2026 ENVIRONMENT OF CARE PLAN

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Table of Contents

Mission, Purpose, and Scope

A. Mission Statement
Aligned with the mission, vision, and values of the Lake County Health Department and Community Health Center (LCHD/CHC), this Environment of Care (EOC) Plan outlines the framework for ensuring a safe, functional, and supportive physical environment; *"Promoting the health and well-being of all who live, work, and play in Lake County".* The plan reflects the organization's commitment to delivering safe, high-quality care by promoting a safe and secure environment for patients, clients, staff, and visitors.

B. Purpose
The purpose of the LCHD/CHC Environment of Care Plan is to reduce the risk of injury or harm to patients, clients, staff, and visitors related to the physical environment.

The EOC Plan is designed to manage physical risks related to:

1. **Buildings** including how physical space is arranged as well as special features that protect patients, clients, visitors, and staff.
2. **Equipment** used to support patient and client care or to safely operate the building or physical spaces.
3. **People** who work within LCHD/CHC, patients, clients, visitors, and all others who enter the environment.

C. Scope
The Environment of Care Plan applies to all buildings, grounds, and areas (owned or leased) used by LCHD/CHC.

Authority, Organizational Oversight, and Reporting Relationships

A. Intervention Authority

The authority to carry out this plan is vested in the Environmental Health and Safety (EHS) Committee by the Lake County Health Department and Community Health Center Executive Director, Deputy Executive Director, and members of the Executive Team.

B. Environmental Health and Safety Committee Oversight

The governance and responsibilities of the LCHD/CHC EHS Committee include:

1. **Multidisciplinary Oversight:** Chaired by the Occupational Health and Safety Specialist, the committee integrates representatives from Safety, Physical Health, Dental, Behavioral Health, Facilities, Infection Prevention, Emergency Management, HR, Clinical Compliance, and Materials Management.

2. **Quarterly Evaluations:** The group meets quarterly to assess the safety, functionality, and regulatory compliance of components under the Environment of Care.

3. **Regulatory Alignment:** Risk-reduction activities and corrective action plans are guided by regulatory standards and best practice including by Occupational Safety and Health Administration (OSHA) and The Joint Commission (TJC) standards to ensure continuous operational readiness.

4. **Strategic Functions:** Primary duties include surveillance, performance improvement, conducting annual hazard vulnerability assessments, developing annual EOC goals and reviewing progress of established goals and objectives.

C. Reporting Relationships

The EHS Committee reports up through the Safety Specialist to the Clinical Compliance Manager and the Deputy Executive Director. Effectiveness of the EOC Plan annual goals and objectives is monitored throughout the year during quarterly committee meetings. An annual evaluation of goals and objectives is conducted in the first quarter of each calendar year; results and projected goals are reported to the Governing Council.

Roles and Responsibilities

A. Environmental Health and Safety Committee (EHS)

The EHS Committee oversees LCHD/CHC environmental health and safety through surveillance, education, and policy development while conducting regular meetings to promote an evidence-based safety culture. Its core functions include coordinating performance improvement initiatives and performing annual evaluations, such as hazard vulnerability assessments and reviews of the Environment of Care (EOC) Plan, to ensure continuous operational readiness and leadership in risk management.

B. Occupational Health and Safety Specialist

The Occupational Health and Safety Specialist (Safety Specialist) develops and manages comprehensive safety programming for LCHD/CHC to maintain regulatory compliance and protect the well-being of patients, clients, staff, and visitors. By conducting risk assessments and implementing preventive measures, this role integrates safety practices into daily operations and the Environment of Care framework. Through collaboration with leadership and continuous staff education and training, the Safety Specialist fosters a proactive culture of safety that aims to ensure standards for workplace protection and community health.

C. Safety Officers

Site-designated Safety Officers serve as vital liaisons between staff and the Safety Specialist to promote awareness and facilitate safety training. Their primary responsibilities include conducting thorough monthly inspections to identify safety hazards and reporting findings for escalation to the EHS Committee and leadership. By meeting expectations for timely inspections and active participation in monthly safety meetings, safety officers ensure LCHD/CHC maintains a compliant, safe environment for all patients, clients, staff, and visitors.

D. Clinical Risk and Patient Safety Management Program

The Clinical Risk and Patient Safety Management Program supports the agency's mission by identifying and mitigating clinical and operational risks in coordination with the Environment of Care Plan. Its functional responsibilities include performing quarterly risk assessments, reviewing patient safety events within the incident management system (Healthcare SafetyZone portal), and convening a multidisciplinary committee to create action plans based on identified risks and loss prevention strategies. This structured approach ensures that organizational practices are continuously revised to enhance patient and client safety and reduce clinical risks.

Emergency Preparedness

Managed by the Emergency Response Coordinator, the LCHD/CHC Emergency Operations Plan (EOP) ensures organizational readiness and resilience during disasters as a critical element of the Environment of Care Plan. This safety framework is reinforced by site-specific Continuity of Operations (COOP) plans, which ensure that essential healthcare services remain uninterrupted during and after emergency events. Through these integrated strategies, LCHD/CHC maintains its commitment to emergency preparedness and upholding the highest standards of care.

Staff Education and Training

The LCHD/CHC Learning and Development department provides a structured framework for staff to recognize, prevent, and manage workplace risks in compliance with OSHA and The Joint Commission standards. Developed through multidisciplinary collaboration, the program includes mandatory orientation, role-specific training, and annual competency assessments covering hazard recognition, incident reporting, and emergency response protocols. Leadership is responsible for verifying that all personnel receive training relevant to their specific roles, while the curriculum is reviewed annually to ensure ongoing effectiveness and regulatory alignment.

Annual Evaluation and Performance Improvement

In alignment with The Joint Commission and OSHA requirements, the Occupational Health and Safety Specialist conducts an annual hazard vulnerability assessment and evaluation of the EOC Plan to measure effectiveness and identify areas for improvement. This comprehensive review, performed alongside subject matter experts and the EHS Committee, analyzes program performance to refine safety policies, enhance staff training, and implement continuous

improvement in environmental controls. By utilizing data from internal monitoring audits, environmental rounds, and incident reviews, the Safety Specialist in conjunction with the EHS committee ensures continuous compliance with regulatory standards and prioritizes corrective actions to maintain a safe, functional environment.

Core Functional Areas and Individual Management Plans

This plan details the process for managing each of the six core functional areas as required by the Joint Commission:

1. Environmental Safety Management

2. Security Management

3. Fire Safety (Life Safety) Management

4. Utility Systems Management

5. Hazardous Materials and Waste Management

6. Medical and Dental Equipment Management

A. Environmental Safety Management Plan

The Environmental Safety Management Plan establishes a comprehensive framework to identify, assess, and manage safety risks across all LCHD/CHC facilities. It promotes a culture of continuous improvement by integrating proactive risk management, staff engagement, and compliance with regulatory standards. Through these efforts, the plan ensures safe physical environments and supports the consistent delivery of high-quality care and services throughout the organization.

1. Annual Environmental Safety Management Objectives (2026)

Planned Performance Improvement Objectives
1. Update LCHD/CHC Emergency Action Plan (Red Flipbooks) with accurate contact information and instructions for responding to emergencies; ensuring updated inserts are disseminated and in place at all facilities by August 1, 2026.
2. Emergency Response Coordinator will facilitate updates to all site Continuity of Operations Plans (COOP) to include essential functions, emergency protocols, contact information, and defined site leadership roles by March 31, 2026.

2. Routine Activities

a. Safety Officers are designated for each LCHD/CHC site and location and recruited as needed by the Safety Specialist in conjunction with site leadership. All Safety Officers receive initial orientation and ongoing education and training in the identification and elimination of workplace hazards, risk-reduction strategies,

proper use and maintenance of safety equipment, emergency response procedures, and the reporting of safety concerns.

b. Safety Officers conduct and document routine safety inspections and periodic assessments to identify and prioritize safety and health hazards requiring corrective action.

c. The Facilities department maintains all grounds, equipment, and facilities in proper working order.

d. Product notices and recalls are monitored and communicated by the Clinical Compliance as applicable.

e. Safety Officers monitor the effectiveness of how all safety processes are carried out during site emergency response exercises and drills.

f. Data submitted and collected through routine monitoring and organizational incident reports within the organizational incident management system (Healthcare SafetyZone) is systematically reviewed by the Safety Specialist and EHS Committee to identify potential safety risks, evaluate and identify trends, and help guide corrective and preventive actions in response.

g. An annual Hazard Vulnerability Assessment (HVA) is completed by the Safety Specialist and EHS Committee to identify and validate areas of greatest risk and concern within the organization to ensure incorporation into the Environment of Care (EOC) Plan.

3. **Routine Performance Monitoring**

a. Safety Officer inspection reports are monitored by the Safety Specialist for completion.

b. Deficiencies noted during Safety Officer inspections are regularly reviewed by the Safety Specialist and corrective action plans are created as needed and monitored through resolution.

c. Other organizational incidents reported through the Healthcare SafetyZone portal are regularly reviewed by the Safety Specialist, Clinical Compliance Manager and other applicable departmental leaders, corrective action plans are created as needed and monitored through resolution

d. Safety suggestions entered by staff into the Healthcare SafetyZone portal are reviewed and addressed by the Safety Specialist as applicable.

4. **Identifying, Evaluating, and Managing General Safety Risks**

All LCHD/CHC staff are responsible for identifying potential safety risks or hazards and reporting them to their supervisor as well as reporting them in the Healthcare SafetyZone portal. The Safety Specialist, in conjunction with other members of the EHS Committee, and the Incident Review Committee, is responsible for identifying, evaluating, and managing safety risks through routine internal monitoring and EOC rounding.

5. **Procedure for Reporting and Investigating all Safety-Related Incidents, Injuries, and Near Misses (Incident Management).** The LCHD/CHC Incident Management protocols are as follows:

   a. **Reporting Timelines:** All safety incidents, injuries, and near misses must be reported to supervisors and documented in the Healthcare SafetyZone portal within 24 hours. Per OSHA requirements all eye injuries, amputations, and/or incidents that result in hospitalization must be reported within 8 hours to the Safety Specialist for mandated OSHA reporting within 24 hours.

   b. **Review & Analysis:** Incident reports are reviewed within 24 business hours, followed by a collaborative analysis between the Safety Specialist and array of program leadership to identify vulnerabilities and need for corrective actions.

   c. **Documentation:** All corrective actions and follow-up must be recorded within the Healthcare SafetyZone portal to maintain up-to-date accuracy and ensure accountability.

   d. **Continuous Improvement:** The Incident Review Committee evaluates trends quarterly and recommends process improvements to the EHS Committee to strengthen overall organizational safety and regulatory compliance.

6. **Process for Managing Product Safety Recalls.** The LCHD/CHC recall management protocols are organized as follows:

   a. **Alert Monitoring:** The Clinical Compliance Manager (CCM) maintains a subscription to FDA MedWatch to receive electronic notifications regarding recalls of drugs, supplements, and medical devices.

   b. **Collaborative Review:** Upon receiving an alert, the CCM coordinates with the Directors of Healthcare Operations, Behavioral Health, and Prevention, as well as Materials Management, to determine the impact on agency operations.

   c. **Site Audit & Remediation:** Affected program and clinical managers are responsible for auditing local inventory and following manufacturer directives for the prompt destruction or return of recalled products.

   d. **Compliance Documentation:** The CCM maintains a centralized file of all recall responses, product dispositions, and correspondence to ensure regulatory compliance and patient and client safety.

7. **Environmental Care Rounding (EOC Tours)**

   Managed by the Safety Specialist, LCHD/CHC conducts biannual multidisciplinary environment of care rounding tours to identify hazards and ensure regulatory compliance across all sites. These multidisciplinary inspections cover both patient/client and non-patient/client areas, with results reported to the EHS Committee to refine safety policies, training, and overall performance. Shared with leadership, these findings drive continuous improvement and risk mitigation throughout the agency's physical environment.

8. **No Smoking Policy**

To promote health and disease prevention, LCHD/CHC enforces a "No Smoking Policy" prohibiting tobacco and e-cigarettes in all facilities and vehicles for everyone on the premises. The only exception involves designated outdoor areas for specific residential or behavioral health clients, though these individuals are encouraged to join the LCHD/CHC Smoking Cessation Program.

B. Security Management Plan

The Security Management Plan establishes a unified approach to safeguarding LCHD/CHC facilities and ensuring a secure environment for patients, clients, staff, and visitors. As an integral component of the Environment of Care framework, it supports compliance with The Joint Commission standards while addressing risks through physical security measures, workplace violence prevention, access control, emergency response, and staff education and training. The primary goal is to reduce security risks through proactive assessment, clear policies, incident reporting, and collaboration with internal stakeholders and external partners, sustaining a safe environment for the delivery of high-quality healthcare.

1. **Annual Security Management Objectives (2026)**

Planned Performance Improvement Objectives
1. The Safety Specialist in conjunction with the Facilities Manager will develop and implement a quarterly duress button testing schedule for all programs with hard-wired and wearable devices to establish oversite of program compliance, device performance, and any applicable maintenance by April 1, 2026.
2. The Clinical Compliance Manager, in conjunction with members of the Emergency Communications Workgroup will meet with an Alertus consultant to evaluate LCHD/CHC's current emergency communication system capabilities and identify opportunities for enhanced emergency notification via integration of available Alertus technology and share findings with Executive Team by July 1, 2026.

2. **Routine Activities**

   a. Maintain education and training programs to teach staff the methods for eliminating security hazards and minimizing security risks within the workplace, how to respond to an emergency, and how to report security issues/concerns.

   b. All staff are provided with training on standardized emergency codes by the Safety Specialist at initial orientation.

   c. Access to security sensitive areas is restricted to those with necessity and controlled with badge access.

   d. Clear access for emergency vehicles is maintained near entrance areas.

   e. Staff are required to wear identification badges at all times within the facility.

f. Two patient/client identifiers are used during appointments to verify patient/client identity as well as the use of photo ID or picture entered into the electronic health record.

g. Staff are trained to report all security incidents using the Healthcare SafetyZone portal during initial onboarding.

3. Routine Performance Monitoring

a. Security Guards complete rounding of physical facilities and grounds during each shift which is monitored by Materials Management.

b. Spot checks are performed by Materials Management on security guard rounds to confirm their activity meets contractual objectives.

c. The Safety Specialist reviews all security incidents with the applicable program/department leadership and staff. Action plans are communicated as applicable and monitored to completion by the Safety Specialist in conjunction with applicable program/department leadership.

3. **Procedures for the Security of Patients, Clients, Staff, and Visitors within all Areas of the Facility.** LCHD/CHC facility security and patient safety protocols include:

a. **Access Control:** Access to sensitive locations, including medication rooms, utility closets, and medical records, is restricted through locked conditions and staff monitoring.

b. **Emergency Access:** All facility entrances must remain unobstructed to ensure immediate access for emergency vehicles.

c. **Identification Standards:** All staff are required to wear issued ID badges, while patient identity is verified using two unique identifiers and digital photography during registration.

d. **Security Services:** Materials Management is responsible for overseeing contracted security services at designated sites to enhance overall facility protection.

4. **Workplace Violence Prevention is an essential component of the Environment of Care and is integrated across all six EOC management plans.** The Joint Commission requires organizations to proactively:

a. Identify, assess, and mitigate risks related to workplace violence as part of environment of care standards and demonstrate leadership accountability for maintaining a culture of safety. This is demonstrated in our annual workplace violence program analysis (attachment 1).

b. LCHD/CHC incorporates workplace violence risk factors into routine safety rounds, incident reporting, annual hazard vulnerability assessments, and multidisciplinary EOC evaluations.

c. Data from the Healthcare SafetyZone portal, panic button assessments, security rounds, and staff feedback are analyzed to identify trends, guide mitigation strategies, and strengthen staff readiness.

d. Through coordinated efforts between Safety, Security, Clinical Compliance, Facilities, and program leadership, workplace violence prevention activities are embedded into the physical environment, staff training, emergency communication systems, and continuous performance improvement processes to ensure a safe environment for staff, patients, clients, and visitors.

5. **Plans for Managing Security Incidents Including Workplace Violence Incidents.** The LCHD/CHC security incident and workplace violence protocols are organized as follows:

a. **Reporting Requirements:** All security incidents involving patients, clients, staff, visitors, or property must be reported immediately to supervisors and documented in the Healthcare SafetyZone portal within 24 hours.

b. **Analysis & Oversight:** The Safety Specialist performs a collaborative analysis of reported incidents, specifically tracking workplace violence incidents to integrate findings into the Environment of Care Plan and provide annual report updates to the EHS Committee and Governing Council.

c. **Mandatory Training:** To proactively mitigate risk, all behavioral health personnel complete initial and annual workplace violence and de-escalation training.

d. **Continuous Improvement:** Data from security incidents and annual workplace violence analyses are used to identify patterns and implement preventive measures to ensure a safer environment across all facilities.

6. **Control of Access to Sensitive Areas.** The following areas have been identified as "sensitive" within LCHD/CHC, and they are equipped with work specific access control measures:

a. Mechanical Rooms

b. Medication Rooms

c. Utility Rooms

C. Fire Safety (Life Safety) Management

The LCHD/CHC Fire Safety Management Plan provides a comprehensive framework to mitigate fire risks and safeguard the well-being of all individuals across its facilities. Aligned with the organization's mission, the plan establishes standardized strategies for prevention and response in strict compliance with Life Safety Codes. These efforts are reinforced by site-specific Fire Response Plans within each location's Emergency Action Plan, ensuring immediate, coordinated action during emergencies to maintain a resilient environment of care.

1. **Annual Fire Safety (Life Safety) Management Objectives (2026)**

Planned Performance Improvement Objectives
1. The Safety Specialist in conjunction with the Manager of Facilities will complete an evacuation sign inventory at two designated LCHD/CHC sites per quarter to identify signage needs and plan for updates as needed.
2. The Safety Specialist in conjunction with the Manager of Facilities and Emergency Response Coordinator will resource and install RACE and PASS signage on or above all fire extinguisher cabinets and/or fire extinguishers and fire pulls to enhance staff fire safety readiness by December 31, 2026.

2. **Routine Activities**

   a. Provide training and education through both annual *Safety-First* training as well as through the Safety Officers to train staff on the methods for eliminating Fire safety hazards and minimizing risks within the workplace, how to respond to an emergency, and how to report Fire safety issues/concerns.

   b. Service and Inspect all fire safety equipment according to required frequency by a licensed fire safety vendor.

   c. Emergency and exit lights are assessed and tested by the Safety Officers monthly.

   d. Fire drills are performed, evaluated, and documented. Fire Drills held per National Fire Prevention Association (NFPA) Life Safety Code for both business occupancy and behavioral health residential settings.

3. **Routine Performance Monitoring**

   a. Fire safety equipment is inventoried on a routine basis by Facilities staff and by Safety Officers.

   b. Fire safety inspections are completed routinely by Safety Officers and annually by a licensed fire safety vendor and monitored by the Safety Specialist and the Manager of Facilities.

   c. Fire drill performance is monitored monthly by the Safety Specialist to ensure program compliance.

   d. Staff completion of *Safety-First* training is monitored during onboarding and annually by staff supervisors and learning and development.

4. **Adherence to Applicable Life Safety Code (LSC) Requirements.** The LCHD/CHC Life Safety and policy management protocols are organized as follows:

   a. **Inventory & Maintenance:** The Facility Manager maintains a comprehensive inventory of all life safety equipment, while Safety Officers conduct monthly inspections to ensure Life Safety Code compliance.

b. **Deficiency Management:** Fire safety deficiencies identified during inspections are submitted as Facilities work orders and reported within the Healthcare SafetyZone portal; the Safety Specialist tracks identified deficiencies in the Healthcare SafetyZone portal and collaborates with Facilities to ensure prompt corrective action is completed.

c. **Interim Life Safety Measures (ILSM):** During construction or system failures, the Facility Manager implements ILSM, which includes notifying the fire department and initiating a fire watch if sprinkler systems are out of service.

d. **Policy Development:** The Safety Specialist develops systemwide safety policies and works with department leadership to create targeted protocols for hazardous equipment and Personal Protective Equipment (PPE).

e. **Enforcement & Review:** All safety policies are reviewed at least every three years, or more frequently based on regulatory requirements, to ensure staff adherence and organizational readiness.

5. **Procedures for Fire Drills.** The LCHD/CHC fire drill and emergency preparedness protocols are organized as follows:

a. **Drill Frequency:** Fire drills are conducted biannually at all business occupancy facilities, including Federally Qualified Health Centers (FQHCs), with one drill occurring in each half of the calendar year.

b. **Residential Requirements:** For 24-hour residential programs, drills are performed bimonthly on every shift to ensure all staff and residents are prepared for fire emergencies.

c. **Documentation & Reporting:** Safety Officers must record all fire drills in the Healthcare SafetyZone portal, documenting staff response times, identified hazards, and need for corrective actions.

d. **Oversight:** Completed drill reports are submitted to the Safety Specialist via the Healthcare SafetyZone portal to facilitate performance reviews and ensure Life Safety Code compliance.

6. **Maintenance of Fire Alarm and Suppression Systems.** The LCHD/CHC fire protection and system maintenance protocols are organized as follows:

a. **System Maintenance & Testing:** The Facility Manager oversees the regular inspection, testing, and maintenance of all fire protection and suppression systems, including fire alarms, detection equipment, and fire suppression systems, to ensure Life Safety Code compliance.

b. **Safety Inspections:** Safety Officers perform monthly fire safety inspections at every site, documenting their findings within the Healthcare SafetyZone portal, while the Facilities Manager maintains all other preventive maintenance records.

c. **Environmental Controls:** All proposed acquisitions for furnishings, window treatments, and decorations are reviewed for fire safety to minimize combustible hazards within the facility.

d. **Emergency Planning:** The agency establishes comprehensive emergency procedures that address building-wide fire responses, area-specific needs, and clearly defined fire evacuation routes to protect patients, clients, staff, and visitors.

D. Hazardous Materials and Waste Management Plan

The LCHD/CHC Hazardous Materials and Waste Management Plan provides a systematic framework for the safe handling, storage, and disposal of hazardous substances in compliance with OSHA standards and The Joint Commission requirements. By integrating rigorous monitoring, staff training, and established safety protocols, the plan aims to mitigate risks to patients, clients, staff, and visitors while driving continuous performance improvement in the management of hazardous waste across all facilities.

1. **Annual Hazardous Waste Management Objectives (2026)**

Planned Performance Improvement Objectives
1. The Safety Specialist in conjunction with the Manager of Clinical Compliance will perform a comprehensive review of Stericycle contract services to include biohazard and pharmaceutical waste to verify service scope, performance, and regulatory alignment by July 1, 2026.
2. The Safety Specialist, in conjunction with the Clinical Compliance Manager and Learning and Development, will modify Safety First training to include updated biohazardous and pharmaceutical waste disposal education for clinical staff by October 31, 2026.

2. **Routine Activities**

a. Provide Safety-First training during initial orientation and annually which covers important aspects of hazardous materials and waste training such as the exposure control plan, use of spill kits to clean up chemical or bloodborne pathogen spills, hazard communication labeling, Safety Data Sheets (SDS) forms and regulated waste handling and disposal.

b. Maintain contract for handling and disposal of hazardous materials and waste including pharmaceutical waste, regulated bio-hazardous waste including sharps disposal, and infectious waste.

c. Routinely assess risk of hazardous materials and waste during environment of care rounding.

d. Routinely monitor Healthcare SafetyZone® portal for hazardous materials/waste spills and/or exposures.

e. Hazardous waste management manifests are maintained by program management at each site.

f. SDS system is monitored and maintained by the Safety Specialist in collaboration with Safety Officers and site leadership. All SDS are maintained and reviewed annually by Safety Officers.

3. **Routine Performance Monitoring**

a. The Healthcare SafetyZone portal is reviewed for reports related to hazardous materials and/or waste management issues by the Safety Specialist.

b. The Safety Specialist monitors staff ability to locate and utilize SDS and/or spill kits during routine environment of care rounding.

c. Staff completion of *Safety-First* training is monitored during onboarding and annually by staff supervisors and learning and development.

4. **Procedures for the Safe Handling, Storage, and Disposal of Hazardous Materials and Waste (e.g., chemicals, pharmaceuticals, biohazards).** The LCHD/CHC maintains strict compliance with OSHA regulations and CDC guidelines for the management of hazardous materials and waste through the following procedures:

a. **Sharps Management:** Contaminated sharps must be placed in wall-mounted or secured, puncture-resistant containers located at the point of use. Once the "full" line is reached, staff must wear gloves, lock the container, and place it in the designated biohazardous waste bin in the secured hazardous waste area for contractor pickup.

b. **Bio-hazardous Waste Handling:** Red bags are collected from exam rooms and placed in designated biohazardous waste bins in the secure hazardous waste area for contractor pickup.

c. **Documentation & Manifests:** All regulated waste removals must be documented with a signed manifest provided by the contractor. These records are maintained at the specific facility to ensure full regulatory traceability.

d. **Personal Protective Equipment (PPE):** Staff are required to wear appropriate PPE whenever handling potentially hazardous chemicals or bio-hazardous waste to prevent exposure and injury.

5. **Availability of Safety Data Sheets (SDS) and Maintenance of Hazardous Materials Inventory.** The LCHD/CHC ensures chemical safety and compliance with OSHA's Hazard Communication Standard and Illinois's "Right to Know" laws through the following protocols:

a. **SDS Access:** To ensure immediate availability, staff are provided with access to SDS binders and access to an online SDS inventory, which serves as the primary resource for ensuring the most accurate and up-to-date SDS is available.

b. **Mandatory Inventory Maintenance:** Site leadership in conjunction with program management are required to maintain and update a current, comprehensive inventory of all hazardous materials annually, or as changes occur, to ensure all substances are accounted for.

c. **Regulatory Labeling:** All workplace chemical containers including secondary containers must feature labels that clearly display product identity, hazard statements, and supplier information in accordance with OSHA's Hazard Communication Standard.

d. **Staff Education:** Employees are informed of their right to receive information about potentially hazardous chemicals during *"Safety First"* training and are given access to new SDS entries and inventory changes communicated through site leadership and program management.

E. Utility Systems Management Plan

The LCHD/CHC Utility Systems Management Plan provides a structured framework for the reliable operation of critical systems, including electrical power, water, ventilation, and medical gas. The plan establishes rigorous procedures for the regular maintenance, inspection, and testing of essential components—such as emergency power generators—to prevent failures and ensure organizational continuity. Additionally, the plan includes comprehensive protocols for managing emergency utility interruptions, integrating proactive risk assessments and industry best practices to safeguard patient care and maintain a resilient, secure healthcare environment.

1. **Annual Utility Systems Management Objectives (2026)**

Planned Performance Improvement Objectives
1. The Manager of Facilities will identify the location of all emergency gas and water shut-off valves and verify that all valves are appropriately labeled and documented within the Excel spreadsheet by May 1, 2026.

2. **Routine Activities**

a. Continual training of maintenance staff on the methods for eliminating hazards and minimizing risks related to utility systems within the workplace is conducted by the .

b. An annual inspection of utility systems is completed by the LCHD/CHC Facilities department in conjunction with licensed contractors.

c. Maintain contracts with utilities service providers.

d. Utility systems deficiencies are reported to and investigated by Facilities.

3. **Routine Performance Monitoring**

a. The Facilities Manager monitors preventative maintenance requests and completion trends.

b. Utility incidents are reported to the Environmental Health and Safety Committee.

4. **Procedures for the Operation of Utility Systems (e.g., electrical power, water, ventilation).** The LCHD/CHC utility management protocols under the Facilities Manager include:

   a. **System Oversight & Maintenance:** The Facilities Manager ensures that essential utilities, including electrical, HVAC, and emergency power systems are maintained in strict alignment with local and state regulations and The Joint Commission standards.

   b. **Risk Abatement:** All utility-related hazards are triaged and resolved based on severity and need, with interim safety measures implemented when immediate abatement is not possible.

   c. **Incident Investigation:** The Facilities Manager evaluates system failures and user errors to identify dangerous trends, utilizing equipment service reports and incident data to implement timely corrective actions.

   d. **Staff Education:** Facilities personnel collaborate with site leadership, Safety Officers, and the Safety Specialist to ensure staff understand the safe operation, risks, and emergency shutdown procedures for utilities in their specific work areas.

5. **Plans for Emergency Utility Interruptions.** The LCHD/CHC utility emergency and inventory protocols are organized as follows:

   a. **Emergency Response Planning:** The Facility Manager maintains and tests emergency response plans that identify alternate utility sources and outline specific procedures for system malfunctions and repair services.

   b. **System Inventory & Mapping:** An accurate inventory of all utility systems is maintained alongside detailed schematics that map layouts, technical controls, and procedures for partial or complete emergency shutdowns.

   c. **Site-Specific Resources:** Each facility is provided with an emergency information sheet identifying the locations of domestic water and gas shut-offs, emergency lighting, and communication systems, with all water and gas shut-offs clearly labeled for rapid identification.

   d. **Policy Distribution & Enforcement:** Systemwide utility policies are distributed to all staff, with site leadership and program managers responsible for enforcing safety protocols and ensuring personnel are notified immediately in the event of a system failure.

6. **Maintenance, Inspection, and Testing of Critical Components (e.g., emergency power generators).** The LCHD/CHC utility maintenance and readiness protocols include:

   a. **Operational Oversight:** The Facilities Manager ensures the reliability of critical utility systems through routine inspections, risk assessments, and mitigation

strategies aligned with local and state regulations and The Joint Commission standards.

b. **Maintenance Strategies:** The Facilities Manager employs a diversified approach to system reliability, including interval-based, predictive, metered, and corrective maintenance to prevent utility failures.

c. **Compliance & Documentation:** All testing and maintenance activities are documented to meet regulatory codes and facilitate audits, supporting continuous improvement and uninterrupted patient and client care.

d. **Staff Readiness:** The Facilities Manager oversees ongoing training to ensure maintenance staff are prepared to respond effectively to utility failures and maintain a safe environment.

F. Medical and Dental Equipment Management Plan

The LCHD/CHC Medical and Dental Equipment Plan ensures patient, client, staff, and visitor safety by maintaining a systematic inventory and service schedule for all medical and dental equipment and devices. By coordinating annual inspections with contracted vendors, the agency ensures all medical and dental equipment is properly tagged, calibrated, and serviced in alignment with The Joint Commission and HRSA standards. The Plan fosters a culture of operational efficiency and patient and client safety across all behavioral health and physical health medical and dental sites.

1. Annual Medical and Dental Equipment Management Objectives (2026)

Planned Performance Improvement Objectives
1. Monitor SharePoint sterilization logs for accuracy and increase the backlog completion rate from 76% to 100% to meet sterilization monitoring requirements as defined by Joint Commission standards by July 1, 2026.
2. The Associate Director of Dental will update sterilization training and work with the Learning and Development team to assign to all applicable dental and podiatry staff by July 1, 2026.
3. The Associate Director of Dental will work with the Lead Dental Assistant to update SensoScientific alarm protocols for managing temperature and humidity excursions ensuring alarms are confirmed in SensoScientific and incident reports are entered into HealthCare SafetyZone portal to ensure timely documentation of instrument integrity by July 1, 2026.

2. Routine Activities

a. Educate and train staff to identify, respond to, and report on medical/dental equipment safety concerns and failures.

b. Review new equipment manufacturers instructions for use (IFUs) to evaluate potential risk as well as safety and/or infection control implications for staff and/or patients/clients.

c. Respond to all medical/dental equipment and supply recalls and/or notices.

d. Contract with vendor to perform initial and routine preventive maintenance.

3. **Routine Performance Monitoring**

   a. Contracted preventive maintenance vendor reports are routinely monitored to ensure equipment checks are completed on time for the right equipment and to ensure failures and/or malfunctions have been corrected.

   b. Healthcare SafetyZone portal is routinely reviewed for equipment malfunction and failure incidents and used to identify trends and resolve equipment issues.

4. **Process for Managing Medical and Dental Equipment Risks and Equipment Inventory.** The LCHD/CHC Medical and Dental Equipment Plan prioritizes risk management and rigorous inventory control through the following protocols:

   a. **Risk-Based Acquisition:** The selection and purchase of equipment is managed through site leadership and program directors in coordination with applicable subject matter experts to evaluate instructions for use, identify physical risks, equipment function, as well as infection control and safety implications.

   b. **Mandatory Pre-Use Inventory and Maintenance:** New equipment and devices must be inventoried and undergo initial preventative maintenance by contracted biomedical vendor to ensure patient and client safety before initial use.

   c. **Centralized Inventory Management:** Materials Management maintains a comprehensive master list of all medical equipment, service contracts, and maintenance schedules, ensuring every item is properly tagged and traceable across all sites.

   d. **Safety Documentation:** Each site must maintain preventative maintenance records, equipment warranties, purchase orders, and staff competency training for all equipment to ensure safe and proper operation.

5. **Scheduled Testing, Inspection, and Maintenance Program (Preventive Maintenance).** The LCHD/CHC's scheduled testing, inspection, and maintenance program is based on risk levels and includes the following protocols:

   a. **Risk-Based Scheduling:** Equipment is inspected, tested, and maintained on an initial and annual basis or in accordance with manufacturer recommendations.

   b. **Vendor-Led Inspections:** Contracted vendors conduct all preventive maintenance and safety testing, applying tags to equipment and identifying non-compliant equipment to be removed from service.

   c. **Sterilizer Testing:** All sterilizers undergo daily spore testing, and daily, monthly, and annual maintenance as required by the manufacturer.

   d. **Documentation and Reporting:** Initial, annual, and as needed maintenance is recorded and copies are provided for site leadership. Findings are reported to the EHS Committee as well as organizational leadership.

e. **Incident Investigation & Disposal:** The agency investigates all equipment failures and user errors that could potentially affect the quality of patient and client care. Faulty equipment is removed immediately, and disposal is coordinated through the Materials Management department.

6. **Procedures for Responding to Equipment Failures and Recalls.** The LCHD/CHC maintains the following procedures for responding to equipment failures and recalls:

   a. **Incident Investigation:** All equipment failures and user errors must be reported through the Healthcare SafetyZone portal, and include the date, location, cause, and actions taken to resolution.

   b. **Immediate Removal:** Faulty or failing equipment must be immediately removed from service and clearly tagged to prevent further use. Site leadership is responsible for coordinating repairs with the manufacturer or securing new equipment.

   c. **Recall Response:** Upon notification of a recall, the affected device is removed from service, and site leadership or program management coordinates replacement or repair according to manufacturer directives.

   d. **Disposal Standards:** Equipment disposal is coordinated through Materials Management to ensure proper handling and must be officially documented on the site's inventory list to maintain regulatory traceability.

2025 Lake County Health Department
And Community Health Center
Workplace Violence Program Analysis
October 29, 2025

LCHD/CHC Workplace Violence Program Analysis

Background and Risk Factors

A. Background

Healthcare workers face a significant risk of job-related violence. The Joint Commission defines workplace violence as "an act or threat occurring at the workplace that can include any of the following: verbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying, sabotage, sexual harassment; or physical assaults involving staff, clients, or visitors."

According to the Bureau of Labor Statistics (BLS) over the 2021-2022 period, there were 57,610 nonfatal cases of workplace violence requiring days away from work, job restriction, or transfer. Of these cases, over 71% resulted in at least one day away from work with a median of 7 days away. Healthcare and social services experienced the highest counts and annualized incidence rates for workplace violence of any private industry sector over that two-year period. There were nearly 42,000 total nonfatal cases of workplace violence requiring days away from work, job restriction, or transfer in healthcare and social assistance programs over this time.

B. Risk Factors

Healthcare workers face an increased risk of work-related assaults resulting primarily from violent behavior of their patients, clients and/or residents. While no specific diagnosis or type of patient predicts future violence, epidemiological studies consistently demonstrate that inpatient and acute psychiatric services, geriatric long term care settings, high volume urban emergency departments and residential and day social services present the highest risks. Pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications and drugs, and disease progression can also cause agitation and violent behaviors. While the individual risk factors will vary, depending on the type and location of a healthcare setting, as well as the type of organization, some of the risk factors include:

1. *General Client and Setting-Related Risk Factors*

a. Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients or clients;

b. Transporting clients;

c. Working alone in a facility or in clients' homes;

d. Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;

e. Poorly lit corridors, rooms, parking lots and other areas;

f. Lack of means of emergency communication;

g. Prevalence of firearms, knives and other weapons among patients and their families and friends; and

h. Working in neighborhoods with high crime rates.

2. *General Organizational Risk Factors*

a. Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from clients, visitors, or staff;

b. Working when understaffed, especially during mealtimes and visiting hours;

c. High worker turnover;

d. Inadequate security and mental health personnel on site;

e. Long waits for clients and overcrowded, uncomfortable waiting rooms;

f. Unrestricted movement of the public in clinics; and

g. Perception that violence is tolerated, and victims will not be able to report the incident to police and/or press charges.

Lake County Health Department and Community Health Center (LCHD/CHC) Workplace Violence Prevention Program

A. The organization has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following *(LD.03.01.01 EP 9)*:

1. Policies and procedures to prevent and respond to workplace violence.

2. A process to report incidents, and to analyze incidents and trends.

3. A process for follow-up and support for victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary.

4. Reporting of workplace violence incidents to governance.

B. LCHD/CHC has established a workplace violence prevention program led by the Occupational Health and Employee Safety Specialist. Elements of the prevention program include:

1. Workplace Violence Prevention Policy that defines workplace violence, outlines the roles and responsibilities of all parties, training requirements, documentation, and how the organization works to prevent and respond to workplace violence.

2. A process for reporting incidents and documenting follow-up in the HealthCare SafetyZone Portal.

3. A process for investigating and analyzing incidents and trends through the Incident Review Committee and an annual review by the Accreditation Regulatory Specialist.

4. A process that is defined in the policy for following up with and supporting anyone affected by workplace violence.

5. A process that is defined in the policy for reporting workplace violence incidents to governance, the Lake County Governing Council.

6. Additionally, a Culture of Safety survey is administered to all staff biannually to assess staff perception of workplace safety and identify areas for improvement. There is also a question on the client satisfaction survey asking for their feedback on the safety of LCHD facilities.

LCHD/CHC Annual Worksite Analysis

A. The organization conducts an annual worksite analysis related to its workplace violence prevention program. The organization takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. (EC.02.01.01 EP 17)

B. A worksite analysis includes a proactive analysis of the worksite, an investigation of the organization's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

1. **Investigation of workplace violence incidents at LCHD/CHC.**

   a. In 2024 there were 18 incidents entered into HealthCare SafetyZone as workplace violence.

   b. A review of the details of these incidents revealed that 10 of them were in line with the definition, but the other 8 did not meet the criteria for workplace violence.

   c. There were another 18 incidents categorized as client behavior that were determined to meet the criteria.

   d. Thus, there were a total of 28 workplace violence incidents reported for the year. 25 of the 28 incidents were verbal and 3 contained some element of physical threat or contact with the victim.

2. **Analysis of policies and procedures, training, and education at LCHD/CHC.**

   a. The Workplace Violence Prevention policy was reviewed and revised in 2025 to better reflect the Joint Commission standards, applicable laws, and regulations.

b. The Clinical Compliance team worked with the Clinical Education and Training department to incorporate workplace violence topics into the Safety First training that is required for all staff upon hire and annually thereafter.

c. Additional Crisis Prevention Institute (CPI) trainers were recruited to accommodate the training needs of staff for de-escalation, nonphysical intervention skills, physical intervention techniques and response to emergency incidents. These classes are scheduled at various times to allow staff to attend.

d. Signage was provided to all locations describing workplace violence and informing all parties that it is strictly forbidden at the Lake County Health Department (LCHD).

3. **Monitoring, reporting, and investigating workplace violence incidents at LCHD/CHC.**

The organization develops and implements a process(es) for continually monitoring, internally reporting, and investigating Safety and security incidents involving individuals served, staff, or others in locations it controls, including those related to workplace violence. (EC.04.01.01 EP 1)

a. All safety and security incidents are reported in the *HealthCare SafetyZone* Portal by any organizational employee. Notifications are automatically distributed to management and other relevant personnel for investigation and follow-up. Additional documentation regarding the resolution of incidents is also entered.

b. The Incident Review Committee meets monthly to review these incidents and identify outstanding issues for follow-up, make recommendations to reduce the likelihood of reoccurrence, and evaluate the effectiveness of mitigation strategies.

c. The Accreditation Regulatory Specialist reviews all reported incidents annually to ensure proper categorization of incidents, including those that might have been labeled as something other than workplace violence, but actually meet the definition.

4. **Workplace Violence Program training, education, and resources at LCHD/CHC.**

As part of its workplace violence prevention program, the organization provides training, education, and resources (at time of hire, annually, and when changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The organization determines what aspects of training are appropriate for individuals based on their roles and responsibilities. (HRM.01.05.01 EP 17)

a. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:

   1. What constitutes workplace violence.

   2. Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement.

   3. Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents.

    4. The reporting process for workplace violence incidents.

   b. Workplace Violence training is provided within 30 days of hire to all new employees, annually and whenever there are changes to the Workplace Violence program as part of the Safety-First training module in the organization's on-line training system. The following information is provided in that training module:

    1. Workplace Violence Definition.

    2. The roles of staff, Human Resources, the Occupational Health and Employee Safety Specialist, program leadership, agency employees, security guards, and external law enforcement.

    3. The procedure for reporting incidents in HealthCare SafetyZone.

    4. A general overview of the Workplace Violence program.

    5. The process for analyzing and investigating Workplace Violence incidents.

    6. Annual reporting to governance.

   c. Training in de-escalation, nonphysical intervention skills, physical intervention techniques and response to emergency incidents is provided to staff per agency policy and Crisis Prevention Institute (CPI) protocols.

5. LCHD/CHC Specific Personnel and Environmental Safety Measures to Mitigate Workplace Violence Risks.

   a. Well-lit waiting rooms and client care areas.

   b. Fire exits and escape routes are clearly marked.

   c. Emergency lighting is tested monthly .

   d. Medication, equipment and supplies are secured.

   e. Furniture in client care areas and waiting rooms is arranged to prevent employees from being trapped.

   f. Broken windows, doors, locks, and lights are replaced promptly.

   g. Security alarms and devices are tested regularly.

   h. Video cameras in some residential facilities.

   i. Keyless door systems for client care and staff office areas.

   j. Wearable panic buttons.

   k. Hard-wired panic buttons in offices.

   l. Alertus mass notification desktop alerting software.

   m. Security guards available for staff support.

   n. Alert Media app for staff working in the community and seeing clients in their home.

   o. Staff identification badges.

p. Signage placed in all locations strictly forbidding workplace violence.

Summary

LCHD/CHC has implemented a comprehensive Workplace Violence Prevention Program led by a multidisciplinary team and the Occupational Health and Employee Safety Specialist. This program centers on a robust reporting process via the HealthCare SafetyZone Portal, with mandatory training for all staff upon hire and annually thereafter. The initiative includes specialized Crisis Prevention Institute (CPI) training for de-escalation, regular worksite analyses to mitigate risks, and a structured system for incident investigation and annual reporting to the Lake County Governing Council.

In 2024, the department identified 28 total workplace violence incidents, the vast majority of which were verbal. To address these risks, LCHD/CHC utilizes a blend of personnel and environmental safety measures, such as keyless entry systems, wearable panic buttons, the Alert Media app for community-based staff, and security guards. The department maintains a proactive "Culture of Safety" by reviewing policies, surveying staff perception biannually, and providing psychological support for victims to ensure compliance with Joint Commission standards.