report for anticoagulants monitoring; Assist in monitoring the Usage of Non-Acceptable abbreviations; Make recommendations to all PSC related issues; and Other duties as needed.

Associate Administrator of Medical Services Signature 2/23/18 Date	Act as liaison between the committee and the Medical Staff in addressing identified issues as relevant to the Medical Staff and MEC, and other duties as needed.
Assistant Associate Administrator of Medical Services Signature 2/23/18 Date	Act as liaison between the committee and the Medical Staff in addressing identified issues as relevant to the Medical Staff and MEC, and other duties as needed.
Medical Staff Member Signature 2/23/18 Date	Act as liaison between the committee and the Medical Staff in addressing identified issues as relevant to the Medical Staff and MEC, and other duties as needed.
Medical Staff Member Signature 2/26/18 Date	Act as liaison between the committee and the Medical Staff in addressing identified issues as relevant to the Medical Staff and MEC, and other duties as needed.
Clinical Representative Telemetry/Unit Nursing Unit Supervisor Signature 1/24/2018 Date	Participate in meetings, plan and conduct staff patient safety training and education; Coordinate with other members of committee in planning and provision of program and development of the hospital personnel; Answer inquiries relating to patient safety and act as a resource; and Other duties as needed.

Hospital Food Services Administrator Signature 2/23/18 Date	Participates in meetings, reports food drug interactions patient education; Answers inquiries relating to patient safety and act as a resource; Provide continuous education for staff as it relates to the National Patient Safety Goals and ensuring complete compliance; and Other duties as needed.
Administrative Assistant Signature 02/23/18 Date	Responsible for creating a packet for the minutes to include the agenda, the minutes, any supporting documentation (i.e.; policies, memorandums written, etc.) that were a part of that particular meeting for filing; and Other duties as needed.

Approved by:

PeterJohn D. Camacho, MPH
Hospital Administrator/CEO — Date: 02/27/18

Lillian Perez-Posadas, MSN, RN
Quality and Safety Chairperson — Date: 5/30/18

Eloy Lizama
Board of Trustees Chairperson — Date: 5/31/18

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96913
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

BOARD OF TRUSTEES
Official Resolution No. 2018-40

"RELATIVE TO THE REAPPOINTMENT OF ACTIVE MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
Kia Rahmani, MD	Surgery	General Surgery	April 30, 2020
Ibrahim Aburiziq, MD	Surgery	Pathology	April 30, 2020
Joel Rubio, MD	Medicine	Endocrinology	April 30, 2020
Vasin Jungtrakoolchai, MD	Medicine	Internal Medicine	April 30, 2020
Daniel Case, MD	Emergency Med.	Emergency Medicine	April 30, 2020
Christian Eusebio, MD	Surgery	General Surgery	April 30, 2020

WHEREAS, the above listed practitioners met the basic requirements for Active Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.2; and

WHEREAS, the Medical Executive Committee on April 25, 2018 and the Joint Conference and Professional Affairs Committee on May 3, 2018 recommended approval of Active Medical Staff Membership reappointment for the above listed practitioners; and

WHEREAS, all reappointments to Active Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to reappoint the above named practitioners to Active Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these reappointments; and be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 31st DAY OF MAY, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-41

"RELATIVE TO THE APPOINTMENT OF PROVISIONAL MEDICAL STAFF PRIVILEGES"

Practitioner	Department	Specialty	Expiration Date
John Holeman, MD	Medicine	Internal Medicine (Hospitalist)	April 30, 2020
Divis Khaira, MD	Medicine	Internal Medicine (Hospitalist)	April 30, 2020
Craig Settle, MD	Emergency Med.	Emergency Medicine	April 30, 2020

WHEREAS, the above listed practitioners met the basic requirements for Provisional Medical Staff Membership as determined by the appropriate Medical Staff Departments and Committees pursuant to the GMHA Medical Staff Bylaws, Article IV, Section 4.3; and

WHEREAS, the Medical Executive Committee on April 25, 2018 and the Joint Conference and Professional Affairs Committee on May 3, 2018, recommended approval of Provisional Medical Staff Membership appointment for the above listed practitioner; and

WHEREAS, all appointments to Provisional Medical Staff Membership require Board approval; now, therefore be it

RESOLVED, that the Board of Trustees approves this recommendation to appoint the above named practitioners to Provisional Medical Staff as recommended; and, be it further

RESOLVED, that the Board of Trustees directs the Hospital Administrator to duly notify the practitioners listed above and all Hospital and Medical Departments of these appointments; and be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 31st DAY OF MAY, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

Guam Memorial Hospital Authority
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BOARD OF TRUSTEES
Official Resolution No. 2018-42

"RELATIVE TO THE ESTABLISHMENT OF THE ASSISTANT ADMINISTRATOR OF NURSING SERICES AND DEPUTY ASSISTANT ADMINISTRATOR OF NURSING SERVICES POSITIONS IN THE CLASSIFIED SERVICE FOR THE NURSING ADMINISTRATION DEPARTMENT"

WHEREAS, the current Assistant Administrator, Nursing Services and the Deputy Assistant, Nursing Services are both under the unclassified service of the government of Guam classification list; and

WHEREAS, the current position is staffed with incumbents holding the unclassified position; and

WHEREAS, the practicality of classifying these two position to provide continuity of the mission and objective of the Nursing Division; and

WHEREAS, for better operational efficiency and coordination of positions, the Assistant Administrator, Nursing Services and the Deputy Assistant, Nursing Services; now, therefore be it

RESOLVED, that the Board of Trustees accepts the recommendation of the HR, BOT Sub-Committee and approves the establishment the Assistant Administrator, Nursing Services and Deputy Assistant Administrator, Nursing Services in the classified service for the Nursing Administration Department positions; and, be it further

RESOLVED, that the classified positions be filled through the competitive administrative recruitment process; and, be it further

RESOLVED, that the Hospital Administrator/CEO is directed to initiate the administrative processes to bring to fruition the utilization of these positions; and, be it further

RESOLVED, that the Board of Trustees Chairperson certifies and the Board of Trustees Secretary attests to the adoption of this Resolution.

DULY AND REGULARLY ADOPTED ON THIS 31st DAY OF MAY, 2018.

Certified by:

Eloy S. Lizama
Chairperson, Board of Trustees

Attested by:

Melissa Waibel
Secretary, Board of Trustees

ASSISTANT ADMINISTRATOR, NURSING
(Proposed Creation)

NATURE OF WORK IN THIS CLASS:

The Assistant Administrator, Nursing is administratively responsible for the provision of all nursing services provided by the Hospital. The employee in this class is responsible for planning, administering, directing, controlling, and coordinating nursing care delivery and the operations of the Nursing Division. The Assistant Administrator, Nursing is expected to collaboratively work-with the Board of Trustees, the Administrator, the Executive Management Council, the Medical Staff, Hospital Departments, and members of the community in meeting the goals and needs of the Nursing Division.

This position reports to the Associate Administrator, Clinical Services. The Assistant Administrator of Nursing Services is a mandatory member of the Executive Management Council.

ILLUSTRATIVE EXAMPLES OF WORK (These examples do not list all the duties which may be assigned; any one position may not include all the duties listed).

Assesses and evaluates the organization of the Division. Initiates modifications in the structure to improve the efficiency·and quality of the nursing services provided.

Identifies annual goals in collaboration with the Nursing Management Team which correspond to the Hospital's mission and annual goals established through the planning process.

Prepares and defends proposals for the capital and operating budgets. Participates in at least a quarterly evaluation of the budgetary performance of the Division.

Determines the number, types, and utilization of nursing personnel for all current and programs being planned. Implements a program for the recruitment and retention of staff.

Administers Government of Guam policies established for the recruitment and management of personnel and for the procurement of equipment and supplies.

Establishes and implements a mechanism to allocate and monitor the allocation of nursing staff on a shift-to-shift basis for each Nursing Unit.

Assures members of the Division have sufficient supplies and equipment to provide quality and safe patient care.

Assures standards of care are established and monitored for each Nursing Unit.

Assures the implementation of the Quality Improvement Program in the Division.

Serves as an advisor to the Hospital Administrator on all matters pertaining to nursing.

Represents the Hospital as the nursing resource person in meetings and conferences between the Board of Trustees, the Executive Management Council, professional nurses, medical staff, department heads, and organizations in the community. Presents the nursing component serving as an educator or patient advocate on the issues which are addressed.

Participates with the medical and nursing staff in the development and formulation of major operational policies of the hospital. Develops, interprets, revises, and implements policies and procedures which promote patient care delivery or the efficient operation of the Division. Assures all policy and procedure manuals are reviewed or revised at least annually.

Periodically conducts unit inspections and visits with staff and patients to assess the compliance to established standards and policies which promote quality, consistency, and safety. Implements appropriate corrective actions based upon these findings.

Maintains knowledge of current Health Care Financing Administration, Joint Commission, and GOSHA standards and applicable health law. Coordinates the education of the appropriate members of the Department to these changes. Assures compliance to these standards and laws.

Assures the continuous implementation of an effective program to orient and continually develop all nursing personnel.

Assures mechanisms are in place to effectively address patients' rights, resolving ethical issues, educational needs, and discharge planning needs.

Establishes and enforces a mechanism for the documentation of the nursing process for all nursing services provided.

Participates in continuing educational activities and review of journal articles and research to keep abreast of current administrative or clinical trends.

Supervises the administrative support staff of the Department.

Performs related work as appropriate and assigned.

MINIMUM KNOWLEDGE, ABILITIES AND SKILLS:

Extensive knowledge of the principles, practices, and theory of hospital nursing administration and the application of techniques in providing nursing care to patients.

Extensive knowledge of supervisory and management principles, strategies, and interventions involved in hospital nursing administration.

Current knowledge of the trends and current developments in nursing administration and the clinical areas of service which are provided by the Hospital.

Thorough knowledge of the methods of prevention and control of communicable and infectious diseases.

Ability to plan, direct, organize, and supervise the work of others.

Ability to develop and defend capital and operating budgets.

Ability to establish and maintain effective working relationships with the Board of Trustees, Administration, Medical Staff, Department Heads and subordinates.

Ability to make decisions in accordance with professional standards, ethics, the law, and rules and regulations.

Ability to effectively express oneself clearly, concisely, and effectively both orally and in writing.

Ability to communicate effectively one-on-one, in small groups, and to large bodies of people.

Ability to monitor the operation of the Division and to prepare complex reports.

Documented clinical experience in at least one nursing area.

MINIMUM EXPERIENCE AND TRAINING:

A. Graduation from an accredited college or university with a Master's degree in nursing administration, or closely related field with four (4) years of progressively responsible hospital nursing experience which includes three (3) years in an administrative or supervisory capacity; or

B. Graduation from an accredited college or university with a Bachelor's degree in nursing and six (6) years of progressively responsible hospital nursing experience which includes at least four (4) years in an administrative or supervisory capacity. All candidates who lack a master's degree must consent to submit a plan for prior approval, to Administration which demonstrates how they propose to complete a master's degree or equivalent preparation within five (5) years of hire.

NECESSARY SPECIAL QUALIFICATION REQUIREMENT:

Possession of a current license as a Registered Nurse on Guam.

DESIRED SPECIAL QUALIFICATION REQUIREMENT:

Certification by the American Nurses Credentialing Center (ANCC) as a Certified Nurse Executive **o r** a Certified Nurse Executive, Advanced.

Established: _____ 2018

KNOW HOW	FII3 400
PROBLEM SOLVING	F4 (50%) 200
ACCOUNTABILITY	E2P 230
TOTAL	830
PAY GRADE	S (NPP)

Approved:

Eloy S. Lizama, Chairman, Board of Trustees

Date: 5/31/18

Deputy Assistant, Nursing Services
(Proposed Creation)

NATURE OF WORK IN THIS CLASS:

This is responsible supervisory and administrative work in assisting the Assistant Administrator of Nursing in directing all nursing services of the hospital.

The employee in this class assists the Nursing Administrator in planning, directing and coordinating the entire nursing services of the hospital.

The employee exercises considerable independent judgment and initiative in accordance with professional nursing standards, established policies and procedures. Work is reviewed through conferences and submission of reports.

ILLUSTRATIVE EXAMPLES OF WORK:

Assists the Assistant Nursing Administrator in planning, directing and coordinating the nursing services of the hospita1, encompassing the day, evening and night shifts.

Participates in analyzing and evaluating nursing and related services rendered to improve quality of patient care, and assists in planning better utilization of staff time and abilities.

Assists in developing policies and procedures; interprets and explains new policies and procedures to nursing personnel.

Participates in coordinating nursing activities of various hospital departments, promoting and maintaining harmonious relationships among nursing personnel and medical staff, patients and the public.

Assists in recruiting, selecting and retaining qualified nursing and auxiliary personnel.

Directs and participates in orientation and in-service training programs for nursing and auxiliary personnel designed to improve nursing care.

Participates in meetings and conferences.

Answers correspondence relating to nursing services, and prepares administrative reports.

Directs and evaluates the application of professional nursing principles and practices, and recommends changes in procedures to improve standards of nursing car

Performs related work as required.

MINIMUM KNOWLEDGE, ABILITIES AND SKILLS:

Knowledge of the principles, practices and theory of professional nursing and application of techniques in providing hospital nursing care to patients, including those basic knowledges related to nursing such as biological, physical, social and medical sciences, and their application for better understanding of patient care problems.

Knowledge of the methods of prevention and control of communicable and infectious diseases.

Knowledge of supervisory and management techniques and procedures involved in hospital nursing administration.

Knowledge of the trends and current developments in nursing, with emphasis in hospital nursing administration.

Ability to plan, assign and supervise the work of others.

Ability to make work decisions in accordance with professional standards, rules and regulations, and to apply departmental policies and procedures to work problems.

Ability to establish and maintain effective working relationships with others.

Ability to express oneself clearly, concisely and effectively, both orally and in writing.

MINIMUM EXPERIENCE AND TRAINING:

(a) Graduation from an accredited college or university with a Master's degree in nursing, administration or closely related field, and three (3) years of progressively responsible professional nursing work, including two (2) years in an administrative or supervisory capacity; or

(b) Graduation from an accredited college or university with a Bachelor's degree in nursing, and four (4) years of progressively responsible professional nursing work, including three (3) years in an administrative or supervisory capacity.

NECESSARY SPECIAL QUALIFICATION REQUIREMENT:

Possession of a current license as a Registered Nurse on Guam.

DESIRED SPECIAL QUALIFICATION REQUIREMENT:

Certification by the American Nurses Credentialing Center (ANCC) as a Certified Nurse Executive **o r** a Certified Nurse Executive, Advanced.

Established: _____ 2018

KNOW HOW	EII3 350
PROBLEM SOLVING	E4 (43%) 152
ACCOUNTABILITY	E3C 175
TOTAL	630
PAY GRADE	R (NPP)

Approved:

Eloy S. Lizama, Chairman, Board of Trustees
Date: 5/31/18